Integrating Telemental Health with the Patient-Centered Medical Home Model

Introduction
The United States healthcare system is in a time of dramatic change. As emerging technologies and medical advancements become a reality, the healthcare system faces increased demands to curb costs and improve outcomes. Developing a strong primary care system is necessary for reforms and the patient-centered medical home model (PCMH) has been promoted to address the necessary system changes (Jackson 2013). The PCMH model recognizes the interdependence of mental health and physical health. Access to an expert mental health care workforce is limited in many parts of the country however, making the integration of mental health into the PCMH difficult. Telemental health is one approach to achieving integration and is one of the most active telemedicine applications used in the United States. Both psychotherapy and medication management are provided via telemental health with increasing evidence of their effectiveness in improving care and outcomes (Hilty et al. 2013).

Patient-Centered Medical Homes
Many patients, providers, and policymakers have only a limited understanding of what differentiates PCMHs from other types of clinical practice. The American Academy of Pediatrics (AAP) introduced the “medical home” concept in 1967 to centralize the care of and the medical records for children with special healthcare needs. The concept has since been generalized to different patient populations. In order to qualify as a PCMH, primary care practices must provide comprehensive care and be responsible for the majority of patients’ care. Inevitably, patients will require specialty care outside of the medical home and care coordination between providers in the healthcare system becomes essential. As such, multidisciplinary teams form the backbone of PCMH model. The members of these teams may be a part of the actual practice itself or be providers and resources in the community. In addition to the coordination of care between team members, the PCMH model requires the implementation of quality and safety programs and encourages the use of evidence-based practices and the measurement, assessment, and improvement of its processes and outcomes (AHRQ 2014).

Mental and Behavioral Health Care Integration
As the body of research supporting the efficacy of PCMHs grows, so does the recognition that mental health care must be integrated with physical health care. Approximately 26 percent of American adults suffer from diagnosable mental health disorders in any given year (NIMH 2008) and many of these disorders develop in childhood and adolescence. The majority of patients seek treatment with their primary care physicians (PCPs) rather than mental health providers. The high rate of mental health disorders in primary care has a profound impact on patients’ physical health. Patients with chronic physical health conditions frequently have more medical complications if their co-morbid mental health conditions are not adequately treated. Patients with mental health disorders frequently present to their PCPs with physical health complaints rather than mental health complaints, which can lead to unnecessary tests and procedures. Mental and physical health care must be integrated to optimize patient outcomes. Given that the PCMH goals are to provide comprehensive, coordinated care, and improve outcomes, this integration makes logical sense for PCMH teams.

The Role of Telemental Health
Despite the need for PCMHs to integrate mental health care into their practices, the shortage of qualified mental health providers, particularly in rural and impoverished areas, significantly limits access to care. By using technology, mental health providers can join as remote team members. The models for integrating telemental health into primary care generally fall into three categories.

Direct Service Models. Mental health providers can provide direct care for patients. Patients are evaluated and managed by mental health providers via telehealth technology. If the telemental health site is located within the PCMH’s clinical space and the mental health provider is an active participant in the PCMH team, the provider helps the PCMH meet the goals of offering comprehensive care using a multidisciplinary team and improving access to services. Multiple benefits exist for providing direct care through telemental health. Patients may be more comfortable being seen by a specialist, but within the familiar environment of their PCMH clinic. Patients may be more willing to seek mental health care if the care is not associated with the stigma of going to a mental health setting. Finally, patients are often seen closer to their homes, limiting travel and the costs associated with time off work or school (Loh et al. 2013).

One limitation of telemental health in this model is that it does not actually expand the access to mental health services. While it may be more convenient for patients to be seen at the PCMH site, they may have to wait just as long to see a provider via telemental health as they would in person. Telemental
health may only redistribute the mental health workforce.

Consultation Models. Consultation care can be used to integrate telerehand health services into the PCMH. In this model, the mental health provider does not offer ongoing care of the patient, but instead evaluates the patient via telehealth and provides the PCP with treatment recommendations. Alternatively, the mental health provider may discuss the case with the PCP as a “curbside” consult. Several programs employing either one or both of these methods have been developed. Regardless of how these relationships are structured, the consulting mental health provider can fill the need for mental health integration in the PCMH either as a remote team member or as a specialist with whom the team coordinates care. Most models also incorporate training for the primary care teams with the goal of PCPs becoming more confident in managing common psychiatric problems, while the psychiatrist assists with more challenging cases. The didactics can be an instrumental component in quality and safety programs within PCMHs.

Reimbursement is a limitation of consultation models. While consulting mental health providers can be reimbursed on a fee-for-service basis for consults in which the patient is seen, subsequent follow-up discussions or other “curbside” consults with PCPs often cannot be billed. Payment reform models may address this limitation in the future, but are not yet readily available.

Collaborative Care Models. Finally, the mental health provider can treat patients collaboratively with the PCP, primarily by providing supervision to an on-site care manager and maintaining a shared treatment plan. The collaborative care model relies on a care manager who administers screening tools, tracks treatment response and adherence, monitors patients to ensure adequate follow-up, and identifies patients who may need a referral to the consulting mental health provider.

Of the three models, the collaborative care model is most consistent with the principles of the PCMH. By definition, the collaborative care model provides comprehensive care by using a multidisciplinary team approach. Not only does a shared treatment plan help ensure care coordination, but tracking and monitoring patients through a care manager leads to quality and safety measures.

Much like the consultation model, reimbursement in traditional fee-for-service environments does not support the collaborative care model. Furthermore, extensive work must be done to establish the relationships, build the clinical processes, and support the care manager’s role for this model to be successfully implemented.

Conclusion

While it is widely recognized that the United States healthcare system faces incredible change, no one can predict what form the evolving system will ultimately take. Patients, providers, and policymakers demand a system that improves access to care, improves outcomes, and reduces total health care costs (Berwick 2008). PCMHs have been accepted as a standard of care for patients with chronic and complex medical problems and are being promoted for general patient populations. Including mental health care will be vital to the success of expanding PCMHs. Telemental health is uniquely poised to address the limited access to mental health services that many patients in PCMHs face. The improved accessibility to mental health care that is created via telemental health will strengthen the approaches to population health and team-based care implemented in PCMHs, making telemental health and PCMHs ideal partners.

References


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