Whole-Person Care: Implementing Behavioral Health Integration in the Patient-Centered Medical Home

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Whole-Person Care: Implementing Behavioral Health Integration in the Patient-Centered Medical Home

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AIMS

• **Objective 1**: Use Practice Case Studies to delineate how models of behavioral health integration are being implemented.
• **Objective 2**: Identify challenges in implementing behavioral health integration, utilizing different models.
• **Objective 3**: Identify transformation support solutions for implementing behavioral health integration.

**BACKGROUND**

**Primary Care Payment Reform (PCPR)**

Massachusetts Medicaid’s (MassHealth) current alternative payment pilot program, that introduces principles of accountable care, behavioral health integration, and Patient-Centered Medical Home (PCMH) in primary care practices.

**Goals:**

– To improve access, patient experience, quality, and efficiency through care management and coordination and integration of behavioral health
– Increase accountability for the total cost of care

**Start:** March 2014

**As of March 2015:** 20 participating practice organizations, 63 sites

**Patient-Centered Medical Home Model**

![Model Diagram](https://example.com/model-diagram.png)

**MassHealth PCPR**

- **Comprehensive Primary Care Payment**
  - Risk-adjusted capitated payment for primary care services
  - 3 Tiers of payment:
    - Patient-Centered Medical Home (PCMH)
    - Primary Care Behavioral Health (BH)
    - Specialty Mental Health

- **Quality Improvement Payment**
  - Annual incentive for quality performance, based on primary care performance

- **Shared Savings Payment**
  - Primary care providers share in savings on non-primary care spend, including hospital and specialist services

**PCMH Joint Principles: Then and Now**

<table>
<thead>
<tr>
<th>2007 - Original</th>
<th>2014 - Integrating Behavioral Health</th>
</tr>
</thead>
<tbody>
<tr>
<td>Personal physician</td>
<td>Home of the team</td>
</tr>
<tr>
<td>Whole person orientation</td>
<td>Requires BH service as part of care</td>
</tr>
<tr>
<td>Care coordination</td>
<td>Shared problem and medication lists</td>
</tr>
<tr>
<td>Quality and safety</td>
<td>Requires BH on team</td>
</tr>
<tr>
<td>Enhanced access</td>
<td>Provides access to physical space to see patients, including exam rooms</td>
</tr>
<tr>
<td>Appropriate payment</td>
<td>Funding pooled and flexible</td>
</tr>
</tbody>
</table>

**RESULTS**

**Transformation Support Solutions**

- Workflow design, test and implementation
- Metric development
- Data collecting, organizing, and interpreting
- Basic QI methodology and skill building
- Scripts, diagrams, and tools that advance implementation
- Financial optimization through billing and alternative payment models

**Examples:**

- **Onsite consultation, observation, and immediate feedback**
- **Group learning and sharing via webinars**
- **Resource design and development**
  - Telephone scripts for staff
  - Checklists and templates appropriate for customization
- **Design workflow and documentation templates to advance billable medication visit**

**IMPLEMENTING BEHAVIORAL HEALTH INTEGRATION IN PCPR PRACTICES**

**Models of Integrated Care: A Continuum**

- **Coordinated**
- **Co-located**
- **Integrated**

**Coordinated Model**

**General Description:** Externally employed Behavioral Health Clinicians (BHCs) partner with primary care practice (PCP)

- Unlike traditional coordinated model, BHCs onsite 20–40% of time
- While onsite, BHCs provide consultations, warm handoffs, intakes, and conduct follow-up

**Referrals, Follow-up, and Information Sharing:**

- PCP refers patient to BHC for offsite therapy (e.g., following positive BH screen)
- Formal agreements, consent and other forms written and agreed upon between PCP and BH clinic
- BHCs utilize forms to send consultation notes, keep appointment records, treatment goals, BH diagnoses, psych meds prescribed, and discharge summary back to PCP
- Traditional psychotherapy notes (i.e., full psychological assessments) are not shared with PCP
- Referral loop is closed when follow-up info is entered into PCP’s EMR

**Care Planning:**

- When possible, BHC attends PCP multidisciplinary care team meetings
- BHC offers insight into care plan and helps to formulate and address patient treatment goals
- If BHC is unable to attend meeting, then BH consultation notes are collected and presented by another care team member

**Billing:**

- Typically, BHC only bills for traditional psychotherapy visits (e.g., 30–50 min), not for consultations

**Challenges:**

- Most BHCs have limited or no experience working in primary care settings and may not be comfortable with the faster paced environment or how best to apply BH skillset to “medical problems”
- BHCs do not have login to EMR, so gaining access to patient information can be cumbersome
- Many BHCs possess licenses (e.g., LMHCs) that limit scope of practice or billing capacity within medical settings

**Co-located Model**

**General Description:** BHC is onsite and provides BH to selected patients using traditional psychotherapy model

- Located in same physical location, but in separate department or in unconnected physical space
- 50 minute one-on-one appointment
- Complete comprehensive BH EMR-based templated intake form

**Referrals, Follow-up, and Information Sharing:**

- BHC receives internal referral using standard internal referral processes
- Not typically available for same day/warm hand-offs
- Chart in restricted part of the EMR may document in problem list
- Unrestricted access to medical EMR
- Shares general treatment goals, diagnosis and communicates larger life context themes that may impact care
- Excludes detailed psychotherapy notes

**Care Planning:**

- May participate in Multidisciplinary Care Team meetings

**Medical:**

- Assesses ability to manage adherence to medications as part of functional assessment

**Billing:**

- Bills independently for psychotherapy consultation

**Challenges:**

- Co-location may provide improved access but not full integration of care
- Lack of shared physical space is a barrier to communication and coordination
- Fully scheduled BHC does not allow for same day/warm handoffs to occur
- Information sharing may be impacted by privacy regulations and separate BH EMR
- Potential loss of revenue associated with decrease in number of billable visits associated with fee for service model

**Full Integration Model**

**General Description:** BHC full time provider within primary care practice

- BHC provides consultations, warm handoffs, and conducts short-term therapy sessions and psycho-educational groups for patients (e.g., pain management group)
- BHC trains medical and front office staff on the principles of integrated work
- BHC drafts workflows on BH screening and follow-up
- BHC participates in daily huddle
- Utilizes same physical space to see patients, including exam rooms
- Monitors medication experience and makes psychopharmac recommendations (within scope of practice)

**Referrals, Follow-up, and Information Sharing:**

- BHC receives warm handoff in real time
- Paged by other members of medical team as needed
- Unrestricted access to EMR
- Documents using free text and practice-specific template
- Notifications are typically far briefer than traditional psychotherapy notes. EMR has ability to “lock” some BH notifications from other providers.

**Care Planning:**

- BHC is full member of Multidisciplinary Care Team
- May be designated team leader based on patient needs
- BHC offers insight into care plan and helps to formulate, address, and update patient treatment goals
- Provides guidance to team on patient needs and strengths, as well as patient capacity to engage in self care

**Billing:**

- Bills for psychotherapy, consultations, warm handoffs

**Challenges:**

- Variable buy-in from PCPs regarding the importance of integrated care
- BHC adjusting to brief appointments that may be interrupted, assessment with triage, orienting patients to new model of care

**IMPLEMENTATION OF BEHAVIORAL HEALTH INTEGRATION IN PCMH PRACTICES**

**REFERENCES**

Anita Morris, MSN, FNP-BC
Joshua Twomey, PhD
Joan Johnston, RN, MS, DNIP(c)
Judith Steinberg, MD, MPH

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**CONCLUSIONS**

- BH Integration is a necessary component of whole person care
- BH Integration is a complex, yet highly accomplishable task
- BH integration models form a continuum that leads to full integration
- BH models provide guidelines for integration, but can be customized to meet the specific needs of the practice
- Numerous transformation strategies can support the clinical, financial, and cultural challenges to integration
- Alternative payment models remain essential to supporting sustainable, expandable, and successful BH services within primary care