

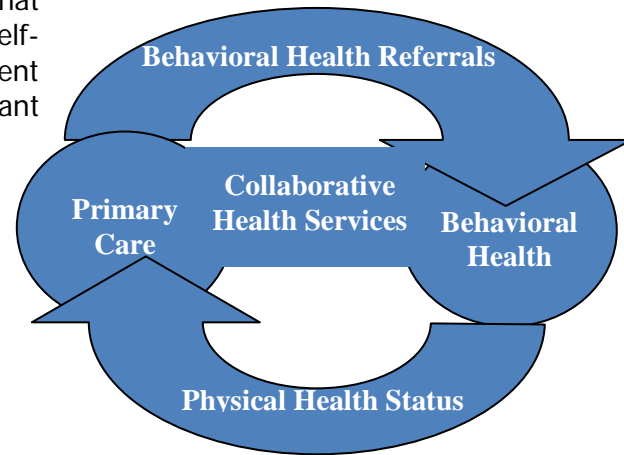
# Integrating Behavioral Health Into the Person-Centered Medical Home

The Patient-Centered Medical Home (PCMH) provides the potential to ensure that appropriate care is structured, delivered and coordinated around the specific needs of each patient. Given that patients bring their medical *and* mental health problems with them to *both* medical care and specialty behavioral health care, planned care for behavioral health must be articulated in the PCMH model in order to successfully address a patient's whole health.

## Behavioral Health as Part of the Medical Home

The medical home's emphasis on self-care resonates with the behavioral health system's movement towards a recovery and resilience orientation. There is also close alignment between the features of the medical home and the core components of research-based approaches to treating depression in primary care settings. One such example is the IMPACT model which delivers **planned care for behavioral health through screening, intervention, care coordination and connection to more intensive services and community resources, as needed.**

At the core of the clinical approach of the PCMH is team based care that provides care management and supports individuals in their self-management goals. In the IMPACT model, the role of care management and support is conducted by a care manager/behavioral health consultant who develops and implements a treatment plan. A psychiatrist supports the team and is available to consult with changes to the treatment plan if a patient does not improve. The IMPACT model has been found to double the effectiveness of care for depression, improve physical functioning and lower long-term healthcare costs.



## Primary Care Services for Individuals Served in Behavioral Health Settings

People living with serious mental illnesses are dying 25 year earlier than the rest of the population, in large part due to unmanaged physical health conditions. In addition, many individuals served by the mental health system are not able to access primary care settings due to coverage issues, stigma, and the difficulties of fitting into the fast-paced visit model of primary care. Without careful consideration of how to assure access for and engagement of persons living with serious mental illnesses, this health disparities population may not benefit from the healthcare delivery system improvements that are being proposed for the general population.

*“Efforts to provide everyone with a medical home will require the inclusion of mental health care if it is to succeed in improving care and reducing costs.”*

The Graham Center, American Academy of Family Physicians

## What Does a Healthcare Home Look Like for People Living with Serious Mental Illness?

PCMH models that support partnerships between primary care and behavioral health providers must assure mission alignment and be deliberate about designing clinical mechanisms for collaboration, supported by structural and financial arrangements appropriate to their local environment. Ideally, the following six components will be available as part of the partnership. The first three should be in place at a minimum:

- Regular screening and registry tracking/outcome measurement at the time of psychiatric visits
- Medical nurse practitioners/ primary care physicians located in behavioral health
- Primary care supervising physician
- Embedded nurse care manager
- Evidence-based practices to improve the health status of the population with serious mental illnesses
- Wellness programs

### State Policy Opportunities

As states develop projects to advance medical home models in state Medicaid and CHIP programs, planned care for behavioral health must be well articulated if the patient-centered medical home is to succeed. States have an opportunity to:

- Identify how behavioral health is thoughtfully incorporated into state supported medical home projects OR on the clinical mechanism for including behavioral health in the medical home
- Examine the state's current efforts to integrate primary and behavioral health care
- Reflect on what community behavioral health has to offer - an expertise and tradition of care coordination that can help support medical home success
- Draw on the evidence-based treatment practices that can help the medical home address behavioral change/management of chronic diseases

To move person-centered healthcare homes forward will require thoughtful, deliberate and adaptive leadership at every level, across clinical disciplines and across the 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.

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### Depression Improvement Across Minnesota, Offering a New Direction (DIAMOND)

The DIAMOND program is one of the nation's promising efforts to improve health care for people with depression because it changes the way the care is delivered and how it is paid for.

The DIAMOND program addresses a patient's mental health and primary care needs through a number of integration of primary care and behavioral activities. For example, a care manager is assigned to educate patients about how to reduce their depression symptoms and improve their ability to function while a psychiatrist reviews new patient cases and consults with the primary care physician on any recommended changes in treatment or referrals to behavioral health treatment. **Research has shown that this method of managing depression in primary care improves patient health by increasing the number of depression free days while also decreasing the risk of suicide.**

One of the truly unique aspects of DIAMOND is its cost structure; health plans give medical groups a monthly fee that covers the bundle of DIAMOND services. **A recent study in the American Journal of Managed Care showed a potential savings of \$3,300 over a 4-year period from programs like DIAMOND.**