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Specialty Care Medical Homes For People With Severe, Persistent Mental Disorders

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ABSTRACT The patient-centered medical home concept is central to discussions about the reform of the health care delivery system. Most descriptions of the concept assume that a primary care practice would serve as the hub of the medical home. However, for people with severe and persistent mental disorders, specialty health care settings serve as the principal point of contact with the health care system. For them, a patient-centered medical home in a specialty setting would be the most expedient way to address their urgent health care needs. Among other issues, implementing this idea would mean reimbursement strategies to support the integration and coordination of primary care in specialty settings.

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The patient-centered medical home concept is front and center in discussions about reforming the health care delivery system. The patient-centered medical home's appeal stems from the body of research suggesting that applying evidence-based primary care, chronic disease management, and advances in health information technology (IT) may result in greater efficiency and improved quality of care.[1] The idea of meeting the preferences and health needs of patients when and where they most frequently interact with the health care delivery system is attractive and practical.[2]

We are concerned with patients who are very sick, are often highly disadvantaged, and do not see the primary care physician as the person with whom they have a well-established relationship. People with severe and persistent mental disorders such as schizophrenia, bipolar disorder, and major depression are a prime case in point. Although fewer than half of all adults who experience serious psychological distress in a year receive any mental health services, those who do receive care are more likely to do so through a mental health clinic or specialty mental health clinician than through primary care.[3] People with severe and persistent mental disorders often are poor; rely on public disability programs for income support; are treated with powerful antipsychotic drugs whose side effects create their own illnesses and disabilities; and are more likely than others to eat poorly, smoke, and abuse substances. Together these circumstances add up to elevated rates of illness and death for people with severe mental disorders relative to otherwise similar people without such illnesses.[4]

How, then, during an era of delivery system reform, do we adapt the important ideas reflected in medical homes to address the health and well-being of people with severe and persistent mental disorders, who are otherwise typically failed by the delivery system? We argue that the pressing health care needs of these people are more likely to be met in an expedient manner by building on the principal connection that they do have with the health care system, which is through specialty, rather than primary, care. To achieve this, we propose a specialty care medical home that builds on the principles of the patient-centered medical home and addresses many of the limitations of primary care for people with severe and persistent mental disorders. At every instance, we are guided by a desire to

ease access to high-quality primary care for a vulnerable population.

We organize this initial exploration into four sections. The first discusses the primary care orientation of the patient-centered medical home and highlights its limitations for people with severe and persistent mental disorders. Section two focuses on the health status of such people, to make the case for the specialty care medical home. Section three identifies the principal gaps in the specialty care medical home and outlines activities and research being undertaken to address these gaps. Finally, section four identifies policy measures, such as identifying reimbursement strategies, measuring key health indicators, and developing the workforce, that could support the specialty care medical home.

The Patient-Centered Medical Home

The patient-centered medical home has been embraced enthusiastically by large segments of the medical and health policy communities as well as members of Congress. The model aims to coordinate the range of services that a patient might need in a manner that recognizes the central role of individuals in determining their own health and health care. The principles of the patient-centered medical home have been set forth in a statement by four major physician organizations and have influenced policy makers as well as accrediting bodies such as the National Committee for Quality Assurance (NCQA).[5]

PRINCIPLES AND STANDARDS The physician organizations' statement lists seven basic principles that define the medical home as involving the following: a one-to-one relationship between doctor and patient; a patient's physician acting as the leader of a team that is responsible for the person's ongoing care; an orientation that considers the range of health care needs and personal circumstances that define the whole person and his or her care requirements; a commitment to coordinating care in a complex health care environment; a fundamental duty to ensure health care that is of high quality and safe; a medical practice that is structured to enhance patient access and promote communication between patients and their health care team; and a payment system that recognizes the value of a patient-centered medical home to patients.

In January 2008 the NCQA released a set of standards to identify medical practices that adhere to measurable attributes of the patient-centered medical home, with the possibility of providing public recognition and financial rewards.[6] Early findings suggest that people cared for in practices that meet the NCQA standards were more likely than others to receive evidence-based preventive services, have their chronic illnesses better managed, have better access to medical care, and experience greater coordination of services.[7]

The Patient Protection and Affordable Care Act signed into law 23 March 2010 includes a new Medicaid state plan option that allows Medicaid enrollees to designate a provider as their health home if they have at least two chronic conditions, have one chronic condition and are at risk of developing another, or have at least one serious and persistent mental health condition. The act also provides support for the development of workforce training programs that focus on primary care models such as medical homes. Thus, the way medical homes are defined, measured, paid for, and lauded has the potential to strongly affect how medical care is delivered in the future.

PRIMARY CARE AT THE CENTER The attention now paid to defining, measuring, and determining how to pay for medical homes assumes that a primary care practice would be at the center of the medical home. For the majority of Americans, it makes sense to focus on a one-to-one relationship between a patient and the health care system and to assign the core responsibility for coordinating care to one primary care entity.

NEED FOR SPECIALTY CARE But there are some important groups of people for whom specialty, rather than primary, health care settings serve as the main point of contact with the health care system because of their personal circumstances and the nature of their illnesses. For these groups, insisting that they adopt a primary care–oriented medical home may increase the complexity and fragmentation of care.

Moreover, if the personal circumstances of these individuals are deeply affected by the problems that bring them to a specialty setting, the primary care practice might not be the most comfortable and welcoming of environments. The questions that arise for such populations are as follows: Can the functions of the patient-centered medical home be embedded in a specialty setting, and, if so, is it most practical and efficient to do so? If the answer is yes, then some modification to the current approach to defining and measuring medical homes may be desirable. We explore these issues using people with severe and persistent mental disorders as a case in point.

We recognize that many, if not most, cases of mental illness may be effectively served by well-designed primary care–oriented medical homes. The collaborative care model has been shown to be effective, and cost-effective, in a variety of primary care settings serving a range of different populations. These include community health

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centers and primary care practice offices serving a mix of ethnic and racial minority populations, low-income groups, and elders.[8] The collaborative care model fits very well with the patient-centered medical home concept in that it focuses on a care team that is led by a primary care physician. The model also relies on tracking of patients over time and support for the self-management of chronic disease. This approach to the delivery of mental health care applies primarily to conditions of mild to moderate severity and has mostly been tested for the treatment of depression and anxiety disorders.[9]

Health Status Of People With Severe And Persistent Mental Illnesses

People with severe and persistent mental disorders not only suffer from disabling mental illnesses but also typically have poor general health status. Preventable medical conditions are the leading cause of premature death among this population. Recent data from the Florida Medicaid program show that enrollees with schizophrenia account for an average of $11,922 in annual mental health spending and an additional $5,733 in medical care spending, compared to $4,024 for the average adult Florida Medicaid enrollee.

Poor physical health in this population results from multiple factors. First, people with severe and persistent mental disorders are generally poor and reliant on public disability benefit payments. Poverty brings with it chronic stress; unsafe living conditions; and limited access to fresh, affordable food. These factors in turn are frequently linked to unhealthy lifestyle habits such as smoking and a lack of exercise. An unhealthy lifestyle creates a series of risk factors for chronic medical conditions, including obesity, hypertension, and high cholesterol. The likelihood of having a serious medical condition increases with the accumulation of these risk factors.[10]

Health risks associated with lifestyle factors are exacerbated by psychotropic medications used in the treatment of severe mental disorders. These medications have been shown to contribute to weight gain, insulin resistance, and elevated blood glucose and lipids. Research shows that annual weight gain associated with modern antipsychotic medications can range from two or three pounds to as much as twenty-five pounds, depending on the medication used.[11]

Poor physical health in the population with severe and persistent mental disorders is also the result of limited access to primary care and, for those who do receive care, poor-quality care. Many people with serious mental disorders are likely to be uninsured and to have limited contact with the health care system, especially outside of specialty care. Few specialty providers are equipped to screen for and treat chronic medical conditions.[12] A health assessment of a sample of patients with schizophrenia found that 88 percent of those with elevated cholesterol and 62 percent of those who met criteria for hypertension were not receiving appropriate medications.[13] Furthermore, recent evidence indicates that people with severe and persistent mental disorders who do receive medical care are less likely to receive care that meets clinical guidelines, compared to the rest of the population.[14,15]

The Case For The Specialty Care Medical Home

The existing evidence underscores a pressing need to ease access to high-quality medical care for this vulnerable population. But will the primary care–oriented medical home, an approach that holds so much promise for the general population, be the most effective and efficient way to meet this need?

HONORING A COMMITMENT Annually, more than 3.5 million adults receive specialty mental health and substance use services in community mental health centers. People with severe and persistent mental disorders are a priority population for these organizations, which are largely supported by public funds. These specialty providers have a commitment to serving this group. The result has been the establishment of trusted relationships between clinicians and individuals with severe and persistent mental disorders within specialty care. Such relationships increase the likelihood that treatment will be accepted and followed and should result in health

improvements.

POTENTIAL FOR DISRUPTION In addition, the care of people with severe mental disorders is easily disrupted by complex treatment and support arrangements.[16] We therefore consider whether improving the efficiency and quality of medical care delivered to these people can be more easily achieved by building on well-established clinical relationships than by redirecting people toward primary care.

PRIMARY CARE A POOR FIT The orientation of primary care itself has been shown frequently to be ill suited to the circumstances of people with severe mental disorders. Primary care providers tend to be inexperienced, and frequently uncomfortable, in dealing with patients with schizophrenia and other major mental disorders. They may, therefore, not engage intensively with patients or actively ask about key symptoms.[17] Furthermore, even well-functioning primary care settings that have developed reliable processes to treat mild-to-moderate mental health conditions are poorly equipped to manage the broad scope of services needed by people with severe and persistent mental disorders. These include such services as assertive community treatment, peer supports, and supported employment. The result is that primary care practices can be inhospitable and ineffective treatment settings for this population.

PUBLIC MENTAL HEALTH SYSTEM There is a strong rationale for building a medical home for people with severe and persistent mental disorders in the public mental health system, where their mental health needs are already being met and where they experience an understanding and accepting environment. The goal in doing so is not to reinforce the segregation of people with severe and persistent mental disorders, as some fear, but to identify the most expedient way to address their urgent health care needs.

MEDICAL HOME CONCEPTS The specialty medical home also need not be viewed as watering down the concept of the patient-centered medical home. We would expect a medical home based in specialty care to have many of the same basic principles as one rooted in primary care. The organizational structures and care processes implemented to make these principles operational would necessarily be different. For example, to enhance patients' access and promote communication, community mental health centers that are developing into specialty medical homes have found it necessary to extend patient consultation times up to an hour. A similar adjustment might not be required in a primary care medical home.

Addressing Gaps In The Specialty Care Medical Home

A central challenge in building a medical home in the public mental health system is that few community mental health centers currently meet core standards for the patient-centered medical home. The most serious gap is in their capacity to adopt a whole-person orientation and to provide coordinated care for the population served. Only a minority are currently able to deliver high-quality prevention and treatment for medical conditions, despite overwhelming evidence that medical and behavioral health problems often occur together.

MEETING STANDARDS OF CARE To address this gap, attention is being focused on developing effective models for the integration of primary care screening, monitoring, and treatment into community mental health centers. By and large, current initiatives are implementing and testing one of three organizational arrangements.

▸ **INTEGRATED MODEL:** The first is a fully integrated model in which the complete range of primary and specialty behavioral health care services is co-located at a single site. This model has been tested in the Veterans Affairs (VA) health system and in other integrated delivery systems but is rare within the public mental health system.

The Cherokee Health System in Tennessee and the Crider Center in Missouri are the only two federally qualified health centers in the country that are also community mental health centers and can provide the full continuum of primary and specialty behavioral health care.[18] Primary care clinics within the Cherokee Health System employ behavioral health consultants, usually psychologists, to support primary care providers in treating mild-to-moderate mental health conditions and help them with the behavior-change aspects of chronic disease management. This means that 80 percent of behavioral health needs are dealt with in primary care, leaving specialty mental health services to focus on people with more acute needs.[19]

▸ **PARTNERSHIPS:** For most community mental health centers, it is not economically viable to deliver a full range of medical services on site.[20] The other two models of integrated care depend on partnerships between community mental health and federally qualified health centers. One model places a nurse practitioner within the specialty setting to provide screening, monitoring, and treatment of common physical health conditions. Through the primary care partnership, the nurse practitioner is supervised by an off-site primary care physician who can provide expert consultation and secure referrals to specialty medical services.

The second partnership-based model places a nurse care manager within the specialty setting to facilitate access to primary care services off site. The care manager does not provide direct care but, rather, acts as a source of information, education, and advocacy for patients and as a broker between patients and medical care providers.

The Integrated Policy Initiative in California has developed an integrated care continuum based on the complexity of mental health and substance use needs across the safety-net population. The continuum is an important reference document to help specialty providers identify the range of primary care services to which they should be able to provide access in order to qualify as a functioning medical home.[21]

ASSESSING OUTCOMES Overall, the continuum makes clear that the organizational structure adopted is less important than the clinical care processes implemented. A strong emphasis on effective screening; the use of clinical registries to track treatment, referrals, and patient outcomes; and a focus on self-management and wellness activities are fundamental across the continuum, irrespective of organizational structure.[22]

Evidence of the impact of integrated models on patient outcomes is limited but positive. Early findings come from trials conducted within fully integrated delivery systems. These are consistent in reporting improvements in medical care, quality of care, and patient outcomes.[23] For example, a small randomized trial conducted in the VA health system assigned veterans with severe and persistent mental disorders to receive primary care either through an integrated care initiative located in a mental health clinic and staffed by a multidisciplinary team, or through a general medical clinic. Veterans served in the integrated care initiative had a greater mean number of primary care visits, were more likely to have received recommended preventive care, and experienced significantly greater improvement in their physical health than those treated in the general medical clinic.[24]

More recent studies are focusing on partnership-based approaches to delivering integrated primary and behavioral health care within community mental health centers. These are also reporting positive early findings.[25] The Primary Care Access Referral and Evaluation (PCARE) study in Atlanta, Georgia, randomly assigned 407 people with severe and persistent mental disorders at an urban community mental health center to care management or to usual care. After twelve months in the program, care management was associated with more than doubling the rate of receipt of evidence-based preventive medical services, and with significantly improving care for cardiometabolic conditions as well as increasing the likelihood that people would have a usual source of primary care. Those receiving services from the nurse care manager were found to have better mental health–related quality of life, although there were no significant differences in physical health after twelve months.[26]

More evidence that can inform the development of the specialty medical home for this population will be generated by the Substance Abuse and Mental Health Services Administration's (SAMHSA's) $25 million primary and behavioral health care integration grant program. Thirteen community behavioral health care organizations were awarded four-year grants in 2009 to implement a model of integrated primary care.[27] The grant program will be evaluated to identify the models of integrated primary care that are implemented; to assess the extent to which specialty providers are successful in implementing screening, tracking, and referral for medical conditions; and to gauge the impact on the physical and mental health of people receiving integrated services. Similar models are being implemented and evaluated as part of a three-year, $4.2 million statewide integration initiative in Missouri.[28] Seven community mental health and federally qualified health center partnerships are co-locating mental health services in primary care settings and primary care services in specialty settings.

Discussion

The patient-centered medical home holds much promise for improving the health and health care management of people whose main contact with the health care system is with a primary care provider. However, given the way that people with severe and persistent mental disorders use the health care system, and the capabilities of primary care practices to address their needs and circumstances, it is likely that simply bringing such populations into a primary care medical home will not address their profound health care needs. Building on the specialty care provided by trusted community mental health providers who know the population seems like a better place to start.

POLICY MEASURES Regardless of which models of the specialty medical home ultimately are shown to be most effective, there are policy measures that can encourage the development and spread of models that seek to attend to the health care issues of people with severe mental disorders. An important first step is to measure key health indicators in such people and to hold health and mental health providers and payers

accountable for those measures. The limited quality metrics that currently exist focus entirely on indicators of the quality of mental health care. Holding health plans, the behavioral health "carve-outs" that manage mental health care on behalf of the plans, and specialty and primary care providers all accountable for the health outcomes of people with severe mental disorders will drive clinical management toward the principles of the medical home.

IDENTIFYING COMMON DISORDERS Implementing such ideas means identifying medical conditions that are especially common in people with severe mental disorders, such as diabetes, high cholesterol, obesity, and smoking rates, and measuring improvement in their management. What's more, identifying reimbursement strategies to support the integration and coordination of primary care in specialty settings will be critical.

INNOVATIVE PAYMENT MODELS Much of the primary care activity in community mental health centers is now sustained by dedicated grant funding. Obtaining reimbursement from third-party payers is often cumbersome if not prohibitive. In this regard, much can be learned from innovative payment models that have been developed to support the integration and coordination of care in primary care such as the DIAMOND initiative in Minnesota.[29]

Under DIAMOND, agreement among private and public payers led to the development of a case-rate payment for the implementation of the collaborative care model on the condition that implementation is faithful to the model found to be effective in research studies. The case-rate payment covers the costs of services that are currently not reimbursed on a fee-for-service basis, such as consultation with an on-call psychiatrist. In 2008 the Minnesota legislature passed health care home legislation that authorizes clinics that have successfully implemented collaborative care under DIAMOND to receive a second case-rate payment to implement a medical home model.[30]

For clinics elsewhere that operate within current fee-for-service billing structures, the prohibition in a large number of state Medicaid programs of same-day billing for primary care and behavioral health care services will need to be addressed.

WORKFORCE DEVELOPMENT Workforce development will also require major attention. Mental health providers who have sought to develop onsite primary care services have reported initial resistance from staff, even over simple issues such as the use of consulting space for an examination table. Mental health and primary care providers operate in culturally separate spheres, and exposure to one another is required to build a shared understanding of their respective contributions to high-quality care and to foster mutual respect.

More opportunities for postgraduate and in-service training in integrated care settings will support the development of a workforce skilled in taking a multidisciplinary approach. An effective workforce will need to be supported by robust health information exchange between primary and specialty care settings. As policy and regulations governing health information technology continue to evolve, it will be especially important to ensure that the full range of specialty providers, including behavioral health and long-term care providers, are included.

Conclusion

The basic data on the life expectancy, health status, and physical well-being of people with severe and persistent mental disorders reflect a vexing failure to serve this vulnerable population adequately. Nearly all segments of the health, mental health, and human services delivery system are implicated. However, a clear path to remediation is not yet evident. We do not have sufficient evidence to point to the precise modifications to the patient-centered medical home model that might work best for this population. The extensive experimentation under way across the country and potential new opportunities under health reform offer hope that we will find effective solutions that can deliver important improvements in the overall health status of this vulnerable population. ■

The views expressed in this paper are those of the authors and do not represent the views of the U.S. Department of Health and Human Services.

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