Chapter 19
Family Therapists in Primary Care Settings: Opportunities for Integration Through Advocacy

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The infrastructure of the American healthcare system has created a distinct crevasse between the behavioral health and physical healthcare systems. However, American adults have repeatedly indicated that primary care is where they prefer to have their mental health needs addressed (Kessler & Stafford, 2008; Reiss-Brennan, 2010; Strosahl, 1994). For over three decades, this desire has made primary care the nation's de facto mental healthcare system (deGruy, 1996; Regier, Goldberg, & Taube, 1978; Regier et al., 1993; Strosahl, 2005). Strikingly, up to 70 % of primary care visits have a psychosocial component (Fries, Koop, & Beadle, 1993; Gatchel & Oordt, 2003).

Primary care providers, or PCPs (e.g., physicians, nurse practitioners, physician assistants), are the main source of identifying and treating mental health disorders. However, they often lack both time and the advanced psychosocial diagnostic training needed to make clinical assessments and identify subclinical concerns before they become problematic. As a result, many disorders go undiagnosed and/or untreated (Bitar, Springer, Gee, Graff, & Schydlower, 2009; Kessler, Chiu, Demler, & Walters, 2005; Kessler & Stafford, 2008; McCann & LeRoux, 2006; Reiss-Brennan, 2010). In a recent national survey, 63 % of urban and suburban and 71 % of rural physicians working in primary care claimed that in addition to the aforementioned issues, inadequate access to mental health services affects their patients' health negatively (Robert Wood Johnson Foundation, 2011). A third issue for PCPs is patients' inability to pay for necessary treatments. For example, 71 % (suburban), 73 % (rural), and 77 % (urban) of PCPs would like to write prescriptions for behavioral health services and have the cost covered by the healthcare system. However, while not all mental health disorders require psychotropic intervention (Kessler et al., 2005), impairments have been shown to impact one's overall

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functioning (especially at home and in social relationships), and even more so than common physical disorders (Druss et al., 2009). Given that up to 84 % of the most common primary care symptoms are not found to have an organic cause and typically include expensive and sometimes unnecessary testing (Kroenke & Mangelsdorff, 1989), it seems logical that MedFTs could make a contribution by focusing on the systemic picture and interventions that target biopsychosocial-spiritual (BPSS) outcomes.

Numerous pioneering authors and organizations have argued that an integrated system that offers medical and mental health treatment simultaneously is sorely needed (e.g., Alfuth & Barnard, 2000; Cummings, 2001; deGruy, 1996; Druss & Bornemann, 2010; Future of Family Medicine Project Leadership Committee, 2004; Hepworth & Cushman, 2005; Institute of Medicine [IOM], 2002; Levant, House, May, & Smith, 2006; President's New Freedom Commission on Mental Health, 2003; Strosahl, 1994), especially given that approximately 25 % of American adults (Druss et al., 2009; Kessler et al., 2005) and 11 % of children (US Department of Health and Human Services, 2010) have diagnosable mental health disorders (American Psychiatric Association, 2013). Although many medical and behavioral health clinicians want to unify their efforts, those working in primary care often lack the time, in-depth training, and billing structures to do so (Blount, DeGirolamo, & Mariani, 2006; Butler et al., 2008; Dickinson & Miller, 2010; Peek & Heinrich, 1998; Robinson & Reiter, 2007). Furthermore, not all behavioral health providers (BHPs) have been trained to address issues that extend past the individual patient (McDaniel, Hepworth, & Doherty, 1992), and/or to work in a primary care setting (Blount, 1998; Dickinson & Miller, 2010; Patterson, Peek, Heinrich, Bischoff, & Scherger, 2002; Robinson & Strosahl, 2009; Strosahl, 2005). Recently, subsets of primary care and behavioral health providers have developed various integrated applications within the fragmented system to address these barriers and strengthen the possibilities for integrated care models to succeed (e.g., Blount et al., 2006; Butler et al., 2008; Collins, Hewson, Munger, & Wade, 2010; Funk & Ivbijaro, 2008; Lopez, Coleman-Beattie, Jahnke, & Sanchez, 2008; Mauer, 2006, 2009; Mauer & Jarvis, 2010; Miller, Kessler, & Peek, 2011; Robinson & Reiter, 2007; Russell, 2010; Tyndall, Hodgson, Lamson, White, & Knight, 2012a).

Recent systematic reviews have found support for the utility of integrated care in improving depression (Archer et al., 2012; Thota et al., 2012), anxiety (Archer et al., 2012), chronic care for both physical and behavioral health of patients (Woltmann et al., 2012), as well as for couples and families (Tyndall et al., 2012a). Integrated care has also been demonstrated to improve global mental health functioning in primary care patients (Bryan et al., 2012; Ray-Sannerud et al., 2012). Bryan and colleagues (2012) found that the degree of improvement was associated with the number of behavioral health consultant appointments that patients attended and that a behavioral health intervention was also effective for patients with severe baseline impairment.

This chapter illustrates an opportunity for MedFTs to punctuate how their relational, systemic, and collaborative skills are prime for providing integrated

care. The paradigm shift from traditional behavior health settings to integrated primary care is discussed, highlighting: (a) how MedFTs can contribute at various levels of integration, (b) the clinical, operational, and financial barriers that MedFTs need to be aware of as they enter healthcare settings to provide co-located and integrated care services, and (c) possible solutions to barriers and recommendations for how MedFTs can become more of a presence in the integrated care movement.

The Role of Family in Health Care

The Institute of Medicine (IOM) recognizes the roles that families play in individual health and has been recommending their inclusion in primary care since 1994. McDaniel and colleagues (2005) asserted, "The family represents what may be the most important challenge and opportunity for today's primary care provider" (p. viii). Involving family members in individual patient care can be influential to the success and efficiency of treatment plans. Family inclusion can range from acknowledging family influence on individual health to specifically incorporating family, friends, and caregivers into routine care (IOM, 1994, 2001; McDaniel et al., 2005). Family intervention involves skills that few behavioral health professionals have, making systemically trained providers a unique contributor to healthcare settings (Tyndall et al., 2012a; Tyndall, Hodgson, Lamson, White, & Knight, 2012b).

Some of the pioneers of the family therapy field were first trained as physicians (e.g., Lyman Wynne, Murray Bowen, Nathan Ackerman, Milton Erickson, Salvador Minuchin) and focused their research and progress on the functioning of the family. Therefore, there is a legacy of relational therapists who have worked in healthcare settings. Family therapists have been practicing in pediatric settings since the 1970s and in research and teaching settings with family medicine providers since the 1980s (Doherty, McDaniel, & Hepworth, 1994). The history of interdisciplinary work is punctuated by Dym and Berman who in 1985 issued a call for "collaboration between family therapist and family physician" (p. 66). In 1986, they described in detail a fully integrated model in which family therapists and family physicians saw all patients together, forming conjoint treatment plans. By 1992, family therapist–physician collaboration had been formally named as "Medical Family Therapy" (McDaniel et al., 1992).

McDaniel et al. (1992) defined MedFT as the, "biopsychosocial treatment of individuals and families who are dealing with medical problems. As we conceptualize it, MedFT works from a biopsychosocial systems model and actively encourages collaboration between therapists and other health professionals" (p. 2). Since nearly 20 years had passed, Tyndall, Hodgson, White, Lamson, and Knight (2010) wanted to study if the definition of MedFT had evolved after advancements have been documented in the science and practice of it. After completing a yearlong

Dephi study, an expert MedFT panel lengthened its description to include what follows below.

> [Medical Family Therapy is…] an approach to healthcare sourced from a BPS-S [biopsychosocial-spiritual] perspective and marriage and family therapy, but also informed by systems theory. The practice of MedFT spans a variety of clinical settings with a strong focus on the relationships of the patient and the collaboration between and among the healthcare providers and the patient. MedFTs are endorsers of patient and family agency and facilitators of healthy workplace dynamics. (pp. 68–69).

Systems theorists hold that the most logical way to work with and study individuals is to consider their biological, relational, and sociocultural influences (Bowen, 1978; Von Bertalanffy, 1968). Engel's biopsychosocial (BPS) approach (1977, 1980) helped to extend systems thinking to a healthcare setting by developing a conceptualization of medical problems as best understood in the contexts of biological, psychological, and social factors. MedFTs are also trained to recognize the roles that spirituality (i.e., belief systems and meaning) may play in treatment (Hodgson, Lamson, Mendenhall, & Crane, 2012; Hodgson, Lamson, & Reese, 2007; Linville, Hertlein, & Prouty Lyness, 2007; Seattle Pacific University, 2010; Tyndall et al., 2012a; 2012b). The addition of spiritual awareness to systems theory and Engel's BPS model (1977, 1980) forms the BPSS approach (Hodgson et al., 2012; Katerndahl, 2008; Onarecker & Sterling, 1995; Prest & Robinson, 2006; Wright, Watson, & Bell, 1996). MedFTs apply this model routinely in their research and clinical work with patients, families, and members of the healthcare system (Tyndall et al., 2012a, 2012b).

Some debate exists as to whether MedFT is a separate field, subdiscipline of family therapy, framework, or an orientation. Tyndall and colleagues (2010) examined this debate in depth. For purposes of this chapter, the term "MedFT" will be used to refer to behavioral health providers who are trained in family intervention and/or family therapy and who work in healthcare settings, bridging physical and BPSS health. Gaining competency in MedFT requires specific training in family therapy models and interventions, behavioral health interventions, brief evidence-based models, the BPSS approach, and healthcare clinical, operational, and financial domains before they begin integration into a healthcare practice (see Chap. 3 in this text for more information; Tyndall, Hodgson, Lamson, White, & Knight, 2014). This training is critical because MedFTs often work side-by-side with PCPs who are aware of interactions between relational and health challenges, but lack the time, training, and compensation necessary to fully address these challenges (American Academy of Family Physicians, 2011; Hepworth & Cushman, 2005; Peyrot et al., 2005; Robinson & Reiter, 2007; Strosahl, 1994). In these cases, MedFTs can use their specialized relational, systemic, and diagnostic training to develop integrated treatment plans and deliver interventions that improve outcomes, especially through the venue of integrated primary care.

Integrated Primary Care

Integrated primary care is the general "service that unifies medical and mental health care in a primary care setting, and the practice of avoiding the dichotomy of 'physical' or 'mental' in defining the problems brought by a patient" (Blount, 1998, p. xi). The basic format of this model consists of PCPs and BHPs collaborating side-by-side with patients to develop, implement, monitor, and evaluate treatment (e.g., Blount et al., 2006; Butler et al., 2008; Collins et al., 2010; Funk & Ivbijaro, 2008; Lopez et al., 2008; Mauer, 2006, 2009; Mauer & Jarvis, 2010; Miller et al., 2011; Robinson & Reiter, 2007; Russell, 2010). However, because the term "integration" has many interpretations and descriptors, it may look different at various healthcare sites, making it difficult to replicate and evaluate (Miller et al., 2011; Peek, 2013).

A variety of taxonomies have been written to describe the levels of integration that a healthcare system can adopt. The most notable taxonomy was written by Doherty, McDaniel, and Baird in 1996. They identified five levels of integrated care ranging from minimal collaboration (BHPs and PCPs work in separate locations and rarely connect) to full integration (BHPs and PCPs working side by side). In 2003, Blount collapsed Doherty et al.'s (1996) five levels of integration into three broader categories: coordination, co-location, and integration. Then in 2010, Collins et al. merged the work of Doherty et al. (1996) and Blount (2003) into one taxonomy. The evolution of integration then inspired Heath, Romero, and Reynolds in 2013 to expand the five levels of integration to six. Retaining the work of Doherty et al. (1996) and Blount (2003), they broke out the three categories into two levels each in order to accommodate more descriptive characteristics so organizations can capture patient and staff experiences, as well as better evaluate their efforts toward integration.

Then in 2013, two separate teams of experts on behavioral health integration identified needed improvements in how integration is assessed and categorized. Heath et al. (2013) expanded Doherty et al.'s (1996) five levels to six levels, taking more of a developmental approach to achieving full behavioral health integration. At the same time, Peek in collaboration with the National Integration Academy Council (2013), published a lexicon model permitting integration sites to track their evolution across seven specific areas: (a) type of spatial arrangement, (b) type of collaboration, (c) level of shared workflows, (d) degree of shared care plans, and (e) degree of use of shared record, and (f) level of shared culture and training, and (g) level of organizational alignment. They believe that the lexicon method allows for a rich meaningful dialogue to take place between the supervisors, supervisee, and the site's "clinicians, care systems, health plans, payers, researchers, policymakers, business modelers and patients working for effective, widespread implementation on a meaningful scale" (p. 1), promoting a common language.

When providers strictly adhere to a coordinated care approach, it invites BHPs and PCPs to discuss patient referrals, but these contacts are rare; therefore, co-location of care is the first step to having medical and behavioral health

providers coexist in the same healthcare setting. Co-located providers might work in a manner described as collaborative or even integrated but contact between them is typically through inter-office referrals or when crisis consults are needed. They might also never communicate with each other about shared patients. While co-location most commonly takes place in healthcare settings, The National Council for Community Behavior Healthcare ([NCCBH], 2009) advocated for a bidirectional model of integration where medical services are brought into behavioral health settings as well. This means that in addition to having behavioral health providers integrated into healthcare settings, medical providers should also be integrated into behavioral health settings.

There is some debate on whether or not integration is best assessed on a continuous or dichotomous basis. Unlike Heath et al.'s (2013) six levels of integration where organizations can be assigned a specific level number, in the "Primary Care Behavioral Health" model (PCBH; Robinson & Reiter, 2007; Robinson & Strosahl, 2009), integration is seen as continuous and may be implemented in three different ways: (a) behavioral health consulting, (b) specialty consulting, and (c) integrated care services. This is similar to the beliefs shared by the Lexicon model developers (Peek & NIAC, 2013).

In behavioral health consulting, on-site BHPs are contacted by a PCP for help with mild to moderate patient behavioral health issues. The BHP will speak with the PCP outside the exam room, provide a brief assessment in the exam room, or talk with the patient about scheduling a brief return appointment, if time is limited. The BHP then provides the PCP with feedback. In specialty consulting, BHPs join other members of the healthcare team in the exam room for patients with more serious issues, but the PCP still initiates the consult. Finally, in an integrated program, patients with the most serious issues and commonly high utilizers of healthcare services are always seen by the PCP and BHP simultaneously as part of the standard of care for that particular issue (e.g., chronic pain).

In most instances, the PCBH model takes the place of a traditional 50-min psychotherapy appointment (Robinson & Strosahl, 2009). The consult model allows for the BHP to immediately be available to the PCP and patient, with a shared treatment plan made collaboratively before the visit ends, ideally, or within a few days. The treatment plan may consist of psychoeducation and patient self-management with PCP/BHP follow up. In addition, the patient will likely have several consult sessions to see the BHP for more intensive skill building, or a referral to specialty mental health services for issues too complex to treat in primary care (Strosahl, 1997).

Because MedFT was developed in family medicine training programs (McDaniel et al., 1992), a logical fit exists between integration and the principles of MedFT (i.e., systemic orientation with a focus on agency, communion, and the influence of families/relationships on overall health and well-being). However, despite the reciprocal influences of behavioral, physical, and relational health, clinical models that sufficiently address all three are not easily achieved in today's fragmented, time- and cost-driven private sector (Doherty, 2007; Patterson et al., 2002; Robinson & Strosahl, 2009). The following section presents a brief overview

of the possible barriers that MedFTs may experience as they assume employment in primary care settings.

Barriers and Strategies to Integration

Although MedFTs have an important role in the integrated care system, policy changes are needed to remove the barriers to integration impacting most BHPs (Blount, 2003; Dickinson & Miller, 2010; Kathol, Butler, McAlpine, & Kane, 2010; Levant et al., 2006). The Three-World view framework (Peek, 2008) offers a structure for reviewing each barrier and identifying where changes are needed. Using this framework, each healthcare system is seen as having three branches (or "worlds"): clinical, operational, and financial. The clinical branch is concerned with quality of clinical care and good provider–patient relationships. The operational branch is concerned with realistic, accessible care, and smooth flow between triage and treatment. The financial branch is concerned with cost-effective care as well as billing and receiving.

To have an effective, affordable, and efficient system, each branch must work together, as a change in one will invariably impact the others (IOM, 2001; Peek, 2008; Waldman, Smith, & Hood, 2003). The individual functions of the branches and the dynamic interactions between them can be conceptualized in terms of family dynamics, particularly first and second order change (Watzlawick, Weakland, & Fisch, 1974). Sometimes only one family member changing his or her thoughts and behavior can allow the family as a whole to reach some sort of stabilization (first order change). The problem itself may remain, but the system is functioning at least a little better. Over time, the new patterns and rules can lead to resolution of the problem (second order change). These patterns are easier to change when all family members are present, and if all branches are attended to, but change in just one person or branch can initiate change in the family or healthcare system. Similar to how family therapy training programs often structure their didactics around working with each person and also within the family system, the "Three-World view" (Peek, 2008) will be used here to help relational providers who are interested in working in primary care settings understand the hurdles they, and the healthcare system, must clear before achieving a fully functioning integrated partnership.

Clinical World

Barrier

Training differences often present an obstacle as medical and BHPs are generally not given instructions on how to work together (Blount, 1998, 2003; Blount & Bayona, 1994; O'Donohue, Cummings, & Cummings, 2009; Patterson et al., 2002; Robinson & Reiter, 2007). The process of integrating care is not always smooth, nor is it innate (Oser & O'Donohue, 2009; Robinson & Reiter, 2007; Tyndall et al., 2012b). Psychosocial health training is becoming more prevalent in medical education, but barriers to including the full range of necessary training have persisted (Association of American Medical Colleges [AAMC], 2011). Training for many PCPs still tends to emphasize the biological aspects of health (AAMC, 2011; Astin, Soeken, Sierpina, & Clarridge, 2006; McDaniel et al., 2005; Patterson et al., 2002), while most BHP training tends to focus on the psychosocial and/or relational aspects of health (Edwards & Patterson, 2006; McDaniel et al., 2005; Patterson et al., 2002). To prepare both sets of providers to function effectively in an integrated care setting, cross training should occur helping to advance integration through early exposure to one another's content and shared learning opportunities. While BHPs generally do not want to see a bleeding patient any more than PCPs want to walk into the exam room and see a crying patient, both are frequent occurrences in primary care settings and BHPs and PCPs need to know what to do when faced with these situations. In healthcare contexts, BHPs are aware that many patients have biomedical health issues, but often feel these issues are outside the scope of their training and thus PCPs should address them (Edwards & Patterson, 2006). Likewise, PCPs often feel overwhelmed by patients' psychosocial concerns and might appreciate someone who is trained, both in educating patients (e.g., how to make healthy choices or how to implement changes) and in addressing general psychosocial issues (Blount et al., 2006; deGruy, 2000; Robert Wood Johnson Foundation, 2011).

Alfuth and Barnard (2000) contended that to advance integration both BHPs and PCPs need to have a shared interest and respect for one another's unique language and culture. In practice, however, any multidisciplinary team of professionals "may not readily appreciate each other's strengths or recognize weaknesses except in crisis situations" (IOM, 2001, p. 131). Lack of insight into each other's traditionally separate worlds can result in differences of opinion that stem from deep-seated values combined with conflicting professional ethics about what is considered to be good clinical care (see special issue on ethics and integrated care in *Families, Systems, & Health*, volume 31, 2013). Conflicts can sometimes be resolved, but have also been identified as a common reason for the failure of integrated care projects.

Part of the conflict stems from the fact that the competencies needed for integrated care are different from those needed for traditional therapy (O'Donohue, Cummings, & Ferguson, 2003). Although many therapists working in integrated

settings feel comfortable in their surroundings (Doherty, 2007), others feel out of place, isolated, and underappreciated (Edwards & Patterson, 2006). Thus, competencies often set a baseline for what therapists should know to function as well as possible in their environment. There are several practice-based lists or texts that address behavioral health competencies in varying degrees, but most are not comprehensive across a variety of integrated care models or settings (e.g., O'Donohue et al., 2009; Patterson et al., 2002; Robinson & Reiter, 2007; Strosahl, 2005) and others are discipline specific (Interorganizational Work Group on Competencies for Primary Care Psychology Practice, 2013; National Association of Social Workers, 2005). However, only one known list has been put forward for MedFTs (see Chap. 3; Tyndall et al., 2014). Tyndall et al. (2012b) constructed a list of competencies specifically for MedFTs, as most resources do not mention specific competencies needed for BHPs providing integrated primary care (IPC) services beyond psychoeducational support for families about the patient's illness and understanding how the illness impacts the family and vice versa. While training differences may or may not significantly affect the basic competencies needed for integrated care, Strosahl (2005) asserted that a clarification of differences in scope of practice between BHP disciplines would benefit not only BHPs but also integrated teams and, ultimately, patients by including important and complementary skill sets. For example, not all BHPs are trained to provide family therapy, understand and advocate for community resources, or conduct psychometric testing.

The idea behind competency is that while each specific integrated care site requires flexibility in methods and models used by BHPs (deGruy & Etz, 2010), consistency in the core competencies of integration would allow for good patient care and open the door for the evaluation of factors contributing to this care (Strosahl & Robinson, 2008). At present, integrated care practitioners and hiring professionals have little a priori evidence of the exact skills or disciplines needed for providing integrated care. To date, no research could be located that formally examines how closely integrated care experts from a wide range of settings agree upon core competencies, or how consistent training opportunities prepare BHPs for this work. Nor does research exist that determines whether one discipline is more prepared or capable of running the behavioral health services in a primary care setting; therefore, the most prepared provider versus a specific discipline-type is a more logical choice.

Strategy

Master's level MedFTs are poised to apply their systemic training to clinical work in a healthcare setting. Doctoral level MedFTs have additional skills and training in administration and research, which are critical to designing, implementing, maintaining, and expanding integrated care programs based on measureable outcomes. However, without training in MedFT, therapists may struggle to apply a systems orientation to working collaboratively within primary healthcare systems.

Web sites and continuing education workshops along with local, regional, and national conferences focused on integrated care (e.g., Agency for Healthcare Research and Quality's Academy for Integrating Behavioral Health and Primary Care (www.integrationacademy.ahrq.gov/), Collaborative Family Healthcare Association (www.CFHA.net), Integrated Behavioral Health Project (www.ibhp.org), National Council for Behavioral Health (www.thenaitonalcouncil.org/), and SAMSHA-HRSA Center for Integrated Health Solutions (www.integration.samhsa.gov)) offer opportunities for BHPs to learn how to adapt their traditional psychotherapy training to a healthcare setting. The opportunities for specific training in MedFT range from weeklong intensives to postgraduate certificates, master's, or doctoral training tracks/programs (see Chap. 3; Tyndall et al., 2014) with varying expectations of learning outcomes and degrees of exposure to MedFT knowledge and skills.

Based on one's level of MedFT training, BHPs can approach primary care practices and highlight how their training, which includes attending to family dynamics and intervening appropriately based on level of training, makes them well suited for contributing to interdisciplinary team efforts of promoting, operationalizing, evaluating, disseminating, and refining integrated care for individuals, families, and healthcare teams. These efforts can also include identifying which competencies and systemic components are most crucial to successful outcomes. As a final clinical strategy, MedFTs should implement competency-based protocols at their clinics and evaluate and conduct new research on these competencies (See Chap. 3 for more information on MedFT competencies; Tyndall et al., 2014. See Chaps. 11–16 on research and design; Lewis, Myhra, & Walker, 2014; Mendenhall, Berge, & Doherty, 2014; Mendenhall, Pratt, Phelps, Baird, & Younkin, 2014; Polaha & Nolan, 2014; Williams-Reade, Gordon, & Wray, 2014; Zak-Hunter et al., 2014).

Operational World

Barrier

The fragmented healthcare system and competing goals of each "world" present major obstacles to harmonious balance between primary and behavioral health care (Hodgson et al., 2012; Peek, 2008; President's New Freedom Commission on Mental Health, 2003). Medical and behavioral health systems are typically trained and reimbursed to operate and attend to issues differently (Thielke, Vannoy, & Unutzer, 2007), with PCPs seen as "care managers" responsible for a patient's overall health and depending on level of integration, BHPs serving as specialists for patients who meet a provider or system's referral criteria (Blount, 2003; Collins et al., 2010; Doherty et al., 1996; Heath et al., 2013). When these two systems are combined, the providers can have a pragmatic culture clash (Kathol et al., 2010).

Therefore, having buy-in from senior clinical and administrative leaders for operational overhaul (Dickinson & Miller, 2010; Kathol et al., 2010; Strosahl, Baker, Braddick, Stuart, & Handley, 1997) is an integral component to smoothing out this clash. Even when all stakeholders prefer an integrated system, merging BHPs of any kind into daily operations of a busy clinic can present a formidable challenge (Kessler, 2008a).

Operational challenges generally center on the logistics of triaging and treating patients. This may include not having enough time or space for patients to be seen or not having a seamless referral and consultation process, for example "the physicians had to call an '800' number to arrange for a therapist colleague to walk down the hall and join a consultation with a patient" (Blount, 1998, p. xii). For PCPs, it may take time to learn to offer a referral in a way the patient is likely to accept (McDaniel et al., 2005). For MedFTs, learning to integrate with PCPs may also take artful logistics, especially in a fast-paced setting where patients spend less than 15 min in an exam room on average. Lastly, not all electronic medical record (EMR) systems have templates for psychosocial information, much less stored, in a manner accessible to physicians (Crane, 2011). Also, EMR systems organized by individual patients make it difficult to link family members together to capture shared medical history (Crane, 2011; McDaniel et al., 2005). Simply co-locating a BHP within the primary care clinic will generally not be successful; the BHP must be immersed and integrated in practice operations (Alfuth & Barnard, 2000; Kessler, 2008a; O'Donohue et al., 2003).

Strategy

Medical family therapists would benefit from workforce development on how to practice collaboratively within the time and space issues common to healthcare settings (see Chap. 4 for more information on merging culture and context; Trudeau-Hern, Mendenhall, & Wong, 2014); the first lesson is that there is often very little of each available. Consequently, families are not usually included in direct patient care (McDaniel et al., 2005), and MedFTs must find ways to adapt their evidence-based systemic approaches to brief therapy opportunities. Working more with individuals than families does not mean that MedFTs must abandon their relational focus and training. Rather, they can emphasize to prospective employers how they are positioned to provide relationally oriented care while acknowledging the realities of the healthcare system. Systems theorists highlight that "a family orientation has more to do with how one thinks about the patient than it does with how many people are in the exam room" (McDaniel et al., 2005, p. 43). When marketing their skills, therapists can point to research demonstrating improved clinical outcomes when relational therapy is added to routine medical care (e.g., Crane & Christenson, 2008; Law & Crane, 2000; Law, Crane, & Berge, 2003; see Chap. 22 for a summary report on family therapy cost-effectiveness research; Crane & Christenson, 2014).

Medical family therapists will want to remember that the operational world calls for realistic, accessible care, and smooth flow between triage and treatment. Realistic care means refraining from using one modality in structured 50-min sessions to using flexible treatment methods in unstructured 5–30 min consults with 50–90 different patients weekly in a fast-paced, unpredictable climate filled with interruptions (Alfuth & Barnard, 2000; Patterson et al., 2002; Strosahl, 2005). Accessible care requires therapists to work in crowded exam rooms instead of quiet offices with comfortable couches (Seaburn, Lorenz, Gunn, Gawinski, & Mauksch, 1996). Smooth flow between triage and treatment means learning how to integrate services without interrupting the workflow while adding value to the patient encounter and healthcare team.

Financial World

Barrier

The cost of adding BHPs in a reimbursement system, where their services are "carved-out" from medical care, is perhaps the most frequently cited barrier to integration (Hodgkin, Horgan, Garnick, Merrick, & Goldin, 2000; Kathol et al., 2010; Levant et al., 2006; Robinson & Strosahl, 2009). Sometimes administrators bypass this issue by starting grant-funded or student-volunteered pilot projects that achieve clinical and operational success. But often, once the grant funding or the student interns used for the pilot project are gone, so is the project (Barry & Frank, 2006; Kathol et al., 2010; Robinson & Strosahl, 2009).

Lack of uniform insurance coverage for BHPs under the Center for Medicare and Medicaid Services (CMS) is part of why pilot projects are not sustainable. "Together, Medicare, Medicaid, and CHIP [Children's Health Insurance Program] financed $823.8 billion in health care services in 2008—slightly more than one-third of the country's total health care expenditures and almost three-fourths of all public spending on health care" (Klees, Wolfe, & Curtis, 2012, p. 4). So while there is a great deal of money available in the system, it is a tangled mess of outdated policies and misinformation about the benefits of IPC and those trained to provide it.

Medicaid alone provides more behavioral health care than any other insurer (American Association of Marriage and Family Therapy [AAMFT], 2012a). Reimbursement by CMS is especially important for Federally Qualified Community Health Centers, as over 70 % are providing integrated care (Lardiere, Jones, & Perez, 2011). However, some BHPs struggle with getting reimbursed due to archaic policies and a lack of general understanding about their knowledgebase and training. For example, approximately 38 states at least partially recognize family therapists as Medicaid eligible providers, but they are completely shut out of nationally run Medicare (AAMFT, 2012a, 2012b). Furthermore, Medicaid billing

for integrated care is more complicated than billing for traditional mental health visits. Therapists may be able to bill "incident-to" a physician or psychologist, but must be diligent in working with their local offices to code this correctly (Kessler, 2008b). Full CMS recognition will allow therapists to independently use Health and Behavior Codes (H&B). These codes are a fairly recent strategy that improves sustainability by allowing same-day billing by PCPs for medical components of care and BHPs for psychosocial components of care related to the physical diagnosis (Kessler, 2008b; Levant et al., 2006; Miyamoto, 2006). These codes allow BHPs to bill for treatment of issues that affect patients' health (e.g., coping with a new diabetes diagnosis) but do not meet criteria for a DSM 5 (American Psychiatric Association, 2013) diagnosis.

All BHPs still use traditional psychiatric/psychotherapy codes for DSM 5 diagnoses; however, same day billing of DSM 5 and H&B codes is not generally permitted (Chaffee, 2009; Miyamoto, 2006; North Carolina Center of Excellence for Integrated Care, 2011), thus limiting the range of integrated care services and foci. While some private insurers limit the use of H&B codes to BHPs in carve-out networks, misinterpret and/or do not recognize the codes (Kessler, 2008b), others either continue to require a DSM 5 diagnosis for reimbursement or will not reimburse for H&B codes if the patient has a co-occurring DSM 5 diagnosis. H&B codes are a big step forward, but confusion surrounding their purpose and CMS rules can prevent payment for services to patients with co-occurring diagnoses or subclinical symptoms, maintain the perception of behavioral health as a disease (Robinson & Strosahl, 2009), marginalize family-based treatment, and present a philosophical challenge for strength-based MedFTs (Yapko, 2008).

Another key financial barrier is that integrating services has required significant up-front expenditures, including added salaries, resources to design new systems, and training costs (Chaffee, 2009). Since the 1960s, these expenses have been shown to slowly give way to cost savings of about 25 %, as clinical outcomes improve, making care more efficient by decreasing the need for services (e.g., Chiles, Lambert, & Hatch, 1999, 2002; Crane & Christenson, 2008; Cummings, 2001; Cummings, Cummings, & Johnson, 1997; Cummings & Follette, 1968, as cited in Cummings, 2001; see Chap. 22 for a review of family therapy cost-effectiveness research; Crane & Christenson, 2014). Eventually, organizational startup costs are fully offset by savings in medical costs (Levant et al., 2006). This phenomenon has been found in nearly 100 published studies (Levant et al., 2006).

Researchers studying family therapy services in primary care settings have demonstrated 21 % cost savings in general populations (Law & Crane, 2000). Importantly, 50 % lower costs and 38–78 % fewer services have been reported for high-utilizing patients (Crane & Christenson, 2008; Law et al., 2003). High-utilizers are the 10 % of patients who account for nearly 70 % of primary care visits (Berk & Monheit, 2001), yet typically have no organic etiology for their symptoms (Kroenke & Mangelsdorff, 1989). Interestingly, costs were also reduced by up to 57 % for these patients' family members (Law et al., 2003). A recent systematic

review has also demonstrated the economic value of integrated care specifically for the treatment of depression (Jacob et al., 2012).

With so much research showing cost-offset, one must wonder why cost continues to be a barrier to integration. The answer is deceptively simple: (a) specific clinical and operational processes must be in place for the offset effect to be seen (Cummings, 2002); and (b) in a healthcare system dominated by third-party payers, most are not willing to spend the up-front money needed for system change knowing it will take 18–36 months for the cost to be offset (Chaffee, 2009; Levant et al., 2006). Thus, integration efforts will continue to be curtailed unless all insurance carriers support a financial overhaul (Barry & Frank, 2006; Butler et al., 2008; Robinson & Strosahl, 2009).

Strategy

Clinically, reimbursement policies are the main obstacle for employers in hiring MedFTs to provide direct patient care. Knowing the value of MedFTs within integrated care, both financially and intangibly, can be important to jumping reimbursement hurdles. MedFTs are particularly affected by the currently fragmented system, especially in the financial world. For now, some organizations are so convinced of the power of integrated care that they hire MedFTs or other BHPs despite the fact that their salaries cannot be offset by insurance reimbursement (Robinson & Strosahl, 2009). Also, grant funding is increasingly available for this work, allowing therapists to offset their salaries for the first few years to help build integrated models (Collins, 2009; Hodgson & Reitz, 2013). According to Korda and Eldridge (2011), there are ways in which integrated care payment-incentives introduced with the Patient Protection and Affordable Care Act can be used to promote positive systemic change. Strategies may include bundled or episode-based payment approaches, gain-sharing, and performance-based payment that incentivizes providers' care team collaboration and/or patients' treatment adherence and self-management (Korda & Eldridge, 2011). Founded by providers with a systemic perspective, the CFHA (www.CFHA.net) is working hard to advocate for integrated care reimbursement models that are sustainable and promote integrated care where behavioral health providers and medically trained providers can work in tandem.

It is important that MedFTs become familiar with successful models of integrated care. For example, models within military healthcare systems and HMOs have a closed financial system wherein the funder and providers are the same organization. Thus, the "insurer" pays for medical services and the providers' salary or contracts (Cummings, O'Donohue, & Cummings, 2009). In this type of staff model, cost risks are offset by gains and the financial system and thus able to absorb the cost of integration (Robinson & Strosahl, 2009). Other systems are leading the way in integrated care and provide a template for financial reform

(see Chap. 23 for more information on financial models for MedFT; Marlowe, Capobianco, & Greenberg, 2014).

Although closed systems like military and staff models make financial barriers easier, reimbursement is necessary for integrated care to succeed in open systems, as well (Miyamoto, 2006; Robinson & Strosahl, 2009). Although state requirements vary, MedFTs are qualified to assess, diagnose, and treat individuals experiencing behavioral health issues (US Government Printing Office via GPO Access, 2009), and are uniquely trained to also address relational concerns. As noted earlier, CMS recognition continues to be a concern. However, some MedFTs (based on training discipline) are not actually prohibited from CMS reimbursement, but rather are simply not included in the list of providers who must be reimbursed, despite being recognized as a core behavioral health profession (AAMFT, 2012b). CMS recognition will help expand what MedFTs can contribute to a healthcare visit and also improve patient access to behavioral health services.

Lastly, family therapists trained in MedFT are currently under-represented compared with other BHPs in regard to state and federal advocacy efforts as a whole. Initial steps to correct this include increasing involvement in and contributions to Political Action Committees (Yapko, 2008), meeting with local and state CMS and private insurance personnel, and getting involved with grassroots organizations invested in changing healthcare laws, specifically reimbursement policies.

Conclusion

Widespread system change is needed in order to support the type of care that patients are demanding today (Druss & Bornemann, 2010). If we as a society of professionals and consumers do not act soon, the opportunity to integrate behavioral and biomedical health care could be lost. Although there are barriers to such integration, it is hoped that this chapter will spark interest for therapists, who are already familiar with first and second order change, and lend structure to the vision of how small changes at the local level can lead to larger ones at the national level.

Current efforts at integration offer MedFTs an entryway into the changing healthcare system (Hodgson et al., 2012; Ruddy & McDaniel, 2003). Demonstrating our natural fit with primary care and advocating for policy changes are critical to securing our place. Understanding and being able to speak to the priorities of stakeholders in each branch of the "Three-World view" is paramount; MedFTs must capitalize on their systemic skills to master this key component of collaboration. To that end, "there is an emerging consensus in the policy community about the central importance of 'aligning incentives' so that providers, payers, the research community, and consumers are all focused on identifying and learning to use the most effective health care" (Robert Wood Johnson Foundation, 2009 p. 1). In striving to find their place within the idealized new system, MedFT clinicians, trainers, program developers, researchers, and policy advocates are

well poised to help each of these voices be heard and understood by others, demonstrating how their systemic orientation and family focus can become part of the solution to our nation's broken healthcare system.

Discussion Questions

1. Based on the Primary Care Behavioral Health model (Robinson & Reiter, 2007; Robinson & Strosahl, 2009), what model of integrated care would you be most comfortable with and why? Please explain your response from a clinical, operational, and financial perspective.
2. Who are the various stakeholders represented in each domain of the Three-World view (Peek, 2008; Peek & Heinrich, 1998)?
3. In your current context, identify one clinical, operational, and financial barrier that may be impeding advancement of integrated care? Identify a strategy for overcoming each barrier.
4. When confronting the barriers noted above, which one do you think would be most important to address first, and why?
5. What are the current family therapy advocacy efforts in your state? Specifically, what is being done to advance opportunities for family therapists in healthcare settings? If unsure, contact your state's AAMFT division president to find out. Reflect on which of the advocacy efforts are paving the way for family therapists in healthcare settings and which are needed to further promote family therapists in primary care contexts.

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