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Melanie Cox
Clinician Perspectives of Behavioral
Health Service Delivery in Patient-
Centered Medical Homes

ABSTRACT

The need to reform health care in the U.S. is evidenced by exorbitant costs that for many patients, fails to produce better outcomes (McCarthy, How, Fryer, Radley, & Schoen, 2011). Provisions within the Patient Protection and Affordable Care Act (PPACA) intend to decrease spending while enhancing the quality of care provided, thus improving patient satisfaction. Notably, the PPACA promotes the patient-centered medical home (PCMH), a model of health care in which a team of practitioners coordinate care for each patient as to ensure that all health needs are addressed (PPACA, 2009a, 2009b). The use of the PCMH model has major implications for many behavioral health providers who have historically provided care in isolation, without collaboration with medical providers (Kessler, Stafford, & Messier, 2009). To investigate the effects of behavioral health integration within this model, six master's level behavioral health clinicians were interviewed about their experiences delivering services at a PCMH. Themes identified within the interviews included a major shift in practice characterized by intermittent behavioral health treatment. While the sample size of the current study greatly limits generalizability, the findings demand further exploration as to understand the future of behavioral health service delivery in the U.S.

**CLINICIAN PERSPECTIVES OF BEHAVIORAL HEALTH SERVICE DELIVERY IN
PATIENT-CENTERED MEDICAL HOMES**

A project based upon an independent investigation,
submitted in partial fulfillment of the requirements
for the degree of Master of Social Work.

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2015
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CHAPTER I

Introduction

The U.S. health care system is, in its current state, characterized by excessive spending that often fails to improve the health of patients (McCarthy, How, Fryer, Radley, & Schoen, 2011). This on-going crisis calls for major reform that aims to cut costs while simultaneously improving outcomes and the quality of care (Berwick, Nolan, & Whittington, 2008). Provisions within the Patient Protection and Affordable Care Act (PPACA; 2009a, 2009b) have the potential to mend the fragmented system of health care through comprehensive models of care like the patient-centered medical home (PCMH). The PCMH also has the potential to mend the fragmentation that segregates behavioral health care from primary medical care.

Although the concept of the PCMH has been conceptualized for decades, major initiatives to pilot this model have only recently been studied. As such, it is unclear how the delivery of behavioral health services will be impacted by integration into the primary care setting. The current investigation aims to explore the effects as perceived by behavioral health clinicians themselves.

Semi-structured interviews were conducted between the researcher and six behavioral health clinicians, all of whom have worked in their current position for a minimum of six months. For the purposes of this study, the researcher only interviewed clinicians who currently practice in a PCMH that has received the highest level of certification from the National Committee for Quality Assurance (NCQA, 2014).

The following chapters describe: the purpose and benefits of conducting this research with respect to the current literature; the methodology used for this investigation; the major findings; and a discussion of the findings in the context of U.S. health care reform.

CHAPTER II

Literature Review

Defining the Medical Home

The term *patient-centered medical home* (PCMH) was originally conceptualized in the 1960's by the American Academy of Pediatrics (AAP; Sia, Tonniges, Osterhus, & Taba, 2004) to describe a model of care for children with special health needs; the PCMH has come to reflect a comprehensive framework for cost-effective, quality health care. The PCMH model, which is informed by Wagner's chronic care model (Wagner, Austin, & Von Korff, 1996), aims to provide all patients with acute, chronic, and preventative care across all stages of the life cycle. Specifically, this model emphasizes the importance of *primary care* for maintaining adequate health. The collaborative nature of the medical home is induced within a team of clinicians who work with one another, as well as with the client, her family, and her community.

The PCMH model is comprised of seven core features that have been outlined by the American Academy of Family Physicians (AAFP) in conjunction with the American Academy of Pediatrics (AAP), the American College of Physicians (ACP), and the American Osteopathic Association (AOA; 2007). These components include: a personal physician with which the patient has an ongoing relationship; a multidisciplinary team of clinicians led by the personal (primary care) physician; a whole person orientation that emphasizes quality of life, rather than symptom maintenance only; care that is coordinated and/or integrated across elements of the health care system and the patient's community; quality and safety such that clinical decisions

are informed by evidence-based medicine and made in conjunction with the patient and her family; structural changes that enhance access to care; and payment reform that incentivizes favorable patient outcomes while discouraging excessive, unnecessary services. Furthermore, these descriptors inform the recognition standards imposed by the National Committee for Quality Assurance (NCQA, 2014).

Justification for the PCMH Model

For the most part, there is unanimous agreement among politicians that the United States health care system is in great need of reform. In 2011, the U.S. received a 65 out of 100 on the National Scorecard (McCarthy, How, Fryer, Radley, & Schoen, 2011), an evaluative measure of health care systems developed by the Commonwealth Fund Commission on a High Performance Health System. The report characterizes the U.S. as delivering care that is inaccessible, inefficient, and inequitable relative to other countries that are producing superior patient outcomes while simultaneously spending far less than the U.S. (McCarthy et al., 2011).

Notably, health care spending represents a significant threat to the U.S. economy, with costs reaching approximately \$2.2 trillion (PricewaterhouseCooper [PwC], 2010) and comprising nearly 18% of the gross domestic product (GDP; Shatto & Clemens, 2011). Consequently, the U.S. remains the only industrialized nation that lacks universal access to health care (Berwick, Nolan, & Whittington, 2008). Furthermore, \$1.2 trillion is believed to be wasteful spending (i.e. that which does not improve patient outcomes; PwC, 2010). As Hussey, Eibner, Ridgely, & McGlynn (2009) note, the dominant fee-for-service payment model, which incentivizes quantity over quality of service delivery, is partially responsible for the health care system's current financial state.

Current Policy Expanding the Role of Medical Homes

The Patient Protection and Affordable Care Act (PPACA), which was passed in 2010, aims to cut excessive spending on health care through financing and reimbursement changes (Croft & Parish, 2013). For example, the health reform law promotes accountable care organizations (ACOs), which are collectives of providers who agree to share responsibility for patients' costs and outcomes. Unlike fee-for-service models, reimbursement within ACOs utilizes capitation (i.e. a group of providers is given a set amount of money to provide care for each patient.) This effectively transfers the majority of the risk from the payer to the provider(s). As indicated by Druss and Mauer (2010), ACOs have the potential to provide financial structure for health care models such as the PCMH.

Although the PCMH model was first conceptualized in 1967 (Sia et al., 2004), its role within the U.S. health care system has been limited up until now; the collective recognition of the model's potential for cutting health care spending while improving patient outcomes has resulted in overwhelming support from federal legislature. Notably, the PPACA contains several provisions that expand the role of PCMHs in order to improve the quality and efficiency of health care service delivery in the U.S. (PPACA, 2009a, 2009b). For example, the establishment of the Center for Medicare and Medicaid Innovation (CMI) intends to test a variety of health care models. In this context, the PCMH model is valued as a potential strategy to "transition primary care practices away from fee-for-service based reimbursement and toward comprehensive payment or salary-based payment" (PPACA, 2009a, p. 715). Other PPACA provisions that advocate for PCMHs establish community health teams intended to support PCMH practices (2009a), primary care extension agencies that assist providers in implementing PCMHs (2009b), and a strengthening of primary care training (2009b).

Research on the PCMH Model

Research is necessary to substantiate the claim that the PCMH model can satisfy the Institute for Health care Improvement's Triple Aim: lower costs, better care, and improved outcomes (Berwick, Nolan, & Whittington, 2008). A wealth of literature in support of the PCMH model has come to light in recent years. For example, the Patient-Centered Primary Care Collaborative (PCPCC) analyzed results from 46 PCMH initiatives across the U.S. and concluded that this model of care reduces unnecessary spending while improving both patient outcomes as well as provider experience (Nielsen, Langner, Zema, Hacker, & Grundy, 2012).

Behavioral health integration in the PCMH. The extent to which behavioral health services are integrated into the current health care system is limited; importantly, mental health care costs are separated from those for medical care through the use of behavioral health carve outs (Kessler, Stafford, & Messier, 2009). The PCMH model has the potential to mend this fragmentation through coordination and collaboration between primary care physicians and behavioral health clinicians.

A subdivision of research on health care reform focuses on outcomes for patients receiving mental health services in a primary care setting. For example, the Primary Care Access, Referral, and Evaluation (PCARE) study (Druss et al., 2010) utilized a randomized trial to examine the benefits of medical care management for persons with severe mental illness. Participants (n = 407) were randomly assigned to either a usual care group or a medical care management group which utilized an intervention designed to overcome patient, provider, and system-level barriers to primary care that are frequently encountered by persons with mental illness. Among the results was the finding that the intervention group experienced a significant improvement on the SF-36 mental component summary (8% improvement) relative to the usual care group (1.1% decline; Druss et al., 2010).

While the PCARE study provides empirical evidence in support of care management models, it is limited by its lack of assessment of the usual care group. The authors write:

Subjects assigned to usual care were given a list with contact information for local primary care medical clinics that accept uninsured and Medicaid patients.

Subsequently, these subjects were permitted to obtain any type of medical care or other medical services. (p. 155)

Without documenting the extent to which participants in this group received *any* care, the significant improvements among participants in the intervention group may be not be attributable to a care management model, specifically, but rather to the presence of an intervention.

In another study, the Prevention of Suicide in Primary Care Elderly: Collaborative Trial (PROSPECT; Alexopoulos et al., 2009), researchers assessed participants for depressive symptoms and the presence of suicidal ideation before and after a suicide prevention intervention in the context of collaborative care. Those receiving care management had a higher likelihood of receiving treatment for depression and had a greater decline in suicidal ideation than control participants.

Despite a wealth of encouraging findings, additional research is beginning to suggest that primary care integration will require scrutiny to ensure that the quality of mental health services is preserved. Importantly, a report prepared for the Agency for Health care Research and Quality (AHRQ) found that while integration of behavioral health care within primary care settings produced positive outcomes, integration itself did not predict improved patient outcomes (Butler et al., 2008). For example, a systematic review of 76 practices (Martin, White, Hodgson, Lamson, & Irons, 2014) revealed that only 60.5% of IPC programs provide psychotherapy; furthermore, 47.3% report communication between providers, and only 15.7% report

collaboration as a “shared decision making process” (Martin et al., 2014). An additional review of 123 practices (Kessler, Stafford, and Messier, 2014) found that only 42% had a behavioral health clinician on site. They also found that half of practices have procedures in place for referrals, communication, and patient scheduling for responding to mental health/substance use services. Such procedures for other subspecialties were found to be present in a greater percentage of practices (e.g., 73% for cardiology; Kessler et al., 2014).

Implications for Behavioral Health Clinicians

Importantly, health care reform resulting from the PPACA is believed to bring in 1.15 million additional users of mental health services by the time it is fully implemented in 2019 (Garfield, Zuvekas, Lave, & Donohue, 2011). Moreover, the PPACA provisions described above have the potential to integrate behavioral health into the primary care system through increased access, financial restructuring, and improved infrastructure (Croft & Parish, 2013; Druss & Mauer, 2010). The hope is that a large proportion of patients will have access to mental health services through their primary care physicians.

Croft and Parish (2013) examined potential barriers to care integration resulting from the PPACA. The authors identified a variety of consequences for both mental health clinicians and their clients. Firstly, there is a concern that having vulnerable populations share the risk pool with patients who have less complicated needs, agencies may redirect resources away from the costlier patient population (i.e. patients with complex needs; Druss & Mauer, 2010). Also pertinent is the fact that care integration relies heavily on quality measurement and health information technology, both of which are under-utilized in behavioral health care (Institute of Medicine, 2006).

The purpose of the current study is to test two hypotheses proposed by Croft and Parish (2013). The first is that the lag in behavioral health quality measurement and health information technology will impede clinicians' ability to effectively provide care in the context of an integrated care model. Moreover, organizations may shift resources away from vulnerable populations that require costlier care. This is due to the payment structure of the PCMH that is characterized by patients with less complex needs "sharing the risk pool" with those whose needs are more complicated. The current study will investigate such barriers to integration from the perspective of mental health clinicians.

CHAPTER III

Methodology

Research Purpose and Question

The purpose of this exploratory investigation is to examine the experiences of behavioral health clinicians working in PCMHs. Specifically, the interview was designed to explore potential barriers to behavioral health integration noted by Croft and Parish (2013). A qualitative approach was chosen to reflect the importance of subjective experience in exploring this issue. Furthermore, an exploratory research design was utilized as this topic has not been adequately explored previously.

Sample

The population was defined as all master's level behavioral health clinicians who practice within a PCMH. For the purposes of this study, recruitment was carried out within a single New England state. This was done for consistency as state-specific PCMH requirements have the potential to produce confounds. Eligibility criteria required that participants be master's level behavioral health clinicians currently employed by an NCQA-certified Level 3 PCMH (NCQA, 2014). Only agencies that had been functioning as a Level 3 PCMH for at least two years were considered. Furthermore, only clinicians who have worked in their current position for at least six months were asked to participate.

It should be noted that the exact size of the population is unknown, in part due to the method of organization used by the NCQA to display all certified PCMHs on their database.

Notably, the database is organized alphabetically by the names of each individual doctor who practices within a medical home; thus, the majority of PCMHs are listed multiple times. Furthermore, the database cannot be organized based on the level of recognition, and thus includes Levels 1 and 2 as well as Level 3 PCMHs.

Recruitment

Due to the specificity of the eligibility requirements, nonprobability sampling methods were utilized to recruit participants. The researcher made contact with clinicians ($N=16$) at eight different medical homes; initial communication with clinicians was done through phone and/or mail. Some clinicians ($n=3$) held managerial positions, and thus were identified as having a potential to distribute the details of the study to a large number of other clinicians.

During the recruitment process, the researcher learned that a study may not be advertised to clinicians unless it is approved by an internal review board within that institution. Thus, the researcher resorted to contacting behavioral health clinicians individually and determining eligibility criteria during the initial communication. This method proved beneficial as the providers who responded with expressed interest in participating ($n=9$) were only those with whom the researcher was able to reach directly via phone; none of the providers who were contacted by mail without initial communication over the phone responded at all. Furthermore, participants were willing to recommend and provide contact information for other individual clinicians working at the same PCMH. As a result, recruitment was facilitated in part by snowball sampling.

Of the participants who responded, one failed to maintain communication with the researcher, and two declined participation due to feeling as though they did not have the

expertise despite meeting the eligibility criteria. Thus, a total of six behavioral health clinicians participated in the current study.

Ethics and Safeguards

The current study was originally approved by the Human Subjects Review Committee of the Smith College School for Social Work on December 5, 2014 (see Appendix A: Human Subjects Review Approval Letter); a revision request of the study (see Appendix Ba: Protocol Change Request) which was approved on March 6, 2015 (see Appendix Bb: Protocol Change Approval Letter), was submitted to allow time for additional data collection (i.e. no other changes were made to the original proposal.)

Both the original proposal and the revision included multiple safeguards in order to preserve confidentiality, thereby protecting participants from financial, social, and legal risks. The researcher obtained informed consent from each participant (see Appendix C: Consent Form for Individual Interview Participant). As to prevent the appearance of coercion, the researcher only interviewed participants with whom the researcher had had no previous relationship. Prior to being interviewed, each clinician was encouraged to “skip any questions that you would like” as to prevent clinicians from experiencing discomfort (see Appendix D: Interview Schedule). All interviews were conducted over the phone in order to ensure that participants would not be seen meeting with the researcher by an agency supervisor or co-worker. In addition, all participants were given the researcher’s contact information and were encouraged to call or e-mail the researcher with any questions or concerns.

Throughout the data collection process, the researcher stored recordings, transcriptions, analyses, and consent forms in a secure location. Participant data, which was identified with assigned numbers in place of names, were stored separately from consent forms; all electronic

files were password protected. In accordance with federal guidelines, all data used for the project will be stored on a password-protected computer for three years after completion of the study and then destroyed unless it is still being used for future research.

For the purpose of reporting the findings, each participant has been assigned a pseudonym which will be used in place of their legal name. Participants' responses presented in the findings chapter have been modified as needed such that no identifying information is provided.

Data Collection

Eligibility for participation was determined over the phone (see Appendix E: Screening Form). Eligible participants then received a consent form in the mail, along with a form intended for the collection of demographic data (see Appendix F: Collection of Demographic Information). Participants were asked to identify their gender, race, and ethnicity, as well as information pertaining to their graduate level education and clinical work. Once a signed consent form was received by the researcher, an interview was scheduled.

The questionnaire (see Appendix D: Interview Schedule), which was designed by the researcher, was informed by the available literature documenting potential outcomes of behavioral health integration in PCMHs (e.g. Croft & Parish, 2013.) Questions included:

How do you understand your role as a behavioral health clinician within a care team of other providers?

How do you communicate with providers who are members of a mutual care team?

What can you tell me about treatment planning for clients with behavioral health needs?

Typically, who is involved in treatment planning, and in what ways are they involved (client, family members, behavioral health clinician, primary care physician, other)?

From your perspective, how are clinical decisions pertaining to a patient's behavioral health needs made by the care team?

All interviews were conducted over the phone; audio recording was used for later analysis.

Phone interviews were used so that the researcher could make contact with a greater number of participants without the need to travel.

Data Analysis

Demographic data were analyzed along with the open-ended responses provided during interviews. Prior to qualitative analysis, the researcher personally transcribed all interviews. All identifiable information was deleted from participants' transcripts.

The researcher approached the transcripts using content analysis and thematic analysis. Open coding allowed the researcher to establish themes within and across transcripts. Each question asked during the interview fell under one or more of the following categories of inquiry: lived experience of behavioral health clinicians; characteristics of the population served; communication and collaboration between primary care and behavioral health; and the implications of behavioral health integration for clinicians and clients.

Limitations

The primary limitation of this study is generalizability to the population, which has been defined as all behavioral health clinicians practicing in PCMHs. First, the researcher chose to interview clinicians employed by agencies that meet the NCQA's scoring criteria for Level 3 PCMHs. This criterion excluded PCMHs with lower scores, including those that are less equipped to integrate behavioral health care into the primary care setting. As such, the results of the current investigation may only be relevant to those PCMHs that have achieved the highest level of behavioral health integration. Similarly, the researcher sampled clinicians practicing in

one state only due to its extensive health reform (including that pertaining to behavioral health integration). As such, the results of interviews cannot be generalized to behavioral health clinicians across the United States. Likewise, the diversity of the participants may prevent the results from being representative of the population. Finally, the researcher must consider the impact of sampling bias. Such a bias has the potential to determine which agencies were contacted (and which ones were dismissed) by the researcher during the recruitment process. Despite these limitations, the current study serves as a first step towards revealing the anticipated *and* unanticipated effects of behavioral health integration in PCMHs.

CHAPTER IV

Findings

The purpose of this study is to examine the impact of behavioral health integration by examining the perspectives of clinicians practicing from within the PCMH framework. The data presented in this chapter include clinicians' written responses to the Collection of Demographic Data Form (see Appendix F: Collection of Demographic Information) as well as verbal responses obtained during semi-structured phone interviews.

Five themes, which were identified during data analysis, provide insight into the impact of the PCMH model as perceived by behavioral health clinicians: redefining work and caseload; the level of care provided; autonomy in clinical decision-making; increased communication and collaboration; and destigmatization of mental illness. These themes will be addressed below, along with the demographic data obtained from each participant. Themes unrelated to the research question will be addressed in the discussion.

Demographic Data

All of the participants ($N=6$) identified as White females. Their ages ranged from 35 to 66 years with average and median ages of 51 and 52 years, respectively. In addition, each carried a master's degree in social work; one reported having an additional master's degree in education. Participants obtained their master's in social work (MSW) between 1980 and 2009; all six clinicians received their MSWs from the same institution.

Clinicians described the title of their current position as “program manager” ($n=1$), “supervisor” ($n=2$), “clinical social worker” ($n=2$), and “psychotherapist” ($n=1$). All participants were behavioral health clinicians currently practicing within a PCMH that had been NCQA-certified for a minimum of two years. The clinicians practiced at four different medical homes (i.e. three clinicians practiced at different sites within one institution.) All of the medical homes were located within one U.S. state in the northeast. The implications of the sample size and diversity will be addressed in the discussion.

Redefining Case and Workload

Clinicians commented on the number of clients they typically have on their caseload, along with a description of the treatment model utilized within the PCMH. Most ($n=5$) clinicians described their caseloads as relatively large in size; some ($n=3$) explicitly stated that their current caseload was larger than for previous positions in non-PCMH environments. For example, Olivia reported seeing an average of “25-28” patients per week and that relative to other types of settings, “Our productivity is really high.” Rosalind, who expressed that she could not quantify her caseload, explained “It could be like, 10-13 people a day.” Furthermore, all of the clinicians reported that the use of shorter-term treatments is preferred over lengthier ones and is more conducive to the PCMH framework.

Importantly, the increased number of clients and briefer treatment models appeared to be accompanied by a decrease in the frequency of behavioral health appointments relative to more traditional models of psychotherapy. This trend, which was reported by the majority ($n=4$) of the participants, is suggestive of a shift away from weekly 45-minute sessions in favor of what may be a more patient-centered approach. Jennifer, who reported a caseload of “45-50 patients” per nine clinical hours, describes the delivery of care from her perspective.

There is an element of intermittent care, much like how you have a primary care doctor. You don't see your primary care doctor more than maybe once a year, but your primary care doctor is never going to drop you... Sometimes I don't see people but once a month or once every two months, and then I sort of lose track of how many times I've seen them. And that intermittent care, the touch and go is what I call it, is what they need. That is the treatment that they want. They don't want it every week.

As Jennifer suggests, some patients in need of behavioral health treatment may not want to engage in weekly sessions, but rather seek support from their medical home as needed. For those who *do* want it weekly, the model can be a challenge. She expressed, "It's hard, because sometimes they just can't get in as frequently as they would like to because I have such a large caseload, so that can sometimes be a barrier to treatment."

Rosalind, who expressed some ambivalence regarding her inability to provide more intensive care, also reflected on the suitability of the treatment model for clients who may not be able to commit to weekly sessions.

I've grown to kind of like the model in a way, but it has its challenges, because if you want to see people more intensively, you usually don't have the option because of your schedule... But I kind of like the fact that we do brief therapy or time sensitive therapy and its not a long term treatment model... It's not like many places where you get a case, you put them in your schedule, and it's 10 o'clock every week, and that's the situation. It kind of presupposes that people have lives, or things going on, and this is just one aspect of their life, and you do a piece of work and they go off and live their life.

The only provider who did not explicitly report a relatively large caseload was Ashley, who reported that a behavioral health clinician could have a caseload of “200 people” but that the caseload does not reflect the number of clients actively engaged in therapy. She explained,

People tend to come and go from treatment very frequently... If they come in and they want to be seen, we see them. Because we are their primary care, you know we are their medical home. And so, they're technically always on my caseload... But you're only actively, at any given moment, you're actively only seeing, you know, 30 or 50 people. But who that 30 or 50 people are is constantly in flux.

Susan described *her* experience of the shift to more intermittent work with clients.

It's the first time I've had to get used to not knowing exactly who my clients are. In working with clients long-term, I'm much more conscious of who the people are in therapy with me... There's a much clearer cut, either you're in therapy or you're not... In primary care, its much more fluid.

Natalie also spoke to her experience of having a caseload that is constantly changing.

I certainly have felt lost in the relationship with the patient, and certainly lost the grasp of what's going on, and more work in terms of paperwork and trying to orient yourself to each new patient. That can be more taxing on that side.

Level of Care Provided

Surprisingly, participants reported different descriptions of the clinical presentations that were considered to be appropriate for the PCMH setting. Half of the clinicians ($n=3$) reported only working with clients with relatively mild behavioral health concerns. For example, Natalie reported,

This group is a healthier group overall because I'm getting a lot more short-term cases that are more appropriate for short-term work. Often, those are people who are dealing with anxiety or depression and don't have, also don't have a trauma history, often don't have Axis 2 diagnoses. So it's kind of spelled out in the model that these are the types of patients that would benefit more from a brief psychotherapy.

Her response suggests that clients in need of behavioral health services are vetted to determine whether the appropriate level of care can be provided from within the primary care setting.

Similarly, Jennifer spoke about a model that she and her colleagues developed in order to assist the primary care department in identifying appropriate referrals.

So we developed this model... and distributed it to the primary care doctors so they would understand what we're looking for. So in primary care, we really don't want you to refer someone who is really high risk, really dangerous to them self, needing lots of services, because in primary care, we can't offer that. We have limited resources in primary care. So in primary care, we were really asking primary care doctors to refer... someone who has a low to mid level anxiety, depression, maybe some life transitional issues or psychosocial issues that were occurring, where a short term therapy course, maybe a little medication attached to that might be enough.

In addition to describing the level of care that can be provided in her setting, Jennifer's response targets a component of behavioral health integration in which clinicians must educate primary care staff. The role of the behavioral health clinician in the integrated care setting will be explored further below.

Unlike Jennifer and Natalie, both Rosalind and Ashley ($n=2$) reported seeing clients with chronic symptoms. In fact, Rosalind reported that she sees a wide variety of presentations. In describing the *current* patient population, she noted,

It's so heterogeneous at the health center. People come because they're depressed; they come because they're anxious; they come because of a life stressor; they come because of a trauma; they come because of an acute trauma, like they've witnessed something on the job; they come because they're harassed at work; they come because they have bipolar disorder. So it's a real mix of acute and chronic psychiatric issues.

Rosalind also spoke about plans within the PCMH that would change the composition of the patient population.

Changing... so that we refer people who are more acute and healthier out into the community to group practices and mental health centers, so that we can see more of the chronic or... more in need of services, and then we have more time to see them intensively. That is more supportive of what the research says is best.

This initiative to keep patients with more chronic presentations in-home was unique to Rosalind's PCMH, and suggests that the patient population may vary depending on the medical home's resources as well as the extent to which behavioral health has been integrated.

Autonomy in Clinical Decision-Making

Clinicians ($n=4$) expressed having some degree of autonomy with regards to making clinical decisions for patients with behavioral health needs. Rosalind provided insight into why she often makes clinical decisions independently.

They're mostly made by me. At the case review meetings, every other week, you know its just one hour every other week for the entire department, we can bring up cases we have questions about, want consultation about, but because we see so many people, we're obviously not going to be able to bring all those concerns up, so we mostly make the decisions ourselves.

Susan described her role as having autonomy with regards to behavioral health while maintaining a collaborative relationship with the primary care doctor.

I feel like the collaborative decisions, I hold the authority around behavioral health, I guess that's the best way I'd describe it. Its collaborative between the client, the primary care doctor, and myself but my, I'm recognized as the expert, at least by the primary care doctor, I don't like that for a client, but in terms of the primary care doctor, like they're the primary care doctor and I'm the behavioral health person, we respect each other in those regards.

Only one clinician (Ashley) reported that the primary care doctor has more authority in regards to behavioral health care decisions. She explained,

I mean, in our health center right now, it's still a little more leaning towards the doctor making the decisions which, I understand that, but as a social worker, knowing the utility of multidisciplinary approach, I'd like to see us making clinical decisions more jointly, but I think that's a culture change. But you know, I think it would take some time to get there.

Clinicians' experience of autonomy within the PCMH may also be impacted by the extent to which they can choose the interventions they deem appropriate. When asked about the extent to which EBP is required and/or mandated, most participants ($n=4$) explicitly reported that

there was no requirement with regards to which types of treatments are offered; none of the participants explicitly stated that the use of evidence-based practice in behavioral health *is* required. Rather, the specific intervention is at the discretion of the therapist. For example, Susan reported,

...we have training in evidence-based protocols, problem solving therapy, DBT, internal family systems, even psychodynamic, although people don't like to acknowledge it as an evidenced based intervention, but the decision making is entirely up to me. There's no requirement... You know, ultimately it's up to my judgment, but when I discuss the options with the client, and I discuss particular options as they suit the client's needs in the timeframe we have together.

Despite the fact that clinicians were able to choose which model to work from, the culture of the medical homes was such that evidence-based practice models were favored in some way. For example, Jennifer reported, "No, nothing's mandated." She added, however, "they're investing money to try to train people who are working in primary care in shorter term treatments." Likewise, Olivia stated, "The doctors are big into CBT because they think its quick. I'm not sure they fully understand it, but they really like that."

Furthermore, two clinicians described ambivalence (on behalf of the primary care doctors) regarding the use of treatment models that are not traditionally accepted as evidence-based. On the topic of alternative models of psychotherapy, Rosalind shared,

Yeah. I mean, I do a fair amount, you know in terms of what I know and what I can do in that setting, but I kinda do it, I'd say a bit covertly, I mean I'm not doing anything illegal or anything... Yeah, it isn't something that I announce to everyone.

Natalie also spoke to the privileging of some behavioral health treatments over others.

So they haven't mandated anything... So we're having a training on cognitive behavioral approaches... and some problem-solving therapy, which is an approach that it's been used by other integrative mental health teams... they're definitely more, I guess I'm not finding the word – precise, or specific approaches that they would like us to use rather than – you know, we're not giving further training on psychodynamic approaches, for example.

Increased Communication and Collaboration

A crucial component of integration is the extent to which behavioral health and primary care clinicians collaborate with each other. This requires infrastructure that enables communication. All participants ($n=6$) reported that they communicate with other providers through electronic health records (EHR); the majority of clinicians ($n=4$) expressed that the EHR enables communication and/or collaboration with other providers. Olivia, for example, reported,

We have electronic medical records, which is really fast, and we don't have to do a ton of paperwork... If we coordinate care, it's through the electronic medical records. We can do that, it's easy. The person is working with the same record you're working with.

When asked about the most common forms of communication with other providers, Rosalind reported,

The electronic health record, I'd say, is the main one, particularly out of the behavioral health department because you don't see them face to face in many formats so that's a big one, but we do have a staff meeting once a week... But to be honest, we see so many people, we don't really talk about the cases we share...

So the electronic medical record actually is, I think, a great thing. Cause, we can send copies of pertinent notes, and again, not every one we share we send a note to, because we'd get constant notes all the time.

According to Rosalind, the EHR is necessary due to there being an insufficient amount of time to meet face-to-face in the primary care setting.

Well, I wish there were more opportunities for us to talk to each other in various settings. You know, I've been there 16 years and I barely know the primary care providers. You know, I see them at a distance, I know some of them, who they are, but because we don't have the time or the format to have meetings together and be discussing this together, the only regular communication I have with them is through the medical records.

Ashley, who reported that behavioral health and primary care departments utilize the same EHR system, expressed that "we can all view each other's notes, which is extremely helpful." She praised this form of communication for reasons similar to Rosalind's.

I think it's fantastic... When I was at the community mental health center, we were supposed to be communicating with primary care doctors, but in reality, that was really like, oh, a letter at the beginning of your treatment with the patient... I think people don't really have the time, just don't have the time, or they don't make the time, so I think it's extremely helpful to be able to coordinate with the primary care doctor and see their notes.

She also spoke to the benefits of co-locating behavioral health and primary care services, a change resulting from PCMH implementation.

We have a clinical social worker who is located in the primary care clinic... and she consults during primary care visits... Or, you know, for crisis, like when a patient comes in and is psychotic or suicidal or something like that, she intervenes... its like working with the doctor to try to figure out what to do. So, and that's been extremely helpful.

Similarly, Natalie spoke to the benefits of co-locating.

So, I attend team meetings once a week where I have interactions with each of the different teams. Also, because I'm right there in the clinic, it's easy for me to go talk to the providers, or for the providers to talk to me at any point in the day, and then I also use the medical record system really frequently to give the providers updates about how patients are doing, or tell them that I've made a referral... They also send me questions or ask me to do things for them through the same system.

In describing the relationship between patients and their providers, Natalie expressed that the doctor is “certainly the main connection to the patient because the patient has a relationship with that doctor.” She added, “It can be very helpful to be on the same page as the primary care doctor especially when the patient is maybe only seeing you when they come to see the doctor.”

Destigmatization of Mental Illness

A theme arose the interviews in which clinicians ($n=3$) praised the destigmatization of mental illness, which is made possible within the PCMH model. For example, Ashley reported,

I think providing behavioral health care in a primary care setting is a fantastic way in some ways to break – to try to get past that stigma because you know, people come to their primary care clinic all the time. And we can just see people right there, and that usually is extremely helpful.

Similarly, Natalie said of the model, “I think it's an important role to reach a lot more patients and make mental health more I guess less stigmatized and more like a common part of people's understanding of their own health.” Thus, the integration of behavioral health into the primary care setting not only has the potential to normalize the experience of seeking services, but also creates a more encompassing conceptualization of health. As Jennifer explained,

I'm trying to make the patient realize that they're a whole person with mind and body and that we have specialists for diabetes... we have orthopedists, blah blah blah, and that this is no different. We're trying to destigmatize the mental health aspect of a person's care.

CHAPTER V

Discussion

The purpose of this exploratory study was to understand how behavioral health clinicians conceptualize their work within a PCMH, a health care model promoting behavioral health integration within the primary care setting. Specifically, the researcher investigated the extent to which the hypotheses posed by Croft and Parish (2013) were supported by qualitative data extracted from semi-structured interviews with providers. Importantly, Croft and Parish have predicted that while integration aims to increase access to care, barriers are likely to persist.

The major findings will be explored within the context of literature pertaining to health care reform, particularly behavioral health integration within the PCMH. Two additional themes, which were omitted from the findings chapter due to being unrelated to the research question, will also be addressed. The strengths and limitations of the present study will be explored. Finally, the researcher will offer recommendations for future investigations into behavioral health integration and the PCMH.

Shift in Practice

Clinical work. The PCMH model aims to integrate all aspects of one's care as to treat the whole person. This objective contrasts from the current fragmented health care system in which behavioral health services are, for the most part, excluded from the primary care setting. As such, clinicians who provide behavioral health services from within the PCMH model are likely to experience a dramatic shift in their practices relative to other health care settings. For

example, behavioral health clinicians positioned within PCMHs are likely to experience a significant increase in the number of clients on their caseload relative to other work environments, as was indicated in the transcripts. Large caseloads, such as those found in the primary care setting, appear to be complemented by a decrease in the number of visits per patient, thus creating a model of care for behavioral health that is more similar to that of medical needs.

Similarly, the cultural shift has led to a preference of treatment models categorized as EBP over other, less researched interventions. Although none of the clinicians reported that the use of EBP is currently mandated, there appeared to be a consensus that EBP is preferred over other interventions and encouraged by primary care staff. Advocates of EBP (e.g. Cummings, Cummings & O'Donahue, 2009; Thomason, 2010) maintain that third-party payers are right to hold clinicians accountable for their clinical work, thus ensuring brief, cost-effective care in which progress can be easily measured and tracked. Health care service delivery characterized by these objectives is consistent with the PPACA provisions (PPACA, 2009a, 2009b) that promote the PCMH model as a response to the U.S. health care spending crisis.

The overall shift in practice is likely to be perceived as a dramatic contrast from the delivery of behavioral health care in, for example, community mental health centers. While some clinicians expressed that they have experienced feeling disconnected from their clients, others have reported that the model of care is more beneficial to clients, many of whom actually prefer to have fewer visits.

Team-based care. The extent to which a behavioral health clinician communicates with providers in primary care is bound to be greater in the context of the PCMH. Notably, the objective of care integration can only be achieved if providers work collaboratively. As Croft

and Parish (2013) note, however, technological lags between primary and behavioral health are likely to create a barrier to integration. It appears that, at the agencies sampled, there were no notable lags in technology.

The transcripts revealed that every clinician was engaged in their institution's EHR. In addition, clinicians reported that their respective electronic health record systems facilitated communication and collaboration with primary care providers by allowing them to read each other's notes. This is consistent with the finding that care integration relies heavily on the field of behavioral health to become acquainted with forms of technology that are already utilized regularly in primary care (IOM, 2006).

Clinicians also shared about their experiences with respect to clinical decision-making. Surprisingly, most clinicians reported that they work independently such that they are able to make clinical decisions on their own.

Access to Behavioral Health Services

Among the objectives of health care reform in the U.S. is the goal to increase access to care. Croft and Parish (2013) hypothesized that reform under the PPACA would lead to patients with more complex health needs sharing the risk pool with healthier individuals. In order to save money, they explained, organizations may redirect resources away from the costlier populations. Several questions asked during the interviews were intended to make distinctions between the populations served within the medical homes and those served in previous positions.

Interestingly, clinicians' descriptions of the symptom severity of their clients varied. While half of the clinicians reported that they only provided services to clients with minimal behavioral health needs, one clinician reported that the agency is in the process of changing in order to provide services for clients with more chronic needs, a move that is contradictory to the

predictions of Croft and Parish (2013).

Additional Themes

Themes unrelated to the original hypotheses were discovered amongst the transcripts. Notably, while these themes do not directly answer the original research question, they provide additional information pertaining to behavioral health care access.

Pediatric behavioral health services. Most clinicians ($n=5$) commented on the age range of the population with which they work in their current position; notably, the majority of those clinicians ($n=4$) either reported working exclusively with adults ($n=2$) or primarily with adults ($n=2$). Rosalind, who works primarily with adults, reported that the percentage of adolescents within her caseload is “maybe 15-20%.” She clarified that the age range of her caseload is “13 and up.” Similarly, Olivia reported that she has “not too many (clients) under ten.”

The finding that behavioral health services for children and adolescents may be severely limited within the PCMH is consistent with the widely acknowledged deficit of pediatric behavioral health providers (Pfefferie, 2007).

Psychiatric services. A theme around psychiatric services was also identified. Importantly, the ability of the medical home to meet the needs of patients relies on the ability to consistently prescribe psychiatric medications. Clinicians ($n=2$) reported that their PCMH’s understaffed psychiatry department has impacted the delivery of services for patients requiring psychiatric medications. While Susan reported that primary care doctors at her medical home tend to prescribe psychiatric medications, she did not express a staffing shortage; in fact, she reported that the primary care clinic at which she works does not have a psychiatrist on site, but rather has access to the psychiatry department within the larger affiliate.

The theme of psychiatric staffing issues, while important, may not be attributable to the PCMH model specifically, but rather to a much larger issue affecting a wide variety of health care models. In recent study by Bishop, Press, Keyhani, and Pincus (2014) indicated that access to behavioral health care is severely limited by psychiatrists' decreasing acceptance rates for insurance.

Implications of Major Findings

As previously stated, the findings of the current study indicate a momentous shift in the way behavioral health care is delivered in the U.S. It is crucial, then, to consider how the changes in infrastructure and service delivery are likely to impact each of the stakeholders of health care. Patients, for example, are likely to vary in terms of the extent to which they can access necessary care. For some patients, access will depend on the level of care they require and that provided by their medical home. Notably, there remains the potential for patients with more complex needs to continue to experience somewhat fragmented care unless their PCMH is able to provide services for more severe and persistent forms of mental illness. Other patients, however, may find that receiving behavioral health services from within their medical home removes the negative stigma associated with mental illness; these patients are likely to receive more services than they would have otherwise, which, as Natalie reported, is "nothing at all."

Needless to say, the shift in service delivery has major implications for behavioral health clinicians whose training is inconsistent with the model of care described in the findings chapter. Importantly, graduate level curricula must be informed by these changes in service delivery in order to adequately prepare new clinicians searching for jobs. This may mean that training programs will need to put a stronger emphasis on briefer, evidence-based practice models that conceptualize behavioral health as one component of a person's overall needs; this, in turn, may

serve to bridge the gap between primary care and behavioral health. Similarly, the internships made available to students should be reflective of the type of clinical work that dominates the field of behavioral health as to teach skills that are relevant to the job market.

The findings are also relevant to the politicians and other policymakers who have strived to create a system of health care in the U.S. that increases access to and quality of care while simultaneously reducing the costs. As previously stated, attempts to resolve the spending crisis may result in patients with more complex needs slipping through the cracks (Druss & Mauer, 2010), thereby reducing access. Access to care is also inhibited by an inadequate physician supply; the current shortage, which is well recognized (Carrier, Yee & Stark, 2011), has the potential to exacerbate as the PPACA is expected to provide coverage to approximately 32 million uninsured people by 2019 (Kirch, Henderson & Dill, 2012). Careers in primary care are disincentivized, however, due in part to the finding that primary care physicians' student debt will exceed their earnings in the first three-five years after completing residency (Palmeri, Pipas, Wadsworth, & Zubkoff, 2010). Similarly, fewer psychiatrists are accepting insurance, thus limiting access to psychiatric services for patients who are unable to pay out-of-pocket (Bishop et al., 2014); in both cases, clinicians are being dissuaded by reduced incomes. Due to the exorbitant costs of medical school, it stands to reason that medical school graduates are simply making career decisions that will allow them to pay off their student loans in a shorter period of time. Policymakers must address the deficit of primary care doctors and psychiatrists as to incentivize careers that sustain the PCMH model.

Strengths and Limitations

The size of the sample, which is in part attributable to obstacles the researcher faced during recruitment, greatly limits generalizability. Contacting individual clinicians by phone, while more effective than alternative methods, still yielded a relatively small sample. As

previously noted, the researcher had intended to advertise within the individual medical homes but learned from several clinicians that this would not be feasible (i.e. only studies approved by a particular institution's IRB could be e-mailed to behavioral health providers). In addition, contacting potential participants via mail resulted in zero responses. Since the researcher only began to contact clinicians individually once other attempts to recruit proved ineffective, the amount of time available to recruit more efficiently was reduced.

Although the sample size limits generalizability, the research question and study design were informed by the current literature on behavioral health integration in the PCMH setting such that the data represent the perspectives of behavioral health clinicians as they relate to the objectives of this study. The researcher also took into consideration the lack of existing literature on clinicians' perceptions of the changes that have resulted from this health care model. This resulted in a qualitative, exploratory design. Moreover, the design was impacted by considerations around potential risks associated with participation, mainly that a clinician may become uncomfortable if they have concerns about confidentiality. Phone interviews were utilized in order to ensure that participants would not be seen in public meeting with the research.

Generalizability was also limited by the lack of diversity (i.e. race, gender, education etc.) within the sample. This is due in part to the lack of diversity within the field of behavioral health, particularly within the population of master's level clinicians. Furthermore, the sample frame only considered clinicians working in one state, as to avoid potential confounds resulting from state-level legislation governing the practices of PCMHs.

Areas for Further Research

Given the limitations of the present study, future investigation of this issue should emphasize the need for a larger, more diverse sample. Similarly, researchers may want to compare findings from medical homes with different levels of NCQA-recognition, as well as providers located throughout the U.S.

As previously stated, there are significant implications for the curricula of graduate level programs in disciplines such as clinical social work and psychology. Further research is needed to understand the extent to which clinicians entering the job market are prepared to work in integrated care settings. This includes examining the course material as well as the field placements offered to students. If the medical home model is to gain significant traction, it is crucial that students have access to training opportunities in such an environment.

More work is also needed to substantiate the concern proposed by Croft and Parish (2013) regarding the care of populations with complex health needs. Such research should focus on the impact of pay-for-performance incentives on patients who require costlier care.

Conclusion

Health care delivery in the U.S. has the potential to shift dramatically as a result of the passage of the PPACA. Importantly, the widely acknowledged spending crisis has led stakeholders to embrace health care models such as the PCMH. Transitioning traditional primary care practices to the medical home model may also mend the fragmentation that isolates behavioral health service delivery from medical care.

The results of the present study provide a glimpse into the practices of behavioral health clinicians positioned within PCMHs. Notably, the practice of behavioral health as described by participants represents a major shift from the delivery of behavioral health services in other environments. While there appear to be many positive effects of behavioral health integration (e.g. destigmatization), questions regarding the model's ability to improve access for all patients

remain and should be researched further.

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Appendix A: Human Subjects Review Approval Letter



School for Social Work
Smith College
Northampton, Massachusetts 01063
T (413) 585-7950 F (413) 585-7994

December 5, 2014

Melanie Cox

Dear Melanie,

You did a very nice job on your revisions. Your project is now approved by the Human Subjects Review Committee.

Please note the following requirements:

Consent Forms: All subjects should be given a copy of the consent form.

Maintaining Data: You must retain all data and other documents for at least three (3) years past completion of the research activity.

In addition, these requirements may also be applicable:

Amendments: If you wish to change any aspect of the study (such as design, procedures, consent forms or subject population), please submit these changes to the Committee.

Renewal: You are required to apply for renewal of approval every year for as long as the study is active.

Completion: You are required to notify the Chair of the Human Subjects Review Committee when your study is completed (data collection finished). This requirement is met by completion of the thesis project during the Third Summer.

Congratulations and our best wishes on your interesting study.

Sincerely,

A handwritten signature in black ink, appearing to read 'Elaine Kersten'.

Elaine Kersten, Ed.D.
Co-Chair, Human Subjects Review Committee

CC: Hannah Karpman, Research Advisor

Appendix Ba: Protocol Change Request



RESEARCH PROJECT CHANGE OF PROTOCOL FORM – School for Social Work

You are presently the researcher on the following approved research project by the Human Subjects Committee (HSR) of Smith College School for Social Work:

Clinician perspectives of behavioral health service delivery in patient-centered medical homes
Melanie Cox
Hannah Karpman, PhD

I am requesting changes to the study protocols, as they were originally approved by the HSR Committee of Smith College School for Social Work. These changes are as follows:

I am requesting that the Deadline to Withdraw for participants be extended as to give me more time to collect data while still finishing before the thesis deadline on April 10, 2015. My original deadline was March 20; I would like to extend it to April 3. If approved, all future consent forms would be revised to reflect this change.

- I understand that these proposed changes in protocol will be reviewed by the Committee.
 I also understand that any proposed changes in protocol being requested in this form cannot be implemented until they have been fully approved by the HSR Committee.
 I have discussed these changes with my Research Advisor and he/she has approved them.

Your signature below indicates that you have read and understood the information provided above.

Signature of Researcher: _____

Name of Researcher (PLEASE PRINT): Melanie Cox Date: 03/06/2015

PLEASE RETURN THIS SIGNED & COMPLETED FORM TO Laura Wyman at LWyman@smith.edu or to Lilly Hall Room 115.

***Include your Research Advisor/Doctoral Committee Chair in the 'cc'. Once the Advisor/Chair writes acknowledging and approving this change, the Committee review will be initiated.

Appendix Bb: Protocol Change Approval Letter



School for Social Work
Smith College
Northampton, Massachusetts 01063
T (413) 585-7950 F (413) 585-7994

March 6, 2015

Melanie Cox

Dear Melanie,

I have reviewed your amendment and it looks fine. This amendment to your study is therefore approved. Thank you and best of luck with your project.

Sincerely,

A handwritten signature in black ink, appearing to read 'Elaine Kersten'.

Elaine Kersten, Ed.D.
Co-Chair, Human Subjects Review Committee

CC: Hannah Karpman, Research Advisor

Appendix C: Consent Form for Individual Interview Participant



**Consent to Participate in a Research Study
Smith College School for Social Work • Northampton, MA**

.....

Title of Study: Clinician perspectives of behavioral health service delivery in patient-centered medical homes

Investigator(s): Melanie Cox, School for Social Work, [REDACTED] (under the supervision of Hannah Karpman, PhD)

.....

Introduction

- You are being asked to be in a research study that will investigate the effects of the patient-centered medical home model on behavioral health service delivery.
- You were selected as a possible participant because you meet the criteria for participation, which include being a master’s level clinician who currently provides behavioral health services at an agency that is certified by the National Committee for Quality Assurance as a Level 3 patient-centered medical home and has been functioning as such for at least 2 years.
- We ask that you read this form and ask any questions that you may have before agreeing to be in the study.

Purpose of Study

- The purpose of the study is to understand potential consequences of behavioral health integration as it occurs within the patient-centered medical home model. The researchers aim to learn about these consequences from the experiences of behavioral health clinicians who practice under this model.
- This study is being conducted as a research requirement for my master’s in social work degree.
- Ultimately, this research may be published or presented at professional conferences.

Description of the Study Procedures

- If you agree to be in this study, you will be asked to participate in a single interview lasting between 45 minutes and 1 hour. You are encouraged to answer any and all questions that you would like, and to skip any questions that you do not feel comfortable answering.

Risks/Discomforts of Being in this Study

- Participants may feel uncomfortable discussing how their work is impacted by the infrastructure of their agency.
- Participants are encouraged to skip any questions that cause discomfort

- Participants may end the interview at any time due to discomfort

Benefits of Being in the Study

- Participants may benefit from having the opportunity to share their experiences and/or gain insight into behavioral health service delivery in their unique setting. Participants may benefit from knowing that their experiences have the potential to influence health care research.
- This study represents an opportunity to compare the experiences of behavioral health clinicians to the implications of the patient-centered medical home model that have been hypothesized in academic literature.

Confidentiality

Your participation will be kept confidential. Consent forms will be stored such that they are separate from notes and transcripts. Furthermore, each participant will be assigned a code number that will be used in place of a name to identify that participant’s notes/transcript. All digital files will be password protected. All research materials including recordings, transcriptions, analyses and consent/assent documents will be stored in a secure location for three years according to federal regulations. In the event that materials are needed beyond this period, they will be kept secured until no longer needed, and then destroyed. All electronically stored data will be password protected during the storage period. We will not include any information in any report we may publish that would make it possible to identify you.

Payments/gift

- You will not receive any financial payment for your participation.
- All participants will be offered an electronic file of the researcher’s thesis once it is completed.

Right to Refuse or Withdraw

- The decision to participate in this study is entirely up to you. You may refuse to take part in the study *at any time* (up to the date noted below) without affecting your relationship with the researchers of this study or Smith College. Your decision to refuse will not result in any loss of benefits (including access to services) to which you are otherwise entitled. You have the right not to answer any single question, as well as to withdraw completely up to the point noted below. If you choose to withdraw, I will not use any of your information collected for this study. You must notify me of your decision to withdraw by email or phone by March 20th, 2015. After that date, your information will be part of the thesis.

Right to Ask Questions and Report Concerns

You have the right to ask questions about this research study and to have those questions answered by me before, during or after the research. If you have any further questions about the study, at any time feel free to contact me, Melanie Cox at [REDACTED] or by telephone at [REDACTED]. If you would like a summary of the study results, one will be sent to you once the study is completed. If you have any other concerns about your rights as a research participant, or if you have any problems as a result of your participation, you may contact the Chair of the Smith College School for Social Work Human Subjects Committee at (413) 585-7974.

Consent

- Your signature below indicates that you have decided to volunteer as a research participant for this study, and that you have read and understood the information provided above. You will be given a signed and dated copy of this form to keep.

.....

Name of Participant (print): _____

Signature of Participant: _____ Date: _____

Signature of Researcher(s): _____ Date: _____

.....

1. I agree to be audio taped for this interview:

Name of Participant (print): _____

Signature of Participant: _____ Date: _____

Signature of Researcher(s): _____ Date: _____

2. I agree to be interviewed, but I do not want the interview to be audio taped:

Name of Participant (print): _____

Signature of Participant: _____ Date: _____

Signature of Researcher(s): _____ Date: _____

Appendix D: Interview Schedule

Introduction:

Before we begin, I want to thank you for meeting with me today. As you know, this interview will allow me to complete my Master's thesis, which is an exploration of behavioral health integration within patient-centered medical homes. Completion of this study, which has been approved by the Smith College School for Social Work Human Subjects Review Committee, will allow me to fulfill my degree requirements. As such, I am greatly appreciative of your willingness to participate.

This interview will last between 45 minutes and 1 hour. I will be asking you a series of questions regarding your experience providing behavioral services within a patient-centered medical home. The purpose of this interview is to more clearly understand how behavioral health care delivery is impacted by the patient-centered medical home model.

I want to remind you that your responses to these questions will remain confidential. Furthermore, you are free to answer any and all questions that you would like to, and skip any questions that you would like.

If for any reason, you would like to contact me after this interview has ended, I will leave you my contact information.

-
1. I am wondering if you are able to tell me a little bit about *yourself* as a behavioral health clinician. Specifically, what are *your* areas of interest? Are there populations with which you are most qualified to work? And do you have a preferred theoretical orientation (regardless of your agency's theoretical orientation)?
 2. What would you say is the approximate number of clients for which you provide behavioral health services?
 3. How does this number compare to that of other positions you have held while providing behavioral health care (i.e. those in agencies that were not patient-centered medical homes)?
 4. How would you describe your caseload demographically (i.e. gender, socioeconomic status, race, ethnicity, etc.)?

5. How do the demographics of your case load as you have just described compare to those of other positions you have held while providing behavioral health care?
6. In what way, if at all, does the size of your caseload and/or your caseload's demographics impact your ability to provide behavioral health services?
7. Based on the clients you have served, what are some of the most common reasons for seeking behavioral health services?
8. In your opinion, how well are you able to provide your clients with the behavioral health services that you deem necessary?
9. I would now like to ask you some questions about your experiences as a behavioral health clinician in your current position. Can you first tell me about any major changes of which you are aware that your agency has undergone in becoming a certified patient-centered medical home?
10. How do you understand your role as a behavioral health clinician within a care team of other providers?
11. How do you communicate with providers who are members of a mutual care team?
12. From your perspective, how are clinical decisions pertaining to a patient's behavioral health needs made by the care team?
13. What can you tell me about treatment planning for clients with behavioral health needs? Typically, who is involved in treatment planning, and in what ways are they involved (client, family members, behavioral health clinician, primary care physician, other)?
14. Can you tell me how the *delivery* of behavioral health services is impacted by treatment planning as you have just described it?
15. To your knowledge, does your agency encourage and/or mandate the use of evidence-based practice for behavioral health service delivery? Which (if any) evidence-based behavioral health practices are most commonly used at your agency?
16. Could you tell me how your agency measures client improvement with respect to behavioral health? For example, are clients regularly assessed, and what types of assessments are used...

17. How is client information documented at your agency? Are you aware of any differences between the method of documenting information pertaining to behavioral health treatment and that of documenting information pertaining to medical treatment?
18. In your opinion, how does your agency's method of documenting information pertaining to behavioral health treatment impact your ability to coordinate and/or communicate with team members?

Conclusion:

Thank you again for your participation. Your responses shed light on the experiences of behavioral health clinicians in patient-centered medical homes. If you have any questions after today, please feel free to contact me at [REDACTED], or [REDACTED]. I would also like to remind you that you have until March 20th, 2015 to contact me if you decide that you would like to have your responses excluded from this study.

Appendix E: Screening Form

1. Are you currently licensed to practice social work in the U.S.?

Yes No

2. Are you currently employed as a licensed social worker?

Yes No

3. Is your place of employment recognized by the National Committee for Quality Assurance (NCQA) as a Level 3 patient-centered medical home?

*All NCQA-recognized Level3 patient-centered medical homes can be found here:

<http://recognition.ncqa.org/>

Yes No

4. If you answered 'Yes' to Question 2, have you been practicing clinical social work at your current place of employment for at least 6 months?

Yes No

If you answered 'No' to answer of these questions, then unfortunately, you do not qualify for this study. Your time is greatly appreciated.

Appendix F: Collection of Demographic Data Form

Collection of Demographic Information

1. How do you identify your:

a. Gender: _____

b. Race: _____

c. Ethnicity: _____

2. What is your age? _____

3. Can you speak and understand English fluently? _____

4. Which (if any) other languages do you speak and understand fluently? _____

5. In what field do you hold a master's degree? _____

6. In what year did you graduate with your master's degree? _____

7. How long have you practiced as a master's level behavioral health clinician? _____

8. What is your title at your current place of employment? _____

9. How long have you held your current position? _____

10. What is your salary? _____

11. Are you a licensed clinician? _____

12. In what year were you first licensed? _____