

# Behavioral Health / Primary Care Integration and the Person-Centered Healthcare Home



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# Executive Summary

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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. To address the gap in current thinking about this health disparity, this paper presents evidence-based approaches to a person-centered healthcare home for the population living with serious mental illnesses. In doing so, it brings together current developments around the patient-centered medical home with evidence-based approaches to the integration of primary care and behavioral health.

In 2007, the American Academy of Family Physicians, American Academy of Pediatrics, American College of Physicians, and American Osteopathic Association released the following Joint Principles of the Patient-Centered Medical Home:

- Each patient has an ongoing relationship with a personal physician
- The personal physician leads a team of individuals at the practice level who collectively take 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 and/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.

At the core of the clinical approach of the patient-centered medical home is team based care that provides care management and supports individuals in their self management goals. Care management is central to the shift in orientation embodied in the medical home away from a focus on episodic acute care to a focus on managing the health of defined populations, especially those living with chronic health conditions.

The medical home's emphasis on self-care resonates with the behavioral health system's movement towards a Recovery and Resilience orientation. However, there has not been a clear articulation in the medical home model of the role of behavioral health. This is despite close alignment between the features of the medical home and the core components of research-based approaches to treating depression in primary care settings, for example the IMPACT model.

The core feature of the IMPACT model 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 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 healthcare costs.

This paper proposes that the national dialogue regarding the patient-centered medical home be expanded to incorporate the lessons of the IMPACT model, explicitly building into the medical home model the care manager/ behavioral health consultant and consulting psychiatrist functions that have proven effective in the IMPACT model. A related idea is the proposed renaming of the patient-centered medical home as the person-centered healthcare home, signaling that behavioral health is a central part of healthcare and that healthcare includes a focus on supporting a person's capacity to set goals for improved self management.

Having articulated the role of behavioral health in the person-centered healthcare home, this paper emphasizes 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. Two models are proposed for behavioral health providers who envision a role as a healthcare home: a unified program similar to the Cherokee model in Tennessee; and focused partnerships between primary care and behavioral health providers.

Using the extensive research on addressing depression in primary care settings as a guide, the paper proposes the following six research-based components that should be available as part of a partnership between a behavioral health organization and a primary care, full-scope healthcare home:

1. Regular screening and registry tracking/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 serious mental illnesses
6. Wellness programs

The Four Quadrant Model, developed by the National Council for Community Behavioral Health, describes the subsets of the population that behavioral health/ primary care integration must address. Each quadrant considers the behavioral health and physical health risk and complexity of the population and suggests the major system elements that would be utilized to meet the needs of that subset. This paper updates the Four Quadrant Model

to reflect the additional features of the person-centered healthcare home as they relate to the population served by each quadrant.

To conclude, the paper articulates a range of barriers to the creation of person-centered healthcare homes and the development of partnerships between behavioral health providers and primary care to meet the whole health needs of people with serious mental illnesses. The paper highlights that similar barriers have been encountered in the integration of depression treatment in primary care. The issues and barriers raised include: financing; policy and regulation; workforce; information sharing; and the need for greater research relating to the costs, cost offsets and health outcomes of patient-centered healthcare home models for the population with serious mental illnesses.