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ORIGINAL PAPER

Integration: Opportunities and Challenges for Family Therapists in Primary Care

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Abstract Integration of behavioral and physical health is becoming critical for the overburdened primary care system. Policy changes are needed to accommodate integration nationally. Locally, medical and behavioral health providers are working together to create models that better fit their patients' comprehensive needs while respecting the clinical, operational, and financial constraints of the current system. Family therapists trained to work in medical settings have an opportunity to emerge as clinical, research, and administrative leaders in this context. However, a paradigm shift is crucial to adapting their systemic orientation to interactions between individual patients, providers, staff, and healthcare and support systems. This article provides family therapists with: (1) an overview of the basic structure and barriers of integration, (2) suggestions on how to deliver quality care despite barriers at the local level, and (3) examples of key advocacy efforts representing possible entryways on a larger scale.

Keywords Behavioral health · Family therapy · Integrated care · Integration · Medical family therapy · Primary care

Introduction

The infrastructure of the American medical system has created a distinct crevasse between the behavioral health and physical healthcare systems. In a recent national survey, 63 % of urban & suburban and 71 % of rural physicians working in primary care claimed that inadequate access to mental health services affects their patients' health negatively (Robert Wood Johnson Foundation 2011). In addition, 71 % (suburban), 73 % (rural) and 77 % (urban) would like to write prescriptions for mental health services and have the cost

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covered by the healthcare system. An integrated system that offers medical and mental health treatment simultaneously is sorely needed (Alfuth and Barnard 2000; Cummings 2001; DeGruy 1996; Druss and Bornemann 2010; Future of Family Medicine Project Leadership Committee 2004; Hepworth and Cushman 2005; Institute of Medicine [IOM] 2002; Levant et al. 2006; President's New Freedom Commission on Mental Health 2003; Strosahl 1994). Although many medical and mental health clinicians want to unify their efforts, those working in primary care often lack time, in-depth training, and feasible billing structures (Blount et al. 2006; Butler et al. 2008; Dickinson and Miller 2010; Peek and Heinrich 1998; Robinson and Reiter 2007). Subsets of primary care and behavioral health providers have developed various integrated applications within the fragmented system (e.g., Blount 1998; Blount et al. 2006; Cummings et al. 1997; Patterson et al. 2002; Robinson and Reiter 2007; Strosahl 1997, 1998; Strosahl et al. 1997).

American adults have repeatedly indicated that primary care is where they prefer to have their mental health needs addressed (Kessler and Stafford 2008; Reiss-Brennan 2010; Strosahl 1994). For over three decades this desire has made primary care the nation's de facto mental health care system (DeGruy 1996; Regier et al. 1978, 1993; Strosahl 2005). Strikingly, up to 70 % of primary care visits have a psychosocial component (Fries et al. 1993; Gatchel and Oordt 2003). Many patients experience mental health issues as physical symptoms, and up to 84 % of the most common primary care symptoms are not found to have an organic cause, often after expensive testing is conducted (Kroenke and Mangelsdorff 1989).

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) are estimated to have diagnosable mental health disorders (American Psychiatric Association 2000). While not all mental health disorders require treatment (Kessler et al. 2005), they have been shown to impair functioning more so than common physical disorders, especially at home and in social relationships (Druss et al. 2009). Primary care providers, or PCPs (e.g., physicians, nurse practitioners, physician assistants) are the main source of identifying and treating mental health disorders but they often lack both time and advanced diagnostic training needed to make clinical diagnoses and identify subclinical concerns before they become problematic. As a result, many disorders go undiagnosed and/or untreated (Bitar et al. 2009; Kessler et al. 2005; Kessler and Stafford 2008; McCann and LeRoux 2006; Reiss-Brennan 2010). These factors offer a logical place for behavioral health providers, or BHPs to contribute (e.g., counselors, family therapists, psychiatrists, psychiatric/mental health nurses psychologists, social workers). However, not all BHPs are trained to address issues that extend past the individual patient (McDaniel et al. 1992), and/or to work in a primary care setting (Blount 1998; Dickinson and Miller 2010; Patterson et al. 2002; Robinson and Strosahl 2009; Strosahl 2005).

This paper was written to illustrate an opportunity for family therapists and to punctuate how their relational, systemic, and collaborative skills are prime for providing integrated care. Illustrations of a needed paradigm shift from traditional behavioral health settings will be presented throughout this paper. The first section will discuss how family therapists can contribute at various levels of integration to behavioral health services in primary care settings. The second section will outline clinical, operational, and financial barriers that family therapists need to be aware of as they enter the healthcare setting to provide co-located and integrated care services. The discussion section offers possible solutions to the barriers and recommendations on how family therapists can become more of a presence in the integrated care movement.

Family Therapy in Medical Settings

The IOM recognizes the role families play in individual health and has been recommending their inclusion in primary care since 1994 (IOM 1994; McDaniel et al. 2005). McDaniel and colleagues (p. viii) asserted, "the family represents what may be the most important challenge and opportunity for today's primary care provider." Involving family members in each other's care can be efficient, informative, and influential to the success of treatment plans. Family inclusion ranges from acknowledging family influence on individual health to specifically incorporating family, friends, and caregivers as part of routine care (IOM 1994, 2001; McDaniel et al.), something that is challenging in today's healthcare climate.

Family therapists are not strangers to working in medical settings. In fact, some of the field's pioneers were first trained as physicians (e.g., Lyman Wynne, Murray Bowen, Nathan Ackerman, Milton Erickson, Salvador Minuchin). Family therapists have been working in pediatrics since the 1970s and in research/teaching settings with family medicine since the 1980s (Doherty et al. 1994). This 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, Dym and Berman 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 defined as "Medical Family Therapy" or MedFT (McDaniel et al. 1992). Supporting and expanding upon the original work of McDaniel et al. (1992), an expert Delphi panel recently empirically redefined MedFT as…

> 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 (Tyndall et al. 2010).

Systems theorists hold that the most logical way to work with and study individuals is to consider their relational, biological, and socio-cultural influences (Bowen 1978; VonBertalanffy 1968). Embracing Engel's biopsychosocial perspective (1977, 1980) augments systems thinking, extending it to a belief that medical problems are best understood in the context of not only biological, but also psychological and social factors. MedFTs are also trained to recognize the role spirituality (i.e., belief systems and meaning) may play in the treatment process (Hodgson et al. 2007; Linville et al. 2007; Seattle Pacific University 2010). The addition of spiritual awareness to systems theory and Engel's perspective forms the biopsychosocial-spiritual model (Katerndahl 2008; Onarecker and Sterling 1995; Prest and Robinson 2006; Wright et al. 1996). MedFTs apply this model routinely in their research and clinical work with patients, families, and members of the healthcare system (McDaniel et al. 1992).

Some debate exists as to whether MedFT is a separate profession, a sub discipline of family therapy, or an orientation. Tyndall et al. (2010) examined this debate in depth. For purposes of this article, the term 'MedFT' will be used to refer to family therapists who work in medical settings and bridge physical and psychosocial-spiritual health. We are not, however, advocating the practice of simply inserting a family therapist into a medical setting and calling that practitioner a MedFT. We believe that gaining competency in MedFT requires specific training (Tyndall et al. 2012a), and we strongly recommend that

family therapists seek out that training before they begin working in a medical practice (see Tyndall et al. 2012b, for more on this). This specialized training is especially critical given that MedFTs work side by side with PCPs who are often aware of interactions between relational and health challenges, but who lack the time, training, and compensation necessary to fully address them (American Academy of Family Physicians 2011; Hepworth and Cushman 2005; Peyrot et al. 2005; Robinson and Reiter 2007; Strosahl 1994). MedFTs can use their relational, systemic, and diagnostic training to develop collaborative 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 healthcare 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 consists of PCPs and BHPs working together (Blount 1998, 2003; Doherty et al. 1996; Gatchel and Oordt 2003; Patterson et al. 2002; Robinson and Reiter 2007; Strosahl 1998, 1997). However, because the term 'integration' has many interpretations and is practiced in diverse settings, integrated care will look different depending on practitioners and practice sites (Patterson et al. 2002). Categorically, integration between PCPs and BHPs involves collaborating side by side with patients to develop, implement, and monitor treatment plans (Blount 1998, 2003; Seaburn et al. 1996). Co-location, a hybrid between integrated care and separate location models, refers to PCPs and BHPs working in the same office, though not necessarily together (Blount 2003). Co-located providers might work in a fashion described as collaborative or even integrated (see Doherty et al. 1996), but they might also never communicate with each other even if they both treat the same patients. For a comprehensive overview of integrated care models, outcomes, and barriers, see Butler et al. (2008).

In the 'Primary Care Behavioral Health' model (Robinson and Reiter 2007; Robinson and Strosahl 2009), integration is seen as a continuous rather than dichotomous variable (Strosahl 1997), fluctuating amongst three anchor points. One, behavioral health consulting, where onsite BHPs are consulted by the PCP for mild to moderate patient issues. The BHP will either speak with the PCP outside the exam room, provide a brief assessment in the exam room, or the patient might need to schedule a brief return appointment if time is limited. The BHP then provides the PCP with feedback. Two, specialty consulting, where BHPs join the medical team in the exam room for patients with more serious issues, but the PCP still initiates the consult. Three, an integrated program, where patients with the most serious issues, resulting in high utilization of health care 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, this consultation model takes the place of a traditional 50-min psychotherapy appointment (Robinson and Strosahl 2009). The consult model allows for the BHP to be immediately available to the PCP and patient, with a shared treatment plan occurring collaboratively before the visit ends, ideally, or within a few days. The treatment plan may consist of psycho-education and patient self-management with PCP/BHP follow up, several consult sessions to see the BHP for more intensive skill building, or a referral to specialty mental health for issues too complex to treat in primary care (Strosahl 1997).

Of note, MedFT (one of many BHP professions) was developed in family medicine training programs (McDaniel et al. 1992), settings that have also housed many pioneers of integrated care (Robinson and Strosahl 2009). 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 and Strosahl 2009). The following section presents a very brief overview of the possible barriers that MedFTs may experience as they assume employment in primary care settings.

Barriers and Strategies to Integration

MedFTs have a place in the integrated care system but need to understand that, in the absence of policy change, barriers impacting most BHPs will continue to curtail integration (Blount 2003; Dickinson and Miller 2010; Kathol et al. 2010; Levant et al. 2006). The 'Three World View' framework (Peek 2008; Peek and Heinrich 1995, 1998) 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 (e.g., worlds). 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.

In order to have an effective, affordable, and efficient system, each branch must work together; as a change in one will invariably change the others (IOM 2001; Peek 2008; Waldman et al. 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 et al. 1974). Sometimes only one family member changing his or her thoughts and behavior can allow the family to reach some sort of stabilization (first order change). The problem itself remains, 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 medical 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' will be used here to help family therapists 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 mental health providers are generally not given instructions on how to work together (Blount 1998, 2003; Blount and Bayona 1994; O'Donohue et al. 2009; Patterson et al. 2002; Robinson and Reiter 2007). The process of integrating care is not always smooth, nor is it innate (Oser and O'Donohue

2009; Robinson and Reiter 2007). 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; Waldstein et al. 2001). Training for many PCPs still tends to emphasize the biological aspects of health (AAMC 2011; Astin et al. 2006; Dym and Berman 1985; McDaniel et al. 2005; Novack et al. 1993; Patterson et al. 2002) while BHP training tends to focus on the psychosocial and/or relational aspects of health (Edwards and Patterson 2006; McDaniel et al. 2005; Patterson et al. 2002). 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, yet both are frequent occurrences in primary care. When placed in a medical context, BHPs are aware that many patients have biomedical health issues, but often feel these issues are outside the scope of their training and thus the PCP should address them (Edwards and Patterson 2006). Likewise, PCPs often feel overwhelmed by patients' psychosocial concerns and might appreciate someone who is trained, both in educating patients (i.e. how to make healthy choices or how to implement changes), and in addressing more general psychosocial issues (Blount et al. 2006; DeGruy 2000; Robert Wood Johnson Foundation 2011).

Alfuth and Barnard (2000) contended, "The process of integration and collaboration requires as a foundation, an enlightened understanding of one another, and a genuine respect and appreciation for each other's unique language and culture" (p. 254). In practice, however, any multi-disciplinary 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 good clinical care (McDaniel and Campbell 1985; McDaniel et al. 2005). Conflicts can sometimes be resolved but have also been identified as a common reason for the failure of integrated 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 et al. 2003). Although many therapists who work in integrated settings feel comfortable in their surroundings (Doherty 2007), others feel out of place, isolated, and under-appreciated (Edwards and Patterson 2006). Several practice based lists of behavioral health competencies have been put forward in relation to integrated primary care (e.g., O'Donohue et al. 2009; Patterson et al. 2002; Robinson and Reiter 2007; Strosahl 2005). Although at least one integrated primary care expert (Strosahl 2005) has mentioned enlisting community and social support as a core competency, none of the lists are written specifically for family therapists, and most do not mention the family at all. Although family members are not typically present in medical exam rooms, their influence on health is arguably important enough to warrant some recognition of family systems training in the basic competencies needed for integrated care, or as a specific skill set that family oriented BHPs can bring to the model. Currently, the lists highlight competencies needed across disciplines and, also, help address a known lack of BHP training opportunities specifically for primary care (Blount et al. 2006; Strosahl 2005). They do not, however, discuss the fact that providers from each behavioral health discipline have specific scopes of practice and licensure requirements, and are thus trained differently (Strosahl 2005). Training differences may or may not significantly affect the basic competencies needed for integrated care. However, Strosahl (2005) asserts 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.

The idea behind competency is that while each specific integrated care site requires flexibility in methods and models used by BHPs (DeGruy and Etz 2010), consistency in the core competencies of integration would allow for good patient care and, also, open the door for the evaluation of factors contributing to this care (Strosahl and Robinson 2008). However, at present, integrated care practitioners and hiring professionals have little a priori evidence of the exact skills needed for providing integrated care. To date, no research could be located that formally examines either 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.

Strategy

Clinically, there is a challenge in getting hired to provide direct patient care because reimbursement policies present an obstacle for employers. Knowing the value MedFTs can add via integrated care (both financially and intangibly) can be an important key to jumping the reimbursement hurdles. A suggested reading list can be derived from the works cited in this paper. Family therapists can also seek specific training opportunities such as post-graduate certificates, master's, or doctoral training tracks/programs. These opportunities are rapidly evolving, thus are best found by exploring the literature and searching the internet.

Family therapists are poised to apply their systemic training to working fluidly within each branch of an integrated system. However, programs that offer courses in MedFT should also augment family therapists' systemic orientations by providing specific training in integrated care. Without this extra training, family therapists may still struggle to learn how to apply a systems orientation to working collaboratively within the individually focused primary care system. Websites and continuing education workshops along with local, regional, and national conferences focused on integrated care offer opportunities for therapists to learn how to adapt. Once trained, therapists can request meetings with primary care clinical directors and medical school training program directors, and offer to give lectures, collaborate off site, and work with patients on site, especially if there is not an existing integrated program. Their entry point may include more traditional therapy versus true integration and consults, but moving along the integrated care continuum takes time and relationship building.

Family therapists can also highlight how their training, which includes attending to each individual part of the system and the entire system as a whole, makes them well suited for contributing to interdisciplinary team efforts of promoting, operationalizing, evaluating, disseminating, and refining integrated care. These efforts can also include identifying which competencies and systemic components are most crucial to successful outcomes. As a final clinical strategy, therapists could implement competency based protocols at their clinics along with evaluating and conducting new research on these competencies as part of a team format similar to Patterson et al. (2002), who provided a BHP primer written jointly by family therapists, psychologists, and physicians.

Operational World

Barrier

The fragmented healthcare system and competing goals of each 'world' present major obstacles to harmonious balance between primary and mental health care (Patterson et al.

2002; Peek 2008; President's New Freedom Commission on Mental Health 2003). Medical and mental health systems are typically trained and reimbursed to operate and attend to issues differently (Thielke et al. 2007), with PCPs seen as 'care managers' responsible for a patient's overall health, and BHPs serving as specialists for patients who meet a provider or system's referral criteria (Strosahl 1994). When these two systems are combined into one, 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 and Miller 2010; Kathol et al. 2010; Strosahl et al. 1997) is an integral component to smoothing out this clash. Even when all stakeholders prefer an integrated system, merging BHPs into daily operations of a busy clinic can present a formidable challenge (Kessler 2008a).

Examples of operational challenges include not having enough time or space for patients to be seen. Another obstacle is not having a seamless referral/consultation process; e.g., "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, learning to offer a referral in the way a patient is likely to accept, takes time (McDaniel et al. 2005). For therapists, learning to follow-up on referrals with PCPs also takes time, especially in a fast-paced setting where documentation of mental health records is not always easily available to the physical health providers (e.g., separate documentation). Not all electronic medical record systems have tabs for psychosocial information to be entered at all, much less stored in a manner accessible to physicians but not non-essential staff (Crane 2011). Also, electronic medical records 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 locating a therapist within the primary care clinic will generally not be successful; the therapist must be immersed in the practice (Alfuth and Barnard 2000; Kessler 2008a; O'Donohue et al. 2003).

Strategy

Family therapists need to understand how to work with time and space issues common to medical settings (Patterson et al. 2002); essentially that there is little of each available. Consequently, families are not usually included in direct patient care (McDaniel et al. 2005). Working more with individuals than families does not mean family therapists 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 medical system. In keeping with systems theory, "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 family therapy is added to routine medical care (Crane and Christenson 2008; Law and Crane 2000; Law et al. 2003).

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 retraining 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 and Barnard 2000; Patterson et al. 2002, 2009; Strosahl 2005). Accessible care requires therapists to work in crowded exam rooms instead of quiet offices with comfortable couches (Seaburn et al. 1996). Smooth flow between triage and treatment means learning how to integrate a PCP

into therapy, secure informed consent and a release to collaborate, and document their work.

Financial World

Barrier

The cost of adding specially trained BHPs in a reimbursement system where their services are 'carved-out' from medical care is perhaps the most frequently cited barrier to integration (Hodgkin et al. 2000; Kathol et al. 2010; Levant et al. 2006; Robinson and 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 student intern used for the pilot project is gone, so is the project (Barry and Frank 2006; Kathol et al. 2010; Robinson and Strosahl 2009).

Lack of uniform insurance coverage for BHPs in Medicare and Medicaid (i.e., 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 et al. 2010, p. 4). Medicaid alone provides more mental health care than any other insurer (American Association of Marriage and Family Therapy [AAMFT] 2012a). CMS reimbursement is especially important for Federally Qualified Community Health Centers, as over 70 % are providing integrated care (Druss et al. 2006).

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 b). Further, 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). H&B 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-IV-TR (DSM-IV; American Psychiatric Association 2000) diagnosis.

BHPs still use traditional psychiatric/psychotherapy codes for DSM-IV diagnoses. However, same day billing of DSM-IV 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-IV diagnosis for reimbursement, or will not reimburse for H&B codes if the patient has a co-occurring DSM-IV 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 mental health as a disease (Robinson and 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 requires significant up-front expenditures, including added salaries, resources to design new systems, and training costs (Chaffee 2009). Since the 1960s, these initial expenses have been shown to slowly change to cost savings of about 25 % as clinical outcomes improve, making care more efficient by decreasing the need for services (Chiles et al. 1999, 2002; Crane and Christenson 2008; Cummings 2001; Cummings et al. 1997; Cummings and Follette 1968, as cited in Cummings 2001; Law and Crane 2000). Eventually, organizational startup costs are fully offset by savings in medical costs (Levant et al. 2006). This phenomenon has been found by most of nearly 100 published studies (Levant et al. 2006). Research teams studying family therapy, specifically, in primary care have found 21 % cost savings in general populations (Law and Crane 2000). Importantly, 50 % lower costs and 38–78 % fewer services have been reported for high-utilizing patients (Crane and Christenson 2008; Law et al. 2003); e.g., the 10 % of patients who account for nearly 70 % of primary care visits (Berk and Monheit 2001) yet typically have no organic etiology for their symptoms (Kroenke and Mangelsdorff 1989). Interestingly, costs were also reduced by up to 57 % for family members of these patients (Law et al. 2003).

With so much research showing cost-offset, one must wonder why cost continues to be a barrier instead of an answer to fragmentation. The answer is deceptively simple: (1) specific clinical and operational processes must be in place for the offset effect to be seen (Cummings 2002); and (2) 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 and Frank 2006; Butler et al. 2008; Robinson and Strosahl 2009).

Strategy

Family therapists 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 BHPs despite the fact that their salaries cannot be offset by insurance reimbursement (Robinson and Strosahl 2009). Also, grant funding opportunities are increasingly available for this work, allowing therapists to offset their salaries for the first few years to help build integrated models (Collins 2009).

It is important that family therapists become familiar with successful models of integrated care. Military healthcare systems and HMOs have a closed financial model wherein the funder and providers are the same organization, e.g. the 'insurer' pays for not only medical services but also provider salaries or contracts (Cummings et al. 2009). In this type of staff model, cost risks are offset by gains and the financial system is able to absorb the cost of integration (Robinson and Strosahl 2009). Thus, they are leading the way in integrated care and provide a template for financial reform (Levant et al. 2006; Miyamoto 2006).

Although closed systems like military/staff models make financial barriers easier, reimbursement is necessary for integrated care to succeed in open systems as well (Miyamoto 2006; Robinson and Strosahl 2009). Although state requirements vary, family therapists are qualified to assess, diagnose, and treat individual DSM-IV disorders (US Government 2009) and are uniquely trained to also address relational concerns. As noted earlier, CMS recognition continues to be a concern. However, family therapists are not actually prohibited from CMS reimbursement, but rather simply not included in the list of providers who *must* be reimbursed, despite being recognized as a core mental health profession (AAMFT 2012b).

CMS recognition will help expand what family therapists can contribute to a medical visit and, also, improve access to mental health services for patients.

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 (Druss and Bornemann 2010). If we as a society (of professionals and consumers) do not act the opportunity to reintegrate behavioral and biological healthcare could be lost. Though there are barriers to such integration, it is hoped that this article will spark interest for family therapists who are already familiar with first and second order change. This will further 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 family therapists an entryway into the changing healthcare system (Ruddy and 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; family therapists 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, p. 1, nd). 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.

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