AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 303
(I-16)

Introduced by: Resident and Fellow Section

Subject: Primary Care and Mental Health Training in Residency

Referred to: Reference Committee C
(Martin D. Trichtinger, MD, Chair)

Whereas, 50% of primary care visits involve concerns about behavioral health comorbidities and 60% of mental illness is treated by primary care providers;[1] and

Whereas, Child and adolescent psychiatry is one of the most underserved medical subspecialties;[2] and

Whereas, Primary care physicians often feel unprepared to manage patients with complex psychiatric comorbidities;[3] and

Whereas, Internal medicine, family medicine, and pediatric residents do not receive collaborative psychiatric supervision during their residency, nor do psychiatry residents and fellows receive training in how to liaise with primary care offices; and

Whereas, Our AMA has policy which encourages practicing physicians to seek out continuing medical education opportunities on integrated physical and behavioral health care and promotes the development of sustainable payment models that would be used to fund the necessary services inherent in integrating behavioral health care services into primary care settings (AMA Policy H-385.915); therefore be it

RESOLVED, That our American Medical Association advocate for the incorporation of integrated mental health and primary care services into existing psychiatry and primary care training programs' clinical settings (New HOD Policy); and be it further

RESOLVED, That our AMA encourage primary care and psychiatry residency training programs to create and expand opportunities for residents to obtain clinical experience working in an integrated mental health and primary care model, such as the collaborative care model (New HOD Policy); and be it further

RESOLVED, That our AMA advocate for appropriate reimbursement to support the practice of integrated physical and mental health care in clinical care settings. (New HOD Policy)

Fiscal Note: Not yet determined

Received: 09/12/16

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[1] Pirl W.F., Beck B.J., Safren, S. A., Kim H (2001). "A descriptive study of psychiatric consultations in a community primary care center". Primary Care Companion Journal of Clinical Psychiatry 3 (5): 190–194. doi:10.4088/PCC.v03n0501.

[2] Simpson G.A., Bloom B., Cohen R.A., et al. U.S. children with emotional and behavioral difficulties: Data from the 2001, 2002, and 2003 National Health Interview Surveys. Adv Data 2005; 23: 1–13.

[3] Loeb D.F., Bayliss E.A., Binswanger I.A., et al. (2012). "Primary care physician perceptions on caring for complex patients with medical and mental illness". Journal of General Internal Medicine. 2012 Aug; 27 (8):945-52. doi: 10.1007/s11606-012-2005-9

RELEVANT AMA POLICY

Integrating Physical and Behavioral Health Care H-385.915
Our American Medical Association: (1) encourages private health insurers to recognize CPT codes that allow primary care physicians to bill and receive payment for physical and behavioral health care services provided on the same day; (2) encourages all state Medicaid programs to pay for physical and behavioral health care services provided on the same day; (3) encourages state Medicaid programs to amend their state Medicaid plans as needed to include payment for behavioral health care services in school settings; (4) encourages practicing physicians to seek out continuing medical education opportunities on integrated physical and behavioral health care; and (5) promotes the development of sustainable payment models that would be used to fund the necessary services inherent in integrating behavioral health care services into primary care settings. (CMS Rep. 6, A-15)

Prevention of Unnecessary Hospitalization and Jail Confinement of the Mentally Ill H-345.995
Our AMA urges physicians to become more involved in pre-crisis intervention, treatment and integration of chronic mentally ill patients into the community in order to prevent unnecessary hospitalization or jail confinement. (Res. 16, I-81; Reaffirmed: CLRPD Rep. F, I-91; Reaffirmed: Sunset Report, I-01; Reaffirmed: CSAPH Rep. 1, A-11; Reaffirmation, A-15)

Access to Mental Health Services D-345.997
Our AMA will: (1) continue to work with relevant national medical specialty societies and other professional and patient advocacy groups to identify and eliminate barriers to access to treatment for mental illness; (2) advocate that psychiatrists and other physicians who provide treatment for mental illness be paid by both private and public payers for the provision of evaluation and management services, for case management and coordination efforts, and for interpretive and indirect services; and (3) advocate that all insurance entities facilitate direct access to a psychiatrist in the referral process. (CMS Rep. 9, A-01; Reaffirmed: CMS Rep., A-11; Reaffirmed in lieu of Res. 804, I-13; Reaffirmed in lieu of res. 808, I-14)

Mental Health Crisis Interventions H-345.972
Our AMA: (1) continues to support jail diversion and community based treatment options for mental illness; (2) supports implementation of law enforcement-based crisis intervention training programs for assisting those individuals with a mental illness, such as the Crisis Intervention Team model programs; and (3) supports federal funding to encourage increased community and law enforcement participation in crisis intervention training programs. (Res. 923, I-15)

Awareness, Diagnosis and Treatment of Depression and other Mental Illnesses H-345.984
Awareness, Diagnosis and Treatment of Depression and Other Mental Illnesses: (1) Our AMA encourages: (a) medical schools, primary care residencies, and other training programs as appropriate to include the appropriate knowledge and skills to enable graduates to recognize, diagnose, and treat depression and other mental illnesses, either as the chief complaint or with another general medical condition; (b) all physicians providing clinical care to acquire the same knowledge and skills; and (c) additional research into the course and outcomes of patients with depression and other mental illnesses who are seen in general medical settings and into the development of clinical and systems approaches designed to improve patient outcomes. Furthermore, any approaches designed to manage care by reduction in the demand for services should be based on scientifically sound outcomes research findings. (2) Our AMA will work with the National Institute on Mental Health and appropriate medical specialty and mental health advocacy groups to increase public awareness about depression and other mental illnesses, to reduce the stigma associated with depression and other mental illnesses, and to increase

patient access to quality care for depression and other mental illnesses. (Res. 502, I-96; Reaffirm & Append: CSA Rep. 7, I-97; Reaffirmation A-00; Modified: CSAPH Rep. 1, A-10; Modified: Res. 301, A-12)

Access to Mental Health Services H-345.981
Our AMA advocates the following steps to remove barriers that keep Americans from seeking and obtaining treatment for mental illness:
(1) reducing the stigma of mental illness by dispelling myths and providing accurate knowledge to ensure a more informed public;
(2) improving public awareness of effective treatment for mental illness;
(3) ensuring the supply of psychiatrists and other well trained mental health professionals, especially in rural areas and those serving children and adolescents;
(4) tailoring diagnosis and treatment of mental illness to age, gender, race, culture and other characteristics that shape a person's identity;
(5) facilitating entry into treatment by first-line contacts recognizing mental illness, and making proper referrals and/or to addressing problems effectively themselves; and
(6) reducing financial barriers to treatment. (CMS Rep. 9, A-01; Reaffirmation, A-11; Reaffirmed: CMS Rep. 7, A-11; Reaffirmed: BOT action in response to referred for decision Res. 403, A-12; Reaffirmed in lieu of Res. 804, I-13; Reaffirmed in lieu of Res. 808, I-14)

Statement of Principles on Mental Health H-345.999
(1)Tremendous strides have already been made in improving the care and treatment of the emotionally disturbed, but much remains to be done. The mental health field is vast and includes a network of factors involving the life of the individual, the community and the nation. Any program designed to combat mental illness and promote mental health must, by the nature of the problems to be solved, be both ambitious and comprehensive.
(2) The AMA recognizes the important stake every physician, regardless of type of practice, has in improving our mental health knowledge and resources. The physician participates in the mental health field on two levels, as an individual of science and as a citizen. The physician has much to gain from a knowledge of modern psychiatric principles and techniques, and much to contribute to the prevention, handling and management of emotional disturbances. Furthermore, as a natural community leader, the physician is in an excellent position to work for and guide effective mental health program.
(3) The AMA will be more active in encouraging physicians to become leaders in community planning for mental health.
(4) The AMA has a deep interest in fostering a general attitude within the profession and among the lay public more conducive to solving the many problems existing in the mental health field. (A-62; Reaffirmed: CLRPD Rep. C, A-88; Reaffirmed: Sunset Report, I-98; Reaffirmation, A-99; Reaffirmed: CSAPH Rep. 1, A-09)

Increasing Detection of Mental Illness and Encouraging Education D-345.994
1. Our AMA will work with: (A) mental health organizations, state, specialty, and local medical societies and public health groups to encourage patients to discuss mental health concerns with their physicians; and (B) the Department of Education and state education boards and encourage them to adopt basic mental health education designed specifically for preschool through high school students, as well as for their parents, caregivers and teachers.
2. Our AMA will encourage the National Institute of Mental Health and local health departments to examine national and regional variations in psychiatric illnesses among immigrant, minority, and refugee populations in order to increase access to care and appropriate treatment. (Res. 412, A-06; Appended: Res. 907, I-12)