



# A New “Home” For People With Serious Mental Illnesses

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The patient-centered medical home, along with universal coverage, is one of the frequently recommended changes in healthcare reform. The treatment of depression, anxiety, and related conditions in primary care requires behavioral health as an element of the medical home. On the other hand schizophrenia, bipolar disorder, and other serious mental illnesses present a unique set of challenges, requiring easy access to effective physical healthcare services.

The National Association of State Mental Health Program Directors found that people living with SMI die 25 years earlier than the rest of the population, in large part because of unmanaged physical health conditions. The report found that three out of every five people with SMI died from preventable health conditions. A Maine study of Medicaid members with and without SMI revealed that people living with SMI had a significantly higher prevalence of major – mostly preventable – medical conditions than did an age- and gender-matched Medicaid population.

To address the gaps in current national thinking on healthcare reform, the National Council for Community Behavioral Healthcare is releasing, in April 2009, *The Person-Centered Healthcare Home*, a report that brings together current developments

around the patient-centered medical home with evidence-based approaches to the integration of primary care and behavioral health. The report also proposes renaming of the patient-centered medical home as the Person-Centered Healthcare Home. The name change is more than cosmetic. Person-Centered Healthcare Home emphasizes that behavioral health is a central part of healthcare, and such a shift in perspective can begin to address some significant health disparities for people with SMI.

## INTEGRATION IS A 2-WAY ROAD

The National Council report also highlights the need for a bi-directional approach, addressing the integration of primary care services in behavioral health settings as well as the need for behavioral health services in primary care settings.

A full-scope Person-Centered Healthcare Home as defined in the report would accept 24/7 accountability for a population and include preventive screening/health services, acute primary care, women and children’s health, behavioral health, management of chronic health conditions and end of life care. These services are supported by enabling services, electronic health records, registries, and access to lab, x-ray, medical/surgical specialties, and hospital care.

The proposed Person-Centered Healthcare Home is based on the stepped care clinical approach, which assures that the need for a changing level of care is addressed appropriately for each person by creating a structure for feedback from specialty care to primary care.

The concept calls for healthcare to be implemented bi-directionally:

- A. Identify people in primary care with behavioral health conditions and serve them there unless they need stepped specialty behavioral healthcare; and,
- B. Identify and serve people in behavioral healthcare that need routine primary care and step them to their full-scope healthcare home for more complex care.

## LESSONS FROM IMPACT DEPRESSION TREATMENT MODEL

*The Person-Centered Healthcare Home* report draws recommendations from a preeminent research example, IMPACT, one of the largest treatment trials for depression, in which Dr. Jürgen Unutzer and his colleagues followed 1,801 depressed, older adults in 18 diverse primary care clinics across the United States for two years, utilizing care management within a stepped care approach. The IMPACT model

has been found to double the effectiveness of care for depression, improve physical functioning and pain status for participants, and lower long-term health-care costs.

Since the research trial's end, several organizations in the United States and abroad have adapted and implemented the IMPACT program with diverse populations, serving people of all ages and expanding the scope of services beyond depression to anxiety, post-traumatic stress disorder, attention-deficit/hyperactivity disorder, and other conditions frequently found in primary care.

The core feature of the IMPACT model applicable to the Person-Centered Healthcare Home is collaborative care, in which the individual's primary care physician works with a care manager/ behavioral health consultant to develop and implement a treatment plan and the care manager/behavioral health consultant and primary care provider consult with a psychiatrist to change the treatment plan if the individual does not improve.

**The National Council report proposes two models – the Partnership and Cherokee models – for behavioral health providers who envision a role as a Person-Centered Healthcare Home.**

#### THE PARTNERSHIP MODEL

One approach to achieving better access to healthcare for mental health consumers is a partnership model. In a partnership model between a behavioral health organization and a full-scope healthcare home, the organizations must assure mission alignment and be deliberate about designing clinical mechanisms for collaboration, supported by structural and financial arrangements appropriate to their local environment.

Given the research to date, the following six research-based components should be included as part of a partnership between a behavioral health organization and a primary care, full-scope healthcare home:

1. Regular screening and registry tracking and outcome measurement at the time of psychiatric visits
2. Medical nurse practitioners/primary care physicians located in behavioral health
3. A primary care supervising physician
4. An embedded nurse care manager
5. Evidence-based practices to improve the health status of the population with SMI
6. Wellness programs.

**The Person-Centered Healthcare Home** is a new National Council report, releasing April 2009, that features evidence-based approaches to a patient-centered healthcare home for the population with serious mental illnesses. Prepared by National Council senior consultant Barbara Mauer, the report presents an overview – for policymakers, planners, and providers of general healthcare and behavioral health services – of the integration of behavioral health and general healthcare services in light of the national conversation regarding the development of patient-centered medical homes. Access the full report at [www.TheNationalCouncil.org/ResourceCenter](http://www.TheNationalCouncil.org/ResourceCenter).

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#### CHEROKEE MODEL

Another excellent model is that of Cherokee Health Systems, an organization with 23 sites in 13 Tennessee counties that is both a primary care provider and a specialty behavioral health provider. Integrated care is central to the organization's vision and mission, and this care is practiced across an array of comprehensive primary care, behavioral health, and prevention programs and services. Cherokee is integrated structurally and financially, a structure that supports the focus on clinical integration. A behavioral health consultant is an embedded, full-time member of the primary care team. A psychiatrist is also available for medication consultation. The behavioral health consultant provides brief, targeted, real-time interventions to address the psychosocial needs and concerns in the primary care setting.

For people who need specialty behavioral health services, a primary care provider is embedded in the specialty behavioral health team. Cherokee hires primary care providers who are comfortable with mental health issues and believes that all frontline, administrative, and support staff must be essential players, committed to the holistic approach. The local community is aware that people are treated for all types of illnesses at Cherokee, and mental health consumers find that all are treated in the same way, which reduces the stigma of seeking mental health treatment.

#### BEHAVIORAL HEALTH RESPONSIBILITIES

Not all behavioral health providers can envision a future role in a Person-Centered Healthcare Home. However, all behavioral health providers have a clinical responsibility and accountability for individuals receiving behavioral health services. If these services include prescribing psychotropic medications, there is an additional set of accountabilities related to the risk of metabolic syndrome and the whole health of the person:

- >> Assure regular metabolic screening and tracking at the time of psychiatric visits for all behavioral health consumers receiving psychotropic medications.
- >> Identify the current primary care provider for each individual, and when none exists, assist the individual in establishing a relationship with a primary care provider and accessing care.
- >> Establish specific methods for communication and treatment coordination with primary care providers and assure that timely information is shared in both directions.
- >> Provide education and link individuals to self-management assistance and support groups.

### CHALLENGES IN INTEGRATION

Organizations that have attempted to integrate care between primary care and behavioral health practitioners have learned about the different cultures, languages, and processes that primary care and behavioral health clinicians bring to collaborative efforts. The success of person-centered healthcare homes depends on the field's ability to bridge this set of differences at the clinical level.

At the system level, these differences result in barriers when primary care is integrated into behavioral health and when behavioral health is integrated into primary care. Typical barriers include financing; policy and regulation; workforce; information sharing; and the need for more research relating to the costs, cost offsets, and health outcomes

The promise of the patient-centered medical home can only be fully realized if it is transformed into the person-centered healthcare home, with behavioral health capacity fully embedded in primary care teams and primary care capacity inlaid in behavioral health teams. Moving the concept forward will require thoughtful, deliberate, and adaptive leadership at every level and across clinical disciplines and sectors that currently segment how people are served, how the delivery of their care is organized, how communication among providers occurs, and how care is reimbursed. For people with SMI who are suffering from unmanaged physical health conditions and dying before their time, the time for this concept to move ahead is now.

*The Person-Centered Healthcare Home report also revises the well-known National Council Four Quadrant Model, which describes the subsets of the population that behavioral health and primary care integration must address. The revised model is on page 10 of this issue.*

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## THE MEDICAL HOME CONCEPT

In 2007, the American Academy of Family Physicians, the American Academy of Pediatrics, the American College of Physicians, and the American Osteopathic Association released the Joint Principles of the Patient-Centered Medical Home (see [www.pccpc.net/node/14](http://www.pccpc.net/node/14)).

The Joint Principles stated the following:

- >> Each patient has an ongoing relationship with a personal physician.
- >> The personal physician leads a practice level team that collectively takes responsibility for the ongoing care of patients.
- >> The personal physician is responsible for providing for all of the patient's healthcare needs or appropriately arranging care with other qualified professionals.
- >> Care is coordinated or integrated across all elements of the healthcare system.
- >> Quality and safety are hallmarks.
- >> Enhanced access to care is available.
- >> Payment appropriately recognizes the added value provided to patients who have a patient-centered medical home.

The clinical approach of the patient-centered medical home focuses on team-based care led by a personal physician who provides continuous and coordinated care management and supports patients in their self-management goals throughout their lifetime. In this model, care management is central to the shift away from a concentration on episodic acute care to a focus on managing the health of defined populations, especially those living with chronic health conditions.

Although the medical home model emphasizes self-care, it has not clearly defined the role of behavioral health, which the Institute of Medicine has identified as a central part of healthcare.

### VOICES

"Clearly, overall well-being is a function of both mental and physical health. Just as screening and evaluation for mental illnesses and addictions is increasingly available in primary care settings, screening and evaluation for general health problems should be available to those in mental health settings."

*Linda Rosenberg, President and CEO, National Council for Community Behavioral Healthcare*