Health Care Reform & How Health Care is being Re-Designed

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This issue of the Health Care Reform Task Force newsletter tackles the various changes that are occurring in health care that will impact mental health services, and by extension psychologists. Here we present some information about several key changes that will occur, and some have started already. Many changes as to how health care will be re-organized within New York State are being formulated and finalized this year, and significant efforts and input will be needed by psychologists if we are to help the profession grow as a key player in mental health treatment. It is our belief that we need to engage in the reform process to ensure that psychology remains vital into the future.

An Overview on Patient Center Medical Homes: Developing Opportunities for Interested Psychologists

Jon Marrelli, PsyD

Given that health care costs are acknowledged to be unsustainable, various health care systems are looking to better integrate different aspects of health care in order to improve savings. One example of this is the patient-centered medical home (PCMH). The PCMH is a new model of delivering primary care that was discussed explicitly in the Affordable Care Act, and is an innovative attempt to improve patient outcomes and control health care costs. A PCMH is a medical setting which must abide by certain principles. One is that they must treat common physical illnesses using empirically supported guidelines, and at least some of these illnesses must be related to unhealthy behaviors (e.g, obesity, smoking, sedentary lifestyle) - which psychologists can play a role in - or a mental health or substance abuse condition. Within the PCMH model, each patient has a personal physician who is the team leader and is responsible for arranging patient care with other professionals on the care team (either in house or possibly even virtually). The psychologist, serving as a behavioral health consultant or direct service provider, can be an important team member, treating psychological problems and behaviors that contribute to poor physical health.

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While there is the potential for great opportunity for psychologists within this model, it is not a given at this time that psychologists will be selected to be the mental health provider of choice within PCMH's -something which would require greater advocacy and more active interest by the profession - or even that mental health would neccessarily be part of the services provided within a PCMH as mental health is not a required component (particularly in smaller group PCMH's, which have fewer funds). If psychologists are to be part of a PCMH there are also concerns for some about loss of professional autonomy with this team-based approach, and a more general concern for potential workforce shortages as psychologists have not historically been trained to work in such integrated care settings. To this end, an increasing number of psychology graduate schools are providing focused training in integrated care, and there are now also several post-graduate training programs in team-based integrated care as well.

This is just one of the changes to how health care services are changing and re-organizing within health care reform. Although some may be wary of treating patients within such a setting, Levant (2004) has said that if psychologists do not respond to the changes in health care, they may be at some risk of becoming an 'inert' part of the health care system in the future.

Psychologists in Patient Centered Medical Homes (PCMH's)

Megan E. Eliot, PhD

Psychologists in patient centered medical homes provide many of the same services they would in any other clinical setting (individual, family, group, and couples therapy; psychological testing; crisis intervention; etc). However, they are also called on to be an integral part of the medical treatment team. This means consulting frequently with medical providers, attending case conferences, and educating other professionals about how each patient's mental health may be affecting other aspects of his or her health and treatment adherence. Psychologists in these settings are also often asked to provide in-service trainings to medical staff on engagement techniques, managing disruptive patient behavior, and symptoms of mental illness.

Integration on a medical team has many advantages for patient care, including increased communication between providers and the opportunity for psychologists to support medical staff in engaging patients more effectively. It does also introduce ethical challenges around confidentiality when the expectation is that patient information to be shared openly with a treatment team. State-wide movements towards electronic medical records will likely exacerbate these challenges. Hospitals across New York State will soon all be using a common record system and the mechanics of how access to information will be limited to the appropriate parties remains unclear. Psychologists will have increasing responsibility to educate our patients about the information that is contained in their medical record and the limits to their confidentiality.

The trend in clinical service provision in PCMHs seems to be moving towards short-term, disease focused interventions. For example, providing an 8 week psychoeducational group on managing chronic pain. This approach seems both appropriate and useful for patients seeking care in a medical setting who are often coping with chronic medical conditions. It also represents a positive shift in focus towards prevention as a way to reduce cost and improve patient outcomes. One possible danger is that bundled payment models could push this disease-focused approach to the extreme. Psychiatrists are now required to obtain prior authorization for any mood stabilizer that is not on a given insurance company's approved list. Similarly, insurance companies may soon create an approve list of treatments for each DSM diagnosis (DBT for BPD, IPT for depression, CBT for anxiety, etc), limiting psychologists freedom to use their clinical judgement and engage in collaborative treatment planning with their patients. As not all psychologists are trained in every existing modality, this could also eventually have the effect limiting the types of patients that insurance companies deem each practitioner as "qualified" to treat.

One interesting and positive trend in PCMH settings seems to be innovative inclusion of patients in the design and implementation of service provision. For example, The South-central Foundation in Alaska is a level 3 PCMH at the forefront of patient-centered thinking. This clinic goes beyond the traditional Community Advisory Board (a board made up of patients or cosumers that makes recommendations to administrators and advocates on behalf of consumers) model of obtaining patient feedback to involving patients from the bottom--up in every level of design and planning including hours of operation, deciding which providers are present during each visit, and identifying and executing Continuous Quality Improvment projects. The foundation describes itself as a Nuka system of care-Nuka being an Alaska native name given to strong, honorable structures or living things. As more and more PCMHs strive to put the intention behind "patient centered care" into action, psychologists have a unique skill set to contribute to this process. We are trained to be culturally competent facilitators, to obtain feedback in a standardized manner, and to integrate qualitative and quantitative data into interventions and program development. If psychologists can do a better job of educating health care administrators about our skill set, we have the opportunity to make ourselves an integral part of how health care service models are designed. Our involvement in the creation of provision models could have an incredibly positive impact on patient care, for example in designing clinic settings that are trauma--informed in their practices.

For more information on Patient Centered Medical Homes:

http://psycnet.apa.org/journals/pro/43/1/17.html

http://effectivehealthcare.ahrq.gov/ehc/products/391/1177/EvidenceReport208_ClosingTheQualityGap-Patient-Centered-Medical-Home_ExecutiveSummary_20120703.pdf

Private Practice in an Era of Health Care Reform

Lubna Somjee, PhD

The Affordable Care Act of 2010 (known also as ACA) will be changing the landscape of health care. The primary aims of this Act are: to decrease skyrocketing health care costs, provide health care coverage to the uninsured thereby providing better care for the population, and improve the quality of patient care especially as it relates to those with chronic illnesses. What this will mean for those in private practice is still largely unknown, even at this late date. We do have the general outline of the ACA law, which will become clearer over time, and what follows are some things which we know will impact those of us in private practice.

In response to federal law, new models of health care have rolled out including Accountable Care Organizations (ACO's) and Patient Centered Medical Home's (PCMH's). These new venues for health care will focus on primary care and the hope is the integration of mental health into primary care settings. Please refer to our Health Care Reform Task Force newsletter that came out in January for more information on these models, as well as other sections of this newsletter.

The financial structures for Medicaid and Medicare, under these two models, are moving away from fee-for-service (which is our current reimbursement model). New models of payment are being adopted that focus on what is called 'pay for performance'. These models are based on the premise that health care professionals should be more accountable for their patient's well-being. Whereas in our current fee-for-service system, critics say that there are no provider incentives to provide efficient and brief care, the 'pay for performance' model will monitor the effect and outcomes that our treatments will have on patients. It is likely that these new models of payment will also be utilized with private insurance companies, and will be used to reimburse private practitioners as well.

Under these new health care reforms, there will be more pressure to utilize health information technology (HIT), or electronic health records (EHR). The thinking behind EHR's is that it will allow health care professionals to communicate quickly and efficiently regarding patient care using shared electronic information. It will minimize any duplication of services, allow for whole-person 'integrated care' by making providers aware of each other's work, and provide real-time information to all those providers who are treating the patient.

In addition, there are the Health Benefit Exchanges (Exchange) in each state. The New York State Health Benefit Exchange will allow people to compare prices of insurance products and purchase insurance. This includes Medicaid, as well as private insurance for individuals, families and small companies. Many more people will have health insurance and they will have also have parity with respect to mental health benefits. A description of health care benefits was chosen for NYS called the 'benchmark' plan. This plan will now be the minimum standard for insurance companies both within and outside the exchange. Please refer to our Health Care Reform Task Force's 'Special Announcement' that came out in February for more information on what the Exchange will mean for New York State psychologists.

Insurance companies will implement use of 'quality metrics' to assess how quickly and effectively we treat our patients. This may require us to fill out more paperwork and the data on patient outcomes will likely determine reimbursement. For example, an insurance company might reimburse based on length of treatment or how quickly a patient's symptoms remit based on quality measures.

What does all this mean for those of us in private practice? One thing to keep in mind is that there are going to be tens of millions of individuals that will require mental health services in the United States. These patients will start to flood the market January 1, 2014.

There are many unknowns when it comes to private practice in the future. Things to consider:

- There is a push to consolidate practices into larger entities and minimize small medical and mental health practices
- New pressures, including new models of payment, EHR's, and use of metrics to track how well patients respond to treatment, might make it cumbersome to maintain small group or independent private practices.
- There will be room for private practices to continue, but likely fewer practices might continue in light of

pressures. On the flip side, ACO's and PCMH's might refer patients to private practices for mental health needs, as well as for behavioral and lifestyle changes, and assessments. This will depend on how many will decide to hire mental health professionals in house, as well as how much focus there will be on mental health services as it relates to overall patient care.

- Out of pocket individual or small group practices that are well established within their communities, with high rates of referrals, are likely to continue.
- It is not clear what will happen with solo or small practices that take insurance. If they can meet the new demands (new reimbursement models, EHR's, and so forth), they will be more likely to find success. There may also be room to work with medical practices and establish a referral base. Private practitioners may also want to diversify and find other income sources within psychology that are not insurance dependent (consulting, forensics, couple's psychotherapy etc). However, many psychologists practice in areas of the state where charging out of pocket is not sustainable.
- Given trends, insurance companies may also dictate to health care professionals what types of treatments to provide their patients. For example, limiting services to cognitive-behavioral psychotherapy only. This is problematic for a number of reasons, including but not limited to the fact that psychologists may not be trained in whatever approach insurance companies are dictating, health care professionals trained in delivering health care may have less say over how to best treat patients and so on.
- Those who are late career psychologists may be able to remain in private practice until retirement without having these reforms impact their practices significantly. The literature often states that it will take a few years for the full effect of health care reform to take hold.
- There may be opportunities for those trained in behavioral and lifestyle interventions for patients with chronic medical illnesses to collaborate with medical clinics. There may also be opportunities for those who provide services already not covered by insurance companies to continue to do so. There may be room for innovation (e.g., consulting, administration, program evaluation and implementation design, development of outcomes measures and so forth).

While much is up in the air, it gives us a window of opportunity to advocate.

For more information, see:

http://psycnet.apa.org/journals/pro/43/6/535/

http://www.e-psychologist.org/index.iml?mdl=exam/show_article.mdl&Material_ID=119

An Illustration of Integration: Independent Practice in a Primary Care Pediatric Office

Mark V. Grudberg, PhD

To illustrate possibilities in how the Patient Protection and Affordable Care Act (ACA) will impact psychologists, Task Force members are exploring how we imagine it will change the work of that one psychologist each of us knows best -- ourselves. I do that happily because I am one of the psychologists in independent practice who not only welcomes ACA, I've been hoping something like it would come along.

I am a pediatric psychologist, trained to work with children fighting chronic and acute medical illnesses and to work with their families as well. I am very proud of the research conducted in our field (APA Div 54), which is research of quality and importance. Pediatric Psychology studies demonstrate that through the application of psychological and behavioral interventions we can achieve more effective management of childhood diseases. As well, we can attenuate pain and distress, lessen disruption to families, and improve quality of life. A pediatric psychologist is trained for such small tasks as preparing a child before an immunization, and such great challenges as easing the myriad physical and emotional pain of a child, and her family, as that child fights cancer. This fight often ends in victory, but when it does not we are prepared to care for patients even through death -- the most intimate moments during which I've had the privilege to help. This is the work of a pediatric psychologist.

In recent years I have been working to integrate pediatric psychology into settings other than the hospital. I've been lucky enough to open my practice within a primary care pediatrics office, and collaborate with the pediatrician on both the well-care and mental health of his pa-

tients. I have been less fortunate in my efforts to integrate with a pediatric subspecialty practice (e.g., peds GI). So very many studies demonstrate the efficacy of integrating psychology and other services within such medical care -- better care that is affordable because of prevention and healthier outcomes -- yet such integration is never implemented because of outdated models of reimbursement. Many excited conversations with medical providers have led to comments like "That sounds great!". An equal number have ended with questions like "How can you get paid for that?". Standard fee-for service, medical-model reimbursement discourages my work. The introduction of Health and Behavior CPT codes was designed to change this, but change here is slow moving and discouraged by insurance company policies. Integrated practice sounds great, and is great, but I can't get paid for that.

The Affordable Care Act (ACA) has codified a model of integrated, multi-disciplinary, comprehensive care. Emphasis is being placed on wellness and preventive care. The behavioral component of health and illness is now a focus (who better to help with health behaviors than behavioral experts?). And the principles of comprehensive care include mental and behavioral health - not by mandate of insurance parity but as central principles of care. The reimbursement models of the ACA free providers to identify the costs they choose (as opposed to only those that will be reimbursed directly), and incentives for shared savings will encourage providers to adopt treatment programs demonstrated to be effective (often within our psychological research).

Until recently, even the most successful pediatric psychology treatment research program was likely to be dismantled once the grant dried up. Psychologists (and other professionals) on soft money no longer collaborated in care. Another efficacious and cost-effective treatment was put on the shelf. So it is here that I see the ACA as offering opportunity and hope. Strict FFS limits care to the CPT code. The ACA encourages overall care through ACOs and reimbursement incentives for other collaborative models like the PCMH. Liberated from the CPT code, medical doctors will be free to implement those effective collaborative programs -- the programs developed by, and employing psychologists. Such models will no longer be the grant-funded exceptions, they can become the cost-saving norms. They can bring better medical and psychological care, and allow an answer to the question of "How can you get paid for that?". I'm excited to play my role.

I know that many who read my words will lament this as further evidence of the "medicalization" of psychology, a meaningful loss to psychologists and clients both. With that I won't argue. I enjoy the world where medicine and psychology merge, but know that it is a land that not everyone wants even to visit, let alone practice. Please know that I am not describing what we will all be asked to do, but what I am choosing -- primary care psychology. This is not where the heavy lifting of psychotherapy will be done. Rather it will be about prevention, basic intervention, and important sources of identification and referral. Some of the good news in the ACA is that more Americans will be insured and more primary care professionals will be thinking about psychological wellness. How we provide our care need not change. But if the world around it is changing (referral partnerships, reimbursement, etc.), then the way psychologists connect with that world is likely to change.

For more information:

http://www.apadivisions.org/division-54/index.aspx

http://www.apadivisions.org/division-54/publications/newsletters/progress-notes/2013/01/primary-care.aspx

http://www.integratedprimarycare.com/

Accountable Care Organizations: A Brief Overview

Jon Marrelli, PsyD

You may have started to see a lot of discussion about ACO's in the context of our changing health system. What is an ACO exactly? This is something that is a source of confusion and concern for all providers withing our broad health care system, not just psychologists. Although this topic is very complex, I will provide only a brief overview here. Those who are interested in learning more may look at the links at the bottom.

ACO stands for Accountable Care Organization. an ACO is an organization that can be run by physicians, hospitals, or other health care providers. In other words, they allow these various providers of services to come together and establish a network. This network is a legal entity which shares responsibility for providing care to a minimum of 5,000 patients, with a focus on primary care taking the lead among the various specialists who take part in the organization. Psychologists can participate, but mental health treatment may not always be part of the services offered in any particular ACO. This is because each group of providers who form the ACO may choose to include different services based on their interests. There are at least four different models that capture the model of an ACO: an integrated delivery system; multi-specialty group practice; physician-hospital organization, and independent practice association. (Wilkness & DeLeon, 2011, see link below). These entities will be accountable for the care, and the cost of care, for each patient.

The network will focus on patient care that is 'integrated' and coordinated. Integrated is the big feature of all these health care reforms. Here it means that ACO's will have health care professionals who will treat multiple health care conditions of the patient at the same time. There will be a whole person orientation to care addressed within the same setting. Coordinated care mean that multiple providers collaborate together to address a patient's health, verbally, on teams, and/or by using the same electronic health record.

Integrated, coordinated care is deemed an essential part of this model. The goal is to eliminate fragmented and uncoordinated services (Hoffman, 2012), thus this can be seen as a reaction to our currently fragmented system in which various specialists are working separately with minimal communication (or collaboration) with each other, even when there are multiple specialists working with same patient.

ACO's are governed by three main principles (Hoffman, 2012). First, primary care will form the basis of the organization; the setting for all aspects of care will be provided within a primary care environment, and the health care team will be led by a physician. Second, payments are dependent upon the delivery of high quality care. Third, the performance of each ACO will be measured to insure that certain standards are being met; currently there are 33 quality measures that are being tracked for physicians. There are financial incentives to meeting these quality measures, and financial costs to not meeting these standards. If the providers are able to work together to help improve the health of the patients, reduce costs, while achieving identified outcomes, they will be able to share in the savings; if not, the group will share in the loss of revenue or penalties for not meeting performance benchmarks.

Initially the law created this new model for Medicare beneficiaries. However, the thing to note is that many hospitals, physicians, and commercial insurers have already announced their plans to form ACO's , so it is likely that in the near future many patients with commercial health insurance coverage will be getting treatment within this setting.

Why is an ACO important for psychologists? First, with health care reform's focus on 'integrated care', the role of the mental health provider will only become more essential (Wilkness & DeLeon, 2011) as ACO's will be an ideal setting to treat both mental and physical conditions and the interplay between them. Second, with the advent of ACO's there is suddenly a new and fast growing area where many of our patients will be going to for services. Third, the general concept emphasizes prevention, early identification and intervention, chronic disease management, and some use of treatments with a firm empirical basis - all areas that psychologists are particularly well suited for. Fourth, inclusion of psychologists ensures the integration of mental, substance abuse disorder and behavioral health with physical health into a more comprehensive integrated care system (APA Practice Central, 2011). Finally, there are important new roles for psychologists in this setting such as in training; service implementation; screening and assessment tools and technology; administration, management, and supervision; program development and evaluation; neuropsychological assessment; psychological testing; and entire new domains of study for those in research as well.

While some psychologists may be more inclined to work in an ACO setting than others, the advent of such new sites of care may be an exciting new practice opportunity for those who are comfortable working in more of a collaborative team-approach, and with patients with comorbid physical health concerns.

For additional information:

http://en.wikipedia.org/wiki/Accountable_care_organization#Providers

http://www.nationalregister.org/trr_spring11_deleon.html

http://www.thenationalcouncil.org/galleries/policy-file/ACOs%20Tipping%20Point%20Paper.pdf

Hoffman, N. (2012, July 15). What is an ACO: A Brief Introduction (blog post). Retrieved February 20th, 2012, from http://healthcarereformandpsychologists.wordpress.com