Comprehensiveness and continuity of care are key elements of primary care system redesign. Comprehensiveness encompasses evaluating the whole person and dealing with the full range of physical, mental, and behavioral healthcare issues; and continuity is based on building healing relationships over time. This article suggests that a focus on comprehensiveness and continuity implies that responding to mental health, behavioral health, and substance use must be core elements of the patient-centered medical home. A list of necessary next steps toward achieving comprehensive and integrated care is recommended.

Keywords: primary care, comprehensive care, patient-centered medical home, collaborative care, behavioral healthcare

This is a period of exciting transformation in the United States healthcare system. The patient-centered medical home (PCMH) provides a framework for such transformation. Seminal reports such as the Future of Family Medicine Project (Future of Family Medicine Project Leadership Committee, 2004) support a PCMH model built on the known strengths of primary care and further incorporate aspects of the chronic care model (Austin, Wagner, Hindmarsh, & Davis, 2000; Bodenheimer, Wagner, & Grumbach, 2002; Coleman, Austin, Brach, & Wagner, 2009; Glasgow, Orleans, & Wagner, 2001) and improved health information technology. Although it is tempting to focus solely on these new elements, reinvigoration and further development of the core pillars of primary care within the PCMH are also necessary. Unless the core pillars of primary care are highlighted and prioritized in any redesign effort, there is a strong risk that their importance will be devalued.

PCMH standards that provide a basis for defining the PCMH and gauging a practice’s accomplishment of “medical homeness” particularly need to reflect the aspects of primary care that have demonstrated importance. It is well established that those things that are targeted for quality measurement receive more attention, often to the detriment of things not being measured. Recent draft standards have been released from the National Committee for Quality Assurance (NCQA), the organization responsible in part for defining the
PCMH because it sets the characteristics necessary for NCQA designation as a PCMH. The new draft standards have incorporated new criteria related to continuity and, to some extent, comprehensiveness, and address mental and behavioral health and substance abuse in the standards for the first time. This seems to be a step in the right direction, but further attention to comprehensive care may be necessary in the future to assure that a full range of primary care services, and particularly those related to mental and behavioral health, are being delivered in PCMH practices. Both the old and the proposed new standards can be found on the NCQA website (http://www.ncqa.org).

One of the strongest arguments in favor of the PCMH is the extensive evidence that has established primary care as an essential component to high-quality and cost-effective healthcare (Starfield & Shi, 2004; Starfield, Shi, & Mackino, 2005; Starfield, 1998). In this literature, primary care is defined on the basis of the presence of four pillars of care, including comprehensiveness, continuity, coordination, and access to first contact care (American Academy of Family Physicians, 2009). Without all four primary care attributes, the well-established benefits of primary care may not survive the transformative change underway in American healthcare through the PCMH. In this article, we focus particularly on the importance of continuity and comprehensiveness of care and make a case for the vital role of mental and behavioral healthcare and substance abuse (generally jointly referred to heretofore as behavioral healthcare) as an integral part of comprehensive primary care.

**COMPREHENSIVENESS OF CARE**

The Institute of Medicine in its primary care report stated that in a well-developed and functioning healthcare system, primary care is the usual and preferred route for entry into the healthcare system (Donaldson, Yordy, Lohr, & Vanselow, 1996). The report defined primary care as “the provision of integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of family and community” (p. 31). Although the specific range of “a large majority of personal health care needs” may be open to debate, the value of comprehensiveness of care has been well established in over 40 years of medical research. Health issues faced by patients often do not fit into the neat and discrete diagnostic categories of our textbooks and our various specialty disciplines, instead needing initial and often definitive diagnosis and management by primary care clinicians trained in dealing with a comprehensive range of physical, mental, and behavioral issues. (Gill, 2004; Stange, 2002).

Starfield and Shi (2009) have provided a very useful definition of comprehensive care in the context of primary care as follows:

Comprehensive care refers to the availability of a wide range of services in primary care and their appropriate provision across the entire spectrum of types of needs for all but the most uncommon problems in the population by a primary care provider. This includes services that promote and preserve health: prevent disease, injury, and dysfunction; and care of illness, disability, and discomfort as long as these needs are not too uncommon for the primary care practitioner to maintain competence in dealing with them (generally occurring in at least one to two thousand people per year). For example, this range of services includes (but is not limited to) prevention, coaching, counseling when appropriate, care for acute and chronic illnesses and injuries, minor surgery, injections, aspiration of joints, simple dislocations, common skin problems, behavioral health
and common mental health problems, and community health resources information. (p. 3)

Starfield and Shi (2002) compared population health outcomes in 13 countries, finding better physical and mental health outcomes for countries with higher primary care scores when controlling for patient income and smoking. The differences between primary care practices in countries with high primary care scores when compared with countries with low primary care scores included, in particular, the degree of comprehensiveness of primary care and a family orientation (here characterized by the degree to which healthcare services were provided to all family members by the same practitioner). In a study of U.S. physician organizations, those that scored higher on primary care attributes and especially comprehensiveness scored higher on chronic care management (Schmittdiel, Shortell, Rundall, Bodenheimer, & Selby, 2006). In another study of 18 industrialized countries including the United States, the stronger the country’s primary care orientation, the lower the rates of premature mortality in general, particularly from asthma, bronchitis, emphysema, pneumonia, cardiovascular disease, and heart disease, even when controlling for various system and population characteristics (Macinko, Starfield, & Shi, 2003). Multiple other studies have shown that practices that offer a comprehensive range of services improve health outcomes, decrease hospitalizations and emergency room visits, and increase preventive care, health behavior change, and early detection of disease (Alpert, Robertson, Kosa, Heagarty, & Haggerty, 1976; Bindman, Grumbach, Osmond, Vranizan, & Stewart, 1996; Forrest & Starfield, 1996; Hochheiser, Woodward, & Charney, 1971; Shea, Misra, Ehrlich, Field, & Francis, 1992; Starfield, 1998). This does not mean that primary care practices should take care of all of the health problems of the population, but that such practices should cover the bulk of healthcare issues faced by their patients, carefully coordinating specialty, community, and hospital care and services for those problems that they cannot adequately serve.

CONTINUITY OF CARE

The Institute of Medicine defined continuity as “care over time by a single individual or team of health care professionals and to effective and timely communication of health information” (Donaldson, Yordy, Lohr, & Vanselov, 1996, p. 43). The connection between the provider and the patient longitudinally allows for a relationship to be formed and trust to be established. It is through this bond that a provider can better understand all of the patient’s needs and know the best way to respond. Continuity has been shown to be related to patient and provider satisfaction, improved care outcomes, and lower healthcare costs (Atlas, Grant, Ferris, Chang, & Barry, 2009; DeVoe, Saultz, Krois, & Tillotson, 2009; Guthrie, Saultz, Freeman, & Haggerty, 2008; Pandhi & Saultz, 2006; Saultz, 2003; Saultz & Albedawi, 2004; Saultz & Lochner, 2005; Smith, Schmidt, Allensworth-Davies, & Saitz, 2009).

THE ROLE OF BEHAVIORAL HEALTH IN COMPREHENSIVE AND CONTINUOUS PRIMARY CARE

The importance of dealing with mental health, behavioral health, and substance abuse issues in primary care has been extensively documented (Butler et al., 2008; deGruy, 1996; Kessler & Stafford, 2008). Not only is primary care the “de facto” mental health system where most people receive their mental healthcare (Regier et al., 1993), but teasing apart mental health conditions from physical health conditions leads to inferior care (deGruy, 1996). For example, it is well established that treating a person with a chronic disease and a mental illness requires treating both conditions
simultaneously; otherwise, there is the risk of both conditions getting worse by only treating the chronic disease (Andrews, 2001; Fortin et al., 2006; Golden et al., 2008; Katon et al., 2003; Luber et al., 2000). The lack of inclusion of behavioral health treatments and behavioral health providers in medical homes could greatly undermine the successful implementation of the PCMH. Patients need to have the full range of their health problems dealt with effectively as part of the services provided by their medical homes, and behavioral health issues are either primary or important secondary issues for the great majority of the population (Kessler et al., 2005).

Many of the barriers to offering effective and efficient clinical behavioral health services are overcome or minimized when well integrated into primary care (Butler et al., 2008). The current mental health carve-outs are a major barrier to the provision of effective mental health services, causing a level of discontinuity that seriously damages the effectiveness of such care. This can and should change if behavioral health issues are seen as an integral part of comprehensive primary care—and are reimbursed accordingly. Ideally, most behavioral health services should be provided on site, as this maintains a sense of continuity of care, improves acceptability and ease of service for patients, and decreases the perceived stigma of going to a behavioral health provider (Blount, 1998). This also reflects the reality that these issues are inextricably intertwined with patient chronic and acute physical health problems and that all of the patient’s problems must be dealt with in an integrated fashion for care to be optimally effective (Ani et al., 2009; deGruy, 1996; Merikangas et al., 2007).

If fully integrated care is not possible, an acceptable next level of integrated care could involve enhancement of these services in the primary care practice with careful coordination of care with behavioral professionals at separate sites. Although this is not the ideal, a great deal of primary care occurs in small practices where it may not be practical to have behavior health professionals on site. Regardless, it is an inescapable and possibly inconvenient truth that mental health, behavioral health, and substance abuse care and services are crucial components of comprehensive and continuous primary care.

If this is the case, why is an acceptable level of integrated care generally not available currently? A complete review of the historical trends that have resulted in our current strangely fragmented care system is interesting, but beyond the scope of this article. Much of the fault lies with us—the primary care and behavioral health professionals who ideally should be working together to provide such integrated care. Primary care physicians have had the opportunity to provide better care for mental health issues and basically have failed miserably (Piette, Richardson, & Valenstein, 2004). There are numerous reasons for this—major reimbursement issues, poor training in the behavioral areas, the traditional separation of mental and physical health issues that still persists in medicine, major time issues for physicians trying to incorporate a full range of healthcare services into ever-shorter visits, and many others. The grim fact remains that mental health carveouts were at least in part a reaction to the problem created by the poor level of care for mental health issues in primary care practices.

Behavioral health providers can certainly share the blame. The lack of a well-integrated system of care, particularly around the sharing of information, has produced a huge, somewhat indecipherable black box of behavioral healthcare that makes it difficult to impossible for primary care physicians to find support in their caring for their patients with difficult behavioral issues. This has caused many primary care physicians to essentially adopt a “don’t ask, don’t tell” type of strategy in
NECESSARY NEXT STEPS TOWARD COMPREHENSIVE AND INTEGRATED CARE

So, what needs to change in order to incorporate behavioral health services as part of a comprehensive medical home? Here is a short list of critical issues that need to be addressed.

1. Behavioral health issues should be included among those conditions that are part of the comprehensive services available in a medical home. Certification or recognition criteria for the PCMH should include measures of comprehensiveness of care that incorporate mental health, behavioral health, and substance use.

2. All of the care, services, and tools in the PCMH should be family-centered. Family issues and dynamics play a crucial role in health behavior on many levels, particularly including chronic illness as well as mental health. Some aspects of the current formulation of the PCMH do not pay appropriate attention to family-related issues and in some cases may actually provide barriers (e.g., the establishment of health information systems that do not include family information or any place to record a genogram).

3. Obviously, the payment system has to change to support this model of integrated care. Adoption of the payment system outlined in the PCMH Joint Principles (American Academy of Family Physicians, American Academy of Pediatrics, American College of Physicians, & American Osteopathic Association, 2007) would be a start, but would not be sufficient. Mental health carveouts must go away, and there are myriad other barriers to this model that also have to change (Kathol et al., 2010). This has not received adequate attention in healthcare reform discussions.

4. Infighting among our disciplines is a problem for the whole process. Our professional associations across the board spend too much time trying to protect the special interests of each of the disciplines instead of figuring out ways to work together to improve care for everyone. Through this period of change in particular, we must keep as our core mission improving care to meet the needs of our patients.

5. Team-based care is a centerpiece of the PCMH, and a team-based approach to the provision of behavioral health services should be a central part of the redesign of practice systems. A team-based approach involving everyone in the practice in providing these services, even without adding personnel, can lead to tremendous improvements in care. Analysis of the current gaps in care and of the local resources and opportunities can lead to the identification of models for improvement that include either closer relationships with community behavioral health providers and services or the integration of such providers into the primary care practice.

6. Our primary care and behavioral healthcare professionals will need to change in key areas to make this happen. Everyone on the medical home team should be trained in an
interdisciplinary, team-based primary care model. This includes not only the primary care clinicians and the behavioral health providers, but the nurses, medical assistants, front office personnel, and care managers. Our siloed models for training health professionals need to be revised to allow much more integrated training. This is vital on multiple levels in preparing the workforce for the PCMH, but particularly stands out for behavioral health. In addition, those of us already in practice will need some retraining and a good bit of adjustment of our role expectations and approaches to practice (Blount & Miller, 2009).

No one said it would be easy. The healthcare system is broken on multiple levels, and this is only one area that needs intensive care. The PCMH is an especially important area deserving attention in healthcare reform and primary care redesign. The provision of comprehensive care, including integrated mental health, behavioral health, and substance use, is a crucial centerpiece of the medical home. We hope that we can all work together to overcome the multiple barriers to accomplish this for the good of our patients and the healthcare system.

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