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ORIGINAL PAPER

Recommendations for Primary Care Provided by Psychiatrists

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Abstract Recent studies have shown that people with severe mental illness have a dramatically lower life expectancy than the general population. Psychiatrists have not traditionally been very attentive to or involved with physical health issues and there has been growing emphasis on integrated care for physical and mental health and access to primary care for all members of the population. This paper examines the role of psychiatrists in the provision of primary care to the patients they treat. Some recommendations are offered for their involvement in the provision of primary care at three levels of complexity: Level 1—Universal Basic Psychiatric Primary Care; Level 2—Enhanced Psychiatric Primary Care; and Level 3—Fully Integrated Primary Care and Psychiatric Management. Some of the obstacles to the provision of primary care by psychiatrists are considered along with some suggestions for overcoming them.

Keywords Integrated care · Primary care psychiatry · Health disparities · Psychiatric training curricula

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Introduction

In recent years there has been growing recognition of the importance of consolidating and coordinating care among providers of mental health and primary care services (Butler et al. 2008). Integrated care allows early identification, intervention and treatment of psychiatric illnesses that may complicate comorbid physical health problems (Kates et al. 1987). The subspecialties of consultation-liaison and geriatric psychiatry have traditionally worked at the interface of somatic and behavioral medicine, but this has not generally been the case for the rest of psychiatry. Nonetheless, there is significant evidence which shows that both general and child and adolescent psychiatrists embedded in primary care settings can address mental health conditions more effectively, with improved health outcomes overall, than traditional approaches (Hunter and Goodie 2010). People with less severe mental illness are often reluctant to identify themselves as "mentally ill" and are unwilling to visit a mental health clinic (Katon et al. 2010). One example, where early intervention in primary care settings may improve outcomes, is depression in patients with coronary artery disease. These co-occurring illnesses are associated with increased morbidity and mortality (Whooley 2006; Woltmann et al. 2012). Several models have been developed to provide behavioral health management in primary care settings, either through additional psychiatric consultation or direct (co-located) psychiatric care (Collins et al. 2010; Pomerantz and Sayers 2010).

While much of the literature has described integrating mental health services into primary care settings, patients with severe psychiatric illness may benefit more from addressing medical/somatic issues within behavioral health settings. Individuals with severe mental illness experience

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morbidity and mortality to a disproportionate degree compared to the general population and appear to have a life expectancy of up to 25 years less than their counterparts in the general population (Pollack et al. 2012). Limited access to primary care may contribute to this disparity.

Among individuals with psychiatric illness, access to high quality primary care may be compromised by stigma, ineffective communication, poor social skills, lack of rapport, perceived lack of credibility, and system complexity and hostility (Hert et al. 2011). Other risk factors for poor health outcomes in this population include comorbid drug and alcohol use, tobacco use, poor nutrition, lack of exercise, poverty, stress and side effects (such as weight gain) associated with many psychiatric medications (Phelan et al. 2001). Understanding and using the complex system of providers is often daunting. It is not hard to imagine that this fragmentation and discontinuity is especially difficult for people with mental illness to navigate. People with more severe mental illness, often feel intimidated and unwelcome in primary care settings (Miller et al. 2003).

There is significant data supporting the greater effectiveness of primary care provided within mental health clinics for this population (Druss et al. 2001; Druss and Mauer 2010). Several different approaches have been used to accomplish this, varying from having primary care clinicians embedded within a mental health clinic (Miller et al. 2003), to primary care being provided in an adjacent clinic specifically dedicated to the care of people with severe mental illness (Dougherty et al. 1996). Both arrangements feature opportunities for ample communication between providers (Cerimele and Strain 2010) and models emphasize close collaboration. In these models, psychiatrists are generally not involved in the provision of primary care.

Unfortunately, widespread access to this kind of collaborative care is not available for most patients with severe mental illness. With the emerging awareness that persons with mental illness have a considerably shorter life expectancy than persons in the general population, the role of psychiatry in addressing physical health issues has come under new and greater scrutiny (Parks 2007; Golomb et al. 2000). Can more attention to physical health issues by all psychiatrists decrease this disparity (Zivin et al. 2010)?

It is not unusual for primary care physicians to provide some basic level of psychiatric care (such as prescribing antidepressants) for patients who might not otherwise seek mental health services. However, psychiatrists have generally not been called upon to provide basic primary care services for patients seen in mental health settings. Should psychiatrists be involved in the provision of some level of primary care services, and if so, when and under what circumstances? Are there certain circumstances in which a psychiatrist's ability to provide some direct primary care interventions could counteract some of the obstacles to accessing care by patients with mental illness?

Although the answers to these questions will require systematic study, we present here some recommendations for primary care treatment by psychiatrists across varying levels of complexity (levels 1–3). At each level we identify potential roles of the psychiatrist in physical health assessment, promotion, monitoring, and provision and coordination of care (Table 1). We then delineate various elements required for psychiatrists to be able to deliver such care (Table 2) and discuss some of the potential challenges of implementing such services.

Primary Care in Psychiatry by Varying Levels of Complexity

Level One: Universal Basic Psychiatric Primary Care

It seems reasonable that all psychiatrists should monitor the physical aspects of their patients' health concurrently while providing behavioral health assessment and treatment. Psychiatrists must consider how physical illness and pain may impact an individual's mental health as well as the impact of mental illness on physical health and substance use (Marder et al. 2004). They must be vigilant in assessing the impact of medications on an individual's health and well-being, as medication regimens become ever more complex (Sani 2006). In addition, prevention and health maintenance must be emphasized in psychiatric practice in order to reduce the disparity in the health status between people with mental illness and that of the general population. As outlined in Table 1, we envision that all psychiatrists should play a role in assessing physical health needs of patients and promoting wellness. The following practices are suggested as a baseline for psychiatrists to achieve these ends:

1. Assessment of Physical Health and Medical Needs
    - Identify any currently treated health issues through communication with client and primary care providers (PCPs)
    - Perform a basic review of systems to identify any health issues or current symptoms that have not been addressed by client or other providers
    - Assess current medications, their possible side effects, interactions, and the client's attitude and adherence in using them.
    - Identify any health concerns, including pain issues that could potentially impact a client's health status.

Table 1 Varying levels of medical services provided within behavioral health settings progressing from more basic screening and monitoring to fully integrated services

Clinic setting	Provision of primary medical care within behavioral health care setting	Relationship to primary care provider
Level 1		
All psychiatrists, including solo practitioners (with or without treatment team or support staff)	Assessment of basic medical needs (active medical issues medications, etc.) Health promotion (exercise, diet, tobacco cessation) Health monitoring (vital signs, weight, blood chemistries, etc.)	Coordination and communication with outside primary care physician (PCP)
Level 2		
Community based care with some treatment team or support staff available	Health promotion, screening and monitoring (as in Level 1) Basic laboratory assessments Unobtrusive physical examinations as required Management of uncomplicated physical conditions (i.e. hypertension) by psychiatrist	Supervision and consultation with PCP with referral for more complicated medical issues
Level 3		
Integrated primary care and behavior health clinic settings with support staff	Health promotion, screening and monitoring (as in Level 1) Full primary care services	Integrated treatment team (behavioral health and primary care clinicians)

Table 2 Elements required to establish multi-level competence in primary care delivered by a psychiatrist

Preparation and training	Infrastructure or facility needs	Target populations	Financing of services
Level 1			
Longitudinal community based primary care experience	No special accommodations needed	All individuals seeking treatment	Minimal accommodations needed; can be incorporated into any practice
Level 2			
As above plus ongoing continuing medical education in primary care	Basic equipment and facility to accommodate primary care activities	Individuals who are unable to meet with a primary care physician	Global funding, Accountable Care Organization. health homes, integrated funding arrangements
Level 3			
Dual training in a primary care specialty and psychiatry	Fully equipped primary care clinic	Individuals with multi, co-occuring chronic disorders	Qualified billing through FFS in primary care and behavioral health settings, other global funding arrangements

- Determine whether there are unmet medical needs and make arrangements for them to be addressed accordingly.

2. Health Indicator Monitoring

- Perform periodic and longitudinal monitoring of physical health indicators such as vital signs, weight, height, body mass index (BMI), waist circumference.
- Observe and document abnormal physical characteristics related to skin or hair conditions, posture and gait, movements, respiration, malformation of limbs or digits, substance use stigmata, etc.
- Obtain periodic laboratory examinations as appropriate; i.e. metabolic indicators such as a lipid profile, fasting blood sugar, thyroid function tests, liver function tests, renal function, etc. The selection of tests and their frequency will be determined

by the specific circumstances of the client and evidence based guidelines
- Encourage screening and vaccination: Verify clients are aware of and participate in screening and vaccination recommendations

3. Health Promotion

- Discuss lifestyle decisions impacting health including exercise, diet, substance use (including tobacco) and sexual practices (NYS Center of Excellence for Cultural Competence 2010).
- Discuss coping mechanisms and their effectiveness
- Provide information about health risks associated with various lifestyle choices
- Discuss exercise, diet, and recreational activities and encourage healthy choices.
- Attend to dental hygiene and oral health
- Provide information on sleep hygiene
- Encourage self-examination
- Encourage engagement in smoking cessation, mutual support, self-help and recreational programs

4. Coordination with Primary Care

- Obtain information about client's association with primary care and permission (although permission is not necessarily required) to contact primary care provider
- Encourage regular contact with primary care provider (Strathdee 1987; Kisely et al. 2006)
- Communicate with primary care provider about unresolved health concerns (i.e. medication interactions or side effects, undisclosed health issues, treatment plan adherence, abnormal results of health status monitoring, etc.)
- Determine the most effective method for communication with PCP, developing a process to facilitate this interaction (Pincus 1987; Tanielian et al. 2000)
- Assist in the engagement of a PCP for clients who do not have one.

Level Two: Enhanced Psychiatric Primary Care

Although most psychiatrists have had limited primary care training beyond medical school, most should maintain minimal competence in managing common uncomplicated medical conditions. In most cases psychiatrists are not the ideal provider to manage a client's primary care needs, but in many cases they will be all that is available or acceptable. Various situations may require psychiatrists to take on the functions of a primary care provider when clients cannot or will not accept the services of another provider. While the need for psychiatrist to take on primary care management will usually be transient, there may be some situations in which a primary care role must be taken on for an indefinite period of time.

Examples of situations that could require a psychiatrist to assume the role of primary care provider include caring for a client who refuses to see a primary care physician, someone who has been homeless or frightened by social interaction, or a person whose illness makes them mistrustful of other providers (Mercer et al. 2012). Persons who are itinerant or homeless will often need primary care but not be motivated to obtain services independently. In these instances and many others, it is the psychiatrist's responsibility to provide basic primary care (up to the limit of their competence) until other arrangements can be made. Psychiatrists who frequently encounter people of this type should obtain continuing education related to primary care to keep their skills sharp (Golomb et al. 2000). They should consult primary care physicians as needed for supervision and support, with the goal to transition ongoing care to a primary care provider as soon as possible.

As outlined in Table 1, in order to provide this level of care, psychiatrists should provide all of the routine health monitoring and wellness promotion described in level one in addition to performing the following functions:

1. Identification and Management of Uncomplicated Physical Conditions

- Hypertension
- Dyslipidemias
- Gastro-esophogeal reflux
- Musculo-skeletal and non-narcotic pain management
- Non-insulin dependent diabetes
- Upper respiratory infections
- Urinary tract infections
- Asthma/chronic bronchitis
- Minor skin diseases
- Thyroid disorders
- Medication assisted tobacco cessation
- Other minor illnesses or conditions

2. Order and Interpret Basic Laboratory Examinations as indicated

- CBC
- Basic blood chemistry panel
- FBS and Hgb A1c
- Liver function tests
- Lipid Panel
- Thyroid Function
- Screening for infectious diseases (i.e. HCV, HIV, and HBV)
- Other exams as indicated and accepted

3. Unobtrusive physical examination as required. Perform basic exams which do not require removal of clothing.
    - Auscultation of heart and lungs
    - Percussion of chest and abdomen
    - Palpation of abdomen for abnormal masses
    - Examination of skin and scalp
    - Basic neurologic exam
4. Support, supervision and collaboration with/from other providers
    - Ensure availability of consultation and assistance from a PCP
    - Engage treatment team (nurse practitioner, physician assistant, case managers, social work) when possible, to assist in maintaining client health
    - Identify non-threatening, welcoming health centers which will assist in engaging clients in traditional primary care setting
    - Transition to sympathetic primary care experience as soon as possible
    - Verify that health maintenance procedures (i.e. colonoscopy, mammography) are current

Level Three: Fully Integrated Primary Care and Psychiatric Management

One provider who can provide comprehensive care for both physical and behavioral health needs is what we would intuitively think of as an ideal model of care. Although there are many psychiatrists who are dually trained in primary care and psychiatry, there have been few opportunities for them to have a holistic practice. This level of care (as outlined in Table 1) would be particularly advantageous in the care of persons with severe mental illnesses who feel uncomfortable in settings that are designed primarily for physical health care. It would be equally important to offer if this care to persons with chronic physical health issues who may feel uncomfortable in behavioral health care settings. Many people with less extreme health issues might also prefer a physician who is capable of addressing all their needs, but demand will likely be much greater than supply for some time to come for these comprehensive care specialists. To create more opportunities to provide this care, systems will need to develop methods to make it more practical (i.e. health homes, financial incentives; see Table 2).

Ideally, care provided by dually trained physicians should take place in the context of a fully integrated treatment team (with physician assistants, nurse practitioners, social workers, case managers, and peer professionals) (Vreeland 2007). In some cases it may feel uncomfortable for patients to confide significant emotional issues to the same MD that performs an in depth physical examination. In cases such as these, it may be important for the physician to be able to delegate some aspects of care to other team members when possible.

Dually trained physicians should be able to assume all aspects of primary care in addition to psychiatric expertise:

1. Complete history and review of systems
2. Conduct comprehensive physical examinations
3. Use of full diagnostic and screening technology (as appropriate)
4. Complete screening and health maintenance activities
5. Refer to and coordinate care with other providers as needed
6. Work in the context of a fully equipped clinical facility (Gyne, Lab, Exam Tables, etc.)

Challenges to the Provision of Primary Care by Psychiatrists

In this period of systems transformation, psychiatrists are being challenged in a number of ways to expand the scope of their practice. The recovery paradigm for the clinical interaction has been given a great deal of attention and calls for psychiatrists to enhance their relationships and collaboration with their clients. Another aspect of the recovery model is a focus on health and wellness to enable people with behavioral health issues to be most successful in their quest to establish a full and satisfying life. Even though these enhancements to traditional practice are being suggested, many psychiatrists are already reeling from what they perceive to be unreasonable expectations for what they can accomplish in the limited time they have to provide care for their patients. There are a variety of other reasons why these recommendations, no matter how reasonable in theory, may not be accepted and implemented easily (Phelan et al. 2001). There are a variety of issues that need to be addressed in order to move this process forward (see Table 2).

Preparation

Most psychiatrists are ill equipped and reluctant to provide even simple care for physical health issues of their clients. For most practicing psychiatrists, training in providing physical health care ended in their first year of residency. Most often this training has been carried out in acute care medical units as part of hospital based "internships" which have had limited relevance to the provision of primary care and health promotion (Shore 1996). This aspect of the curricula for psychiatrists primarily serves the interests of training programs and affiliated hospitals rather than those

of the populations being served, and because of this, it is likely there will be significant resistance to change.

Psychiatry training programs must increase emphasis on physical health care with increased outpatient training, particularly for trainees who anticipate a community based practice for their careers. Opportunities to manage both physical health and behavioral health issues for selected patients should continue through the training years. In order to offer an adequate amount level 3 care, the number of combined training programs would need to be increased, and those programs must include experience in comprehensive management of physical and behavioral issues. Ironically, although some programs exist that provide dual training, few opportunities exist for those who are trained to actually provide fully integrated care.

Even if the recommended changes in the training paradigm were accomplished, it would take some time before they could have a significant impact on standard practice. Most psychiatrists who have been in practice for several years are far removed from any type of physical health care and feel incompetent to provide it. It will be critical to develop extensive CME opportunities and possibly mandatory requirements for license renewal or maintenance of certification to accelerate the process of change.

The Therapeutic Relationship

Some people have argued that spending a significant amount of time addressing physical health issues will not only subtract from the time they have to spend treating behavioral health problems, but will also detract from the quality of the therapeutic relationship they can establish with their clients. There are also those who are especially wary of physical contact with their clients and the possibility that it could be threatening or misinterpreted. While these may be legitimate concerns in certain circumstances, in most cases the psychiatrist's holistic concerns are likely to be interpreted positively, as an indication of caring, more than a narrow focus on symptoms and medication. When physical examination is indicated, misunderstanding and offensiveness can usually be avoided with careful explanation and by obtaining permission before proceeding. It is obviously important to be sensitive to a client's level of comfort and understanding when providing primary care.

Liability

Fear of liability for problems that might arise that were undetected, undertreated, or even mistreated has often been cited as a reason for psychiatrists to avoid involvement in primary care activities. Fear of litigation has been a by-product of our health system. Although this is often a legitimate fear, its grip has extended itself beyond the realm of reasonable possibility to areas in which it is completely unwarranted. Risks associated with providing the types of care outlined in Levels 1 and 2 above are practically negligible. People are much less likely to become litigious toward doctors they know and trust, even if obvious mistakes are made. As long as psychiatrists are clear in communicating their limitations, maintain appropriate documentation, and make efforts to refer clients to others when it is indicated, it is unlikely that they would be found negligent even if a suit were brought (Bland et al. 2014).

Time Management

Both private and public sector psychiatrists feel intensely pressured to maintain a fast pace to meet the financial needs of their practice or that of the agency in which they work. They are often seeing clients in rapid succession (15–20 min appointments are common) and feel that they have time for little other than attention to symptom assessment and medication management. This situation exists in part because of financial pressures, but also due to a demand for services (particularly in the public sector) that is greater than the psychiatric workforce can comfortably manage.

While there are no easy solutions to this situation, there clearly needs to be more creative approaches than those we have been employing, namely seeing more patients in less time. This model has been unsatisfying to both psychiatrists and the people they work with. Even in the context of a brief visit, much more can be accomplished if people using services are questioned in advance of their appointment regarding symptoms and medication effectiveness. The results of a questionnaire of this type can be reviewed and highlighted for the psychiatrist prior to their meeting, providing more time for relationship building as well as the holistic, health promoting activities described above (Deegan 2010). In some instances, it may be more helpful to include a case manager or peer specialist in the interview to allow a more rapid (and accurate in some cases) identification of medication issues and allowing more time for other elements of care. Another underused modality is group treatment which provides much richer information about a person's overall condition and can be much more efficient and satisfying for both the consumer and provider. Other creative solutions should emerge which will allow the psychiatrist more time to provide health promotion and primary care when necessary.

Infrastructure

Most facilities in which psychiatric care is provided are ill equipped to allow the provision of primary care activities. Simple equipment such as stethoscopes and

sphygmomanometers are usually not available and even scales are often absent. For levels 2–3, arrangements are needed to provide simple physical exams (i.e. exam table, sinks, examination materials, etc.) Support staff to assist in gathering health information is essential is these services are to be provided efficiently. Improvements to facilities and staffing arrangements will need to be part of the transformation needed to accomplish the integration of primary care.

Financing

As alluded to in the previous section, financial pressures and disincentives to innovation can often contribute to resistance to change from both providers and the systems in which they work. Funding streams for physical health and behavioral health are often separate, creating difficulties for those who attempt to bill for integrated services (Druss et al. 2011). Licensing and other payer policies may stand in the way of billing for services provided in an integrated manner. Consultative processes, that are part of many models, are not billable services in most cases, so that psychiatrists providing primary care are discouraged from obtaining needed advice. Not only is this time not compensated for them, but they may need to pay the primary care providers they would consult (Kisely et al. 2006). In most cases there are not provisions to cover the expense of additional support staff such as LPNs or peer specialists.

Changes in the CPT coding that went into effect for psychiatry in 2013 have created some opportunities for additional reimbursement for more complex clinical encounters. Providing financial incentives to clinicians and organizations, such as pay for performance models, will also give integrated care positive momentum if the proper indicators of performance are used (Unützer et al. 2012). The development of Accountable Care Organizations and health homes within the framework of the Patient Protection and Accountable Care Act (Croft and Parish 2013; Mechanic 2012), may also provide greater flexibility in how the medical workforce can be deployed and eliminate some of the boundaries that have made integrated care challenging (Druss and Mauer 2010; Alakeson et al. 2010; Katon and Unutzer 2011). Creative approaches to put funding in place that will cover the provision of primary care by psychiatrists will be needed if full participation by psychiatrists is to be realized.

Conclusion

The provision of primary care has been presumed to be outside the scope of practice in psychiatry for many years. As a result, most psychiatrists currently in practice are reluctant to think about making significant changes to their current practices, and may feel especially uncomfortable and incompetent when the inclusion of primary care is part of those changes. In many cases, facilities and supporting staff are not available to them, and it is often difficult to obtain compensation for these services when they are provided.

This paper provides a hierarchy of complexity for primary care that psychiatrists might provide. It is our hope that these will be a framework for thinking about solutions to some of the obstacles that may be encountered in implementation of these practices. As training programs embrace curricula that truly reflect the needs of the community and the profession, we will move toward a workforce that is comfortable and capable of providing primary care in those circumstances in which it is needed.

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