William O'Donohue
Alexandros Maragakis *Editors*

Integrated Primary and Behavioral Care

Role in Medical Homes and Chronic Disease Management

Springer

William O'Donohue • Alexandros Maragakis
Editors

Integrated Primary and Behavioral Care

Role in Medical Homes and Chronic Disease Management

Springer

Editors
William O'Donohue
Department of Psychology
University of Nevada
Reno
Nevada
USA

Alexandros Maragakis
University of Nevada
Reno
Nevada
USA

ISBN 978-3-319-19035-8 ISBN 978-3-319-19036-5 (eBook)
DOI 10.1007/978-3-319-19036-5

Library of Congress Control Number: 2015942823

Springer Cham Heidelberg New York Dordrecht London

Printed on acid-free paper

Springer International Publishing AG Switzerland is part of Springer Science+Business Media (www.springer.com)

Integrated Primary and Behavioral Care

Contributors

Jillian Bailie School of Professional Psychology, Wright State University, Dayton, OH, USA

David E. Bauman Central Washington Family Medicine Residency, Yakima, WA, USA

Selah, WA, USA

Bridget R. Beachy Central Washington Family Medicine Residency, Yakima, WA, USA

Selah, WA, USA

Daniel R. Evans Warren Alpert Medical School of Brown University, Providence, RI, USA

Dennis Freeman Cherokee Health Systems, Knoxville, TN, USA

Roy Grant New York, NY, USA

Joel Hornberger Cherokee Health Systems, Knoxville, TN, USA

Gayle Hurd Best Practices Administrator, Rneown Health, Reno, NV, USA

Larry C. James School of Professional Psychology, Wright State University, Dayton, OH, USA

Christos Lionis Clinic of Social and Family Medicine, School of Medicine, University of Crete, Heraklion, Crete, Greece

Robynne M. Lute Behavioral Medicine, Midwestern University, Downers Grove, USA

Lesley Manson Arizona State University, Phoenix, AZ, USA

Alexandros Maragakis University of Maryland School of Medicine, Maryland, USA

University of Maryland School of Medicine, Reno, USA

Robert E. McGrath School of Psychology, Fairleigh Dickinson University, Teaneck, NJ, USA

K. Minkoff ZiaPartners, Inc., San Rafael, CA, USA

Justin M. Nash Departments of Family Medicine and Psychiatry and Human Behavior, Memorial Hospital of Rhode Island, Warren Alpert Medical School of Brown University, Pawtucket, RI, USA

William O'Donohue University of Nevada, Reno, Reno, USA

J. Parks Columbia, MO, USA

Elena Petelos Clinic of Social and Family Medicine, School of Medicine, University of Crete, Heraklion, Crete, Greece

Merck KGaA, Darmstadt, Hesse, Germany

Jeffrey T. Reiter Swedish Medical Group, Seattle, WA, USA

Jacob T. Shoenleben School of Professional Psychology, Wright State University, Dayton, OH, USA

Marisa Sklar Joint Doctoral Program in Clinical Psychology, San Diego State University, University of California, San Diego, USA

Jeanne Wendel Department of Economics (0030), University of Nevada, Reno, NV, USA

Contents

Part I
Introduction

Chapter 1
Patient-Centered Medical Homes: The Promise and the Research Agenda

Alexandros Maragakis and William O'Donohue

What is a Patient-Centered Medical Home?

To address numerous problems with costly, unsafe, and inefficient fragmented care in the US health-care system, primary care reform has become a major area of interest. Proposed reforms have been centered around goals first articulated in the Institute of Medicine's (IOM's) *Crossing the Quality Chasm* (2001), namely reducing medical errors, controlling cost, increasing patient-centered care, improving access, increasing the use of evidence-based care, including preventative services, and overall improving both the quality and the efficiency of the health-care delivery. A new model that is fair to say has gained the most attention by professional organizations, and many health-care stakeholders are the patient-centered medical home (PCMH) (Rittenhouse and Shortell 2009). The PCMH is defined by five core functions (AHRQ 2014):

1. Comprehensive care
2. Patient-centered care
3. Coordinated care
4. Accessible services
5. Quality and safety

While not new, the term "medical home" was first used in 1967 to describe a system of care to meet the needs of children with special health-care needs. In 1992, this system of care was recommended by the American Academy of Pediatrics to be expanded into general care of children, including an emphasis on accessibility, comprehensiveness, coordination, and compassion (Kilo and Wasson 2010). From there, the concept of medical homes had been discussed for general use in the pri-

A. Maragakis (✉)
University of Maryland School of Medicine, Maryland, USA
e-mail: Al.maragakis@hotmail.com

W. O'Donohue
University of Nevada, Reno, USA

W. O'Donohue, A. Maragakis (eds.), *Integrated Primary and Behavioral Care*,
DOI 10.1007/978-3-319-19036-5_1

mary care setting, but it was not until 2007 the term "PCMH" was agreed upon by multiple professional agencies. This new model came at an ideal time, given that rising health-care costs became a center of policy reform, and primary care was seen as playing a vital role in reducing those costs (Kilo and Wasson 2010). The five functions have been defined by federal agencies like the Agency of Healthcare Research and Quality (AHRQ). Below is a description of how each of these functions is described, and what their role in promoting quality primary care is.

Comprehensive Care

The primary care setting is the ideal location for patients to have the majority of their physical and behavioral health concerns addressed. To be able to provide the comprehensive care that patients need, the PCMH focuses on providing care in a team-based approach. These teams may consist of medical providers (e.g., medical doctors, nurse practitioners, and physician assistants), pharmacists, behavioral health providers (e.g., psychologists, social workers, and licensed clinical providers), and various other health-care providers that may provide enhanced preventative, acute, or chronic care for patients. These teams may be designed to be provided entirely within a clinic or may be built virtually by linking various providers in a community (AHRQ 2014).

While a comprehensive care team may sound ideal, it is still uncertain what professionals are needed to ensure that the comprehensive needs of patients are met. While various professions (e.g., behavioral health, nursing, and pharmacy) have written about their role in the primary care setting, there have been little data discussing how these teams should be formed, and what their goals are. For example, until recently, behavioral health professions were not consistently recommended as an integral part of the comprehensive care team.

Another issue faced with this new approach is who will pay for multiple providers seeing a patient on the same day. These team approaches may initially be more expensive than standard care, with the hope that they will produce healthier patients and offset future costs. While many have written on payment reform (Rosenthal 2008), there are still no consistent systems of payments, as these vary state by state.

Patient Centered

There has been a shift in the medical community to focus on a relationship-based orientation to health-care delivery. This new focus places the patient and their families as core members of the care team and moves to actively involve them in their treatment planning. It is within the role of health-care providers to support patients and provide them with skills to manage their own care at the level of their choosing (AHRQ 2014).

Patients are supported to better self manage and to take more responsibility for their health. To augment patient-centered care, the AHRQ offers four recommendations to help providers: (1) communicate with patients about the new model of care and what the patient's new role is in the model, (2) promote self-care by helping patients reduce risk factors and help patients with chronic illness create and achieve self-care goals, (3) partner with patients about decision-making by helping reviewing treatment options and aid them in understanding the likely outcomes, (4) improve patient safety, by allowing them access to their records (Peikes, Genevro, Scholle and Torda 2011).

Coordinated Care

Beyond being the setting for which patients receive the majority of their care, the PCMH is also responsible for coordinating care across the broader health-care system. These coordinated services are intended to be delivered in a "stepped-care" manner to match the needs of the patient. For example, a patient being discharged from an emergency room for a suicide attempt may require in-person consultation involving primary care and behavioral health specialists. Other consultations may achieve their goal of enhancing patient's needs with providers or support staff interacting over the phone (Croghan and Brown 2010). It is hypothesized that this coordination is particularly important when patients need to access specialty care or are being discharged from the hospital. By doing this, the PCMH acts as the hub between patients, primary, and specialty care to ensure that needs are met and health-care plans are followed (AHRQ 2014).

Accessible Services

In order to ensure that patients have access to more affordable primary care and rely less on emergency services when urgent needs arise, it is the goal of PCMHs to create short wait times. To accomplish this, PCMHs normally offer enhanced in-person hours (e.g., working past normal business hours), provide around-the-clock telephone access to health-care providers, and use alternative methods of communication such as e-mail (AHRQ 2014).

While it is not explicated how exactly this enhanced accessibility to services should be executed, the National Committee on Quality Assurance's (NCQA) recognition process (described below) offers very clear factors for how agencies are graded. For example, enhanced hours may include being open at 7 a.m. or closing at 8 p.m. or being open on at least two Saturdays during the month.

Quality and Safety

The use of evidence-based practices as well as clinical decision-support tools to guide treatment is a major component of the PCMH. Technologies like electronic health records (EHRs) are to be implemented to help guide decision-making and reduce the potential for error. In order to produce consistent increases in quality of care, it is also recommended that providers engage in performance measurement (e.g., number of patients within a normal blood pressure or blood sugar range). Through the use of this continued commitment to quality improvement (QI), PCMH will be able to provide more effective and safer care to their patients (AHRQ 2014).

It is hypothesized that all five of these functions must be met for primary care to fulfill its role in reducing overall health-care costs and improving the quality of care patients receive (AHRQ 2014). Therefore, creating a PCMH requires a radical shift from traditional primary care settings. This shift has given rise to national recognition processes to ensure that these services are adequately delivered. The following section describes one of these recognition models, designed to ensure the quality and integrity of a PCMH.

Recognition Process of Patient-Centered Medical Homes

Given the amount of new services required for a medical setting to deliver care consistent with the PCMH model, agencies have create national recognition standards. This process is designed to ensure that settings that use the PCMH label actually provide the enhanced services a PCMH is intended to offer. The largest recognition program in the USA, which about 10% of all primary care clinicians operate under, is through the NCQA (2014). This section provides information on what services the NCQA requires from medical settings to achieve various levels of PCMH recognition status.

History of the Patient-Centered Medical Home Recognition Process

As more data have become available on the utility and practices of PCMH and health-care policies change, the NCQA's PCMH recognition has adapted to ensure that these new sources of information are integrated into practice. As such, the NCQA's PCHM standards have been through four revisions, with the latest in 2014.

The precursor to the PCMH was launched in 2003, under the name of Physician Practice Connections (PPC). The PPC model emphasized the use of information technologies (IT) and systematic change to reduce the amount of medical errors

that occurred from standard practices, increase the use of evidence-based care, and ensure follow-up with patients and other medical providers (NCAQ 2014).

In 2007, the joint PCMH principles were released, and in 2008, the NCQA followed with its first standards of a PCMH, which included an emphasis on the ongoing personal relationship with physicians, a team-based approach to care, care coordination, and a focus on quality and safety. There have been two updates since the 2008 release of PCMH standards, one in 2011 and the latest in 2014. Each update has "raised the bar" in order to ensure that patients receive the highest quality of care. For example, the 2014 updates have included more emphasis on integration of behavioral health care and overall team-based approaches, focused case management for high-needs populations, and more QI initiatives (NCQA 2014). The following information reflects the NCQA's 2014 Standards and Guidelines for medication settings applying for PCMH recognition.

Who is Eligible for Patient-Centered Medical Home Recognition

As denoted by the NCQA, the PCMH recognition program is a practice-based evaluation for clinicians, who may be doctors of medicine, doctors of osteopathy, advanced practice registered nurses, or physician assistants who focus on primary care specialties. Those who do not offer primary care services are not eligible for PCMH recognition. Single practices and multisite systems (i.e., systems that involve three or more sites) are eligible for the PCMH recognition (NCQA 2014).

The National Committee on Quality Assurance's Standards of a Patient-Centered Medical Home

As of 2014, there are six PCMH program standards that are provided by the NCQA. Each of these standards was created in order to target key aspects of primary care. These general standards are broken down by elements that include specific details about performance expectations. Each element is further broken down into factors, which are specific services that the element is measured by. There are some key factors, referred to as "critical factors," that are required for settings to receive more than minimal, or any point, for the specific element. Table 1.1 lists all of the NCQA standards, their elements, and how many points each standard is worth.

Must-Pass Elements

Beyond the six standards, the NCQA lists six must-pass elements that are considered essential components of the PCMH. To achieve PCMH recognition on any

Table 1.1 Patient-centered medical home (PCMH) standards. (NCQA 2014)

Standard	Elements	Point value
PCMH 1: Patient-centered access	A. Patient-centered appointment access B. 24/7 access to clinical advice C. Electronic access	10 points
PCMH 2: Team-based care	A. Continuity B. Medical home responsibilities C. Culturally and linguistically appropriate services D. The practice team	12 points
PCMH 3: Population health management	A. Patient information B. Clinical data C. Comprehensive health assessment D. Use data for population management E. Implement evidence-based decision support	20 points
PCMH 4: Care management and support	A. Identify patients for care management• B. Care planning and self-care support C. Medication management D. Use electronic prescribing E. Support self-care and shared decision-making	20 points
PCMH 5: Care coordination and care transitions	A. Test tracking and follow-up B. Referral tracking and follow-up C. Coordinate care transitions	18 points
PCMH 6: Performance measurement and quality improvement	A. Measure clinical quality performance B. Measure resource use and care coordination C. Measure patient/family experience D. Implement continuous quality improvement E. Demonstrate continuous quality improvement F. Report performance G. Use certified EHR technology	20 points

EHR electronic health record

level requires a minimum score of 50% on all of these six elements. Table 1.2 lists all six of the must-pass elements as well as the critical factor and required number to pass.

Levels of Accreditation

The NCQA recognizes three levels of PCMH status. Each level indicates the degree to which a medical setting provides the services indicated by the standards. As mentioned earlier, points are awarded to settings based on the number of factors that a medical setting is able to provide for each element listed. The determination of a setting's level is based on the points earned by a medical setting. As mentioned earlier, regardless of the PCMH level, NCQA recognition requires that all settings meet the six must-pass elements in order to achieve any status. Table 1.3 provides the number of points necessary to achieve a certain PCMH level.

Table 1.2 Must-pass elements (NCQA 2014)

Must-pass elements	Factors	Minimum number of factors needed to achieve 50% pass rate
PCMH 1: Patient-centered appointment access	1. Providing same-day appointments for routine and urgent care[a] 2. Providing routine and urgent-care appointments outside regular business hours 3. Proving alternative types of clinical encounters 4. Availability of appointments 5. Monitoring no-show rates 6. Acting on identified opportunities to improve access	Two factors including critical factor
PCMH 2: The practice team	1. Defining roles for clinical and nonclinical team members 2. Identifying the team structure and the staff who lead and sustain team-based care 3. Holding schedule patient care team meetings or structured communication process focused on individual patient care[a] 4. Using standing orders for services 5. Training and assigning members of the care team to coordinate care for individual patients 6. Training and assigning members of the care team to support patients/families/caregivers in self-management, self-efficacy, and behavior change 7. Training and assigning members of the care team to manage the patient population 8. Holding scheduled team meetings to address practice functioning 9. Involving care team staff in the practice's performance evaluation and quality improvement activities 10. Involving patients/families/caregivers in quality improvement activities or on the practice's advisory council	Five to seven factors including critical factor.
PCMH 3: Use data for population management	At least annually, the practice proactively identifies populations of patients and reminds them, or their families, or needed care based on patient information, clinical data, health assessments, and evidence-based guidelines including: At least two different preventive care services At least two different immunizations At least three different chronic or acute care services Patients not recently seen by the practice Medication monitoring or alert	Two factors
PCHM 4: Care planning and self-care support	The care team and patient/family/caregiver collaborate to develop and update an individual care plan that includes the following features for at least 75% of patients identified for care management: Incorporates patient preferences and functional/lifestyle goals Identifies treatment goals Assesses and addresses potential barriers to meeting goals Includes a self-management plan In provided in writing to the patient	Three factors