The Future of Behavioral Health—Harnessing the Potential of Psychiatric Mental Health Nurse Practitioners

Ulrike Muench, PhD, MSN; Taressa K. Fraze, PhD

The toll of mental illness in the US is substantial: 1 in 5 adults live with a mental illness. As the population ages, greater numbers of individuals will need care for the comorbidities associated with older age and their mental health needs. There is a lack of mental health services nationwide, and access to clinicians who can provide high-quality behavioral health services will become paramount to achieving population health.

Shortages in the behavioral health workforce have been noted for years. Primary care clinicians experience difficulty securing mental health referrals for their patients, requiring an already stretched primary care workforce to care for people with complex mental health needs. This problem is compounded by an uneven geographic distribution of specialty mental health clinicians, especially in rural areas where a primary care clinician might be the only clinician providing care.

Oh et al examined changes in the number of psychiatrists and psychiatric mental health nurse practitioners (PMHNPs) billing Medicare from 2013 to 2019. Linking data from all clinicians who have a National Provider Identification number with Medicare claims, they found that the total numbers of PMHNPs increased by 134.1% compared with 14.9% for psychiatrists. The number of psychiatrists billing Medicare decreased, and the number of PMHNPs held steady. It is unclear what is driving these patterns, and potential explanations, such as whether psychiatrists are moving from fee-for-service to out-of-pocket models, should be explored in future research.

The analysis also reported the availability of psychiatrists and PMHNPs who billed Medicare in rural and urban health care markets using Hospital Service Areas (HSAs). They found that most rural HSAs had no Medicare psychiatrist or PMHNP, which is notable given that 1 in 5 individuals reside in the rural US. During a 6-year period, the number of rural HSAs with only a psychiatrist decreased (6.9 percentage points) and the number of HSAs with only a PMHNP increased (5.2 percentage points) compared with urban HSAs. Rural HSAs with both a psychiatrist and a PMHNP also increased (4.4 percentage points) compared with urban HSAs, perhaps owing in part to the increase of PMHNPs billing Medicare.

The study advances prior research illustrating a lack of specialty mental health clinicians across large parts of the rural US. The study also bolsters previous findings showing that advanced practice registered nurses successfully contribute to alleviating workforce shortages and provides insights about the substantial role of PMHNPs in providing care to Medicare beneficiaries in rural areas. By 2019, there were nearly as many rural HSAs that had only a Medicare psychiatrist as there were rural HSAs with only a Medicare PMHNP.

It is worth noting that studies examining services provided by nurse practitioners (NPs) or physician assistants in the Medicare population underestimate the care provided by advanced practice clinicians, including PMHNPs. This is due to incident-to-billing practices that allow billing of services provided by advanced practice clinicians using a physician’s National Provider Identification number. This practice, which should be eliminated, is common but somewhat less likely in rural areas and in states with scope of practice laws allowing NPs to practice and prescribe without physician oversight.

PMHNPs are currently underused despite the important contributions they make by delivering high-quality specialty mental health services to a range of clinical populations across the life span. One study examined the role of PMHNPs in caring for Medicaid insured youth, and another recent
study assessed the contributions of pain and psychiatric medication prescribing of PMHNPs in nursing home residents living with dementia.

The extent to which PMHNPs can meaningfully address the demand for mental health care depends on a variety of factors. First, the growth of this workforce in the coming years is an important factor. The analysis by Oh et al estimated that approximately 9917 PMHNPs participated in Medicare Part D in 2019, compared with 29,711 psychiatrists, with an annual growth rate of PMHNPs billing Medicare of between 1% and 3%. Strategic investments in increasing the PMHNP workforce should be considered as an approach to improving access to mental health services. Second, it will be key for states to implement full practice authority for nurse practitioners. Only if PMHNPs can provide comprehensive mental health care without needing to rely on physician collaboration and supervision even for basic mental health services will the full potential of this workforce be realized. A wealth of research has assessed the quality of care provided by NPs, including PMHNPs, with studies demonstrating improved access and care outcomes when states implemented full practice authority, including improvements in access to mental health services and mental health outcomes. Third, it is critical that PMHNPs be optimally integrated within primary care. Careful consideration should be given to determine how primary care practices can best capitalize on the clinical expertise of these specialized clinicians.

Data on effective clinician configurations—including both primary care physicians and PMHNPs—to deliver high-quality primary care to patients with mental illness are needed to guide primary care practices in navigating these challenges. In addition, innovative team-based primary care models consisting of configurations with extended roles for advanced practice clinicians, registered nurses, social workers, and direct care workers together with effectively deploying virtual care integration will be needed to care for the increasingly complex behavioral, medical, and social needs of US residents.

The COVID-19 pandemic has exacerbated the demand for mental health among health care professionals and within the population at large. Rates of substance use, overdose deaths, suicide, gun violence, and major depression are all increasing. Successfully addressing these issues while providing care to an older population with co-occurring mental health and chronic conditions will require access to mental health services for all who need it. If current trends continue, PMHNPs will play a central role in the future of behavioral health services delivery.

ARTICLE INFORMATION
Published: July 29, 2022. doi:10.1001/jamanetworkopen.2022.24365
Open Access: This is an open access article distributed under the terms of the CC BY License. © 2022 Muench U et al. JAMA Network Open.

Corresponding Author: Ulrike Muench, PhD, MSN, Department of Social and Behavioral Sciences, University of California, San Francisco, 490 Illinois St, Floor 12, Box 0612, San Francisco, CA 94143 (ulrike.muench@ucsf.edu).

Author Affiliations: School of Nursing, Department of Social and Behavioral Sciences, University of California, San Francisco (Muench); School of Medicine, Philip R. Lee Institute for Health Policy Studies, University of California, San Francisco (Muench, Fraze); Healthforce Center, School of Medicine, University of California, San Francisco (Muench, Fraze); School of Medicine, Department of Family and Community Medicine, University of California, San Francisco (Fraze).

Conflict of Interest Disclosures: Dr Muench reported receiving grants from Commonwealth Fund and grants from California Health Care Foundation and funds for research consulting from Brown University and Taxes Health Science Center at Houston; Dr Fraze reported receiving grants from the Agency for Healthcare Research and Quality, National Institutes of Health, Commonwealth Fund, California Healthcare Foundation, Hellman Foundation, and Robert Wood Johnson Foundation outside the submitted work.

REFERENCES


