

The Medical Home and Integrated Behavioral Health

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The patient-centered medical home (PCMH) is at the hub of transformative changes to address the triple aim of reducing health care costs, improving the patient experience, and bettering population health. In May 2013, the PCMH research conference, sponsored by the Agency for Healthcare Research and Quality, the Veterans Health Administration, and the US Department of Veterans Affairs, brought together representatives of the Society of General Internal Medicine, the Society of Teachers of Family Medicine, and the Academic Pediatric Association to discuss evidence related to the PCMH and to recommend policies to advance the model. One of 5 expert workgroups at this conference focused on research and policy priorities related to integration of primary care and behavioral health (encompassing both mental health and substance abuse). Members of this workgroup have authored an article in this issue of *Pediatrics*.¹ They make a strong case for the benefits of integrating behavioral and primary health in the PCMH and summarize the workgroup's recommendations for policies supporting practice and research regarding integrated models.

The workgroup sought to address behavioral health needs across the full spectrum of severity: those individuals who are at risk but not yet symptomatic and those with emerging symptoms, as well as those experiencing impairment from disorders. The workgroup's 5 recommendations were to: (1) build well-funded demonstration projects to test various approaches to integration; (2) identify best practices and

develop interdisciplinary training programs to support members of the integrated care team; (3) implement strategies to improve behavioral health at the population level; (4) eliminate behavioral health carve-outs and test new payment models that encourage and support integration; and (5) develop new measures to evaluate the impact of integration on population health and society as a whole. This agenda aligns well with the work of the American Academy of Pediatrics' Task Force on Mental Health.²⁻⁴

For future projects, youth and families (including those served by the behavioral health system) will be needed to advise those who are planning and evaluating integrated PCMH models. Children with severe mental illness use primary care services less frequently than do those without mental illness.⁵ Many have not experienced the benefits of the PCMH; however, they may have benefited from specialized supports in the behavioral health system, such as community health workers, patient navigators, and peer advocates. Some behavioral health advocates with these realities in mind (and the knowledge that people with severely impairing behavioral health conditions die of medical causes many years before their peers⁶) believe that the ideal form of integration is the addition of primary care services to the behavioral health care setting; this model is encompassed by the term "health home" in the Patient Protection and Affordable Care Act of 2010.⁷ It will be important to compare costs, patient experience, and outcomes in this model versus PCMH models. It will also be necessary to provide reassurance to

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behavioral health advocates that payment reforms such as elimination of carve-outs do not result in decreased financial support for the behavioral health specialty system.

The PCMH research conference of 2013 has outlined an ambitious and worthy research and advocacy agenda for the integration of behavioral health and primary care. It is gratifying to see that the primary care research community has united behind it. It will be critical to involve youth and parents affected by behavioral health conditions in advancing this agenda.

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THE DANGERS OF LATE NIGHT SNACKING: *I have long been told by my mother not to eat any food after midnight. Her view is that food consumed after that time of day had little nutritional value and only led to the development of fat. When growing up, we tended to eat supper early in the evening and we had no snacks after supper. As an adult, I like eating supper much later in the evening, and at home we tend to sit down for supper around 9 PM. My view has always been that I like the social aspects of late dining, and I am hungrier at that time anyway. Besides, I could not see why a calorie consumed at 7 PM would be handled any differently from one consumed at 10 PM. As reported in The New York Times (Well: January 15, 2015), it turns out that my mother may have been right after all. Over 38 weeks, researchers fed adult mice one of four diets. In each of the four diet groups some mice were allowed to eat whenever they wanted, while others were restricted to feeding periods of 9 to 12 hours. Regardless of the type of diet or the timing of the feeds, all mice had the same caloric intake. Some mice in the feeding restricted groups were allowed to eat whenever they wanted on weekends. Some of the mice previously allowed to eat whenever they wanted were shifted to a time restricted diet. The effect of time-restricted feeding was staggering. The mice that could eat whenever they wanted were obese and metabolically ill. Mice that only ate within a specified time frame, even if they cheated on weekends, had normal weights and were metabolically healthy. Interestingly, mice that switched from an unrestricted diet to a restricted eating schedule lost some of the weight they had gained. The data suggest that restricting caloric intake to a narrow window of time both prevented and reversed obesity. The reason may be that caloric intake affects circadian rhythm which in turns drives many metabolic pathways. While the experiment was conducted in mice, not humans, the data suggest that to help prevent obesity, food should be consumed within a 12 hour period. I will have to tell my mother – after I finish eating my late evening dinner – that she may have been on to something after all.*

Noted by WVR, MD

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