The patient centered medical home: a great opportunity to move beyond brilliant and irrelevant

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We can observe three things:

1. A brilliant, elegantly designed research literature supports the efficacy of psychological and behavioral interventions for the treatment of medical and psychological problems typically seen in primary care. This body of research is made irrelevant by its lack of knowledge in primary care
2. There is rapid penetration of brilliant mental health clinicians now becoming embedded in primary care practices. Such efforts are made irrelevant by lack of data collection to evaluate the effectiveness of such embedding, lack of use of evidence-based practices by the newly embedded clinicians, and an almost sole mental health focus with neglect of substance abuse, health behaviors, or lifestyle change
3. Significant developing clinical, operational, and financial changes are infiltrating primary care. A major element of that change revolves around the Patient Centered Medical Home (PCMH), which has as a core element whole person care. The American Academy of Family Physicians recently took the position that without the inclusion of mental health, the PCMH will fail [1]

In primary care, mental health, substance abuse, and health behavior remain a series of silos that operate and function almost autonomously. No unifying label, function, or position includes all of the siloed elements. A recent survey of all National Center for Quality Assurance PCMH practices indicates that while some attention is being devoted to mental health, substance abuse, and health behavior services are minimally present. Even though smoking cessation was the most organized health behavior intervention, fewer than a third of practices implemented an evidence-based treatment protocol [2].

From where I stand on the ground in primary care, there is much brilliant rhetoric but little real system change toward a health behavior focus. *Translational Behavioral Medicine* offers the perfect forum to discuss these issues, consistent with its mission to bring actionable science to practitioners and prompt debate on policy issues that surround implementing the evidence. Translating behavioral medicine into primary care requires not only a shift in attitude and culture in primary care, but a shift in culture concerning how we do research and how we do practice. Instead of silos with little communication and cross effect, we need to make the two synonymous.

Russ Glasgow and I recently recommended that researchers consider pragmatic, transparent, contextual, and multilevel designs that include replication, rapid learning systems and networks, mixed methods, and simulation and economic analyses to produce actionable, generalizable findings that can be implemented in real-world settings [3]. Such a shift would incorporate greater focus on the needs of practitioners as well as other end users of the evidence. Likewise, given the more practice relevant evidence base that would emerge, it becomes incumbent on practitioners to use this data to influence their practice.

This special section of TBM includes papers from early adopters who perceive the PCMH as an opportunity to leave brilliant and irrelevant behind. By making evidence and practice synonymous, they aim to generate the needed, directly relevant evidence base to evaluate mental health, substance abuse and health behavior interventions for implementation within primary care and patient centered medical homes. As a group, the papers inform the clinical, operational, and financial elements of care and care models. The reported research illustrates both the challenges and the promise of “on the ground research” and highlights the methodological features and challenges associated with such research. The patient-centered medical home clearly offers a vibrant laboratory for decision makers to test out policy options. But lest we put the cart before the horse, the behavioral interventions to be evaluated need to be practical and show convincing evidence of effectiveness (i.e., not just efficacy) before being considered as policy options. Finally, the opportunity to take full advantage of the PCMH will be limited until the clinicians who are spending their lives in primary care feel motivated and empowered to integrate the evidence in actual practice.

The papers in this volume represent a diversity of approaches and research strategies. The rationale

for the special section is framed by Levey and colleagues who provide background about the opportunities offered by the PCMH. Massa and colleagues highlight differences between how behavioral health and health behavior are organized, as compared to the medical subspecialties. Hunter and Goodie outline the evolution, challenges and major successes of integrated care across the Department of Defense. In a private sector Internal Medicine Practice, by comparison. Young and colleagues present the 3-year developmental progression of an integrated PCMH. Auxier and colleagues address the *need* for mental health, substance abuse and health behavior services to be present in primary care by pointing out an age old bugaboo: patients referred from primary care to specialty behavioral services generally do not attend [4]. In contrast, while the service is available within the primary care practice, a majority of patients initiate care. Other papers highlight innovations in the primary care setting: care for cancer survivors within the PCMH (Hudson et al., this issue), and behavioral interventions to assist self-management of diabetes in primary care (Glasgow et al., this issue).

Taken as a whole, this area is in early development. Although not yet representing a mature clinical or research enterprise, the papers in the special section are provocative. They call upon the clinical and research communities to engage in new forms of relationships and activities in order to achieve an elusive goal: the end of irrelevant and the pursuit of the brilliant in translational behavioral medicine.

1. American Academy of Family Physicians (AAFP). Guidelines for patient-centered medical home (PCMH) recognition and accreditation programs: AAFP; 2011.
2. Kessler RS, Miller B, Scholle S, Trakur M, Kennedy A, Maclean C, Littenberg B, Pace W. Mental health, substance abuse and health behavior services in NCQA patient centered medical homes: a national survey. Unpublished manuscript; 2012.
3. Kessler RS, Glasgow R. A proposal to speed translation of healthcare research into practice: dramatic change is needed. *Am J Prev Med*. 2011;40(6):637-644.
4. Kessler RS. Effects on mental health treatment initiation of incorporating mental health services into primary care practice. *J Am Board Fam Med*. 2011;25(2):255-259.