



From the American
Board of Family Medicine



Ann Fam Med 2014;183. doi: 10.1370/afm.1634.

THE DEVELOPMENT OF JOINT PRINCIPLES: INTEGRATING BEHAVIORAL HEALTH CARE INTO THE PATIENT-CENTERED MEDICAL HOME

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The world of primary care was galvanized in 2007 by the publication of the Joint Principles of The Patient-Centered Medical Home (PCMH) that spells out the fundamental features of a primary health care setting in which a team of clinicians offers accessible first-contact primary care.¹ This care should be personal, coordinated, continuous, and comprehensive—it should address most or all of a person's health care needs.

Comprehensiveness confers value to the PCMH, and is an especially important principle.² By some means, "all of a person's health care needs" must be addressed in the PCMH. This cannot be achieved without including the behavioral aspects of health. Yet comprehensiveness often is not achieved in PCMH efforts because behavioral issues are not addressed. This shortfall requires redress.

Representatives from 6 national Family Medicine Organizations, the American Academy of Family Physicians (AAFP), the American Board of Family Medicine (ABFM), the Association of Departments of Family Medicine (ADFM), the Association of Family Medicine Residency Directors (AFMRD), the North American Primary Care Research Group (NAPCRG), and the Society of Teachers of Family Medicine

(STFM) came together to draft and endorse a set of Joint Principles for Integrating Behavioral Health Care into the Patient-Centered Medical Home. This in no way supplants the original Joint Principles document, but instead stands as a codicil that elaborates a rarely followed principle implied in the original document.

This draft was forwarded to the signers of the original Joint Principles document—the American Academy of Pediatrics (AAP), the American Osteopathic Association (AOA), and the American College of Physicians (ACP)—for comments and endorsement. Two of these 3 organizations—the AOA and the AAP—negotiated a few editorial changes and then endorsed the new Joint Principles presented here. In addition, the Collaborative Family Healthcare Association (CFHA) and the American Psychological Association (APA) have tendered endorsements.

Integrated behavioral health care is a core principle of the PCMH. This document establishes the primacy of that principle.

References

1. American Academy of Family Physicians, American Academy of Pediatrics, American College of Physicians, American Osteopathic Association. Joint principles of the patient-centered medical home. 2007. <http://www.medicalhomeinfo.org/Joint%20Statement.pdf>.
2. Starfield B, Shi L, Macinko J. Contribution of primary care to health systems and health. *Milbank Q*. 2005;83(3):457-502.

JOINT PRINCIPLES: INTEGRATING BEHAVIORAL HEALTH CARE INTO THE PATIENT-CENTERED MEDICAL HOME

Ann Fam Med 2014;183-185. doi: 10.1370/afm.1633.

Introduction

The Patient-centered Medical Home (PCMH) is an innovative, improved, and evolving approach to providing primary care that has gained broad acceptance in the United States. The Joint Principles of the PCMH, formulated and endorsed in February 2007, are sound and describe the ideal toward which we aspire. However, there is an element running implicitly through these joint principles that is difficult to achieve yet indispensable to the success of the entire PCMH concept. The incorporation of behavioral health care* has not always been included as practices transform to accommodate to the PCMH ideals. This is an alarming development because the PCMH will be

*"Behavioral health care" is a problematic term for a number of reasons, but until a more widely accepted alternative arises, it will be used here to mean mental health care, substance abuse care, health behavior change, and attention to family and other psychosocial factors.

incomplete and ineffective without the full incorporation of this element, and retrofitting will be much more difficult than prospectively integrating into the original design of the PCMH.

Therefore we offer a complementary set of joint principles that recognizes the centrality of behavioral health care as part of the PCMH. This document follows the order and language of the original joint principles while emphasizing what needs to be addressed to insure incorporation of the essential behavioral elements. It is intended to supplement and not replace the original Joint Principles document, which still stands.

This document has been reviewed and endorsed by a number of Family Medicine and Primary Care Organizations, including the American Academy of Family Physicians (AAFP), the American Academy of Family Physicians Foundation (AAFP-F), the American Board of Family Medicine (ABFM), the Association of Departments of Family Medicine (ADFM), the Association of Family Medicine Residency Directors (AFMRD), the North American Primary Care Research Group (NAPCRG), the Society of Teachers of Family Medicine (STFM), the American Academy of Pediatrics (AAP), the American Osteopathic Association (AOA), the Collaborative Family Healthcare Association (CFHA), and the American Psychological Association (APA).

Principles

Personal physician. Every patient in the PCMH has a personal physician who knows the patient's situation and biography and who is committed to the wellbeing of each patient, accepting responsibility for appropriate care.

Physician directed medical practice. The physician's practice will generally be the physical location of the PCMH, and this practice will rely on a team of health care professionals who will act together to integrate the physical, mental, emotional, and social aspects of the patient's health care needs. This may be done onsite by the practice-based team or by making use of connected behavioral health specialists in the medical home's neighborhood. The physician operates best through a facilitative leadership style involving shared responsibility, seamless teamwork, honoring the unique abilities of each team member, and enabling members of the health care team to work to their full potential.

Whole person orientation. The original Joint Principles state, "The personal physician is responsible for providing for all the patient's healthcare needs..." Science has rendered untenable the artificial division of people into parts, particularly mental and physical parts. Given that over one-half of primary care patients have a mental or behavioral diagnosis or symptoms

that are significantly disabling, given that every medical problem has a psychosocial dimension, given that most personal care plans require substantial health behavior change—a PCMH would be incomplete without behavioral health care fully incorporated into its fabric. A whole person orientation simply cannot be imagined without including the behavioral together with the physical.

Care is coordinated or integrated across all elements of the complex health care system. Perhaps the single factor that most seriously harms the quality and integrity of our health care system is fragmentation. Fragmentation is the problem this particular principle addresses, since the most serious fracture in our health care system, the most fully institutionalized separation of elements of care, is the separation of behavioral health care from primary care. Carved out funding streams, behavioral health organizations (BHOs), separate medical records, different rules of confidentiality, different traditions of training, different practice cultures, and other factors have conspired to maintain this fragmentation. Health care must be coordinated and integrated via shared registries, shared medical records, (especially shared problem and medication lists), shared decision-making, shared revenue streams, and shared responsibility for the patient's care plan. The real and perceived barriers to communication among health care professionals must be clarified and addressed in a way that makes regular sharing of information for purposes of better care the rule rather than the exception.

Quality and safety are hallmarks of the medical home.

- The partnership around the care planning process between the physician, the patient, and the patient's family must include behavioral health clinicians.
- Information technology, particularly electronic health records, with appropriate security, privacy and confidentiality protections, must incorporate the behavioral health provider's notes, mental health screening and case finding tools, and the tracking of behavioral health outcomes.
- The voluntary recognition process must include demonstration that attention to behavioral health care issues are incorporated into the medical home model.

Enhanced access includes access for patients, families, and physicians to behavioral health care resources through systems of collaboration, shared problem solving, flexible team leadership, and enhanced communication. Sites that have integrated behavioral health providers should consider open access clinics for behavioral health care, behavioral health and substance use. The medical home's "neighborhood" must contain culturally effective behavioral health care professionals who are accessible physically, telephonically,

and electronically, in synchronous and asynchronous arrangements, to integrate as easily and as completely as possible the care for the patient at the right time and in the right location. Physical integration of a behavioral health professional into the PCMH is a particularly attractive strategy for improving both access and coordination, making possible warm handoffs at the moment patients or families are ready. This reduces stigma, improves adherence, and augments access to support groups, parenting programs, and other medical neighborhood services.

Payment appropriately recognizes the added value of behavioral health care as part of the PCMH, and of the behavioral health clinicians as members of the team. It is in the best interest of patients, families, employers, and payers to improve and sustain the mental health of patients by paying for behavioral health care in the PCMH and paying for effective collaboration between primary care clinicians and behavioral health clinicians.

Funding streams must not be diverted from the provision of behavioral health care, but should be pooled and applied flexibly such that fragmented care ends. Payments should not separate primary care behavioral health payment from primary care medical payments. Models for such payment may be a per-member per-month primary care capitation that includes funding for integrated behavioral health. Payment should be based on:

- The value of behavioral work done face-to-face during clinical encounters as well as work done outside the face-to-face visit, such as telephone work, asynchronous electronic communication, or remote monitoring
 - Services provided after hours
 - Mental health and substance abuse screening and early intervention
 - Services associated with coordination of care among behavioral caregivers
 - Enhanced communication between patients, their families, and all members of the PCMH team, including school personnel if indicated
 - Services rendered by separate team members, even if rendered in the same site and on the same day
- Adjustments for complexity, just as hospital payments are adjusted for case severity
 - Behavioral health clinicians sharing in the cost savings associated with coordinated care
 - Additional payment for improved quality behavioral health care
 - Patients who change their health behaviors will be healthier and have lower health care costs. They should be rewarded with lower premium payments, cash rebates, or other tangible incentives for health behavior change

Additional Critical Issues

In order to realize these Behavioral Joint Principles there are critical needs that must be addressed, including:

1. Agreement on clear and consistent language across disciplines
2. Understanding of the central role of the patient and family in articulating needs and developing a care plan
3. Defining the different roles and skill sets required for physicians, behavioral health clinicians, and other members of the health care team to provide whole-person care
4. Interdisciplinary training for practicing clinicians & other team members, faculty, fellows, residents, and students, for the roles that behavioral health clinicians as well as primary care clinicians will assume in the PCMH
5. Research to better define the optimal provision of whole person health services in the PCMH, with attention to patient, practice, training, and financing issues
6. Recognition of local adaptations of integrated, whole-person care so as to include all persons and to take advantage of the differing requirements and resources of different communities across the entire country
7. Assurance that behavioral health services, as described in the Mental Health Parity and Addiction Equity Act of 2008, are included in all benefit plans