Improving Health Equity Through the Integration of Mental Health Services Within Primary Care

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This commentary demonstrates how the integration of mental health services within primary care aligns with calls for improving health equity and access within the health care system.[1] By recognizing the advantages of a range of integrated care models within primary care, clinicians, health care administrators, and policymakers can advocate for the model within their systems not just to improve health and wellness outcomes, but also to improve opportunities for all individuals – particularly those from minoritized groups – to access quality, whole-person health care.

Disparities in accessing quality mental health care among minoritized groups and individuals living in poverty is a widespread problem. For instance, data from the National Health Interview Survey in 2021 found that around 30.4% of White adults received mental health treatment within the past year, compared to 14.8% of Black, 12.8% of Hispanic, and 10.8% of Asian adults.[2] Further, geographic data across the United States demonstrate that communities within the lowest income quartile are less likely than those within the highest income quartile to have access to a physician mental health specialist (8% vs 25.3%), a nonphysician mental health professional (12.9% vs 35.1%), and any community-based mental health treatment resource (23.1% vs 42.5%).[3] A variety of structural and perceptual barriers may affect access to quality mental health care. Structural barriers include lack of insurance status or limited financial resources, while perceptual barriers could include stigma or lack of trust with the health care system.[4] Relatedly, experiences of discrimination or racism also affect willingness to continue with care in communities of color.[5]

Delaying or failing to access timely, quality mental health care can lead to chronic mental health problems and impaired functioning. Lack of access to mental health treatment in minoritized communities also is associated with lack of access to health care in general and poorer health outcomes.[6] For instance, Black and Brown communities have higher rates of chronic illnesses, such as obesity, diabetes, and hypertension, and are less likely to receive needed care for these conditions.[6,7] Psychosocial factors, such as untreated depression, can affect health, including attendance at appointments and follow-through with a medical regimen, while impaired health status can further exacerbate one's health problems. In other words, mental health disparities are associated – and often exacerbate – other health disparities and vice versa.

> Integrated care increases access to services and improves patient outcomes, improves primary care clinicians' efficiency and self-reported competency and satisfaction with care delivery, and increases follow-up with mental health referrals.

Primary care may be the ideal setting to address these mental health and health disparities. Mental health care is considered specialty (secondary) care and is, by definition, less accessible. Workforce shortages of psychiatrists and psychologists – particularly in rural medically underserved areas – create long waitlists for specialty mental health care in the community.[8] As a result, primary care physicians are often the first professionals that individuals go to in order to discuss mental health problems and provide most mental health care.[9,10] For the patient, there may be comfort in discussing concerns with a provider they have seen previously.

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It is also convenient and does not require a referral or transfer of care to an unfamiliar clinic or provider. As the first point of care for most in the health system, primary care clinics may be well-positioned to improve access to mental health care for underserved communities.

Despite its promise, there are many barriers to primary care clinicians addressing mental health problems in primary care.[9,10] These barriers include a lack of collaborative infrastructure (eg, shared electronic medical record, shared space, curbside consults, warm hand-offs) to address mental health needs in a way that is effective and coordinated with mental health clinicians. They also include a lack of time in addressing mental health concerns, as typical reimbursement systems do not incentivize assessment or treatment. Further, if needs do arise that necessitate further treatment or consultation, some practices may not have systems in place to facilitate referrals to specialized care and, thus, many individuals do not receive the level of care that is necessary.

Fortunately, there are a range of models that integrate mental health clinician services in primary care, spanning from offsite coordinated care to onsite collaborative care and integrated care. Coordinated care models use offsite psychiatrists to provide training and case-based consultation to increase the knowledge, skills, and confidence of primary care clinicians around mental health (eg, Massachusetts Child Psychiatry Access Project [MCPAP]).[11] Collaborative care models collaborate in patient care onsite by screening for a specific, high-frequency condition (eg, depression, attention deficit hyperactivity disorder) and engaging in a protocol-driven decision process that may include onsite or coordinated mental health services using care managers and offsite psychiatric consultation (eg, Reaching Out to Adolescents in Distress [ROAD], Improving Mood-Promoting Access to Collaborative Treatment [IMPACT]).[12,13] Integrated care models embed mental health clinicians onsite for shared patient care that may include same-day access, joint treatment plans, and shared real-time collaboration with primary care clinicians.[14]

Integrated care increases access to services and improves patient outcomes, improves primary care clinicians' efficiency and self-reported competency and satisfaction with care delivery, and increases follow-up with mental health referrals.[15,16] These models also improve equity in access and outcomes since receiving mental health care where patients receive their physical health care is less stigmatizing and more comfortable, particularly for Black and Brown patients who face the greatest disparities in mental health access.[1,17-18] Mental health in primary care also improves overall health and health disparities.[19,20] Addressing mental health and psychosocial factors that affect chronic health conditions, such as asthma, diabetes, and obesity, has enormous potential to improve physical health and wellness and reduce unnecessary medical procedures, hospitalizations, and emergency department visits.[1,19]

The sustained and widespread implementation of models that integrate mental health in primary care to improve health equity will require transformations in practice, policy, and payment. Health insurer reimbursement must account for the downstream cost savings that results from reduction of unnecessary medical procedures, hospitalizations, and emergency department visits when patients receive high-quality and whole-person primary care that addresses mental health and physical health needs proactively in primary care.[21,22] This cost savings can be reinvested in paying for upfront costs of hiring and training mental health clinicians and other primary care team members (eg, care managers, social workers, system navigators, health educators) and covering annual physical health and mental health wellness check-ups, including mental health screening in primary care.

Moving forward it will be important to increase the accessibility of the integrated primary care model. Evaluations show that the model can yield improved care outcomes and cost savings, while reducing ethnic/racial disparities in care.[9] The integration of mental health services within primary care faces a number of implementation challenges, such as reimbursement, confidentiality rules for mental health, limited capacity, and resistance to change.[23] We must have a call to action to continue to advance this model given its potential to improve not only health and wellness outcomes, but also health equity.

Funding/Support: None declared.

Financial Disclosures: None declared.

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Do Internal Medicine Advanced Practice Providers Perceive a Benefit in Mentorship?

Dear Editor:

Mentorship programs across medicine have shown multiple benefits, including increased professional satisfaction and retention, participation in academic scholarship, and development of leadership skills.[1] Historically, opportunities for advancement to faculty positions within academic institutions have not existed for advanced practice providers (APPs); however, the Medical College of Wisconsin (MCW) is changing that. Faculty promotion typically requires involvement in scholarly work, research, and education. APP education models focus on clinical knowledge and work, offering limited exposure to research and publication, with the goal of filling clinical shortages. Therefore, APPs rarely participate in academic scholarship early in their careers.[2] Recent studies show the first 3 to 5 years of an academic provider's career are the most important in developing research and publishing skills, because after that time, they are often recruited by other nonacademic organizations.[3]

In January 2023, an anonymous Qualtrics survey was sent to all 61 APPs in the Division of General Internal Medicine at MCW to assess their perception of mentorship among general internal medicine APPs. A total of 50 APPs completed the survey, with a response rate of 81% (64% hospitalists, 14% primary care, 14% perioperative medicine, and 8% observation unit). Ninety percent of respondents were female, and 62% had less than 5 years of experience as an APP. About 90% of APPs said mentorship was important, and of those who have had a mentor, 74% reported finding it beneficial. Perceived benefits of mentorship included advancing clinical knowledge, gaining skills for precepting students, and building your CV for career advancement and leadership opportunities. Perceived barriers to mentorship included time constraints, mentor availability, and lack of structured mentorship program. Regarding structure preference in a mentorship program, 74% of APPs prefer a mentor from the same section; and 26% prefer APP to APP, 20% prefer MD to APP, and 26% prefer mixed APP and MD to APP, depending on career interests.

Based on the interest and perceived benefits, our division is developing a mentor program for APPs. Participation will be optional, and pairing mentors and mentees will be aligned with career interests. Our future work will be focused on evaluating the effectiveness of this formal program. This mentorship model might encourage other institutions to implement similar programs to support APP career development and advancement.

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Funding/Support: None declared.

Financial Disclosures: None declared.

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