Collaboration between NCQA Patient-Centered Medical Homes and specialty behavioral health and medical services

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ABSTRACT

There is increased recognition that more mental health concerns are seen in primary care than any other healthcare setting. The Patient-Centered Medical Home (PCMH) is a significant redesign of primary care, and many of the principles of the PCMH appeal to the usage of a whole person mind-and-body treatment approach that is responsive to all the patient's needs. This study examined the level of collaboration between National Committee for Quality Assurance (NCQA)-recognized PCMH primary care practices and outpatient specialty behavioral health services (when compared to other medically oriented specialties). In 2010, a 20-item survey was sent to 238 NCQA PCMHs to learn what they were doing to address behavioral health needs in primary care. A sub-dataset from the survey was analyzed in order to look specifically at referrals, communication, and scheduling-support processes. These data were compared with how the practice responded to similar questions about endocrinology and cardiology. Results from the participating 123 practices revealed that very few practices address behavioral health conditions as they would other medical conditions. This is evidenced by the lack of routinized processes to assist with referrals, communication, and scheduling to outpatient behavioral health services. There appears to be significant opportunity to improve how behavioral health is addressed in the patient-centered medical home.

KEYWORDS

Patient-Centered Medical Home, Primary care, Behavioral health

INTRODUCTION

The Patient-Centered Medical Home (PCMH) movement has revitalized the field of primary care [1,2]. The PCMH movement surfaced as a response to a provocative call for change [3] proposed in 2004 by a task force of national experts commanded with reassessing and shaping the future of family medicine. This group proposed six key changes in the provision of primary care medical services. That is, services are now required to be under a whole-

Implications

Practice: To abide by a whole-person oriented care, Patient-Centered Medical Home practices need to increase the degree to which they collaborate with behavioral health services.

Policy: National accrediting organizations, such as the NCQA, should incorporate language that enhances referrals, communication, and scheduling processes with outpatient behavioral health.

Research: Further research needs to be done examining the enhanced coordination of care with outpatient behavioral health services.

person framework that are safe, effective, timely, efficient, equitable and above all, patient-centered [3]. The PCMH (a concept introduced in 1967 by the American Academy of Pediatrics [4]) appealed as a suitable model due to its core components that involved collaborative and coordinated care, a person-physician, physician-led team, and a whole-person orientation [5].

Primary care practices across the nation began to adopt Wagner's Chronic Care Model as a standard for being more comprehensive and patient-centered [6]; yet, at the time (2006) there was no consistency on what constituted being a patient-centered medical home practice. As a result, a number of key national organizations came together to propose a set of guidelines in March 2007 to define the PCMH model in primary care practices (i.e., the Joint Principles of the Patient-Centered Medical Home [4]). Subsequently, the National Committee for Quality Assurance (NCQA) launched the three-tiered Physician Practice Connections-Patient Centered Medical Home (PPC-PCMH) Recognition Program [7] also based on the Chronic Care Model [6] and the guidelines put forth by the American Academy of Family Physicians (AAFP), American Academy of Pediatrics, American College of Physicians, and the American Osteopathic Association [4]. The goal was to redefine primary care practices in order to provide services using a more coordinated and comprehensive "whole-person" approach.

In a recent Agency for Healthcare Research and Quality publication examining the early evidence of the PCMH, the authors determined that of the 12 studies included within their analysis, six presented rigorous outcomes that showed positive effects on the triple aim (improving the health of the population, enhancing the patient experience of care and reducing healthcare cost) [8,9]. While many positive findings were reported from these analyses, the authors called for more robust evaluation of the PCMH model [9]. Interestingly, there were no studies included within the authors' evaluation criteria that addressed mental health, behavioral health or substance use issues. In another AHRQ report on the PCMH, Croghan and Brown [10] make a case that the PCMH model is conducive for integrating and better addressing mental health, behavioral health and substance abuse issues. While the authors conclude that many high-quality studies have been completed demonstrating the impact of integrating behavioral health providers, much of this evidence is in primary care and not in the PCMH.

Outcomes from large systematic reviews examining integrated behavioral health providers in primary care find that there is indeed many positive benefits to integration. In fact, much is known about treating depression in primary care with care managers and other behavioral health providers [11,12]. These strategies and approaches help achieve a whole-person orientation in PCMH practices [11–15]. The role of behavioral health providers in primary care settings is considered essential to promoting health behavior change, prevention, treatment adherence, promoting healthy relationships, and developing comprehensive treatment plans, among other aspects of integrated primary care [12,14]. Moving toward a collaborative approach between behavioral health and primary care is not only important due to its impact in promoting a whole-person orientation, but is crucial because of the tendency of consumers to use their primary care settings as the de facto mental/behavioral health services provider [16].

Although collaboration between disciplines has been in the forefront of primary care medicine, little is known about the degree to which NCQA designated PCMH practices are engaging in collaboration with outpatient specialty behavioral health services. Throughout this paper, the terms PCMH and PPC-PCMH will be used interchangeably to refer to the NCQA's recognized primary care practices (in any of their three tier levels of accreditation).

Purpose of the paper

This paper provides current evidence of the state of collaboration between primary care and outpatient behavioral health among NCQA-recognized PCMH practices. Specifically, this paper will report the differences in how primary care practices treat certain referrals to specialty medical providers (i.e., cardiology and endocrinology) and behavioral health.

METHODS

This paper is the result of a secondary data analysis from a survey conducted in PCMH practices across the United States. This analysis aimed to understand the degree to which PCMH-recognized practices were addressing behavioral health services when compared to other medically oriented specialties. The original data set was used in another paper currently under review (Kessler R, Miller B, Scholle Trakur M, Littenberg B, Maclean C, Kennedy A, Pace W. Mental health, substance abuse and health behavior services in NCQA Patient Centered Medical Homes: A national survey), which addressed the state of the integration of behavioral health in primary care including barriers and other issues related to public policy and clinical care (i.e., triple aim). The original (parent) study consisted of a 20-item multiple-choice survey conducted among 238 NCQA's recognized PCMH practices. The sample pool from the parent study was identified from the database of 447 NCQA-recognized PCMH practices listed as of March 2010. In cases of (multi-site) organizations with more than one practice recognized, the largest practice was selected leaving the total sample pool at 238. A total of 123 practices responded to the original survey, making the response rate 52 % (i.e., 123/238).

Primary care organizations included the following specialties: internal medicine (22 %), family medicine (41 %), pediatrics (6 %), adult and pediatrics (14 %), family practice and pediatrics (12 %), and other (5 %). The sizes of the practices were as follows: 55 % of the responders were from small practices with less than five providers per practice and 45 % were from large practices (i.e., >5 providers). Seventeen percent of all of the practices were part of a multi-site network. Behavioral health was referred to in the survey as mental health, substance abuse, and health behavior services, given the parents study foci. Responders to the survey varied by site ranging from practice leaders, physician, nurse managers, and administrative staff. The Institutional Review Board (IRB) of the AAFP approved this study. Lastly, the survey of the parent study had face validity across a panel of senior researchers.

This paper targeted five particular questions from the 20-item survey. These five questions addressed issues of collaboration between PCMH practices and three particular specialty clinics (i.e., cardiology, endocrinology, and behavioral health). The data presented in the "Results" section includes the percentage of participants responding to each option within a question. Specifically, the percentages reported below are the ratio between the total number of responders to a given question and the total number of responses to a given item choice. Responders were allowed to opt out of answering any questions (i.e., one participant did not answer the question about communication and two participants did not respond to the question about helping patients scheduling appointments).

For the present paper, the level of collaboration between primary care and outpatient providers was measured by looking at the following domains:

Making Referrals

	Cardio	Endo	BH
Yes	73%	69%	50%
Yes but	18%	21%	33%
No	9%	10%	16%

Tracking Referrals

	Cardio	Endo	BH
Yes	50%	45%	33%
Yes but	35%	38%	42%
No	15%	17%	25%

Fig 1 | Referrals

referrals, communication, and scheduling. That is, PCMH practices were asked to report on their referral practices and specifically whether or not they regularly use standardized processes to make and track referrals. Both communication out (providing patient's history and other pertinent information to the specialty clinics) and communication in (receiving or requesting consultation reports from those clinics) was also measured. Lastly, specialty care was assessed by inquiring about whether or not these NCQA-recognized PCMH practices helped patients with scheduling appointments with outside specialists.

RESULTS

Participants were asked to answer questions about the quality and level of engagement with behavioral health, cardiology, and endocrinology. The abbreviations used to present the results (i.e., Yes, Yes but, and No) correspond to the survey's multiple-choice options. Specifically, the multiple-choice options were, "Yes, (*and it*) works well," to indicate that the collaboration between PCMH and the specialty clinic is happening and working well; "Yes, but needs improvements," to indicate that they are making an effort to engage in collaboration with specialty clinics but the process is not working as expected; and "No," to signal that they do not engage in collaboration at all with the specialty clinics. Abbreviations for the disciplines/specialties included: cardiology (Cardio), endocrinology (Endo), and behavioral health (BH). Results were grouped under three domains: referrals, communication, and scheduling.

Referrals

Two questions assessed the referral practices between PCMH and specialty care: (1) "Does your practice regularly use a standardized process to make referrals to the following specialties?" and (2)

"Does your practice regularly use a standardized process to track referrals to the following specialties?" Figure 1 reflects the responses by specialties.

Communication

The following two questions were used from the original survey to look at communication: (1) "Does your practice provide patients' history and other information to the following kinds of specialists when they are involved in your patients' care?" and (2) "Does your practice regularly receive consultation reports from the following specialties?" Responses to the first question were categorized as "communication out," whereas responses to the second question were listed under "communication in" (Fig. 2).

Scheduling

Lastly, a fifth question from the original survey (i.e., "Does your practice help patients schedule appointments with specialists outside the practice for the following specialties?") was used to assess the degree to which PCMH staff facilitate the process of scheduling appointment with specialty clinics (Fig. 3).

DISCUSSION

The purpose of this paper was to examine the level of collaboration between NCQA-recognized PPC-PCMH primary care practices and outpatient behavioral health clinics when compared to other medically oriented specialties (i.e., cardiology and endocrinology). Collaborating with behavioral health has been recognized as an important step to provide whole-person oriented care, yet little was known in terms of the emphasis that PCMH practices were giving to collaborating with behavioral health services.

The analysis of this sub-dataset indicated that PPC-PCMH practices were not collaborating with outpatient specialty behavioral health clinics to the

Communication Out

	Cardio	Endo	BH
Yes	72%	71%	59%
Yes but	24%	25%	25%
No	4%	4%	17%

Communication In

	Cardio	Endo	BH
Yes	71%	60%	34%
Yes but	25%	36%	43%
No	4%	4%	23%

Fig 2 | Communication

	Cardio	Endo	BH
Yes	69%	66%	41%
Yes but	17%	18%	37%
No	13%	16%	22%

Fig 3 | Help with scheduling appointments

same degree as with other medically oriented specialty clinics. Specifically, PCMH practices were less likely to use standardized processes to make referrals, communicate, and/or help scheduling appointments with behavioral health specialty clinics when compared to cardiology and endocrinology. Although this paper looked at the degree to which staff and medical providers were collaborating with behavioral health clinics rather than looking at the degree to which patients followed up with behavioral health referrals, it is worth exploring whether or not patient's poor compliance with outpatient behavioral health referrals is accounted for by a lack of collaboration between providers. That is, would it be possible that primary care staff and medical providers are not engaging in collaboration with behavioral health clinics due to the expectations that patients will not go to a specialty behavioral health clinic?

At this point, it is important to note that the recently published 2011 NCQA PPC-PCMH guidelines have included an additional number of behavioral health requirements as a condition to be recognized as a PCMH practice. While the guidelines do not specifically discuss the integration of services into the PCMH, they emphasize the operational processes needed to address behavioral health conditions. Therefore, it remains to be seen what role behavioral health will play in primary care practices. While the survey analyzed for this study only sampled practices using the 2010 PCMH guideline criteria, many of the lessons are the same for the practices now using 2011 NCQA criteria.

It is also important to note that the present analysis examined collaboration with behavioral health clinics rather than the integration of behavioral health providers in primary care settings. Yet the degree to which these clinics were collaborating with outpatient behavioral health clinics sheds some light on the extent to which these practices viewed behavioral health conditions as important. Integrating behavioral health services into primary care settings will be the next step for most of these practices; as such, we need to first understand their stand on the importance of addressing behavioral health conditions if we aim to move the integration agenda forward.

As in any study, there were limitations. The parent study lacked control over who within the practice completed the survey (e.g., administrator versus medical providers). It is also possible that the sample used in this study might not be fully representative (i.e., NCQA practices might not be representative of all the patient centered medical homes).

The findings from this study showed that more education is indeed needed to inform medical providers about how crucial it is to address behavioral health conditions in order to (a) provide whole-person oriented services and (b) ultimately improve the overall physical health of the population. Future research should explore the extent to which integration of behavioral health services into primary care settings may be one solution to enhance collaboration and move these practices into operating as truly patient-centered medical homes.

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