

# The Humpty Dumpty Syndrome

## Integration and Behavioral Health

**Poor Humpty Dumpty.** Life was good. Everything was connected and working properly – or so he thought. Then he fell into an Alice-in-Wonderland world of health care, where he broke into a thousand pieces, and all the king's horses and all the king's men couldn't put him together again...



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St. Luke's Health Initiatives

*A Catalyst for Community Health*

*AHF is published three times a year by St. Luke's Health Initiatives*

# The *Humpty Dumpty* Syndrome: Integration and Behavioral Health



... Not that they didn't try. They reconnected him in all sorts of curious configurations: his mind over here, his body over there, good intentions dangling everywhere. "I don't feel like I'm broken," he confessed one day to the Queen of Hearts. "I've always felt whole."  
"You're broken!" The Queen bellowed. "You don't fit the plan."  
"What plan?" Humpty Dumpty asked. "Why do I have to fit it?"  
"That's none of your business," the Queen snapped. "You don't fit the plan, and you won't be back together until you do."

**ITEM** A man with a history of bi-polar illness visits a primary care physician for muscle twitching and unsteady gait. The physician discovers he is taking a combination of Lithium, Prozac and Resperidal, plus over-the-counter Motrin for chronic back pain. Testing reveals Lithium in the toxic range; he is admitted to the hospital. It takes the physician's office three days to establish contact with the man's psychiatrist in a separate public mental health system and get the doctors together to work out a medication and monitoring strategy.

**ITEM** A Medicare patient sees a neurologist about memory loss. The neurologist suspects the onset of Alzheimer's Disease, but she's not sure. If she codes the diagnosis as Alzheimer's Disease, she gets reimbursed in full for the visit. If she codes it as memory loss, Medicare considers it a behavioral health diagnosis; and she gets paid half the rate with the patient responsible for the rest. She codes it as Alzheimer's Disease.

**ITEM** A man with a history of schizophrenia who is on Supplemental Security Income support develops an acute toothache. He doesn't have a dentist, he doesn't have a phone and he doesn't know what to do. He walks two miles to the office of a local public foundation, where he knows someone. They call a dentist, who agrees to treat him on short notice, and drive him to the appointment.

## All the King's Men

In this issue of *Arizona Health Futures* we examine one of the most prevalent and perplexing characteristics of the American health care system: the fragmentation of services for integrated conditions, and its consequences.

As in the examples above, the mind and the body are hardwired inseparably from the ground up. The systems that treat them, unfortunately, are not.

This is the world of All the King's Men, who carve up the patient into separate and distinct parts, carve out treatment plans to deal with each, and then attempt to reconnect the parts in a tangle of financial, regulatory and bureaucratic arrangements that have more to do with the needs of the system – the "plan" – than the needs of the patient.

Actually, this is not quite correct. In the logic of the Wonderland world we are about to enter, *everything that is singular is plural*: The System is really "systems." The Plan is really "plans."

We focus on behavioral health, because it is here that the disconnect between knowledge and treatment is the most obvious – and the most troubling. But we could just as easily apply the analysis to the fragmentation of health care generally, the consequences of medical specialization and its impact on access, quality and cost.

## The Humpty Dumpty Syndrome

This isn't a completely negative tale. We have seen stunning advances in all aspects of human life from scientific, technological and organizational specialization. We break down complex systems into their constituent parts, learn how they interact and connect and then reassemble them for maximum control and effectiveness.

But at what cost? The issue isn't specialization, it's integration, or more precisely, *reintegration*: how we reconnect Humpty Dumpty in a continuum of care that reintegrates specialized interventions in ways that are *seamless and whole* to the patient.

The "syndrome" here is that we don't put Humpty Dumpty back together again, but leave the "parts" scattered about in separate systems of care that don't always communicate well and have their own needs, interests and cultures.

## Integration and Behavioral Health

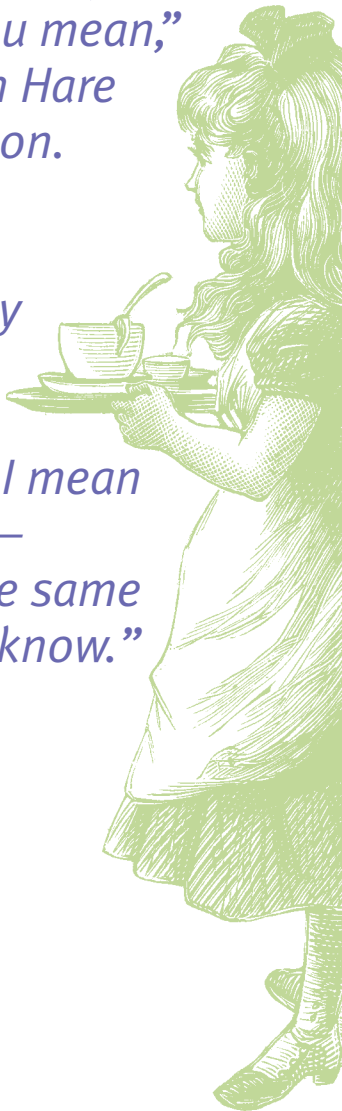
To what extent we can – or even ought to – do something about this in Arizona is the focus of this Issue Brief. We explore the myths and the realities of behavioral health integration: What it is, what it isn't – and what it could be. We review definitions and history, look at various Arizona examples and strategies for closer collaboration and coordination between primary care and behavioral health services, tap into the experience and views of people in the field and present strategies for action at the local and state levels.

## A Note on Definitions

*“You should say  
what you mean,”  
the March Hare  
went on.*

*“I do,”  
Alice hastily  
replied.*

*“At least I mean  
what I say –  
that’s the same  
thing, you know.”*



How we define something – and what we call it – often makes a difference in how we approach it.

It's not for nothing that the Kaiser Permanente Medical Group refers to on-site psychologists as “behavioral medicine specialists.” There is a stigma attached to seeing a “mental health” professional. There's less stigma in seeing a “medical” specialist or consultant.

Some people use the terms ‘mental health’ and ‘behavioral health’ interchangeably; others wouldn't be caught dead doing so. Without getting into a tortuous discussion of the differences between the two terms – and the vested interest powerful professional groups have in each – we choose to ignore the distinctions and use the broader term of ‘behavioral health’ when there's a choice. We use the terms ‘mental health,’ ‘mental illness’ and ‘mental disorders’ when so used in report sources.

Our intent is not to focus specifically on issues affecting the serious mentally ill (SMI) or any other subcategory of mental disorders, but to look at a broad spectrum of behavioral health issues that often present in a primary care setting. In addition to serious mental illnesses and disorders, this might include alcohol and drug abuse, stress in job, family and personal relationships; behavioral issues that result from major life events, and even the occasional neuroses and anxieties of the “worried well.”

We're less interested in where definitions come from than in where they go.

# Behavioral *Health and Disability*: A 21st Century Issue

*One could go on in this vein with additional indicators on the impact of drug addiction, suicide, violence and other behavioral conditions on all dimensions of society. The scope and magnitude of these issues are not in dispute. What's less clear is what to do about them, and the roles organized systems of health care can – and ought to – play in the process.*










Behavioral health is a growth industry in the United States and other industrialized nations, and is destined to become even more dominant in the future as wrenching economic, social and cultural change puts pressure on the adaptability of human behavior.

The issue is not mortality, but disability: the impact of behavioral conditions on family, work and relationships. Mental illness accounts for 25 percent of all disability across major industrialized countries, and alcohol and drug abuse account for an additional 12 percent. (*World Health Organization, 2001*) That's a total of 37 percent attributable to behavioral conditions – and it's growing.

Left unchecked, behavioral conditions are barriers to increased productivity, better social relationships and a more meaningful and satisfying life. With advances in diagnosis and treatment (medications, therapy, social arrangements) and improved health delivery systems (primary care, outpatient, new roles for health professionals), lives can be improved immeasurably.

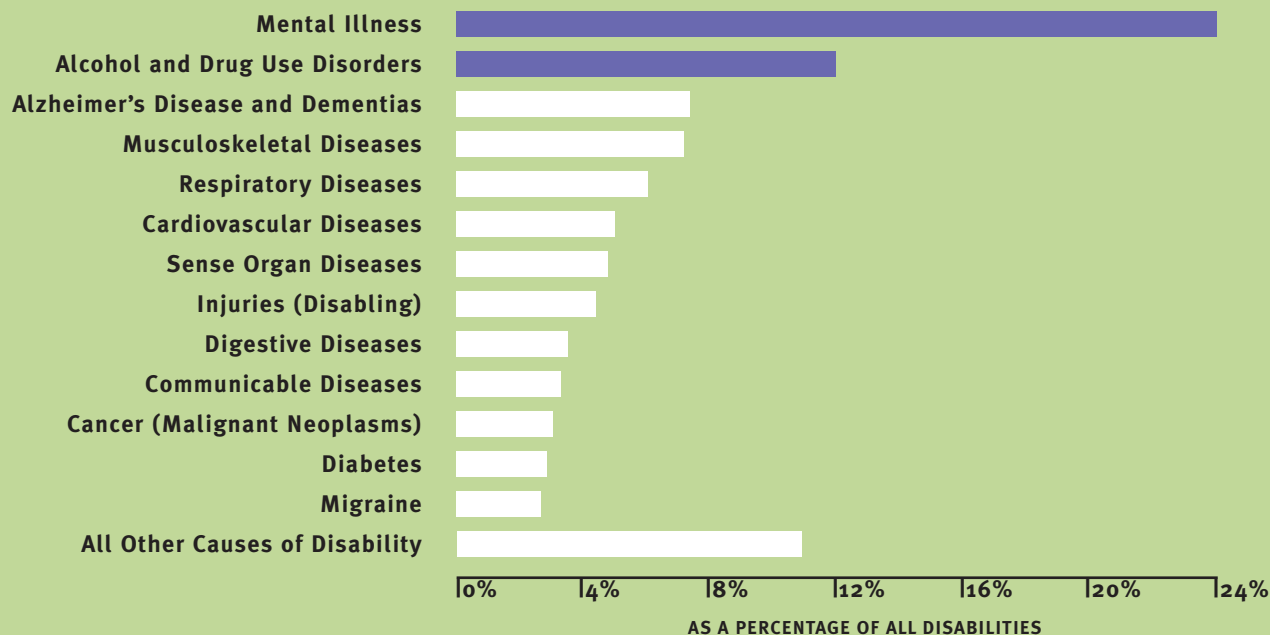
## A Parade of Indicators

**The dimensions of behavioral health's impact on society in general, and on health care in particular, are huge. Here is a selective list of indicators:**

-  Approximately 20% of the U.S. population suffers from a diagnosable mental disorder in any given year. (*National Institutes for Mental Health*)
-  Depression costs the U.S. \$43.7 billion annually, including \$31.3 billion in indirect costs such as decreased worker productivity and absenteeism. (*National Mental Health Association*). The number of people seeking treatment for depression in the U.S. tripled between 1987-97. (*JAMA*)
-  People reporting persistent depression have annual adjusted medical costs that are 70% greater than those who report not being depressed. (*JOEM, 1998*)
-  Approximately 15% of all adults who have a mental illness in any given year also have a co-occurring substance abuse disorder, which complicates treatment. (*Surgeon General's Report on Mental Health, 1999*)
-  About 12 million women in the U.S. experience depression annually – roughly twice the rate of men. (*NIMH, 1999*)
-  Medical costs for “high-utilizing” Medicaid patients who received psychosocial interventions decreased by 21% eighteen months later, compared to a 22% increase for those who received no intervention. (*Pallek, et. al, 1995*)
-  A national company that reduced employee mental health benefits by 40% over a three-year period experienced an offsetting 40% increase in primary health care expenses. (*Rosenheck, et. al, 1999*)
-  Analysis of risk factors associated with health care insurance claims revealed that depression and stress were the two most significant factors in increased claims expenditures – greater than obesity, high blood pressure, high cholesterol and tobacco use. (*Goetzel, et. al, 1998*)
-  The number of children taking psychiatric drugs more than doubled from 1987 to 1996. (*Archives of Pediatrics and Adolescent Medicine, January 14, 2003*)

# The *Top Causes* of Disability\*

## Causes of Disability, U.S., Canada, Western Europe, 2000



\*Source: World Health Organization (2001)

## Which Came First?

### Is Behavioral Health a Primary Condition or a Secondary Diagnosis?

An estimated 60 percent of patients who seek primary care have symptoms that appear to have no serious medical basis. One of the arguments used by opponents of mental health insurance parity is that it will encourage more submitted claims by these “worried well” persons, more treatment of symptoms whose root causes are unknown or dubious at best and drive up health care costs.

Of course, these same proponents of separate and unequal systems of care for behavioral and physical health have no problem paying for treating the symptoms of arthritis and other physical diseases whose causes are not fully known, but that’s another story. The point is that regardless of whether physical symptoms are caused by bacteria or a bad year, they are real enough, have major consequences in all dimensions of our lives and ought to be treated as efficiently and humanely as possible in environments that promote healing.

### It’s All in Your Head

Science is making rapid progress in unlocking the secrets of the brain and its connection to the body (psychoneuroimmunology, neuroscience). We may look forward to a day when the Cartesian mind-body duality is relegated to the dustbin of antiquated ideas, and our health care system reflects the biological and social whole of human experience.

In the meantime, the duality engenders endless diagnostic quandaries: Is this a medical problem with psychological implications, or is it primarily a psychological problem with physical manifestations (somatization)? Is this person “really” sick, or is it “all in their head?”

How we make the diagnosis – and the language and tools we use in the process – contributes to the Humpty Dumpty syndrome. Researchers estimate that close to 75 percent of patients seeking primary care services have behavioral health and/or psychosocial issues, and general practice physicians prescribe nearly 75 percent of all antidepressants in use. (Hylan, et. al, 1998)

Yet based on findings from a 1997 Institute of Medicine study, primary care providers tend to under-diagnose depression, substance abuse and other behavioral health problems. (IOM, 1997) If true, how many more people could get the timely care they need if we had an integrated continuum of care instead of a fragmented one, and trained providers accordingly?

# The *Road* to Wonderland\*

*The Road to Wonderland is long and filled with interesting side trips, but we scan it here from 30,000 feet to get a better understanding of how we came to have a fragmented system of health care in the United States, with a focus on behavioral health care specifically.*

## 1920S

*Physicians become licensed professionals, states enact medical practice acts. Docs see everyone and deal with patients directly on a cash basis.*

## 1930S

*Prepaid health plans arrive on the scene. Hospitals create Blue Cross as a mechanism for steady revenue streams. Blue Shield arrives later as the physician counter response for prepaid outpatient services. States enact laws for Blues-type plans that exempt them from financial reserve requirements imposed on other insurers.*

## 1940S

*Health insurance plans continue to grow. Behavioral health care is conspicuously absent. Plans do not pay for psychotherapy on the belief that it “was not subject to actuarial cost controls, as it was couched in psychobabble and dispensed by long-term therapists who were unaccountable and staunchly believed that more is better.”*

(Cummings, 2001)

## 1950S

*De-institutionalization – the movement from psychiatric hospital-based care to community-based care – gets underway on the principle of providing care in the “least restrictive setting.” A “system” of community services for these people – created in crisis mode with little thought to coordination and communication – mushrooms willy-nilly across layers of government, multiple payers and agencies.*

## 1950S-1960S

*Kaiser Permanente, one of the first “managed” care plans, adds prepaid psychotherapy benefits on data that show 60 percent of their patient visits are tied to significant emotional factors. The result: a 65 percent decrease in medical utilization among patients receiving behavioral health treatment. The American Medical Association calls the Kaiser Permanente model “socialized medicine.”*

## 1960s

The creation of Medicare and Medicaid “institutionalizes” the triangulation of patient-provider-third party payer. Faced with increasing paperwork and regulations, physicians learn how to “manipulate” third-party payers.

## 1970s

The feds seize upon a newly coined term and model – HMO or Health Maintenance Organization – as the solution to rising health care costs following the birth of Medicare and Medicaid. The HMO Enabling Act of 1975 supports the formation of new HMOs. After a rocky start, the “movement” takes off.

## 1980s

The “business” model comes to dominate health care, and practically every other aspect of American life. Efforts to control costs become paramount; a debate ensues on whether quality of care is compromised or enhanced under the managed care model. The feds create Diagnosis Related Groups (DRGs) in an effort to control galloping hospital costs. It works – and many hospitals start to go bankrupt. Proprietary businesses snap them up and apply “sound business principles,” i.e., “unprofitable” lines of business, “streamlining” staff, etc.

## 1980s-1990s

While DRGs reduce medical and surgical costs, no one can figure out how to apply them to mental health and substance abuse. Behavioral health costs skyrocket as hospital execs convert empty beds to psychiatry and substance abuse. Once again the feds turn to the private sector for a solution: an emerging for-profit industry “carves out” behavioral health care services from the medical mainstream.

## 1990s

Consolidation sweeps American health care. A handful of behavioral health “carve-outs” end up controlling two-thirds of the national market at the decade’s end. Managed care succeeds in controlling costs, but only momentarily; high demand and market saturation encourage unsustainable “bottom feeding” and “low balling” bidding practices; consolidation occurs on the provider side to counter payer consolidation; the resulting standoff passes on higher costs to employers and consumers.

## 2000s

A Surgeon General’s Report (1999) concludes that the U.S. mental health system is a fragmented, inefficient and inequitable mess. A group is convened to figure out how to “carve in” behavioral health care in the primary clinical care setting. Lots of ideas, models and enthusiasm but – so far – not a lot of success.

\*This tour through history relies to some degree on “A History of Behavioral Healthcare,” a chapter by Nicholas A. Cummings, Ph.D., in *Integrated Behavioral Healthcare: Positioning Mental Health Practice with Medical/Surgical Practice* (2001). Cummings, the founder of American Biodyne, is hardly a disinterested observer; others might “spin” the story differently.

# What is a *Carve-Out*?

Carve-Outs are the management of behavioral health care by firms that are legally and administratively separate from the firm managing general medical care. Under a carve-out arrangement, a state Medicaid program, employer or health plan contracts with a managed behavioral health organization(s) (MBHO) to administer, manage – and occasionally even insure – behavioral health services for enrollees.

Why carve out behavioral health services? Here are two general arguments:

1. Behavioral health populations are special populations with special needs that aren't necessarily served well in a primary medical setting. They need to be "carved out" for special care in special settings with special dollars. This is especially true for those with serious mental illnesses (SMI) and complex substance abuse problems.

2. Carve-outs are efficient and save money. In general managed care capitation plans, a behavioral health carve-out sets aside a specific amount of money for services that, if they weren't carved out, could be lost or eaten up in the larger capitation pool. Behavioral health has long been the "poor sister" of physical health care: lower on the prestige pole, lower on the money pole, and off the chart on its own stigma pole. Proponents of carve-outs say that they get better results with lower costs than fee-for-service "carve-ins." Others dispute this, claiming that they save money by "rationing through obstruction."

## A Carve-Out Carve-Out

What do we know about behavioral health carve-outs? There's a good deal of evidence that MBHOs reduce behavioral health spending through reduced reliance on inpatient care, lower provider fees and less time in outpatient treatment. (Busch, 2002) The research is considerably more limited and equivocal on the effect of this reduction in spending on quality of care and outcomes: some studies say quality is better, some say it is worse. Clearly much depends on the MBHO's experience, total dollars and capitation rates, the availability of trained staff, and communication with other parts of the health system.

It also depends on who is interpreting the quality/cost ratio. The "cost" for a primary care doctor to track down a patient's behavioral health provider to find out what meds the patient is taking is not factored into the cost of the behavioral health carve-out. That's the primary care doctor's problem, not theirs. Critics of the carved out model point out that it provides incentives for both medical and behavioral health providers to shift risks and costs in order to get a bigger slice of the health care pie. It also perpetuates the mind-body duality and clinical separation at a time when medical science points toward clinical integration.

Then there's the "carve-out carve-out." The behavioral health sector – like the physical health sector – is neither monolithic nor of one mind when it comes to

*Carve-Outs are the management of behavioral health care by firms that are legally and administratively separate from the firm managing general medical care.*





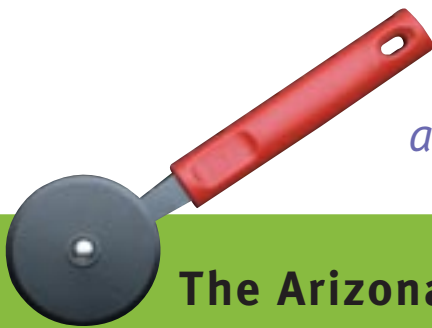
defining populations, treatment models, outcomes and financing mechanisms. For example, it is not unusual to see alcohol and substance abuse treatment plans carved out of the larger behavioral health carve-out in order to make sure they, too, aren't "lost or eaten up" in the larger pool. This occurs despite evidence suggesting that patients with co-occurring disorders do better in an integrated setting.

### **Curiouser and Curiouser**

And so it goes. A patient with multiple diagnoses – a mental disorder, a substance abuse problem, diabetes – can face a bewildering array of specialty providers and financing mechanisms within an even more bewildering array of organization carve-outs, each with its own logic, interests and needs.

One would think the case for integration would be obvious, but just as Alice noticed as she went deeper and deeper into Wonderland, things get "curiouser and curiouser."

*Arizona was the last state in the nation to sign up with the Medicaid program, and one of the first states to implement a Medicaid managed care model.*



### **The Arizona Carve-Out**

With the exception of its long term care program (ALTECS), the Arizona Health Care Cost Containment System (AHCCCS) employs a carve-out model for mental health and substance abuse treatment. AHCCCS contracts with the Arizona Department of Health Services/Division of Behavioral Health Services (ADHS/DBHS), which in turn subcontracts with five Regional Behavioral Health Authorities (RBHAs) to manage services to the entitled populations in designated areas of the state. Some RBHAs, in turn, contract with specialty behavioral health systems, which then can contract with direct behavioral health providers. Under the carve-out, primary care providers can still prescribe psychotropic medications to AHCCCS members with mild behavioral health disorders.

So it is that an AHCCCS member with behavioral health needs is often referred to a RBHA, which may then refer her down the line until a provider relationship is established. Knowledge and communication across the separate parts of the system are the keys to making it work smoothly.

We make cars this way. It's the industrial model, and it defines a good deal of the American health care system. The issue is whether the model makes sense for the future, and if so, how it might be improved.

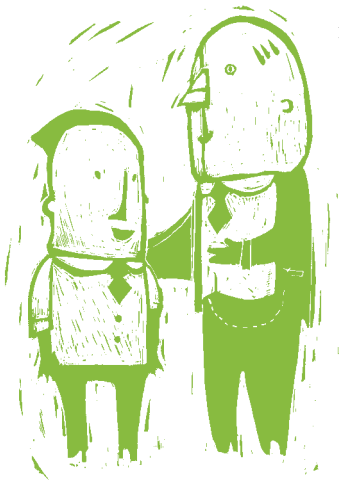
*The state did not include behavioral health services until 1990 – about 25 years after the rest of the country.*

# Integration: *Putting* *Humpty Dumpty Together Again*

Integration is a term that's easy to define in theory, but much harder to define in the particular and put into practice.

Integration is the holy grail of race relations, field theories in physics, electronics, economics and any area where we seek to form a "harmonious whole" from the combination, coordination, collaboration or otherwise "fusion" of separate parts. In the integration of areas where human beings are involved, we often seek the "incorporation of equals," as in integrated communities. If they are not equals, we have *subordination*, not integration.

Because of the all too real and pernicious effects of stigma, this turns out to be a major problem for the integration of behavioral and physical health.



*"A failure. Integration is retreating as an issue. 'Collaborative care' is better terminology. It suggests an applied use."*

## Integration: Street Definitions

For this AHF Issue Brief, SLHI interviewed physical health and behavioral health providers, health plan officials, advocates, consumers, public health officials and others about behavioral health integration definitions, models, problems and prospects. Without attribution, here is a sampling of the essence of 'integration' as heard on the street:

### *Integration is –*

*"More initial treatment by primary care physicians and a seamless referral system to behavioral health providers with good feedback and follow-up."*

*"Having a psychiatrist on site."*

*"Living medicine."*

*"The seamless treatment of mental and physical disorders."*

*"Family practitioners providing basic and crisis care, and getting paid for it."*

*"More treatment by primary care providers."*

*"Sharing information."*

*"Primary care and behavioral health providers at the same site, with mutual trust and respect."*

## A Continuum of Care

Michael Puthoff, President and CEO of the EXCEL Group in Yuma (the county RBHA), reminds us that the mind and body have always been integrated in biology but have become separated in cultural attitudes and practice, and must now be *reintegrated* along a *continuum of care*. In his own words:

“The reintegration of behavioral health and primary care, to be successful, would be a continuum of care. At one end, behavioral health clinicians are working in primary healthcare clinics providing consultation to physicians and brief behavioral health interventions with specific patients, and when necessary and appropriate, referring them to behavioral health specialists.

“On the other end of this continuum, you would have primary health care staff located in behavioral health clinics, specifically serving the SMI and SED population and/or other behavioral clinical staff as necessary and appropriate. In between these two spectrums would be consultation and education services readily available to be used by either primary health care or behavioral health care practitioners.”

## Where the Rubber Meets the Road

While everyone has their own spin on defining integration in the health care setting, they all come down to the three “Cs”: *Coordinate, Collaborate, Cooperate*.

Ideally, this continuum of verbs would be integrated along the Big “C” – a *Continuum of Care*. But just as different computer operating systems need brokers, translators and converters to work with each other, so do separate and distinct parts of the health care system need their own “helping hands” to cross the great divide of stigma and separate systems of care to work with each other.

*Communication* – the essence of any continuum – is where the rubber meets the road in the integration of behavioral health and primary care.

*Communication*  
– the essence of any continuum –  
is where the rubber meets the road  
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behavioral health  
and primary care.

C = 3C



# Barriers to *Integration*

*“Physicians think they’re God. They think they don’t have to talk to psychologists and social workers, let alone hang out with them.”*

*Behavioral  
Health Provider  
(non-physician)*

If the integration of behavioral health care services in a primary care setting is a good thing, why don’t we see more of it?

Some contend that the idea of integration is just a smokescreen that clouds our ability to coordinate care, and we’d be better off focusing on the nitty-gritty details of the latter instead of the pie-in-the-sky idealism of the former. We return to this point at the conclusion of this Issue Brief.

Regardless of what we call it, our community interviews uncovered significant barriers to achieving it.

## **The God Bias**

The “God Bias” charge against physicians by non-physicians in the health care setting – and by segments of the general population – has long been noted in American culture. There’s a pecking order in health care, and physicians are at the top. This can breed resentment and some anger down the line, especially when a physician displays arrogance and sees cooperation as a one-way street.

Getting physicians to actively collaborate with non-physician behavioral health specialists is a challenge, according to many behavioral health providers in the community. For example, RHBAs have phone consultation available to primary care providers to talk with a psychiatrist about a particular issue, but since its inception 18 months ago only one call has been received. In the words of a line from the movie, *Cool Hand Luke*, “What we have here is a failure to communicate.”

## **Communication**

A failure to communicate is hardly limited to the “God Bias.” Even physicians have trouble communicating with each other, especially when they’re in separate systems of care.

“Communication between primary care physicians and psychiatrists is dismal at best,” says Gary D. Smethers, M.D., Senior Vice President and Chief Medical Officer of Blue Cross and Blue Shield of Arizona.

Traditionally, the medical and psychiatric sides have not worked well together, even though psychiatrists are trained medical doctors and are certified by the same Board that certifies neurologists. Smethers believes that the divide won’t be overcome until professional organizations themselves find a way to promote better understanding between the disciplines. Managed care tried to force those relationships through the payment mechanism, but it didn’t work.

Some primary care practices have an informal referral relationship with mental health providers, usually with a master’s level social worker through a common patient thread that allows for continual patient referral to occur. But at higher degree levels, those relationships tend to diminish.

## **The Churn**

According to Bill Bonfield, M.D., M.P.H., a psychiatrist and Chief Medical Officer at ValueOptions, the Regional Behavioral Health Authority (RBHA) for Maricopa County, “Huge problems remain with the sharing of information because of frequent changes in the patient’s primary care provider, as well as behavioral health provider changes. Providers on both sides don’t know who to call, how to reach them, or if they will even know who the patient is.”

The “churn” – the rate at which people move in and out of Arizona, change jobs and insurance plans, move on and off insurance – makes it difficult to establish continuity and communication between providers themselves, and between providers, plans and patients. Just when you get to know whom to call, they move, and you have to start all over again. This is a significant issue for establishing continuity in many aspects of life in the Valley, and not just health care.

## Education

Basic and ongoing training of primary care providers and behavioral health providers often focuses narrowly on the clinical components specific to either physical or mental health – not both. There are signs that this is changing, but it’s slow in coming, and many providers have an insufficient understanding of what the “other side” does – and ought to do.

According to Kathleen Garast, former vice-president for Catalina Behavioral Health and CEO for the Arizona Plan, there’s a “cultural gap” between primary care physicians and behavioral health specialists. For physicians, this “results in a misunderstanding of what behavioral health specialists can do,” and vice versa.

Catalina initiated written progress notes to educate the primary care community, but they “didn’t always get back to where they were supposed to go.” Garast and many others with whom we talked emphasized the need for broad education for both medical and behavioral health providers on the clinical interrelationships of their domains and the advantages to each from ongoing communication and collaboration.

## Reimbursement

While many of the reasons for integrating behavioral health and primary care are *clinical*, many of the reasons for continued fragmentation are *financial*.

Despite the creation of new billing codes for behavioral health issues (see page 14), the difficulty of getting reimbursed for providing behavioral health services in a primary care setting is one of the chief barriers to integration.

Driven by the fear of getting lost in a maze of medical care issues and funding streams, mental health advocates have fought long and hard for behavioral health funding carve-outs. The irony is that while carve-out models of care increase the focus on behavioral health issues, they also increase fragmentation and, ultimately, the amount of money available for mental health treatment across the entire system, which includes many more people than just the “entitled” carve-out populations.

Payers, on the other hand, are reluctant to reimburse models of care that, while lowering the overall cost of mental illness, may increase *their* costs. Even in commercial plans where the “carve-out” is a designated subcontract for behavioral health services, problems exist.

## Why Integration and Primary Care?

Primary care is usually the first point of patient contact. Up to 50 percent of all visits to primary care physicians (PCPs) are due to conditions that are caused or exacerbated by mental or emotional problems. (CFHC, *Collaborative Family Healthcare Coalition*, 1998)

- Many people prefer to receive behavioral health services in a primary care setting. It is perceived to be less stigmatizing than going to see a psychiatrist or psychologist.
- Selected populations with behavioral health issues are heavy users of primary care:
  - Over 90 percent of elderly patients receive behavioral health services in a primary care setting.
  - Approximately 70 percent of community health center patients have behavioral and/or chemical dependency disorders.
  - More than one-third of behavioral health visits by privately insured children are to a primary care physician rather than to a specialist. (<http://www.rand.org/publications/RB/RB4541/>)
- Providing behavioral health services in a primary care setting can be cost effective if they are supported by systems incorporating patient and physician education, proactive specialty consults and patient monitoring.
- Providing behavioral health services in a primary care setting reinforces the idea that mental health is fundamental to overall health, and is not separate from physical health.

*“The insurance companies seem to have no concept of team management that would include the physician and psychologist working together.”*



Case in point: one Arizona provider noted her problems with a commercial plan that wanted her to refer all of her patients to their carve-out mental health provider. In her words:

“They consider ‘tobacco abuse’ as a mental health diagnosis. When a claim for a diagnosis of depression comes back not paid, either the patient pays or we don’t get paid. We have learned to put down symptoms as the diagnosis, such as headache, backache and diarrhea, rather than the real diagnosis, in order to get reimbursed.”

### **Stigma**

The stigma attached to behavioral disorders is pervasive and presents a formidable obstacle to the integration of behavioral and physical health. Good science, good reasons and good intentions pale against the backdrop of centuries of deep seated fears and prejudice concerning the “mentally” ill and the shame of not having the fortitude and character to “snap out of it” and take control of “what’s in your head.”

The ignorance – and the stigma it engenders – concerning behavioral disorders is profound. Afflictions of the body are somehow beyond our control. Afflictions of the mind are somehow “our fault.”

## **The Best Codes You Never Heard Of**

At the beginning of 2002, the Centers for Medicare and Medicaid Services (CMS) established six new codes, as recommended by the American Psychological Association (APA), in the Current Procedural Terminology (CPT) manual for behavioral, social and psychophysiological procedures for the treatment and management of physical health problems.

The codes, which “acknowledge psychology’s role in physical health care,” appear to be the best kept secret in Wonderland. Ironically, while lack of reimbursement is regularly cited as a key barrier to providing behavioral health care in the primary care setting, few of the providers and other key informants we interviewed knew about the codes, and only one person had actually used them.

### **A FEW KEY POINTS:**

- ☞ The codes are intended for patients whose primary diagnosis is physical.
- ☞ Federal reimbursement comes out of medical, not mental health funds.
- ☞ Outpatient services are reimbursed at 80%, versus 50% for behavioral health services.
- ☞ They can be billed in multiple increments of 15 minutes.

More information is available at [http://www.apa.org/practice/cpt\\_2002.html](http://www.apa.org/practice/cpt_2002.html).

### **THE BEST CODES YOU CAN’T USE**

Here’s a surprise: The new codes provided an opportunity for officials to signal they are serious about finding ways to reduce health care expenditures in light of Arizona’s fiscal crisis. They recently made the decision to close the new CPT codes and require primary care providers to either refer patients to the RBHA system or provide the psychotherapy themselves.

Budget crisis 1, integration 0.

Just as many people do not seek treatment from a behavioral health professional, they are often reluctant to discuss “personal” matters such as excessive drinking or feelings of hopelessness with the family physician. Obviously, the 10-minute office visit isn’t designed to invite empathy and disclosure.

Stigma can be especially critical for persons of different cultural backgrounds. Within the El Rio Community Health Clinic system in Tucson, where approximately 67 percent of the clients are Hispanic, staff are able to refer clients to an on-site counselor through a partnership with C.O.P.E., a local behavioral health organization. Otherwise, staff report, there is no way the patient would ever see a behavioral health provider on their own. There is simply too much stigma attached to it.

Trying to get a primary care patient to see a psychiatrist is difficult, concurs Gary Smethers, M.D., Medical Director at Blue Cross Blue Shield of Arizona. It’s easier to get them to see a therapist for counseling. In the minds of many patients, seeing a therapist has different connotations than seeing a “shrink.”

## Systems Issues

The biggest barriers to integration are system issues, says J. Michael Powers, M.D., a Phoenix neurologist and past president of the Arizona Medical Association. In particular, problems occur in the way behavioral health services are carved out in the Medicaid system and in commercial health plans.

As a neurologist, Powers finds communication in a carve-out environment to be problematic. In the event that medications for psychiatric problems have a negative effect on a patient’s neurological problems, it is often difficult – if not impossible – to track down the treating psychiatrist. Likewise, carve-outs create an artificial barrier to providing services for cognitive-based problems associated with Alzheimer’s and other neurological disorders.

The hardest part of integration, Powers says, isn’t getting psychiatrists and primary care doctors together. Most psychiatrists are receptive to educating primary care physicians on how best to prescribe and counsel patients with behavioral issues. “Most psychiatrists recognize that primary care doctors aren’t going to become mini-psychiatrists, just as primary care doctors don’t become mini-neurologists simply because they treat a patient with epilepsy.”

For Powers, the biggest barrier is “how to get the system to allow primary care doctors to treat behavioral health problems, through access to formularies and compensation for services provided.”

## Infrastructure Support

Successful integration requires infrastructure support for sharing information, coordinating care and monitoring results. Research is quite clear on this point. If patients don’t comply with medication schedules, don’t return for follow-up visits or are jettisoned back into toxic family and community environments, chances for recovery and a successful outcome are compromised.

After spending significant time and money to train primary care providers in how to utilize behavioral health resources, they often have to practice in an environment that lacks this infrastructure: no money for planning, no time for patient monitoring, no basic electronic information systems that cross payers and provider systems. Then we wonder why they don’t use their newly gained knowledge to improve system integration.



*“Discussion time should be reimbursed, too,” one clinician opined. “You tend to fill your time with what you can bill, not what you can’t.”*

## **Time**

The sheer lack of time is a major barrier to the effective integration of behavioral health and primary care.

Primary care providers often see over 30 patients per day, leaving little time to address complex needs. Interviews with physicians indicate that while they can provide brief, focused intervention, when it comes to ‘talk therapy’ they have to refer the patient to a behavioral health provider.

Jim MacKenzie, Ph.D., Assistant Residency Director in Family Practice at Banner Health, cites lack of time as a major deterrent to integrated care. “We have 25,000 patient visits per year and at least 50 percent involve psychosocial factors. The residents need time to sort out what is going on, [and] the psychosocial factors are not straightforward. In the first year, residents are allowed 45 minutes per patient, but by the third year they have only 15 minutes per patient.”

Lack of time is a barrier in more places than just seeing patients. Executive and clinical staff from the AHCCCS Office of Managed Care note that practitioners on both the physical and behavioral sides frequently don’t have enough time in the day to step back from seeing patients and talk with each other about complex cases and treatment options.

Then there’s the issue of patients’ expectations of “enough” time. In a culture where problems are routinely solved within the 30-minute duration of their favorite television show, a patient can have unrealistic expectations of how much time it takes to work through complex issues – and how much time and personal effort is expected of them (follow-up meetings, therapy sessions, home work) in the process.



## **A Consumer’s View**

Consumers often find that physicians are suspicious of anyone diagnosed with psychosis. Once a doctor discovers that a patient is on medication for a mental illness, “he refuses to listen and assumes that the symptoms are in the patient’s head,” says Ed Knight, Ph.D., Vice President for Recovery, Rehabilitation and Mutual Support at ValueOptions, the Maricopa County RBHA.

Knight has firsthand experience. Suffering from chest pains, he was refused a stress test by a doctor who believed the problem was a result of his mental illness. And he is not alone. As one of the nation’s foremost consumer advocates, he knows how difficult it can be for people with mental illness to receive appropriate primary care.

“Doctors’ stigmatizing attitudes put people’s lives at risk,” Knight says. “No matter the patient, a doctor should treat presenting physical conditions the first time around. If the condition is somatic, then that will become apparent through testing for physical symptoms.”

The unwillingness of primary care doctors to address mental health issues encourages a climate in which certain psychiatric medications are over-prescribed. “A ridiculous number of prescriptions for Prozac and tranquilizers are written for minor issues,” Knight says. “Filling out a prescription is just one more way to avoid interacting and dealing with mental health issues.”



## Staffing

Shortages of nurses, physicians and other health care professionals is well documented in Arizona and other states, and includes a litany of problems affecting access, quality and cost. (*Boom or Bust: The Future of the Health Care Workforce in Arizona, Spring, 2002*) To no great surprise, these issues show up in the integration of behavioral health and primary care as well. With limited availability of psychiatrists, psychologists and social workers/counselors, the competition for qualified behavioral health providers is intense, both from the physical and behavioral side of the house. Arizona ranks 29th and 27th in the U.S. respectively in number of psychiatrists and psychologists per 100,000 population. (*Bureau of Health Professions, State Health Workforce Profiles, 1998*)

The situation is compounded in an integrated or “shared” environment, where professional roles and relationships are often not as clearly delineated – and rewarded – as they are in more traditional carve-out settings. Everyone is looking for quality people, and there are not enough of them to go around.

## Treatment Standards and Guidelines

The integration of behavioral health in a primary care setting – and vice versa – is relatively uncharted territory for “standardized” treatment protocols. Professionals disagree, for example, on both the definition and value of “brief therapy,” which represents a significant change from the way services are provided in a managed care behavioral health carve-out plan. Behavioral health providers have developed evidence-driven protocols for treating specific problems (depression, alcoholism, etc.) in one setting that aren’t necessarily feasible in a setting with a different provider and “time mix.” Standards and treatment guidelines are being developed for integrated practices, but it takes time to see them widely adopted in practice.

According to David Landrith, Vice President for Policy and Political Affairs at the Arizona Medical Association, “without the guidance of accepted policies and standards of care at the state level and in the professional communities, there is no clear idea of how to go about integrating care, and determining who is responsible for what in delivering services.

# A Faux Humpty Dumpty?



Practically everyone supports the concept of integrated care, but the majority of professionals on the behavioral health side of the equation are reluctant to relinquish the carve-out model because it protects behavioral health funding and benefits.

One response to protecting those dollars and benefits and still have an integrated delivery system is to find ways for vendors to offer “integrated contracts.” Here a general contractor purchases components of an integrated system in modular form and puts them together, specifying the details in the contract and monitoring management.

There is a difference, of course, in an integrated system that is more than the sum of its parts and one that is a collection of separate parts that are “managed” to *appear* integrated. The difference may well be moot for patients who *perceive* a collection of separate parts as a seamless and transparent whole in the clinical setting, but it is always relevant on the financial and management side of the house, where Humpty Dumpty still lies on the cutting room floor with contractors picking over the separate pieces and accounting for their own “carve-outs” separately.

But if a faux Humpty Dumpty appears whole, who’s the wiser – and who cares anyway?

# Models of *Integration*



*“A developmental continuum is needed that starts with recommendations for coordination, moves to a higher level of collaboration, and then toward integration.”*

*Center for Health Care Strategies, 2002*

Models of integration can be framed within an analysis of system sectors, models of sector organization and a continuum of collaboration between sectors.

## System Sectors

The Surgeon General’s 1999 report on mental health identified four general system sectors:

- **THE SPECIALTY MENTAL HEALTH SECTOR** – services provided by specialized mental health professionals.
- **THE GENERAL MEDICAL/PRIMARY CARE SECTOR** – services provided by general health care professionals.
- **THE HUMAN SERVICES SECTOR** – services provided by social welfare, criminal justice, educational, religious and charitable groups.
- **THE VOLUNTARY SUPPORT NETWORK** – services provided by community-based organizations and self-help groups.

A fully integrated model of care assumes that all of these system sectors are in place and available to consumers. This obviously isn’t the case in many rural areas and other places where basic primary care often is hard to find, let alone specialty behavioral health care, and transportation and coordination over long distances present significant challenges.

## General Organization Models

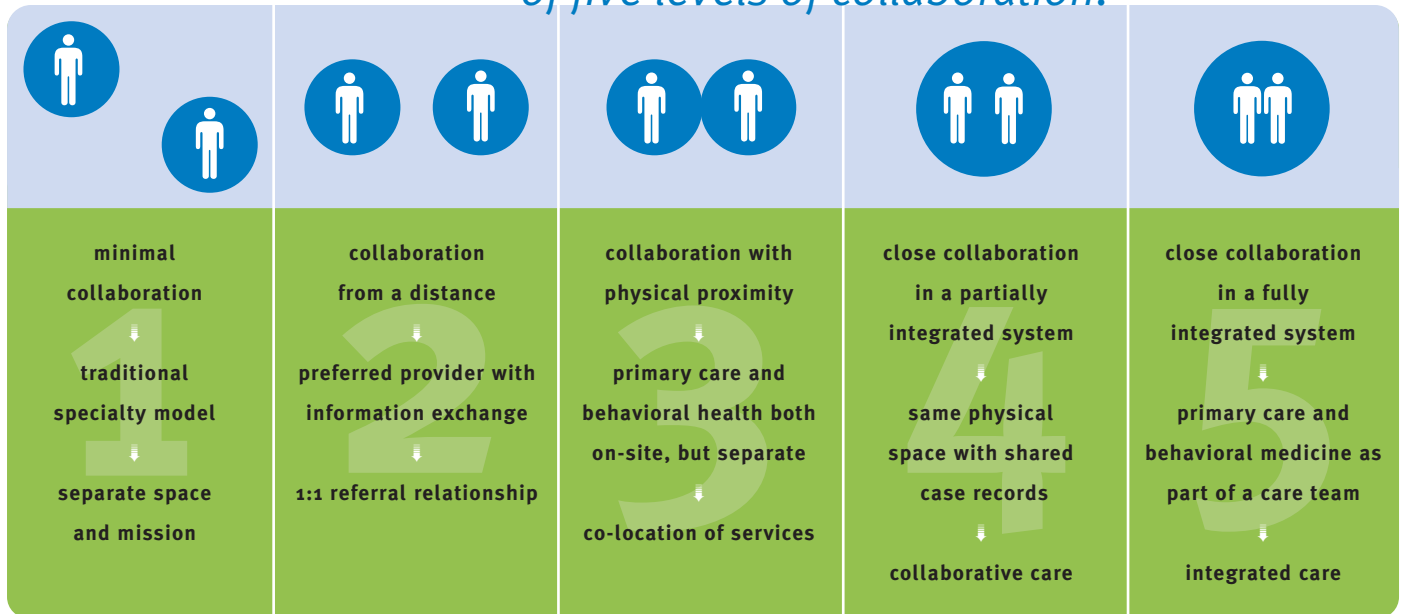
In the actual practice of integrated care, there are three general approaches or models:

1. **SEPARATE SYSTEMS** with formal methods of referral between them.
2. **A PRIMARY CARE SYSTEM** with specialty care for behavioral health included.
3. **A BEHAVIORAL HEALTH SYSTEM** with primary care included.

The involvement of the other two systems sectors – human services and volunteer/community-based networks – provide even more opportunities for integrated models of care, but our focus here is on the primary care and specialty behavioral health care sectors specifically.

# A Continuum of Collaboration\*

Across the models is a continuum of five levels of collaboration:



\*Adapted from several models (K. Strosahl, W. Doherty, et al)

## Models in Practice

Successful integration models generally have two elements in common. First, the primary care and behavioral health providers work in close physical proximity to one another. Second, they are both trained in and committed to the idea of integration.

Even with this, no model is perfect. The culture of care between mental health and primary care providers is vastly different in terms of communication style and duration of office visits. This culture clash is also evident in administrative and organizational norms, where record keeping, scheduling, billing and reporting practices can vary dramatically.

And did we mention turf battles and a failure to communicate?

## Examples –

- **THE EXCEL GROUP** serves as the Regional Behavioral Health Authority (RBHA) in the Yuma area, and has developed a model where the primary health care program is physically located in the behavioral health care outpatient clinic. The primary care providers are either employed or under contract with Excel. To complete the model, Excel plans to locate behavioral health clinicians in primary health care clinics, and to bring on a full-time education specialist to provide training and consultation services to physicians and hospitals.
- **HOSPICE** is often cited as one of the best examples of integrated care, bringing together the medical, psychosocial and spiritual aspects of care in a holistic manner according to the wishes and needs of the patient and family. Hospice providers work as an interdisciplinary team with the medical director, RN care coordinator, social worker, pastoral counselor, home care aide and family support volunteers.

According to Bette Croce, R.N., B.S.N., Care Coordinator at Hospice of the Valley, the interdisciplinary team sees the patient and his/her family as their “coach” as they teach the family to be the primary caregiver. The hospice team also coordinates care with the patient’s primary care physician, especially concerning medications. Communication is key, and is accomplished through weekly interdisciplinary team meetings.

- **THE KAISER PERMANENTE MEDICAL GROUP** in California is often cited as the gold standard of integrated care. In the Roseville/Sacramento area, care is provided through 17 primary care teams, 13 of which currently have a psychologist working with about 10 physicians, nurse practitioners and support staff.

The psychologists – called Behavioral Medicine Consultants to clarify their role and reduce stigma – co-manage mental health problems such as depression and anxiety, and work with the primary medical providers to manage patients with symptoms of chronic pain, headaches, fatigue and insomnia, as well as diabetes, hypertension and coronary heart disease.

- **VALUEOPTIONS**, the Maricopa County RBHA, has “rapid response” teams that are available 24/7. The first contact is generally a psychiatric nurse or Master’s prepared counselor who goes on-site to provide clinical and discharge planning. A psychiatrist is also available to assist with cases that present a challenge for discharge planning.

According to Bill Bonfield, M.D., M.P.H., the chief medical officer for ValueOptions, “This is integration, as there are two delivery systems on-site. Before, it was done by phone with the hospital in control, which had to call the RBHA for authorization. The new on-site system works better and provides better clinical care. The goal is to do clinical and discharge planning, not utilization management.”

By next August, the plan is to roll the program out to every Valley hospital for Title XIX patients.

- **BANNER HEALTH SYSTEM FAMILY PRACTICE RESIDENCY PROGRAM** has developed a collaborative model of graduate medical education in which residents are trained to care for the entire range of patients and illnesses “from cradle to grave,” including medical, behavioral and preventive care.

The faculty consists of nine family practitioners, a psychologist, two Master’s prepared social workers and two graduate psychology interns. A nutritionist and gerontologist are also available. The presence of the psychologist on the faculty is a requirement of all family practice residency programs.

Jim MacKenzie, Ph.D., Assistant Residency Director in Family Practice, describes the program as “de facto” integration, where every effort is made to let patients know that behavioral health is as important as physical health. The goal is to make sure the patient is able to get behavioral health treatment before they leave the building. The most frequent patient problems encountered are substance abuse, tobacco cessation and depression.

- **THE SCOTTSDALE HOLISTIC MEDICAL GROUP**, a private group practice, has combined primary care with behavioral health since 1989. According to the Group’s founder, Gladys Taylor McGarey, M.D., their guiding philosophy is the recognition that “humans are ‘total beings’ made up of mind, body and spirit, and there is often a need to get to what’s behind the (physical) illness.”

Dr. McGarey notes all of the familiar problems faced by integrated programs, including lack of reimbursement, patients who want quick fixes and time constraints. Still, she believes integrative care provides superior results in addressing many conditions such as arthritis, diabetes, multiple sclerosis, fibromyalgia and even cerebral palsy.



# Integration and Community Health Centers

Leading the way in the effort to fund integrated behavioral health services is the Bureau of Primary Care at the federal Health Resources and Services Administration (HRSA). The Bureau offers ongoing \$100,000 grants for federally funded community health centers to place a behavioral health professional in their primary care clinics.

Over the next five years the Bureau wants to provide integration grants to 95 percent of the nation's federally funded community health centers. This year it will award an additional 70 to 90 grants for behavioral health integration.

Four Arizona centers began receiving these grants last year: El Rio Health Center in Tucson, Marana Health Center in Marana, Mountain Park Health Center in Phoenix, and North Country Community Health Center in Flagstaff. Additional Arizona community health centers are expected to apply this year.

## The Marana Example

The Marana Center, located about 20 miles northwest of Tucson, sees about 85 patients a day on its medical side. Its mental health department reports approximately 500 sessions a month. The Center also has a department for serving people in the Women, Infants and Children (WIC) program, and a community services department, which runs a food bank and other programs. The majority of Marana's clients are enrolled in the AHCCCS program (about 80 percent), but the Center says it is working to change the payer mix.

The behavioral health specialist chosen to fill the primary care position at Marana, which was officially funded in December 2002, is a social worker from the behavioral health department. However, he is considered a fulltime member of the medical department, and his entire day is spent working with primary care patients.

## Medical, Not Behavioral

As far as the patients are concerned, the specialist is neither a counselor nor a behavioral health professional. Instead, he is referred to as a medical consultant, says Michelle Ellis, Ph.D., Marana's Director of Behavioral Health.

As many have observed, patients don't always react well if a doctor recommends they speak with a psychologist or other behavioral health professional. "A patient may think that the doctor is suggesting that the problem is all in the patient's head," Ellis says.

At Marana, the doctors make their references as nonchalant as possible. They refer to the behavioral health specialist as a medical consultant who can be helpful to the patient in dealing with his or her problem. Ellis reports that several months into the program, at least two doctors are using the behavioral health specialist on an ongoing basis. Other doctors on the staff of seven aren't using him as much as they could, but the program is still in its early stages.

## The Need is There

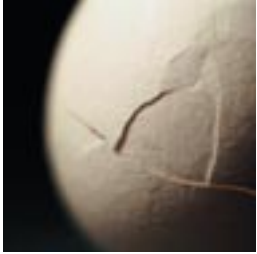
Certainly the need is there, Ellis says. About 70 percent of patients found in the waiting room of the rural community health center have some sort of behavioral health issue.

There is a tendency to want to refer those patients to the mental health side, Ellis says, but the point of the program is to first work with them in the primary care setting in order to reduce the number of services they use.

If a patient is in need of psychiatric help, the specialist will refer the patient to the behavioral health side of the center. Otherwise, the behavioral health consultant and the primary care doctor meet to discuss how to treat the client. The doctor may decide to change the patient's medications, or the consultant may develop a behavioral contract with the patient and see if that helps lower the patient's utilization of medical services.

*According to Ellis, Marana hasn't experienced many of the barriers between medical and psychiatric departments that are often found in community health centers. For example, one of the center's social workers, who is experienced in shiatsu, has worked with primary care doctors for years in the area of pain management.*

# Fractured Providers, Fractured Choices



*Let's look at providers and their choices from both sides of the continuum:*

## **Primary Care: Five (not so easy) Choices\***

On the primary care side, the physician has five choices – quandaries, really – for handling behavioral health issues:

1. Against great time constraints (and assuming appropriate training) she can treat the mental health aspects herself.
2. She can refer the patient to a behavioral health provider, conscious of the odds that only one patient in four will actually show up for the first appointment.
3. She can write a prescription, knowing that medication without therapy isn't very effective, although it can be costly.
4. She can refer the patient to another medical specialist for further diagnosis and treatment of the ongoing physical symptoms.
5. She can establish an on-site behavioral health service and realize (significantly) less revenue per square foot for her office space.

For the primary care provider, almost all of the reasons for integrating behavioral health care on-site are clinical. Almost all of the reasons for carving it out are financial.

\*Adapted from workshop materials by Kirk Strosahl, Ph.D., Mountainview Consulting

## **Behavioral Health: Two (often illusionary) Choices**

Kirk Strosahl, Ph.D., a behavioral health expert on integrated care with the Mountainview Consulting Group, describes integration against the backdrop of two directions:

**HORIZONTAL INTEGRATION** – delivering a large volume of brief, targeted psychosocial services with the goal of systematically improving the behavioral health status of the population. This is consistent both with a broad definition of primary care that includes wellness and prevention, and also the use of non-physician providers who focus on behavioral principles, populations and social services wraparounds.

**VERTICAL INTEGRATION** – providing targeted, specialty behavioral health services to a well-defined subpopulation, e.g., people with major depression and other serious mental illnesses. While vertical integration assumes some co-management of the patient with the primary care provider, it is more consistent with the medical and psychiatric expertise of the psychiatrist or psychiatric nurse practitioner.

Tom Sawyer, Ph.D., president of Southwest Health Alliance and Health Directions Consulting, sums up the differences between horizontal and vertical integration by noting that, “You need to have some ‘generically trained’ behavioral health professionals who have

brief therapy skills and tools for such issues as stress and depression. But you also need to have mental health professionals who have a specialty with chronic illness, such as diabetes, who can improve the emotional and cognitive functioning of the patient.”

What one needs, and what one can get, however, are often two different things. Roles and relationships between behavioral health providers – psychiatrists, psychologists, counselors and social workers are no less fractured and contentious than they are among physical health providers. To cite just one example, bring up the issue of whether Ph.D. psychologists ought to be able to prescribe psychotropic medications and watch people go ballistic.

### **Competition for Providers**

Even if the differences and settings that best suit the unique knowledge and skills of providers are appropriately matched, the choices are illusionary if providers can't be found to fill the demand. Bill Bonfield, the Chief Medical Officer for ValueOptions, notes that to find and hire psychiatrists and other behavioral health staff at all levels is difficult.

The competition for providers will likely increase in the future as federal funding pushes the co-location of behavioral health and primary care services in federally funded community health centers (CHC) as part of an overall effort to expand the number, capacity and capabilities of the CHCs.

Under the new initiative, funding goes directly from the federal government to the clinics, which are not required to coordinate service delivery with existing mental health services funded under the Substance Abuse and Mental Health Services Administration (SAMHSA). This could set up some stiff competition for providers in a state that graduates fewer doctors, nurses and psychologists than many other states on a per capita basis.



## *At the Crossroads: M.S.W.s*

Blue Cross/Blue Shield of Arizona is currently contemplating whether to allow direct access to behavioral health providers, or to manage its behavioral health benefits through a gatekeeper, such as the primary care provider.

If the plan moves to an open arrangement rather than having the gatekeeper model, the next question is whether to include professionals with Master's degrees in social work and counseling (M.S.W.) as eligible providers. Gary D. Smethers, M.D., Senior Vice President and Chief Medical Officer of the large Arizona plan, believes they are well worth including, but not all medical and behavioral health professionals agree.

For most primary care patients who are referred to an M.S.W., beginning the therapy is the easy part. Determining when to end therapy is the challenge. If utilization is excessive, it will drive health care costs up. On the other hand, if it removes the “walking worried” from the medical system, where patients may undergo expensive diagnostic tests for what turns out to be a stress-related problem, then the system saves money.

One possibility, Smethers says, might be to assign a higher relative value to the counseling. A \$5 co-pay is simply too little for patients to get a sense of the value of the services they are receiving.

# Does *Integration* Pay?

*A 10 percent reduction in medical/surgical costs resulting from integrated behavioral health care interventions would exceed today's entire mental health budget.*

*Nicholas Cummings, 2000*

## **The Medical Cost Offset**

An “offset” occurs if medical utilization decreases as a result of behavioral health intervention. The term for this is *medical cost offset*, and there’s ample evidence in research and practice to indicate that significant savings can be derived from providing people with appropriate behavioral health services before they use more expensive acute care medical services. (See [www.apa.org/practice/offset3.html](http://www.apa.org/practice/offset3.html) for an introduction to the literature.)

But savings for whom? This is where the issue gets cloudy.

## **Cost to You, Revenue for Me**

Advocates for the closer integration of behavioral and primary care health services point to savings of 20-40 percent of total system costs – and a general increase in system efficiency – from well designed integration programs. (*Strosahl, 2001*)

But remember one of the central characteristics of health care Wonderland: Everything singular is plural. There is no health care system. There are only systems, and they often work at cross purposes and in intense competition with each other.

A medical cost offset is a plus for the patient and his health plan because they are spending less money and getting a good outcome. It’s also a plus for the behavioral health provider, because it’s revenue on their side of the “system” ledger.

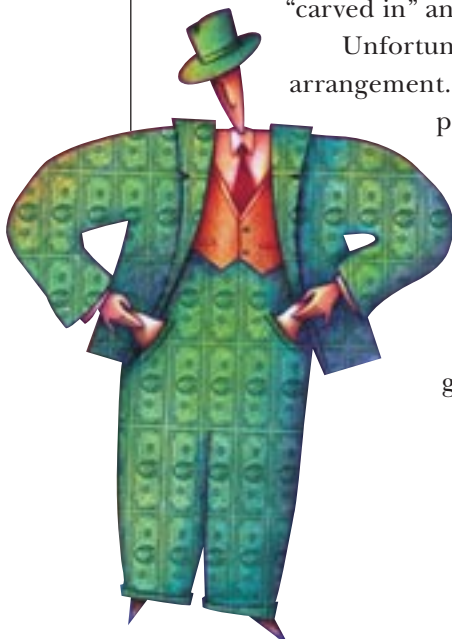
But it’s potentially a minus for acute care providers, who realize less revenue from fewer office visits, lab tests, hospital admissions, referral to specialists, etc. There’s a food chain here that depends on high demand for services, and the idea of providing *fewer* services is, economically speaking, a nonstarter for certain groups, depending on where they sit in the chain.

## **Where It Works the Best**

The benefits of the medical cost offset are seen most clearly in tightly integrated managed care plans like Kaiser Permanente, where behavioral health and medical services are “carved in” and managed for maximum efficiency and quality.

Unfortunately, many consumers and providers don’t like the managed care arrangement. Consumers say they want the freedom to choose providers; providers say they want to practice independently, deal with patients directly and are in the best position to decide what the client “really needs.” And, of course, everyone wants low costs and high revenues for themselves.

In this environment, the medical cost offset argument plays a distant second fiddle to the autonomy and control argument. One wonders whether a focus on “saving money in the system” is going to get us very far.





# Rules On the Road to Integration

*Clinically, the integration of behavioral health and primary care services makes sense. In terms of fragmented financial, organizational and political forces, however, the movement to put Humpty Dumpty together again faces some formidable challenges.*

*By way of summary of central themes in this Arizona Health Futures Issue Brief, here is our take on rules to follow in traveling down the integration road.*

## Fragmentation Rules

**FRAGMENTATION RULES.** We *understand* the world as a whole – we just don't *live* in it that way. Practice trumps theory every time. We live between the cracks of systems, and not in systems themselves. If we start with the reality of systems fragmentation and design our trip in smaller steps down the integration road accordingly, we will travel much farther than if we insist everyone see the clinical and financial wisdom of integrated systems at the start of the journey and get on board.

## Language Matters

**LANGUAGE MATTERS.** Stigma and language go hand in hand. The cultural baggage and myths carried by the term 'mental' overwhelm the logic of science and biology. Providers who have made progress with systems integration know this; that's why they refer people to "behavioral medicine" specialists and not to psychologists and "mental health" professionals. What we call something often makes all the difference in the world.

This applies to the term 'integration' as well. To both a behavioral health and primary care provider, the term can connote loss of control, and even loss of quality. It means something different than the terms 'cooperation,' 'collaboration' and 'coordination.' We might want to use the term 'integration' less and concentrate on better coordination and collaboration among behavioral health and primary care providers first. Integration will flow forward in the process.

## Space and Time Converge

**SPACE AND TIME CONVERGE.** Health care is provided in real space and time: the clinic, the home, the office, the hospital, even the street. Time for care can vary widely; behavioral health providers used to spending one hour with someone to probe the psychosocial dimensions of their medical problems often aren't prepared for a 15-minute consult in a fast-paced medical clinic, or working in a team setting where they aren't the leader.

Co-location of behavioral and primary care health services has demonstrable clinical advantages, especially for the patient. But it often isn't practical or even desirable, depending on whether the patient needs to be in the care of specialists in specialized settings, whether providers are trained to work in integrated settings, and whether financial incentives are aligned with the interests of all the parties.

Here, the best can be the enemy of the better. Where it's hard to co-locate behavioral and primary medical services and make the financial numbers work out, providers can improve communication and coordination between themselves through better technology, transportation and education. We don't have to see the end of the journey to take the first step.

## Technology Is Key

**TECHNOLOGY IS KEY.** Regardless of whether they share the same physical location, primary care providers are going to have patients who need behavioral health services, and behavioral health providers are going to have patients who need medical services. Everyone with whom we spoke on the issue of behavioral health integration agreed on the need for better communication between all parties, and the role technology can play in that process.

For example, Bill Bonfield, M.D., Medical Director at ValueOptions, puts an information sharing system with instant access between physical and behavioral health providers at the top of his list for improving integration of care.

“Health care is behind the times with technology, and it could solve so many problems. I envision a system in which technology – real time information on patients plus evidence-based practices and provider profiles – is available. Providers could monitor their own performance, and there would be a decrease in medication errors. The technology is there – we’re just not using it yet.”

Others agree. Diane Christensen, clinical coordinator for the behavioral health unit of AHCCCS’s Office of Managed Care, says that an AHCCCS workgroup is currently investigating ways to share data among its multiple data systems.

“The behavioral health side needs to know which primary care doctor has been assigned to each of their clients, and the primary care side needs to know whom to contact for particular patients with behavioral health needs,” says Christensen. “A data-sharing system would provide basic information about each shared patient: contact names and numbers, medications each system is prescribing, lab work, diagnoses and major medical conditions.”

## Education and Respect

**EDUCATION AND RESPECT ARE INSEPARABLE.** Time and time again we heard from both sides of the fence about arrogant physicians, clueless behavioral health providers, unrealistic expectations and different cultures. Behavioral health providers think they don’t get the respect they deserve; front line physicians think behavioral health providers don’t understand the pressures and time constraints they face every day.

In the successful collaborative and integrative models we saw, the key to success was constant, deliberate communication and ongoing education and training. This starts with the formal education of physicians and behavioral health providers; integrative resident training programs like Banner Health’s Family Practice Program; and on-site collaborative practice, where physicians and behavioral health providers spend time together in a coordinated team environment to discuss patient treatment plans, planning and monitoring issues.

As easy as cynicism is in a fractured health care environment, it wilts under mutual respect and dialogue. This doesn’t happen automatically. It starts from education in the theory and techniques of integrative practice from professional school and residency programs onward to team training in daily practice settings. In the best integrated programs, ongoing education feeds mutual trust and respect.

## Money Talks

**MONEY TALKS.** The depressing thing about most clichés is that they’re true. America’s acute care health system is driven by high tech, intensive and costly services, and those whose palms are greased by the money flow will not go gently into the good night of cost effective integrative practice without the requisite financial incentives.

Of all the barriers to the integration of behavioral health and primary care, aligning financial incentives with the needs and interests of the players is arguably the most difficult. It’s fairly straightforward and transparent in an integrated managed care system, where every-

one “works” for the plan, so to speak; it is considerably more opaque and thorny where everyone at the tea party keeps time to a different financial clock.

To wit: A young woman is both bipolar and diabetic. During a manic phase, she is unable to manage her diabetes and is hospitalized. Although her bipolar disorder is stabilized, her blood sugar levels remain erratic. Her fragile mental state does not allow a quick discharge as she would be unable to manage her diabetes. The medical health plan argues that this is a mental health issue, while the behavioral health plan argues that the mental health situation is stable, and the problem is now primarily medical.

No one seems to have an obvious answer to this. One interesting possibility is to find ways to integrate the patient’s reimbursement options into the clinical treatment planning process. Information systems are being developed that actually could promote this. The downside, of course, is that an “unbiased” decision on the best treatment could be compromised by the patient’s reimbursement options.

That’s the thorn in the integration rose: How pure can we afford to be when money talks?

## *Protocols Push Practice*

**PROTOCOLS PUSH PRACTICE.** When it comes to having evidence-based treatment protocols and guidelines, the integration movement is in a Catch-22: We don’t have protocols because we don’t have enough integrated treatment practices in which to test and use them; we don’t have enough integrated practices because we don’t have the protocols to push and validate them.

To be fair, the lack of widespread adoption of treatment protocols isn’t limited to the small universe of integrated behavioral health and primary care practices. In the medical world, some practices know full well the protocols for the cost effective treatment and prevention of heart disease, but they still run as many people as possible through the cardiac surgery suite because the big margins go straight to their financial bottom line.

A core group of dedicated professionals on both sides of the aisle is working on evidence-based treatment protocols in integrated settings, but it’s slow going in the Humpty Dumpty world we’ve outlined here. Still, they’re coming. The logic and good reasons are all there. The trick is to align them with providers’ perceived self interests.

## *Leadership Is Critical*

**LEADERSHIP IS CRITICAL.** We heard this time and time again: If leadership isn’t behind integration efforts 100 percent, it won’t happen, no matter what you have going for you. Jim MacKenzie at Banner Health put it succinctly: “Leadership is critical. They can’t have mixed feelings about it [integrating behavioral health and primary care]; they have to be willing to spend money on it. If a social worker costs \$50,000 a year, they have to be willing to front the money and wait for the payoff on the back end.”

One ingredient that separates a leader from a good manager is vision. The integration of behavioral health services and physical health services is the right thing to do for all the right reasons of good science, good clinical practice and good outcomes. But it is the hard thing to do for all of the reasons of short-term financial, personal and organizational gain. The personal costs of standing against the crowd of inertia and expedience inevitably take a toll.

But that’s what leaders do. Instead of taking things apart, they put things together.

# Strategies for Action

*Here are action steps we can take today in Arizona to achieve a closer integration of behavioral health and primary care services. As in past Arizona Health Futures issue briefs that have focused on overcoming the fragmentation of services in health care, these steps place a heavy emphasis on better communication, coordination, research and education.*

**BUILD RELATIONSHIPS.** We don't have to wait until the stars magically align to get started with the promotion of team-based integrative care. The place to start is where everything begins in the social world: building relationships. Get primary care physicians and behavioral health providers together; sponsor workshops and conferences, call people up, network. It takes will, energy and patience; it doesn't have to cost a lot of money.

**START FROM WHERE YOU ARE.** We found a number of promising models and practices of integrated care in both the public and private sectors. We should build on those and not insist on a one-size-fits-all model. What we should insist on is collaborative, team-based care in all settings, not just behavioral health and primary care.

**LOSE THE OBSESSION WITH INTEGRATION AND CO-LOCATION.** We use the term 'integration' throughout this issue brief because it dominates the literature, but we would probably be better off to use the terms 'collaboration' and 'coordination,' which imply togetherness without losing one's separate identity and "place" in the world. Co-location of services, too, is not a necessary condition of integration, and can even be a detriment if the shared space and staff lack integrated management and financial systems. Where it makes sense, providers should pursue it. If not, there are many ways to work more cooperatively across sectors without being in the same physical space.

**FOCUS FIRST ON OUTCOMES, NOT COSTS.** One of the reasons we have skyrocketing health care costs in this country is that we don't pay enough attention to what we're getting for our money – the outcomes – and end up with care that is often unnecessary, expensive and does little to improve health. Health plans, public agencies, professional training programs, businesses and funding groups should support the development of evidence-based protocols in integrated clinical settings that demonstrate superior outcomes; disseminate these to purchasers and providers for adoption and leverage, and educate their constituencies, members and employees on the advantages of seeking care in integrated settings that use the protocols. In the end, this will do more to control costs than short-term cost-cutting measures.

**SUPPORT THE DEVELOPMENT OF INTEGRATED DATA INFORMATION SYSTEMS.** Integration at the level of patient care is difficult, if not impossible, without integration at the level of administrative and financial infrastructure. Having patient records, treatment plans, medication schedules, and financial information in one electronic record that's easily and quickly

accessible – with safeguards – to both behavioral health and primary care providers can go a long way to making clinical integration more likely. Many organizations are working on this already with their own systems; we need more public-private partnerships to encourage data sharing across systems to make it possible for behavioral health – and all of health care – to focus on population-based studies and outcomes.

**STEP UP EDUCATION AND TRAINING ACTIVITIES IN TEAM-BASED CARE.** There is no substitute for exposure to the principles, techniques and possibilities of behavioral health and primary care integration through ongoing education and training in team-based care. This has two dimensions:

- An earlier and more thorough introduction to the principles and practices of integrative, team-based care in professional training for all health care providers and administrators. We all learn about the fragmented world of American health care soon enough; providers ought to at least be exposed to the right principles and practices of team-based integration in professional training programs. We can start with revising curricula along the entire continuum of care.
- More public-private training and dissemination partnerships in team-based integrative care: workshops, conferences, web-based materials, small demonstration projects, marketing successful models. One of the ironies of modern health care is that the field is awash in data, and practitioners are isolated from interpreting and applying it in practice. Health plans, public agencies and funders should combine resources to disseminate successful models and techniques.

**ALIGN FINANCIAL INCENTIVES.** We know it's heresy to say this in the current climate of managed care bashing, but the integration of behavioral health and primary care services appears to work best in tightly managed care settings where all of the financial incentives are under one roof, so to speak. Where they are not, we should look for new ways of providing incentives for providers to do the team-based planning and case management necessary for holistic care. Carve-outs aren't going to go away anytime soon – nor should they for special populations like the seriously mentally ill – but the health of the fragmented parts can't exist for very long without connections to the health of the larger whole.

Health care is a social enterprise, and successful social enterprises work best in team settings supported by integrated and transparent communication and information systems. Despite our seemingly unlimited propensity for taking things apart, the world is hooking up at a breathtaking pace, and the transformation to integrative and holistic care is on the horizon.

*We just need to get on with it.*



## Acknowledgements

The following individuals provided significant background information and insights into the complexities of behavioral health and primary care integration. We sincerely appreciate their thoughtful contributions to this publication. We especially wish to acknowledge the work of Debra Trachy, Trachy Healthcare Management, for conducting interviews and providing a wealth of relevant research material.

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**Diane Redulla**  
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## Our Mission

*To improve the health of people and their communities in Arizona, with an emphasis on vulnerable populations and building the capacity of communities to help themselves.*

The purpose of *Arizona Health Futures* is to unravel an important health policy topic of relevance to Arizonans, provide a general summary of the critical issues, background information and different perspectives on approaches to the topic; tap into the expertise of informed citizens, and suggest strategies for action.

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Comments and suggestions for future issues, as always, are welcome.

St. Luke's Health Initiatives is a public foundation formed through the sale of the St. Luke's Health System in 1995. Our resources are directed toward service, public education and advocacy that improve access to health care and improve health outcomes for all Arizonans, especially those in need.

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