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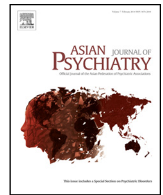

Review

Behavioral Health Homes: An opportunity to address healthcare inequities in people with serious mental illness

Mark Viron [a,b,c,*], Kathryn Zioto [c,d], Jason Schweitzer [c,d], Gail Levine [a,c,e]

[a] Massachusetts Mental Health Center, Boston, MA, USA
[b] Beth Israel Deaconess Medical Center, Department of Psychiatry, Boston, MA, USA
[c] Harvard Medical School, Boston, MA, USA
[d] Harvard Longwood Psychiatry Residency Training Program, Boston, MA, USA
[e] Brigham and Women's Hospital, Boston, MA, USA

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ABSTRACT

People with serious mental illness (SMI) face striking reductions in lifespan versus the general population, in part due to the inadequacy of healthcare systems in meeting the substantial physical health needs of this group. Integrated care, the strategic combination and coordination of behavioral health and primary care services, has been proposed as a potential healthcare service delivery solution to address these care gaps. Inspired by the primary care Patient-Centered Medical Home concept, Behavioral Health Homes bring primary care services into the community mental health center in various ways. In this paper the authors review the literature describing Behavioral Health Home interventions and highlight an integration project that provides co-located and coordinated primary care and wellness services in a community mental health center. Such approaches hold great promise for improving the health and healthcare of people with SMI.

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* Corresponding author at: Massachusetts Mental Health Center, 20 Vining St, Boston, MA 02115, USA. Tel.: +1 617 626 9353; fax: +1 617 626 9510.
E-mail address: mark.viron@state.ma.us (M. Viron).

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1. Introduction

Globally, the physical health needs of people with serious mental illness (SMI) are underappreciated and sub-optimally addressed (De Hert et al., 2011a,b). A 2006 study highlighted a 25-year mortality gap between people with SMI and the general U.S. population (Colton and Manderscheid, 2006), and similar disparities are found in international studies, which have also demonstrated a widening of this gap over time (Chang et al., 2011; Lawrence et al., 2013; Nielsen et al., 2013; Saha et al., 2007). The mortality differential is mostly attributable to early death from preventable and treatable physical illnesses, accounting for 77% of excess deaths in one study (Lawrence et al., 2013). Causes of death are most frequently cardiovascular disease (CVD), which is responsible for some 40% of excess death from physical illnesses (Lawrence et al., 2013). Early deaths from cancer and respiratory illness are also common (Crump et al., 2013a,b). Physical illnesses commonly co-occur alongside SMI, with one study demonstrating that approximately 70% of people with SMI have one or more chronic physical illnesses (Druss and Walker, 2011), and people with SMI are more likely to die from these illnesses compared to the general population (Crump et al., 2013a,b).

Healthcare access barriers, fragmentation of services, and poor quality of care contribute to substandard health outcomes in this population (Viron and Stern, 2010). Access barriers include difficulties obtaining and keeping primary care appointments, a lack of knowledge of how to navigate the healthcare system, and the inexperience and discomfort of primary care providers in treating people with psychiatric disabilities (Pastore et al., 2013). Providers' discriminatory beliefs and diagnostic overshadowing, where physical symptoms are misattributed to mental illness, create unwelcoming and dismissive environments of care (Jones et al., 2008; Viron et al., 2012).

Numerous studies document inferior quality of physical health care for people with SMI (Bjorkenstam et al., 2012; De Hert et al., 2011a; Mitchell et al., 2009). Individuals with schizophrenia are less likely to receive guideline concordant care following acute myocardial infarction and have an increased risk of subsequent mortality (Druss et al., 2001b; Kurdyak et al., 2012; Laursen et al., 2009). CVD risk factors (smoking, obesity, hypertension, hypercholesterolemia, and diabetes mellitus) are significantly more common in people with SMI (Mitchell et al., 2013; Osborn et al., 2006; Vancampfort et al., 2013) but often go unrecognized and unaddressed, despite the existence of effective interventions (De Hert et al., 2011b). Screening for these issues is not routinely done in psychiatric or primary care settings, and a lack of communication between behavioral health and primary care providers further exacerbates the situation (Mangurian et al., 2013). Simple risk factor counseling about diet, exercise and smoking can produce meaningful behavior changes (De Hert et al., 2011b), but people with SMI receive fewer such interventions versus the general population (Druss et al., 2002; Nocon, 2006).

Successfully addressing these well-characterized healthcare inequities requires novel system-wide solutions. The Behavioral Health Home, an evolving model of integrated behavioral health and primary care supported by a growing body of evidence and various U.S. healthcare reform initiatives (Alexander and Druss, 2012), has the potential to improve the health and healthcare of people with SMI by creating a patient-centered system of care that addresses behavioral and physical health collaboratively and comprehensively.

2. Healthcare integration defined

Use of the term *integration* varies in the literature as do approaches to integration in service delivery design. Broadly defined, *healthcare integration* is the unification of care for physical and behavioral health concerns. Butler et al. conceptually define the term as "the systematic linkage of mental health and primary care providers" (2008). Integrated care should manage complex interactions among various conditions (Center for Evidence-Based Practices at Case Western Reserve University, 2011), increase access to timely care, achieve parity for physical and behavioral health conditions, and decrease intersystem divisiveness (Smith et al., 2013). Applied integrated models are diverse but can be arrayed along a continuum of integration, from offsite or onsite collaboration (regular communication, at times face-to-face) to a fully integrated system and facility in a "seamless bio-psycho-social web" of care (Heath et al., 2013).

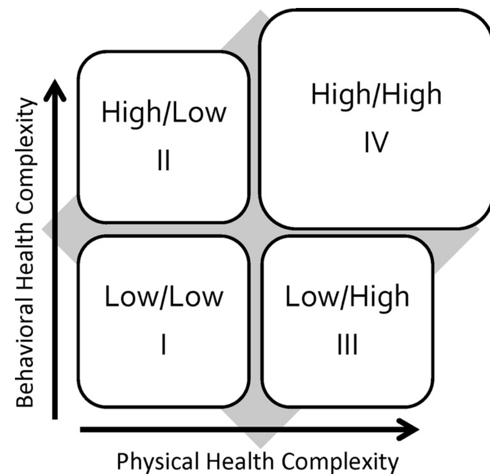

Fig. 1. Four quadrant model of physical and behavioral healthcare integration (Adapted from Mauer, 2006). Quadrant IV patients are best severed in specialty behavioral health settings with integrated primary care services.

Regardless of degree of unification, integration models draw from several broad concepts: *the health care team*, *stepped care*, *four-quadrant clinical integration*, and the *medical home* (Collins et al., 2010). Expanding the one-to-one "physician-patient" relationship, the *health care team* concept emphasizes the "team-patient" relationship as the vehicle of care, with the team including the patient and a range of providers (physician, nurse, care manager, administrators, etc.). *Stepped care* applies a stepwise clinical framework to individualized treatment planning, prioritizing effective initial interventions with minimal disruption to the patient's life and with the lowest level of intensity and cost. The intensity of service is then increased if patient response is inadequate. The *four quadrant clinical integration model* (Fig. 1) applies a stepwise framework at a macro-service level, helping to determine the ideal healthcare setting for integration depending on the combined physical and behavioral health complexity of the population being served (Mauer, 2006). Services and organization design are tailored to needs of the population in each quadrant, with people with low behavioral health complexity receiving integrated treatment in primary care settings and people with high behavioral health complexity (e.g. SMI) being served in specialty behavioral health settings. The last of these integration concepts, the *medical home*, is perhaps the most influential factor in the emergence of Behavioral Health Homes.

3. The Patient-Centered Medical Home

The medical home has evolved since it first emerged in the literature in 1967, described by the American Academy of Pediatrics, noted for improving care for children with special needs (Larson and Reid, 2010). Current Patient-Centered Medical Homes

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