

The Economics of Behavioral Health Services in Medical Settings: A Summary of the Evidence

Alexander Blount

University of Massachusetts Medical School

Michael Schoenbaum

RAND Corporation

Roger Kathol

University of Minnesota Medical School

Bruce L. Rollman

University of Pittsburgh

Marshall Thomas

Colorado Access and University of Colorado Hospital

William O'Donohue

University of Nevada at Reno

C. J. Peek

St. Paul, Minnesota

The health care system in the United States, plagued by spiraling costs, unequal access, and uneven quality, can find its best chance of improving the health of the population through the improvement of behavioral health services. It is in this area that the largest potential payoff in reduction of morbidity and mortality and increased cost-effectiveness of care can be found. A review of the evidence shows that many forms of behavioral health services, particularly when delivered as part of primary medical care, can be central to such an improvement. The evidence supports many but not all behavioral health services when delivered in settings in which people will accept these services under particular administrative and fiscal structures.

Keywords: economics, cost offset, behavioral health, psychology, medical settings

ALEXANDER BLOUNT received his EdD in counseling from the University of Massachusetts at Amherst. He is professor of clinical family medicine at the University of Massachusetts Medical School and director of behavioral science in the Department of Family Medicine and Community Health. He is chair of the Collaborative Family Healthcare Association. His areas of professional interest include the integration of behavioral health services into primary care settings and the training of primary care psychologists and family medicine residents.

MICHAEL SCHOENBAUM received his PhD in economics from the University of Michigan. He is a researcher for the RAND Corporation. His interests include analyses of the Palestinian health system, identification of policy options for improving clinical performance and economic viability in health care, economic analyses for national trials to improve care for depression, and Web-based modeling and decision-support tools to help consumers make health benefits choices.

ROGER KATHOL received his MD from the University of Kansas School of Medicine. He completed an internship in internal medicine at Good Samaritan Hospital in Phoenix, Arizona; residencies in psychiatry and internal medicine at the University of Iowa in Iowa City; and a year of endocrinology fellowship in Wellington, New Zealand. He is adjunct professor of internal medicine and psychiatry at the University of Minnesota Medical School. He has extensive experience in the integration of general medical and behavioral health care. He has international expertise in the development and operation of cross-disciplinary programs and services for clinics and hospitals; health plans; software vendors; case, disease, and disability management organizations; employee assistance programs; and employers.

BRUCE L. ROLLMAN received his MD from Jefferson Medical School and his MPH from Johns Hopkins Medical School. He is an associate professor of medicine and psychiatry at the Center for Research on Health Care at the University of Pittsburgh. He is involved with the planning and implementation of clinical trials to improve the quality of treatment for depression

and anxiety disorders in primary care settings and for patients with cardiac disease and other comorbid medical conditions. He also leads a team of health services researchers as part of a national Robert Wood Johnson Foundation Program to develop a financially sustainable model for treating depression in primary care.

MARSHALL THOMAS received his MD from Baylor Medical School. He is vice president of medical services and chief medical officer for Colorado Access, Denver, Colorado. He is also vice chairman of psychiatry at the University of Colorado Health Sciences Center Department of Psychiatry and medical director of the University of Colorado Hospital Psychiatric Services. His interests include integrated psychiatric and general medical care, implementation of chronic care models and evidence-based medical practice, mood disorders, and psychopharmacology.

WILLIAM O'DONOHUE received his PhD from the State University of New York at Stony Brook. He is Nicholas Cummings Professor of Organized Behavioral Healthcare Delivery and honorary associate professor of philosophy at the University of Nevada at Reno. He is director of the university's Victims of Crimes Treatment Center and also of its Sexual Assault Prevention and Counseling Services.

C. J. PEEK earned his PhD in clinical psychology at the University of Colorado. He is a consulting psychologist with 25 years of clinical, managerial, and organization development experience in large health care systems, including the integration of biomedical and behavioral health care, patient-clinician communication, and productive conversations across disciplines and organizational areas. He presents regularly on the integration of mental health and medical care and other topics that blend clinical, organizational, and leadership perspectives.

CORRESPONDENCE CONCERNING THIS ARTICLE should be addressed to Alexander Blount, Department of Family Medicine and Community Health, University of Massachusetts Medical School, 55 Lake Avenue North, Worcester, MA 01655. E-mail: blounta@ummc.org

It is in the area of behavioral health that the U.S. health care system could find the largest potential payoff in reduction of morbidity and mortality and the largest increase in the cost-effectiveness of care. (For a discussion of the use of terms such as *behavioral health* and *mental health*, see the Appendix.) The most prominent contributors to premature death are tobacco use, diet and activity patterns, alcohol abuse, microbial agents, toxic agents, firearms, sexual behavior, motor vehicles, and illicit drug use (McGinnis & Foege, 1993). These factors account for about half of all deaths. Of these, individual behavior plays a major role in 86% of these deaths, or 43% of all deaths (McGinnis & Foege, 1993). These factors are commonly, but not always effectively, addressed in primary medical care. Primary care is also the de facto mental health service system for 70% of the population (Regier et al., 1993). It seems to make sense to add behavioral health staff to the primary care team to help physicians meet these identified needs. The crisis in health care costs makes it necessary to show that the introduction of collaborating behavioral health staff at least increases effectiveness of care and may save costs overall. In the past 15 years, randomized controlled trials have been conducted and models developed that allow us to have some confidence in describing how this might be done.

The history of the managed care era is largely a history of attempts to control the supply of health care. The system has controlled the supply of care by denying hospital days, by creating incentives for physicians to use less expensive medications over more expensive ones, by limiting tests, and by controlling access through the use of preferred providers. All of these measures contained costs at first but now have proven to be failures in the marketplace. Costs are rising again. The evidence suggests that if the system meets patients' needs more precisely by addressing the presently unmet behavioral health needs people bring to primary care, the best area for new cost savings may be available. This may provide an alternative to simply asking providers to do more, faster, and for less: a strategy bound to have disastrous effects on the quality of the workforce and care in the long term.

The purpose of this article is to summarize the evidence about the economic value of behavioral health care, especially in primary medical settings; to recount the history of this kind of study; and to describe some of the clinical, administrative, and financial implications of this evidence. Additional articles in the Health Care for the Whole Person series are "Benefits of Comprehensive Health Care for Improving Health Outcomes in Women" (Jarrett, Yee, & Banks, 2007), "Health Care for the Whole Person: Research Update" (Kaslow et al., 2007), and "A Rural Perspective on Health Care for the Whole Person" (Stamm, Lambert, Piland, & Speck, 2007).

People and Institutions Viewed as Established Voices in This Area

The term *medical cost offset* was coined by Cummings, Dorken, Pallak, and Henke (1990). In the 1980s, they were the first to put forward the idea that mental health treatment could be used programmatically to reduce medical costs in a way that would more than pay for the cost of the mental health treatment. The emergence of systems-based brief therapy in the 1970s in works such as *Problem Solving Therapy*, by Jay Haley (1977), and *Change: Principles of Problem Formation and Problem Resolution*, by

Watzlawick, Weakland, and Fisch (1974), provided an opportunity for cost savings that had not seemed possible under the hegemony of the long-term psychoanalytic approaches that were practiced by most psychotherapists.¹ Cummings et al. began targeting people who had chronic medical illnesses for referral to these services even if they had not requested psychotherapy. Initial positive results in California led to the Hawaii Project, in which the entire Medicaid population of Oahu and subscribers to the government health insurance plan on the island became the first large implementation and test of the cost-offset thesis. After randomization, the cost reductions were 38% for Medicaid patients who were not chronically ill, 18% for Medicaid patients who were chronically ill, 35% for "employed" patients (the project's term for patients on group health insurance through an employer) who were not chronically ill, 31% for employed patients who were chronically ill, and 15% for Medicaid patients who had substance abuse diagnoses (Cummings et al., 1990).

Evidence of the effect of bringing behavioral health care into large health systems has tended to arise only when there have been HMO-based health systems that used both physicians and mental health professionals in the same organization. The most productive center for the study of mental health problems in primary care and the development of programs to address them has been collaboration between the University of Washington and Group Health of Puget Sound in Seattle. Wayne Katon is the leader of a team that includes Gregory Simon, Jurgen Unützer, Elizabeth Lin, Michael von Korff, and Patricia Robinson. These researchers have provided 20 years of studies that have formed the foundation of evidence on the clinical effectiveness and cost impact of behavioral health interventions in primary care. Their watershed article documenting the effectiveness of collaborative care for treating depression in primary care was published in 1995 (Katon et al., 1995). An eloquent spokesman for integrating behavioral health into primary care, including articulating the cost savings and the clinical impact, has been Kirk Strosahl. Strosahl worked in both Group Health of Puget Sound and the Kaiser Permanente system in northern California (see Strosahl, 2002).

Core Findings From the Evidence

The majority of visits in primary care are related to behavioral health needs but not to identified mental health disorders. Kroenke and Mangelsdorff (1989) reported that fewer than 20% of patient visits to primary care physicians are for symptoms with discoverable organic causes and that 10% are clearly psychological in nature. That leaves the vast majority of patient visits with no discoverable organic pathology found yet occurring because of physical complaints. The 10 most common presenting symptoms are chest pain, fatigue, dizziness, headache, edema, back pain, dyspnea, insomnia, abdominal pain, and numbness. These complaints account for 40% of all visits, and of patients with these complaints, only 10%–15% were determined, after a year of study, to have an organic diagnosis (Kroenke & Mangelsdorff, 1989).

¹ Using many similar techniques, cognitive-behavioral therapy eventually gained ascendancy over other brief therapies through its attention to developing evidence to support its clinical effectiveness and its adaptability to patient education.

About 75% of patients with depression present physical complaints as the reason they seek health care (Unützer, Schoenbaum, Druss, & Katon, 2006). People who might benefit from behavioral health services to relieve the problems they bring to their physician usually do not think that is what they need when they first come to the doctor. These same people are more likely to come to the doctor's office. The decision by a patient to go to the doctor is usually not related to how sick he or she is (Berkanovic, Telesky, & Reeder, 1981). A person who has a psychological disorder is much more likely to make a visit to a physician for a physical complaint than a similar person without a psychological disorder.

Better identification of behavioral health needs and better targeting of care to those needs, particularly via multidisciplinary collaborative care, lead to lowered overall medical cost in many cases and to more cost-effective treatment when properly designed. People with a diagnosis of depression have about twice the health care costs that people without the diagnosis have (Kathol et al., 2005; Simon, VonKorff, & Barlow, 2003). Randomized controlled trials have shown significant improvement in clinical effectiveness and cost-effectiveness of collaborative models when care managers are used over usual primary care (Lave, Frank, Schulberg, & Kamlet, 1998; Pyne et al., 2003; Schoenbaum et al., 2001; Simon et al., 2001). Some large studies have shown that collaborative care for depression can be cheaper than usual care (Katon et al., 1995). Collaborative protocols in primary care for panic disorder not only are cost-effective but more than offset their cost in savings on other health care (Katon, Roy-Byrne, Russo, & Cowley, 2002). A review of 91 studies found that in the presence of active behavioral health treatment, patients with diagnosed mental health disorders reduced their overall medical costs by 17%, whereas controls who did not get behavioral health care increased costs an average of 12.3%. Behavioral health intervention included crisis intervention, psychiatric consultation, brief psychotherapy, relaxation training, biofeedback, and education about emotions and symptoms (Chiles, Lambert, & Hatch, 1999).

There are a number of ways that behavioral health services can be provided in primary care that would not be considered mental health treatment. These are aimed at many of the behavioral problems brought to primary care that are not identified as mental health problems by patients. Some of these services have come to be called *health behavior coaching*. Reviewing the field in 1995, Friedman, Sobel, Myers, Caudill, and Benson identified seven pathways for better meeting patients' needs in medical settings through behavioral health means. All were found to yield overall cost savings. (Statements below not specifically cited are found in Friedman et al., 1995).

1. Proactive programs that teach patients what level of care they need and how to manage their own illness, both acute (e.g., fever) and chronic (e.g., arthritis), more than pay for themselves in lowered need for services (Kemper, Lorig, & Mettler, 1993).

2. Relaxation response methods taught to patients for conditions affected by stress, such as hypertension, save money by reducing the need for medication and doctor visits (Fahrion, Norris, Green, Green, & Schnar, 1987).

3. A change in unhealthy behavior, such as smoking, drinking, or overeating, works best when it is done through a program rather than through individual encounters with physicians (Black & Bruce, 1989). Highly intensive and expensive programs can pay off by saving a few very expensive procedures. Mutual of Omaha

has reimbursed subscribers for expensive heart health programs, given that one bypass operation costs more than 10 times the program's cost. Much less intensive programs pay off by lowering general health care costs. Mailing personalized health risk reports to older patients along with suggestions for lifestyle modifications led to a 10%–20% reduction in health costs (Fries et al., 1993).

4. Targeted social support to patients facing very difficult medical situations, such as recovering from a heart attack or giving birth, can improve outcomes (fewer new heart attacks and fewer caesarian births) and save money (Frasure-Smith, 1991).

5. Patients with physical symptoms are much more likely to use emergency room services and other medical services when they have co-occurring mental disorders. Screening for mental disorders and providing treatment in populations with as diverse medical problems as chest pain and hip fracture more than pays for the mental health treatment, often by a factor of four or more (Strain et al., 1991).

6. People who experience and express the pain in their life as physical pain are very common. There are many cultural groups and demographic groups (children, older adults, and people with less education) for whom this is the norm. Physicians call them somatizers, although few meet criteria for a diagnosis of somatization disorder. Somatizers rarely accept a referral for mental health treatment, because they do not experience their pain as psychological in origin. Consultation by psychiatrists or other behavioral health practitioners to the primary care doctor and targeted programs for somatizers that are part of a primary care practice have been shown to pay for themselves and reduce overall medical costs (Hellman, Budd, Borysenko, McClelland, & Benson, 1990). These same programs greatly reduce frustration on the part of private care practitioners (PCPs).

7. Patients with chronic pain are very high utilizers of medical services, even though their encounters with physicians are often frustrating to both parties. Behavioral health services targeted to chronic pain patients reach enough people and make enough difference in reduced utilization of medical services to more than pay for the cost of the behavioral health services (Caudill, Schnable, Zuttermeister, Benson, & Friedman, 1991). Chronic disease self-management programs in the form of seven to eight small-group sessions focusing on building coping skills with common symptoms and emotions can lead to cost savings in medical care of \$10 for every \$1 spent (Lorig et al., 1999). The services also contribute to patient and provider satisfaction.

It appears that the better targeted the behavioral health intervention is to the needs of patients with specific medical conditions (by means of behavioral medicine, care management, or behavioral health integrated care), the more medical cost savings are realized. The more generic the behavioral health intervention (outpatient psychotherapy) is, the less medical cost savings are realized.

Behavioral medicine in medical settings shows cost offset, but psychotherapy in outpatient mental health settings has not reliably shown the same effect (Chiles et al., 1999; Fraser, 1996; Harvey et al., 1998). Care management by mental health providers (social workers, psychologists, or psychiatrically trained nurses) and consultation to physicians by psychiatrists or psychologists are the methods that currently have the most evidence supporting their effectiveness and cost-effectiveness (Pincus, Pechura, Keyser, Bachman, & Houtsinger, 2006).

The separation of funding streams into two separate worlds of medical and mental health services greatly impedes innovation in the development and implementation of targeted behavioral health programs in medical settings. Patients, providers, and health care economics all suffer when the design of the system (its interlocking clinical, operational, and financial aspects) is mismatched to the basic scientific and clinical realities it confronts daily. In the case of American health care, the design flaw is in the fact that the system operates as if biomedical and psychosocial were separate and parallel domains (Pincus et al., 2006). This problem has been described from within the field of medicine and without. Two of the most notable examples are George Engel's (1977) call for a biopsychosocial model and, more recently, the Institute of Medicine's (2005) *Improving the Quality of Health Care for Mental and Substance-Use Conditions: Quality Chasm Series*.

General medical health plans and government agencies commonly outsource mental health and behavioral care to restricted provider networks that are funded and administered separately from general medical care (behavioral "carve-outs"). Under our current carve-out system, more than 70% of those with mental health or substance abuse problems receive no treatment for those illnesses. Only a fifth of the 30% who are treated (6% of total need) receive what normally would be considered evidence-based care (Kessler et al., 2003; Narrow, Rae, Robins, & Regier, 2002). Independently managed behavioral health business practices prevent general medical and psychiatric service coordination.

In short, the health care system is providing effective treatment to only a few of the patients who need it. In practice, this causes cost shifting of behavioral health service use from specialty services to general medical providers, who have limited expertise and little time flexibility for addressing behavioral issues. Recognizing these two interlocking problems is only half the battle. Presently, it is very difficult to improve the situation because of competing financial interests between behavioral health and general medical managed care organizations.

Low-income populations have significantly higher levels of behavioral health needs. Forty percent of adults whose low income qualified them for Medicaid in Colorado were identified as having a mental disorder. The presence of any mental health diagnosis increased total health care costs by a factor of 2.24. For members with bipolar and psychotic diagnoses, increased health plan costs were predominately due to increases in pharmacy and specialty mental health costs. In contrast, increased costs for members with depression, anxiety, or substance abuse were the result of increases in general medical services (Thomas, Waxmonsky, McGinnis, & Barry, 2006). Collaborative care appears to be particularly beneficial to people from ethnic minority groups, who tend to be less likely to use specialty mental health care. This makes collaborative care an important approach in reducing disparities in care among groups (Schoenbaum, Miranda, Sherbourne, Duan, & Wells, 2004).

The more broadly we account for the impact of behavioral health services in primary care, the greater the identified savings are, but the more difficult it is to document these savings rigorously. Employers have much to gain from collaborative care in both health premiums' cost savings and reduction of disability days (Broadhead, Blazer, George, & Tse, 1990), yet usually only the costs of medical care are counted when the cost-effectiveness of care is being studied. Improved occupational functioning is one

of the most immediate results of improvement from depression through treatment (Ormel et al., 1993). Depression is associated with an average of 4 to 5 lost work days per month in addition to any days lost to accompanying medical conditions. Underfunctioning ("presenteeism") as a result of depression can equal the same loss in productivity as 2.3 days absent per month (Wang et al., 2004). The monthly cost to an employer of an employee with depression is over \$550, significantly greater than the monthly cost of evidence-based collaborative treatment in primary care. In fact, the estimated annual cost in lost productive time to employers is \$44 billion (Stewart, Ricci, Chee, Hahn, & Morganstein, 2003). One study showed a marked savings in productive time when employee depression was improved. Patients with severe depression who improved reduced their disability days by 36%, and patients with moderate depression who improved reduced their disability days by 72% (von Korff, Ormel, Katon, & Lin, 1992).

Historically, employers have put the cost of disability and health insurance associated with depression in different categories. Some have developed employee assistance programs to provide in-house counseling for employees' problems with substance abuse, depression, or family problems. Substantial savings have been documented in studies of behavioral health services offered by employers through these kinds of employee assistance programs. A clear example was documented by the McDonnell-Douglas Corporation (1989). An independent company conducted a comprehensive longitudinal analysis over a period of 4 years of approximately 20,000 employees who were identified as having alcohol and drug problems or emotional problems. Employees who used the in-house counseling service lowered their health care and dependent health care costs. The users of counseling services showed 34%–44% decreases in absenteeism and had a 60%–80% lower attrition rate. The McDonnell-Douglas Corporation saved \$4 in health costs, absenteeism, and attrition for every \$1 spent on the in-house counseling. Yet there were many employees in the same situation who did not use the service. Today, millions of employees in other corporations do not have access to an in-house employee assistance program. Primary care is the venue in which problems such as depression, substance abuse, and family conflict can be first addressed and treated or referred. Primary care needs to be incorporated into an overall approach to dealing with emotional and substance abuse problems in the workplace.

Substance abuse services should always be a part of any plan to bring behavioral health services into medical settings, both because of the level of need presenting in medical settings and because of the overlap of substance abuse problems with medical and mental illnesses. The cost offset in treating substance abuse is a result of heading off the dramatic increase in health care costs that occurs as the illness becomes acute (Holder, 1998). When substance abuse services are integrated into primary care, the cost of treatment is about the same as when the services are provided separately for substance-abusing patients who do not have a substance abuse–related medical illness. For patients with medical illnesses related to substance abuse, the cost of integrated care is less than half the cost of separated care (Parthasarathy, Mertens, Moore, & Weisner, 2003). A significant percentage of people in treatment for alcohol abuse meet criteria for a diagnosis of major depression, and many people have their first major depressive episode after a period of alcohol or drug use (Lennox, Scott-Lennox, & Bohlig, 1993). People with combined alcohol abuse

and depression have significantly higher health care costs than those with only an alcohol abuse diagnosis, but the former are also more likely to seek treatment than the latter.

Recommendations

Merging funding streams so that all health care plans pay for medical and mental health care from the same pot of money is the long-term goal that would structurally align incentives for collaborative care (Goldberg, 1999; Pincus et al., 2006). This needs to be done in an environment in which people do not change coverage plans frequently. The movement between plans takes away the advantage of savings over the long term that can be realized if programs are better targeted to patient needs. It makes controlling the supply of care the only effective cost-control strategy. As the health insurance market matures, "carving in" behavioral health benefits—that is, reintegrating these benefits with medical benefits—is becoming more common. It is particularly important that Medicaid plans in the various states take the lead in this process.

Several influential leaders in health care, such as the Health Resources and Services Administration and the Substance Abuse and Mental Health Services Administration (Smith, 2004), the American Academy of Family Physicians (Kahn, 2004), and the Institute of Medicine (2005), have formally recommended the inclusion of behavioral health practitioners (BHPs) on the primary care service team. Unfortunately, when primary care practices attempt to implement an integrated approach, they often run into barriers that can prove insurmountable at the local level. These barriers are related to health insurance carriers' billing and record-keeping regulations. The clinical routines of integrated primary care are substantially different from those of separated primary care and specialty mental health, but most billing and administrative regulations were designed only for the latter.

It is not uncommon for employers who are invested in quality of services and cost control to become interested in the phenomenon of behavioral health in primary care. When negotiating with health plans, they may receive assurances that behavioral health is supported by the plan. These assurances are generally made in good faith. The representatives, to the best of their knowledge, believe their plan supports integrated care. However, most of the health plans have numerous barriers that need to be addressed before behavioral health can become a part of the plan.

A list of fairly minor changes in billing and record-keeping regulations implemented by health plans that can greatly facilitate behavioral health providers working in medical settings can be important if the evidence is to be translated into practice. This brief discussion provides suggestions for employers or health plans that want to make the minimal adjustments in regulations and billing practices that would facilitate the initiation of integrated primary care. For a discussion of ways that the system as a whole can facilitate the introduction of behavioral health into medical settings, see Pincus et al. (2006). For the purpose of this discussion, there is a distinction between integrated care and colocated care (cf. Blount, 2003). Colocated care is behavioral health care provided in the primary care site by a BHP. It is provided on a referral basis. Commonly, patients are encouraged to make the initial appointment with a BHP through their PCP. In many practices, the BHP may be introduced to the patient as part of the referral process, because an introduction increases the likelihood that the

referral will result in behavioral health care for the patient. The benefits of colocated care include a quantum leap in information exchange between the BHP and PCP over care in separate locations. Referrals are much more likely to be successful. Patients who would not accept care in a psychiatric facility will see a BHP who is part of their PCP's practice.

Integrated care describes care that has medical and behavioral health components. The patient perceives care as one treatment plan targeted to his or her needs. Because a PCP is directing the plan, most patients experience it as medical. This is necessary for the very high percentage of patients in primary care who have severe behavioral health needs but would not accept care defined as mental health or psychiatric care. Care management programs for depression, special programs targeted at patients with chronic illnesses, and behavioral health consultation or care provided in the flow of patients' visits to their PCPs are all examples of integrated care.

Some Specific Helpful Changes

1. For many patients who need care, the best opportunity for offering care is on the day the needs are identified. Because they experience their problems as medical, patients are not likely to accept a referral to a BHP, although they are willing to meet with a BHP as part of their primary care visit. The PCP feels the need to involve the BHP, but the patient will not make (or keep) an appointment at another time. To the degree that a company has restricted same-day billing between psychological and medical providers, this proscription should be withdrawn.

2. Because it is common for patients to be unwilling to work with a BHP without the active involvement of the PCP, some overlapping time in which both providers are working with the patient needs to be billable. The payer needs to be explicit that this is acceptable, because most conscientious providers will worry about the potential for being charged with fraud in such billing. The practice of the PCP billing for a certain level of office visit and the BHP billing for his or her time under a mental health or behavioral health code should be allowed and affirmed.

3. Because patients are identified as needing service on the day that service should be delivered, to the degree that a company requires preapproval of the first visit in nonemergent situations, this requirement should be waived in primary care practice.

4. Because it is impossible to do a full assessment at an initial contact in primary care, particularly if the patient is not seeking mental health services, it should be explicitly permissible for shorter units of time to be billed before an assessment is done.

5. Because contacts in primary care can be very brief, units of billing as short as 10 min should be allowed.

6. Because contact with the BHP can often be part of the medical care in primary care, the note from the BHP should be able to be part of the medical contact notes, signed by the BHP.

7. Notes that are part of a colocated mental health treatment conducted on a referral basis should be able to be kept in a separate section of the medical chart. This section would enable the extra layer of permission required for release of mental health notes to be obtained. The extra layer of permission is required for notes of treatment because the patient would identify the treatment as mental health treatment, not because it is provided by a mental health professional or because it is paid for by the mental health benefit. Much of the care provided by mental health professionals

in primary care would be identified by the patients as medical and should be part of the medical chart.

8. Consultation to a PCP about a specific patient by a licensed psychologist or qualified psychiatrist should be reimbursed at a rate similar to psychotherapy of the same duration when it is supported by a consultation note from the consultant.

9. Rates should be set and funding authorized for care under the behavioral health codes designating behavioral care given to patients who do not have a psychiatric diagnosis. These would pay for services such as motivational interviewing by a skilled BHP for someone who needs lifestyle changes for cardiac risk factors. These codes were developed by the American Psychiatric Association and have been widely promulgated. A payment rate has been set for these codes by Medicare and some health plans, but many plans have not yet followed suit. When companies begin paying these codes, it is important to promulgate specific instructions regarding how to bill for them and what record keeping is necessary.

10. There are numerous evidence-based protocols that have large or small behavioral components for treating chronic illnesses. There is good evidence for the effectiveness and cost-effectiveness of care management approaches for depression in primary care in addition to behavioral aspects of protocols for diabetes, hypertension, arthritis, irritable bowel syndrome, and asthma as well as problems such as somatization and chronic pain. These protocols are too complex to be mandated through a universal rate for a universal approach to each illness or problem. In this very important area, the insurance company should set up a mechanism for approving and setting a rate for protocols proposed by a practice. To get a protocol approved, a practice would need to cite the evidence in a convincing way; make a case for why its program was described by the evidence; designate the target population; and describe the recruitment strategy, the participating staff, the number of meetings, the meeting activities, and the outcomes that would be tracked.

11. Training for BHPs who can work in primary care is woefully behind demand. Health plans should establish a mechanism to support training in primary care by approving a payment scale for specific services provided by trainees in primary care-based programs approved by the relevant accrediting bodies.

We believe that the way forward requires an iterative process. Existing evidence supports new, more integrated practice that makes new sorts of evidence possible. To achieve wider implementation of new practices, reforms in billing and administrative regulations are necessary. Broader implementation of new practices will transform the assumptions about care of providers and patients, leading to new ideas for improvements in practice. Barring a collapse in funding, the next few years should be a particularly generative time in primary care and behavioral health integration.

References

- Berkanovic, E., Telesky, C., & Reeder, S. (1981). Structural and social psychological factors in the decision to seek medical care for symptoms. *Medical Care, 19*, 693–709.
- Black, J. L., & Bruce, B. K. (1989). Behavior therapy: A clinical update. *Hospital Community Psychiatry, 40*, 1152–1158.
- Blount, A. (2003). Integrated primary care: Organizing the evidence. *Families, Systems, & Health, 21*, 121–134.
- Broadhead, W., Blazer, D., George, L., & Tse, C. (1990). Depression, disability days and days lost from work in a prospective epidemiologic study. *Journal of the American Medical Association, 264*, 2524–2528.
- Caudill, M., Schnable, R., Zuttermeister, P., Benson, H., & Friedman, R. (1991). Decreased clinic use by chronic pain patients: Response to behavioral medicine interventions. *Clinical Journal of Pain, 7*, 305–310.
- Chiles, J. A., Lambert, M. J., & Hatch, A. L. (1999). The impact of psychological intervention on medical cost offset: A meta-analytic review. *Clinical Psychology, 6*, 204–220.
- Cummings, N. A., Dorken, H., Pallak, M. S., & Henke, C. (1990). *The impact of psychological intervention on healthcare utilization and costs*. San Francisco: Biodyne Institute.
- Engel, G. L. (1977, April 8). The need for a new medical model: A challenge to biomedicine. *Science, 196*, 129–136.
- Fahrion, S., Norris, P., Green, E., Green, A., & Schnar, R. (1987). Biobehavioral treatment of essential hypertension: A group outcome study. *Biofeedback and Self Regulation, 11*, 257–278.
- Fraser, F. S. (1996). All that glitters is not always gold: Medical offset effects and managed behavioral health care. *Professional Psychology: Research and Practice, 27*, 335–344.
- Frasure-Smith, N. (1991). In-hospital symptoms of psychological stress as predictors of long-term outcome after acute myocardial infarction in men. *American Journal of Cardiology, 67*, 121–127.
- Friedman, R., Sobel, D., Myers, P., Caudill, M., & Benson, H. (1995). Behavioral medicine, clinical health psychology, and cost offset. *Health Psychology, 14*, 509–518.
- Fries, J. F., Koop, C. E., Beadle, C. E., Cooper, P. P., England, M. J., Greaves, R. F., et al. (1993). Reducing health care costs by reducing the need and demand for medical services. *New England Journal of Medicine, 329*, 321–325.
- Goldberg, R. J. (1999). Financial incentives influencing the integration of mental healthcare and primary care. *Psychiatric Services, 50*, 1071–1075.
- Haley, J. (1977). *Problem solving therapy*. San Francisco: Jossey-Bass.
- Harvey, I., Nelson, S., Lyons, R., Unwin, C., Monaghan, S., & Peters, T. (1998). A randomized controlled trial and economic evaluation of counseling in primary care. *British Journal of General Practice, 48*, 1043–1048.
- Hellman, C. J., Budd, M., Borysenko, J., McClelland, D., & Benson, H. (1990). A study of the effectiveness of two group behavioral medicine interventions for patients with psychosomatic complaints. *Behavioral Medicine, 16*, 165–173.
- Holder, H. D. (1998). The cost offsets of alcoholism treatment. *Recent Developments in Alcoholism, 14*, 361–374.
- Institute of Medicine. (2005). *Improving the quality of health care for mental and substance-use conditions: Quality chasm series*. Washington, DC: National Academy Press.
- Jarrett, E., Yee, B., & Banks, M. (2007). Benefits of comprehensive health care for improving health outcomes in women. *Professional Psychology: Research and Practice, 38*, 290–297.
- Kahn, N. B. (2004). The future of family medicine: A collaborative project of the family medicine community. *Annals of Family Medicine, 2*, S3–S32.
- Kaslow, N. J., Bollini, A. M., Druss, B., Glueckauf, R. L., Goldfrank, L. R., Kelleher, K. J., et al. (2007). Health care for the whole person: Research update. *Professional Psychology: Research and Practice, 38*, 278–289.
- Kathol, R. G., McAlpine, D., Kishi, Y., Spies, R., Meller, W., Bernhardt, T., et al. (2005). General medical and pharmacy claims expenditures in users of behavioral health services. *Journal of General Internal Medicine, 20*, 160–167.
- Katon, W., Roy-Byrne, P., Russo, J., & Cowley, D. (2002). Cost-effectiveness and cost offset of a collaborative care intervention for primary care patients with panic disorder. *Archives of General Psychiatry, 59*, 1098–1104.
- Katon, W., von Korff, M., Lin, E., Walker, E., Simon, G., Bush, T., et al. (1995). Collaborative management to achieve treatment guidelines: Impact on depression in primary care. *Journal of the American Medical Association, 273*, 1026–1031.

- Kemper, D. W., Lorig, K., & Mettler, M. (1993). The effectiveness of medical self-care interventions: A focus on self-initiated response to symptoms. *Patient Education and Counseling, 21*, 29–39.
- Kessler, R. C., Berglund, P., Demler, O., Jin, R., Koretz, D., Merikangas, K. R., et al. (2003). The epidemiology of major depressive disorder: Results from the National Comorbidity Survey Replication (NCS-R). *Journal of the American Medical Association, 289*, 3095–3105.
- Kroenke, K., & Mangelsdorff, A. D. (1989). Common symptoms in ambulatory care: Incidence, evaluation, therapy and outcome. *American Journal of Medicine, 86*, 262–266.
- Lave, J. R., Frank, R. G., Schulberg, H. C., & Kamlet, M. S. (1998). Cost-effectiveness of treatments for major depression in primary care practice. *Archives of General Psychiatry, 55*, 645–651.
- Lennox, R. D., Scott-Lennox, J. A., & Bohlig, B. A. (1993). The cost of depression-complicated alcoholism: Health-care utilization and treatment effectiveness. *Journal of Mental Health Administration, 20*, 138–152.
- Lorig, K. R., Sobel, D. S., Stewart, A. L., Brown, B. W., Bandura, A., Ritter, P., et al. (1999). Evidence suggesting that a chronic disease self-management program can improve health status while reducing hospitalization: A randomized trial. *Medical Care, 37*, 5–14.
- McDonnell-Douglas Corporation. (1989). *Employee Assistance Program Financial Offset Study: 1985–1988*. Long Beach, CA: Author.
- McGinnis, J. M., & Foege, W. H. (1993). Actual causes of death in the United States. *Journal of the American Medical Association, 270*, 2207–2212.
- Narrow, W. E., Rae, D. S., Robins, L. N., & Regier, D. A. (2002). Revised prevalence estimates of mental disorders in the United States: Using a clinical significance criterion to reconcile 2 surveys' estimates. *Archives of General Psychiatry, 59*, 115–123.
- Ormel, J., von Korff, M., Van den Brink, W., Katon, W., Brilman, E., & Oldehinkel, T. (1993). Depression, anxiety, and social disability show synchrony of change in primary care patients. *American Journal of Public Health, 83*, 385–390.
- Parthasarathy, S., Mertens, J., Moore, C., & Weisner, C. (2003). Utilization and cost impact of integrating substance abuse treatment and primary care. *Medical Care, 41*, 357–367.
- Pincus, H. A., Pechura, C., Keyser, D., Bachman, J., & Houtsinger, J. K. (2006). Depression in primary care: Learning lessons in a national quality improvement program. *Administration and Policy in Mental Health and Mental Health Services Research, 33*, 3–16.
- Pyne, J. M., Rost, K. M., Zhang, M., Williams, D. K., Smith, J., & Fortney, J. (2003). Cost-effectiveness of a primary care depression intervention. *Journal of General Internal Medicine, 18*, 432–441.
- Regier, D., Narrow, W., Rae, D., Manderscheid, R., Locke, B., & Goodwin, F. (1993). The de facto mental health and addictive disorders service system. *Archives of General Psychiatry, 50*, 85–94.
- Schoenbaum, M., Miranda, J., Sherbourne, C., Duan, N., & Wells, K. (2004). Cost-effectiveness of interventions for depressed Latinos. *Journal of Mental Health Policy and Economics, 7*, 69–76.
- Schoenbaum, M., Unützer, J., Sherbourne, C., Duan, N., Rubenstein, L., Miranda, J., & Meredith, L. S. (2001). Cost-effectiveness of practice-initiated quality improvement for depression. *Journal of the American Medical Association, 286*, 1325–1330.
- Simon, G. E., Katon, W., VonKorff, M., Unützer, J., Lin, E., Walker, E., et al. (2001). Cost-effectiveness of a collaborative care program for primary care patients with persistent depression. *American Journal of Psychiatry, 158*, 1638–1644.
- Simon, G. E., VonKorff, M., & Barlow, W. (2003). Health care costs of primary care patients with recognized depression. *Biological Psychiatry, 54*, 216–226.
- Smith, S. (2004). *Remarks to the HRSA-SAMHSA Primary and Behavioral Health Care Summit*. Retrieved May 3, 2006, from the Health Resources and Services Administration Web site: <http://newsroom.hrsa.gov/speeches/2004speeches/smith-oct26-health-care-summit.htm>
- Stamm, B.H., Lambert, D., Piland, N. F., & Speck, N. C. (2007). A rural perspective on health care for the whole person. *Professional Psychology: Research and Practice, 38*, 298–304.
- Stewart, W. F., Ricci, J. A., Chee, E., Hahn, S. R., & Morganstein, D. (2003). Cost of lost productive work time among U.S. workers with depression. *Journal of the American Medical Association, 289*, 3135–3144.
- Strain, J. J., Lyons, J. S., Hammer, J. S., Fahs, M., Lebovitz, A., Paddison, P. L., et al. (1991). Cost offset from psychiatric consultation-liaison intervention with elderly hip fracture patients. *American Journal of Psychiatry, 148*, 1044–1049.
- Strosahl, K. (2002). Identifying and capitalizing on the economic benefits of primary behavioral health. In N. Cummings, W. O'Donohue, & K. Ferguson (Eds.), *The impact of medical cost offset on practice and research: Making it work for you* (pp. 68–78). Reno, NV: Context Press.
- Thomas, M. R., Waxmonsky, J. A., McGinnis, G. F., & Barry, C. L. (2006). Realigning clinical and economic incentives to support depression management within a Medicaid population: The Colorado Access experience. *Administration and Policy in Mental Health and Mental Health Services Research, 33*, 26–33.
- Unützer, J., Schoenbaum, M., Druss, B., & Katon, W. (2006). Transforming mental healthcare at the interface with general medicine: Report of the President's New Freedom Commission on Mental Health. *Psychiatric Services, 57*, 37–47.
- von Korff, M., Ormel, J., Katon, W., & Lin, E. (1992). Disability and depression among high utilizers of health care. A longitudinal analysis. *Archives of General Psychiatry, 49*, 91–100.
- Wang, P. S., Beck, A. L., Berglund, P., McKenas, D. K., Pronk, N. P., Simon, G., & Kessler, R. C. (2004). Effects of major depression on moment-in-time work performance. *American Journal of Psychiatry, 161*, 1885–1891.
- Watzlawick, P., Weakland, J., & Fisch, R. (1974). *Change: Principles of problem formation and problem resolution*. New York: Norton.

Appendix

Definitions of Terms

1. *Behavioral health services*—an overarching term combining services that are called mental health and substance abuse and services that are called behavioral medicine.

2. *Behavioral medicine*—services designed to intervene on physical health using behavioral means. Examples are health behavior change programs; education for better coping with illness; programs to improve adherence to medical regimens; and services that access the relaxation response, such as relaxation training, biofeedback, hypnosis, visualization, and mindfulness.

3. *Collaborative care*—care provided by a team with at least one medical provider and one behavioral health provider. In some

protocols, the behavioral health provider is a consulting psychiatrist. In others, he or she is a mental health professional functioning as a care manager.

4. *Mental health services*—therapies and medication treatments to address conditions that meet the definition of mental disorders.

5. *Substance abuse services*—therapies to aid people who overuse, abuse, or are dependent on alcohol, prescription medication, and/or illegal drugs.

Received April 11, 2006

Revision received August 22, 2006

Accepted August 23, 2006 ■

Members of Underrepresented Groups: Reviewers for Journal Manuscripts Wanted

If you are interested in reviewing manuscripts for APA journals, the APA Publications and Communications Board would like to invite your participation. Manuscript reviewers are vital to the publications process. As a reviewer, you would gain valuable experience in publishing. The P&C Board is particularly interested in encouraging members of underrepresented groups to participate more in this process.

If you are interested in reviewing manuscripts, please write to the address below. Please note the following important points:

- To be selected as a reviewer, you must have published articles in peer-reviewed journals. The experience of publishing provides a reviewer with the basis for preparing a thorough, objective review.
- To be selected, it is critical to be a regular reader of the five to six empirical journals that are most central to the area or journal for which you would like to review. Current knowledge of recently published research provides a reviewer with the knowledge base to evaluate a new submission within the context of existing research.
- To select the appropriate reviewers for each manuscript, the editor needs detailed information. Please include with your letter your vita. In the letter, please identify which APA journal(s) you are interested in, and describe your area of expertise. Be as specific as possible. For example, “social psychology” is not sufficient—you would need to specify “social cognition” or “attitude change” as well.
- Reviewing a manuscript takes time (1–4 hours per manuscript reviewed). If you are selected to review a manuscript, be prepared to invest the necessary time to evaluate the manuscript thoroughly.

Write to Journals Office, American Psychological Association, 750 First Street, NE, Washington, DC 20002-4242.