

A Unique Opportunity to Integrate Behavioral Health Into the Person-Centered Medical Home

The Patient Protection & Affordable Care Act (PPACA) established a new **medical home pilot program** which allows states to enroll Medicaid beneficiaries with chronic conditions, which include serious and persistent mental illness and substance use disorders, into medical homes beginning in 2011. Health homes will be composed of a team of health professionals that will provide a comprehensive set of medical services, including care coordination.

What Does this Mean for States?

States that apply for and receive a State Plan Amendment (SPA) to operate this pilot program will receive a **90% federal match** (FMAP) for medical home services provided to beneficiaries through the pilot program.

The Patient-Centered Medical Home (PCMH) is an approach to care delivery that emphasizes appropriate care that 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.

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

Moving to person-centered healthcare homes forward will require thoughtful, deliberate and adaptive leadership at every level, across sectors that currently segment how people are served. Key questions to address include how the delivery of their care is organized, how communication among providers occurs, and how care is reimbursed.

Examples of Behavioral Health and Patient-Centered Medical Home Initiatives

The Depression Improvement Across Minnesota, Offering a New Direction (DIAMOND) program is improving health care for people with depression and reducing costs because it changes the way the care is delivered and how it is paid for.

Washington State passed legislation to amend their state privacy law in support of communication and collaboration between primary and behavioral health providers.

California has a number of Primary Care, Mental Health, and Substance Use Services Integration Policy Initiatives exploring the legislative and regulatory opportunities and barriers.

Colorado's vision for medical home addressed the need for a team approach to coordinating mental, oral and physical health care.

Medical Home pilots in North Carolina are embedding community behavioral health staff in the Community Care Teams responsible for coordinating care.

For more information contact Laura Galbreath, Director of Health Integration and Wellness Promotion at LauraG@thenationalcouncil.org or 202-684-7457, x 231.