

## Editorial

# Mental health specialty care in the medical home

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People with mental health problems present an important subclass of patients who sometimes or even frequently require care from specialists. In thinking about need for referrals – or perhaps even need for ongoing care from a specialist – several aspects of care require specification.

The role of primary care within health systems has been very well defined as providing a set of functions including person-focused care over time, comprehensiveness in the sense of making available and providing (when indicated) a broad range of services for all health problems (except those too uncommon for competence to be maintained in delivering them), co-ordinating care when people do have to receive services elsewhere, and being available for first contact care. These functions make care more effective, less costly, and more equitable in terms of reducing or eliminating systematic differences in health across population groups defined socially, geographically or demographically.<sup>1</sup> The functions of primary care involve interacting with other health-related specialists.

By virtue of the co-ordination function of primary care, its practitioners need to be aware of the role that specialists play in the ongoing care of patients. Forrest<sup>2</sup> categorised these as ‘cognitive consultant’, ‘procedural consultant’, ‘co-manager with shared care’, ‘co-manager with principal care’, and ‘primary care’. Missing from his conceptualisation is the large group of patients who fall into a grey area: those who have been seen by a specialist and are given instructions to return to the specialist for follow-up. Data from a representative sample of visits to US physicians indicated that about half of all visits to specialists are for this latter category of care. For psychiatrists, the corresponding figure is 74%.<sup>3</sup> (55% of visits to psychiatrists were by referral; 7% were by new patients; 4% were by a known patient with a new problem; 12% were by a known patient with a recurrence of an old problem; and 74% were for preventive or routine care of a known patient with a known problem.) Only 15% of visits were for care

shared with the primary care physician, and 93% of the patients were given an appointment to return to the psychiatrist. (Of course, a large proportion of mental health visits are to non-physicians and therefore not included in the data on which this analysis is based, but it is unlikely that these percentages would be very different.) Given these realities, what *should* be the role of the primary care physician relative to that of the mental health specialist in the ongoing care of people with mental illness?

The 2007 Joint Principles from the US primary care societies<sup>4</sup> was a strong affirmation of the principles of primary care within the proposed Patient-Centered Medical Home (PCMH) concept. Coincidentally, it came at a time when attention was drawn to the relative increase in chronic illnesses compared with acute illnesses, particularly in industrialised countries, and the concomitant development of the ‘chronic care model’ (CCM). Although the CCM was developed with a focus on diseases and not in the context of person-focused primary care, it became a focus in the proposed ‘recognition’ of practices as medical homes. Thus, the prototypical evaluation of medical homes focuses less on achievement of primary care functions than on structures of practice purportedly pursuant to management of chronic illnesses, especially decision support systems, electronic health records, and redesign of practices, including the deployment of teams of professionals. The functions of primary care are conspicuously absent from the recognition process, particularly for comprehensiveness of care, i.e. cares for as many different kinds of health problems as possible. This chronic disease focus feature of the PCMH recognition process creates the possibility that specialty practices could be recognised as PCMHs even if they were to focus on a limited set of chronic diseases.

In order to resolve the problems that are presented when specialty services are redefined as PCMHs and still maintain the focus on the evidence-based functions of primary care, the American College of

Physicians (an organisation of specialty care internists as well as general internists) proposed that two new categories of specialist practice be created: specialty practices that fulfil the 'requirements' of a medical home and an alternative 'PCMH-neighbour'. The former could be achieved by focusing on 'complex healthcare needs requiring the specialist's expertise but also meeting most of the patient's general health care needs, and meeting the requirements of a PCMH recognition process that ... has the structural capacity and systems in place to provide care consistent with the PCMH model'. The second option requires specialist practices to work in conjunction with PCMH practices to 'enhance coordination of care, improve consultations and co-management, and create seamless transitions for patients moving through different components of the health care system'.<sup>5</sup> Smith and Sederer<sup>6</sup> seem to have anticipated these two types of specialty roles in their proposal for 'mental health home', but without indicating the percentage of patients in different communities who would be eligible for each type of practice or what specific functions would be appropriate to each type.

The contrast between the proposed innovations and the characteristics of current specialty care is striking. Currently, the largest component of specialty practices is routine follow-up care under the control of the specialist, yet this role is not mentioned in the proposals.

In order for US health services to be provided in ways that facilitate greater effectiveness, efficiency, and equity in achieving health, it will be necessary for specialists of different types to get to grips with to define their role – just as has been done for primary care within the most recent two decades.<sup>1,7</sup> The unrestrained growth in specialty practice without rationalisation of the role of specialists threatens to worsen the outcomes of patients, especially those with a multiplicity of different kinds of conditions.<sup>8</sup> What problems are sufficiently common to be in the purview of primary care led services (with consultation with specialists directly as needed, rather than through referring patients)? How can new technology, such as electronic health records and teleconferencing, be made pursuant to innovation in relationships between primary care and specialty care? What should be the relative balance among the functions of specialty care – including routine

follow-up? Can primary care physicians assume responsibility for routine follow-up, with notification and consultation with specialists as appropriate?

It is clear that specialty societies, including the various specialties within the mental health community, have homework to do. In doing so, they could help everyone understand the proper role of secondary and tertiary care in the increasingly complex world of comorbidity, technology, and evidence base for the delivery of health services everywhere.

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