If Robin Henderson, PsyD, gets her way, the hospital where she works will slowly contract. “I have a running joke with our CEO that I’ll know we’re successful when the hospital’s fifth floor becomes a yoga studio,” says Henderson, director of government affairs at St. Charles Health System in Bend, Ore.

Henderson hopes to improve the health of central Oregon’s residents so much that hospitalization rates drop dramatically, a goal she’s helping to achieve by integrating psychologists into every level of the health system.

Henderson isn’t the only one driving such integration. With health care reform encouraging greater consolidation among health service professionals and organizations, the trend is toward integrating mental health, behavioral health and substance use services in all kinds of treatment settings.

Of particular interest to psychologists are emerging opportunities in new types of settings, such as patient-centered medical homes and accountable care organizations. But whether integration takes place in primary care or at the health system level, the “triple aim” goals are the same: enhancing the experience of care, improving the health of populations and reducing costs.

Integrating primary care

Primary care as traditionally practiced can’t achieve that triple aim, says Frank V. deGruy, MD, who chairs the department of family medicine at the University of Colorado School of Medicine. That’s because traditional primary care is problem-focused, not patient-centered, he says.

“Primary care practices are built on the assumption that the basic problems we’re set up to deal with are acute care problems,” says deGruy, citing as examples cystitis and ear infections. Yet 80 percent of health care dollars are spent on chronic conditions, he says, which can’t be handled the same way acute problems can. “You can’t wait until diabetic people can’t see or need their foot amputated,” he says. “You have to get people into a program of care before they’re physically or psychologically symptomatic.”

Enter the patient-centered medical home, which offers care that goes beyond what’s offered in what deGruy calls the traditional “reactive” form of primary care. Focusing on chronic disease, patient-centered medical homes at their most basic feature care managers who coordinate services, quality improvement initiatives and disease registries that help clinicians keep track of patients with specific diseases and identify gaps in care.

But to truly achieve better care, health and costs, says deGruy, patient-centered medical homes have to be comprehensive. Up to two-thirds of deGruy’s patients meet the diagnostic criteria for mental health disorders, have psychological symptoms or substance abuse problems that are impairing their health or have chronic physical conditions that require difficult behavior change, he estimates. “Lucky for us, there’s an easy way to become comprehensive,” he says: incorporating behavioral health care into everything a patient-centered medical home does.

In addition to joining patient-centered medical homes in primary care settings, psychologists can help in other ways. “The patient-centered medical home is no more than a small island in a sea of health care resources,” says deGruy. “I invite you to be in our patient-centered medical homes, but you also need to be in a lot of other places.”

Health care reform offers new opportunities for psychologists.
Psychologists and other specialists in the community can help individuals make their personal care plans work, for example. They can use the same integration model that works in primary care in more specialized settings such as neurology practices and pain clinics.

Working this way creates practice opportunities for some psychologists. However, according to deGruy, hospitals and the health system as a whole “face a very interesting predicament.” That’s because when health care is done right, he says, the result is fewer hospital admissions and lower revenues for health systems.

More than half of adults in the United States – 57 percent – will meet the diagnostic criteria for a behavioral health condition at some point, says Rebecca B. Chickey, MPH, director of the American Hospital Association’s Section for Psychiatric and Substance Abuse Services. Sixty-eight percent of adults with mental health conditions also have medical conditions, which results in people with severe and persistent mental illness dying eight to 25 years earlier than their counterparts without mental illness. And 29 percent of adults with medical conditions have co-occurring behavioral health conditions.

These statistics underscore the case for integrating behavioral and physical health care, says Chickey. And psychologists should be working to make that case.

“If you’re working with hospital ‘C suite’ teams, that’s the kind of information they need to know and understand,” she says, referring to hospital chief executive officers, chief operations officers and chief financial officers. “You’re the people who can bring passion, knowledge and data with you as you work toward integration.”

Evidence for integration’s benefits abounds, says Chickey:

- **Increased risks.** To take just one example, Chickey says, depression is associated with significantly increased risks not just of having a stroke but of dying from it. Untreated depression is associated with a 55 percent increase in fatal stroke, for instance. Similar studies link mental illness with obesity and diabetes, she says.

- **Increased costs.** Mental disorders are one of the most expensive conditions adults can have, says Chickey, with health care spending on mental disorders ranking third for women – behind only heart disease and cancer – and fifth for men. Plus, having a mental health disorder boosts treatment costs for chronic medical conditions, she adds.

- **Shrinking inpatient capacity.** There has been a significant decline in inpatient mental health services over the last two decades, says Chickey, with a corresponding increase in outpatient services. At the same time, drugs prescribed by primary care doctors have become an increasing part of mental health expenditures. “That’s another reason it’s so important to integrate behavioral health and physical health at the primary care level,” says Chickey. “It’s where so many people are getting their behavioral health services right now.”

- **Improved access and lower costs.** Research shows that integrating behavioral and physical health care improves people’s access to appropriate care, says Chickey. In integrated care, for instance, 85 percent of patients with serious mental illness get their blood pressure tested, compared to just 66 percent of patients in other settings. Plus, she says, evidence shows that coordinating care can lower total costs for patients with serious mental illness.

For more data about why integrating behavioral health and physical health is so important, see the American Hospital Association’s January, 2012 Trendwatch at bit.ly/4PYfe2.

**WHY INTEGRATION MATTERS**

“Why would a hospital that depends on admissions contribute to the development of a system that results in fewer hospital admissions?” deGruy asks. “It’s a question that hospitals are answering right now.”

**Integrating health systems**

St. Charles is one of the health systems busy answering that question. The answer lies in new financing mechanisms, such as bundled payments, capitation and shared savings programs, in which hospitals and health systems are beginning to assume some risk.

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“How are we going to get paid in the future? For the outcomes we produce,” says Henderson. With these new financing models, hospitals and health systems do better when their patients get better.

That’s the case for St. Charles, which is part of one of Oregon’s coordinated care organizations. Overseen by the Central Oregon Health Council, which Henderson directs, the coordinated care organization has launched several initiatives that show that integrating physical and behavioral health care improves patients’ outcomes and reduces Medicaid costs. Thanks to a shared savings agreement with Medicaid, the health system gets to keep some of the money saved. As a result, says Henderson, the incentive is now to provide better care rather than to drive admissions.

And that means integrating behavioral health care into just about every corner of the health care system. The coordinated care organization’s “transformation initiatives” include embedding psychologists into a wide range of settings to offer behavioral interventions to individuals of all ages who have medical problems. In obstetrics, psychologists help women comply with recommended regimens; provide screening, brief intervention and referral to treatment for substance use problems; and are on the look-out for post-partum depression.

Putting a psychologist in the neonatal intensive care unit, which Henderson says is the most expensive place in any hospital, has already reduced lengths of stay and costs. The psychologist also identifies children with special health care needs, so that intervention can begin right away.

“Five percent of children are responsible for 60 percent of pediatric health care spending,” says Henderson. “When we intervene earlier, we lower lifetime health care costs.”

At the pediatric level, a psychologist is helping young patients learn how to better control their asthma, a major source of expensive emergency room visits. Psychologists also help patients transition out of the hospital. “It’s been remarkable to see the impact on re-admissions,” says Henderson.

The same strategy works for adult patients with complex health care needs, says Henderson, explaining that just 12 percent of patients account for 82 percent of costs. By embedding psychologists in primary care, the coordinated care organization is beginning to identify and intervene with patients on their way to developing chronic conditions.

Behavioral health integration is even beginning to happen outside the formal health care system. The coordinated care organization’s next initiative is to put mental health professionals in school-based health centers. Doing so will not only benefit children, says Henderson, but also parents and everyone else in the neighborhood. “We want to bring mental health to where people are,” she says.

**Opportunities for psychologists**

Some of these changes have made psychologists and other mental health professionals in central Oregon anxious, says Henderson.

Some worried that they would have to give up their independent practices and join the staff of the coordinated care organization. Others worried that the psychologists embedded in primary care would “steal their referrals,” says Henderson. That didn’t turn out to be the case.

When Henderson put two psychologists in a primary care clinic in the small town of Redmond, for example, specialty mental health providers – including both psychologists and master’s level practitioners – worried that their work would dry up. Instead, says Henderson, the psychologists in the clinic typically see clients for a few visits, decide they need therapy and refer them to a provider in the community. “The next thing you know, we didn’t have anyone to refer to in Redmond,” says Henderson, adding that the need was so great she soon opened an outpatient mental health clinic across from the primary care clinic that has since become the community providers’ main referral source.

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How can psychologists take advantage of the opportunities health care reform is bringing? The first step should be to apply for medical staff privileges at your local hospital, says Henderson. “That’s where you build relationships,” she says, encouraging psychologists to join physicians on grand rounds and invite medical colleagues out for coffee. Together, she says, you can start brainstorming about ways to integrate services and thus improve care.

And you can start small, Henderson adds. Even an experiment with a handful of patients or even just one can become the basis for improvements on a larger scale, she says, urging psychologists to launch pilot projects.

“All of our transformation initiatives were small ideas someone had that we took and turned into big action and big cash,” she says. “That’s how we’re going to change health care.”

NOTE: This article is based on a workshop presented during the March 2013 State Leadership Conference in Washington, D.C. sponsored by the American Psychological Association (APA) and the APA Practice Organization.

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Blais is also active in the Society for Personality Assessment (SPA), chairing the Personality Assessment Proficiency Committee. In 2010, APA recognized personality assessment as an area of proficiency within professional psychology. SPA is responsible for implementing the proficiency, which includes awarding of proficiency status to qualified psychologists along with creating educational materials to serve as models for proficient personality assessment training and practice.

“The society is dedicated to using proficiency status to help enhance training at the doctoral and internship levels and help guide psychologists interested in having personality assessment be a significant portion of their practice,” says Blais.

Changing payment models and the need for advocacy

Noting that it can be difficult to get psychological testing authorized and to get an adequate number of hours authorized to do a good job, Blais is also an advocate for personality assessment on the reimbursement front. As the health care system shifts from fee-for-service to a bundled care model, he says, “We have to be ever vigilant that our services are not only recognized for their value but reimbursed at a level that makes it possible for us to make a living.”

Blais is working with SPA and other groups to encourage psychologists to adopt a model similar to that used by radiologists in the 1990s, when the proliferation of imaging technologies prompted pushback from insurers. In response, radiologists examined different clinical scenarios, identified appropriate imaging procedures for each of them, and then determined the relative value and time involved.

Psychologists specializing in personality assessment should do the same, Blais says, urging his colleagues to identify 20 to 30 clinical indications that warrant a comprehensive evaluation, identify the tests that are appropriate to conduct those evaluations, then determine how much they could impact patient care and how much time those evaluations would take.

“If we could create that kind of model and get buy-in from payers,” says Blais, “we would take back control.”