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Bridging the Gap. The Involvement of Community-based Specialty Mental Health Services in Primary Care: Lessons from the Behavioral Health Home Model in the U.S. for the Integrated Care of Serious Mental Illness in France

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Individuals with serious mental illness (SMI) constitute a specific population with complex physical health needs that remain inadequately addressed, as evidenced by their striking and persistent excess mortality. This situation suggests an inadequacy of existing care delivery models that requires critical transformations to address the fragmentation of somatic and mental healthcare. A possible approach is reverse integrated care systems that deliver or coordinate primary care within community-based specialty mental health services (such as *Centres médico-psychologiques* (CMPs) in France). The United States is unique in its adoption of this approach over the last ten years as part of the Medicaid behavioral health home model supported by the Affordable Care Act. This issue brief presents the lessons to be learned from evaluations of this model in real-world settings. Notably, the model relies on the presence of a salaried nurse with a role in coordinating care within community-based specialty mental health services who work in partnership with a primary care professional for predefined tasks (e.g., health promotion, comprehensive care management, referrals to other services) for individuals with SMI. Some positive impacts have been demonstrated, including more frequent use of primary care and improved detection and monitoring of physical health conditions and their risk factors. However, initial evaluations reveal that to achieve long-term effects, this type of model requires support through the development of financing models that encourage collaboration and shared responsibility between mental and somatic care professionals, through building workforce capacity within community-based specialty mental health services and through investing in data infrastructure for the collection and exchange of health data. These findings offer valuable insight for France, where similar local initiatives are emerging within CMPs without the support of a coordinated national strategy.

Serious mental illnesses (SMIs) are enduring conditions, notably psychotic and bipolar disorders, that cause serious functional limitations that interfere with major life activities, such as work and social relationships. Individuals with SMI account for a relatively small but significant share of the population – up to 6% of adults (NIMH, 2023; *Santé Publique France*,

2022). They have complex healthcare needs, including poor physical health, with highly prevalent comorbidities (e.g., diabetes or cardiovascular disorders) [Gandré and Coldefy, 2020; McGinty et al., 2015], that have not been adequately addressed by health systems worldwide. While healthcare expenses for people with SMI are particularly high, these people experience a 15- to 20-year shorter

life expectancy, markedly increased premature deaths from somatic illnesses and a risk of all-cause mortality twice that of the general population with a widening gap over time (Coldefy and Gandré, 2018; Correll et al., 2022; Nordentoft et al., 2013). This situation has been labeled a "scandal" (Thorncroft, 2011) and is increasingly considered among the main indicators of care quality in international

comparisons of health systems (OECD, 2021). The identified causes are multifactorial and include adverse health behaviors, iatrogenic harm from antipsychotic drugs, social and economic disadvantages, and inadequate healthcare (Gandré et al., 2022; Liu et al., 2017). Across the world, mental and somatic care have consistently been funded and provided separately, creating barriers to access and hindering coordination between medical specialties while complicating the adaptation of healthcare delivery to the needs of people with SMI. The use of general medical care, such as preventive health services (e.g., for cardiovascular risk factors or cancer screening), remains limited in persons with SMI (Baller et al., 2015; Gandré and Coldefy, 2020; HAS, 2024). Recent studies have also highlighted quality issues in somatic care once accessed; lower use of guideline-concordant care has often been found for this population (Gandré and Coldefy, 2020; Gandré et al., 2023; McGinty et al., 2015; Seppänen et al., 2023, 2024).

Research, clinical, and health policy communities have started to recognize the need for critical system-level transformations that address the fragmentation of physical and mental care to increase equity for people with SMI (Bao et al., 2013; Gandré et al., 2023; Liu et al., 2017; French ministry in charge of health, 2024). Models that integrate behavioral health services into primary care settings, such as the collaborative care model developed in the U.S. and currently pilot tested in France (*Sésame, ARS Ile-de-France*, 2023), are increasingly common. However, these models mostly address the needs of people with mild to moderate mental disorders and are not tailored for people with SMI for whom the mental health sector is often the main, and sometimes only, point of entry into the health system (Bao et al., 2013; Maragakis et al., 2016). This is also where people with SMI tend to form the most long-standing relationships with healthcare professionals. A recent international movement has therefore supported the implementation of "reverse" integrated care systems that enable the delivery or coordination of primary care in mental health settings (Alakeson et al., 2010; Maragakis et al., 2016; Ward and Druss, 2017). This movement particularly supports the involvement of community-based specialty mental health services, which serve the majority of individuals with SMI in the communi-

ties where they reside. Specifically, this implies the presence of professionals who ensure care coordination within these services working in partnership with primary care providers (with or without the collocation of services). In the U.S., this has become the leading approach to address the complex health needs of people with SMI through a whole-person philosophy over the last decade within the framework of the behavioral health home (BHH) model (McGinty et al., 2021).

In France, although initiatives have been developed to improve the integration of psychiatric and somatic care, these initiatives still need to be strengthened (Inset 1). In particular, new models to deliver primary care to people with SMI in alternative settings are needed. The French public mental health system relies on hospitals that are responsible for providing mental healthcare to the population in administratively defined catchment areas called "psychiatric sectors" (*secteurs psychiatriques*). Public outpatient mental healthcare centers, called *Centres médico-psychologiques* (CMPs), are the ambulatory component within this care organization. As such, they constitute the main point of regular mental health follow-up for individuals with SMI. In France, 80% of the population treated in the public mental healthcare system receives only ambulatory care (Coldefy and Gandré, 2020), and those with SMI are nearly twice as likely to be seen in CMPs rather than by self-employed psychiatrists in the community¹. France benefits from a wide network of approximately 3,000 CMPs spread throughout the country, with more than half dedicated to the adult population (DREES, 2022). They are generally located outside of hospital settings in the community, which facilitates their access. They rely on multidisciplinary teams (e.g., psychiatrists, psychologists, nurses, social workers) that are responsible for coordinating all outpatient mental care. They therefore represent an adequate setting to pilot test innovative models of mental and primary care integration for people with SMI that rely on their usual place of follow-up, similar to the BHH model developed in the U.S.

However, supporting the extension of organizational innovations requires strong evidence on their impact and implementation in real-world settings. To inform future healthcare policy and

CONTEXT

This issue brief falls within a long series of studies conducted by IRDES on the excess mortality and somatic care disparities faced by individuals with SMI in France (e.g., Coldefy and Gandré, 2018; Gandré and Coldefy, 2020; Gandré et al., 2023; Seppänen et al., 2023, 2024). It aims to inform policy and practice regarding delivery system innovations that should be supported and pilot tested in the French health system to increase physical health equity for people with SMI. This brief was written in collaboration with Dr. Beth McGinty, Chief of the Division of Health Policy and Economics in the Department of Population Health Sciences and the Livingston Farrand Professor of Public Health at Weill Cornell Medicine in New York City. She is a prominent researcher and health policy expert in the mental health field (McGinty, 2023) and has led initial evaluations of the Medicaid BHH model in real-world settings in the U.S. (e.g., Bandara et al., 2020; McClellan et al., 2020; McGinty et al., 2020; Murphy et al., 2018, 2020; Stone et al., 2020).

practice in France, our objective is therefore to synthesize the lessons of the initial evaluations of reverse integrated care programs to coordinate primary care within community-based specialty mental health services for individuals with SMI in the U.S., where they are among the most advanced to date.

Behavioral health homes for individuals with SMI: A model for coordinating primary care within community-based specialty mental health services

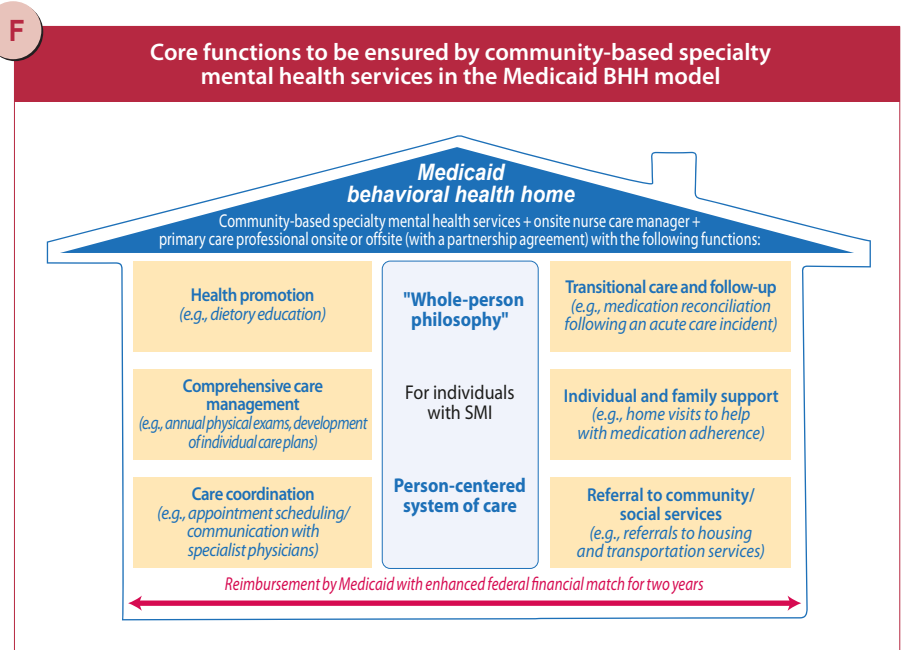
The behavioral health home (BHH) model, developed in the U.S., consists of the coordination and management of the physical health of people with SMI embedded in community-based specialty mental health services where individuals with SMI already receive care. This model relies on the presence of professionals with a role in coordinating somatic care within these mental health programs working in partnership with primary care providers. Randomized controlled trials provided initial experimental evidence and demon-

¹ Provisional estimate based on the French National Health Data System, taking into account the incompleteness of the data linkage of CMP activity, which has been possible since 2020 but is still not exhaustive.

strated that BHHs improved somatic care utilization, the receipt of preventive care, the quality of cardiometabolic care, and care coordination for people with SMI (Druss et al., 2017; McGinty et al., 2021).

In real-world practice, BHHs have been developed in the U.S. through several initiatives. Starting in 2009, they have included the Substance Abuse and Mental Health Services Administration's Primary and Behavioral Health Care Integration (PBHCI) program (Breslau et al., 2021). This program was not broadly scalable because it depended on temporary federal grants for limited sites, which restricted the generalization of findings.

The main effort to significantly scale up the BHH model in the U.S., which is the focus of this issue brief, was part of the 2010 Affordable Care Act, a law aimed at increasing equitable access to care in the U.S. (Rice et al., 2020). It created a specific waiver for BHHs in Medicaid, a public insurance program designed to provide health insurance for people with low incomes and resources, which covers approximately 70% of individuals with SMI (Frank and Glied, 2006; Khaykin et al., 2010). This is an incentivized option (enhanced federal financial match for two years) for voluntary state Medicaid programs to offer primary care coordination and health promotion to enrollees with complex needs, including people with SMI (Centers for Medicare & Medicaid services, 2023). For this population, the waiver provides a financing mechanism by which community-based specialty mental health organizations, which can be of several types across U.S. states (e.g., psychiatric rehabilitation programs, community mental health centers or other outpatient mental health programs; publicly or privately owned; affiliated with a hospital or not), can be reimbursed for the coordination of somatic care services in addition to behavioral healthcare. For this purpose, they all include an onsite nurse care manager responsible for coordinating health home services whose salary is covered by Medicaid per-member per-month payments for patients included in the BHH. Based on the number of eligible beneficiaries, this position may be shared by several programs or part-time. A primary care consultant, most often funded by fee-for-service payments, is also involved in the BHH and is either a physician or a nurse practitioner. That person may be onsite or offsite (e.g., via a contract with



a local primary care clinic). In the case of Medicaid BHHs, these professionals are in charge of providing core health home services for people with SMI that are pre-defined at the federal level and all related to primary care (e.g., health promotion, comprehensive care management, referral to other services) [Figure], although the package of delivered interventions to fulfill these missions can vary across BHHs. To date, 19 U.S. states as well as the district of Columbia have specifically implemented Medicaid BHHs for enrollees with SMI (Centers for Medicare & Medicaid services, 2017, 2023).

Some positive impacts in real-world settings on the primary care of individuals with SMI

Initial evaluations of Medicaid BHHs in real-world settings show encouraging findings that suggest that they have led to more frequent primary care use and to improved detection and monitoring of physical health conditions and their risk factors (such as blood pressure measurements) among people with SMI (Fortuna et al., 2020; Murphy et al., 2018, 2020). These are essential first steps and represent valuable progress toward improving the physical health of this population, which is an encouraging sign given the major difficulties they face in accessing appropriate primary care. Moreover, while the evaluations were conducted separately in several U.S. states using diverse methodologies, these effects are also encountered

in studies that use the most robust quasi-experimental designs (Murphy et al., 2018, 2020). They also show an impact of BHHs on reducing all-cause emergency department (ED) visits driven by reductions in ED visits for somatic causes (Bandara et al., 2020).

However, more time is needed for the new care processes enabled by the model to influence all physical health outcomes and behaviors of people with SMI after increasing their primary care access. Thus, initial evaluations of Medicaid BHHs have not yet shown effects in terms of improving diabetes control, weight management or smoking cessation (Fortuna et al., 2020; Murphy et al., 2018). Furthermore, the effectiveness of Medicaid BHHs is partly linked to their implementation process. To achieve long-term effects, it is necessary to remove certain barriers in this process, as highlighted by initial evaluations in real-world settings. These need to be planned upstream of the development of similar interventions in France.

Financing models that should focus on sustainability

Limited financial incentives are among the main barriers to the implementation of Medicaid BHHs highlighted in real-world settings. While this model has been supported by an enhanced federal financial match, this lasts for only two years. This short-term incentive may explain

why some U.S. states have already discontinued their BHH program or have chosen not to implement it. Furthermore, healthcare providers and services need to obtain payments that incentivize participation, notably by covering care coordination and management, which require significant time to do well. To date, limited per-member per-month Medicaid insurance reimbursements for specialty mental health organizations that implement BHH programs have been deemed insufficient to cover the structural costs associated with care integration (such as, in certain cases, the nurse care manager salary or the software and staff necessary to develop population health management or integrated electronic health records with shared access by mental health and primary care providers) [McGinty et al., 2021; Murphy et al., 2018].

In addition, payment mechanisms are typically one-sided and flow entirely to the BHH, sometimes without any financial incentives for the additional time that primary care health professionals in the community must spend on care coordination and management for their patients. This could explain why engaging external providers in BHHs when they do not work onsite is among the main implementation challenges for the model (Murphy et al.,

2018). Refined financing models for the successful scale-up of BHHs should incentivize two-way collaboration between specialty mental health organizations and general medical providers. Finally, shared accountability between these professionals is necessary, and payments should be tied to performance metrics that correlate with improved care and health outcomes for individuals with SMI. Further research is required to develop and evaluate strategies to implement valid measures (McGinty et al., 2021). In addition, the literature on value-based payments in other healthcare fields shows inconclusive findings in terms of improved quality of care (OECD, 2022).

In France, new remuneration schemes for health professionals have recently been tested in primary care to support care coordination and integration. These schemes could provide inspiration. They were developed for multidisciplinary group practices (*Maisons de santé pluriprofessionnelles*, MSPs), which are local care facilities where different self-employed primary care professionals share a practice. Their mode of remuneration includes collective funding with a lump-sum per patient provided on top of the fee-for-service payments delivered to each health professional of the facil-

ity. In return, they engage in care coordination and interprofessional cooperation (with a healthcare project involving all professionals and skill-mix protocols) as well as in improving accessibility (e.g., longer opening hours) and the sharing of information (e.g., accredited electronic health records, EHRs) [Loussouarn et al., 2023]. In addition, general practitioners (GPs) in the community, regardless of their place of practice, have the ability to charge higher fees for so-called "complex" or "very complex" consultations that follow up certain conditions that are difficult to manage or unstable and specific situations with significant public health stakes. Surprisingly, this does not include physical health check-ups for people with SMI. The introduction of similar provisions for primary care professionals working jointly with CMPs to provide comprehensive care to their patients could be a lever to ensure long-lasting multidisciplinary collaboration.

Building workforce capacity

Regarding the workforce, insufficient capacity has been identified as a key barrier to care integration in Medicaid BHHs (McGinty et al., 2021, Murphy et

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In France, some initiatives to promote the physical health of people with SMI that still need to be strengthened

The excess mortality of individuals with SMI and the need to improve their somatic care pathways have been considered public health issues only over the last decade in France. They were mentioned for the first time in the 2011-2015 National Mental Health and Psychiatry Roadmap (French ministry in charge of health, 2012). Subsequently, a partnership charter was signed in 2014 between general practice and hospital psychiatry to facilitate the coordination of care for this population. Although the cardiometabolic follow-up of patients treated with antipsychotic drugs has been the subject of good practice guidelines since 2010 (Afssaps, 2010), it was not until 2015 that more comprehensive recommendations were issued by the French Psychiatric Federation and the National Professional Council for Psychiatry (FFP-CNPP, 2015). In particular, these recommendations support the introduction of a systematic somatic exam during psychiatric hospitalization. They have been complemented by recommendations from the French National Authority for Health (HAS) that aimed to improve coordination between GPs and other health professionals

in the care of people with mental health issues (HAS, 2018). However, they cover both follow-up of mild to moderate mental disorders in primary care and monitoring of the physical health of individuals with SMI, which limits the clarity of measures to support for this specific population. From 2018 onward, formal territorial networks (*Projets territoriaux de santé mentale*, PTSM), involving all mental care providers in a given area, include among the priority objectives to provide access for people with SMI to somatic care adapted to their needs at the local level. However, this is being accomplished without the support of a coordinated national strategy. Finally, the relevance of involving specialty mental health services to improve somatic care in the hard-to-reach population with SMI has been acknowledged in the current national mental health roadmap. Related measures rely on the development of multidisciplinary primary care teams in hospitals specializing in psychiatry that are in charge of providing consultations in psychiatric wards and facilitating links with other medical specialties. However, these measures are applicable to

only approximately 40 hospitals nationwide (French ministry in charge of health, 2024), which limits their impact. Overall, while these measures are implemented in the right direction, they are still not sufficient, particularly for the majority of people who are not hospitalized but who are followed up on an outpatient basis. Recent research has demonstrated that the provision of primary care in usual settings for people with SMI in France is not optimal; these people do not receive sufficient preventive care (including cancer screening and some immunizations), experience a significant number of avoidable hospital admissions linked to conditions that should not lead to hospitalization if they are adequately followed up in primary care, and face delays in accessing specialized care (Gandré et Coldefy, 2020; Gandré et al., 2023). Furthermore, mental healthcare teams often express difficulty finding a referring GP for their patients (*Centre hospitalier Le Vinatier*, 2019; Fau et al., 2017; *GHU Paris Psychiatrie & Neurosciences*, 2024), while GPs feel helpless to adequately follow this specific population (HCSP, 2016).

al., 2018) since the model relies in part on the availability of staff dedicated to care coordination. This is a major barrier that is difficult to address, especially as the U.S. faces significant shortages of mental health providers (Butryn et al., 2017). This shortage is also found in France, which has vacant positions and long waiting times for access to mental care in the public sector (FHF, 2024). Moreover, feedback from health professionals in the French context points to difficulty filling general medical care positions in psychiatric hospital wards. This could also be observed within CMPs in a country where the number of doctors per capita is below the European average, particularly for GPs, with strong territorial disparities (Or et al., 2023).

Multicomponent strategies to address staff shortages should be developed in the short term, for instance by addressing insufficient insurance payments or focusing on strategies to reduce stigma around mental illnesses (McGinty et al., 2021), which negatively impacts the career attractiveness of behavioral healthcare. In France, the youngest generations of primary care physicians are increasingly willing to work in group practices (Chaput et al., 2019; Chevillard and Mousquès, 2021). The possibility of working conjointly with mental health specialists could be a lever to facilitate the recruitment of primary care staff, although successful recruitment will also depend upon the destigmatization of persons with and services for SMI.

Greater use of multiprofessional teams, including nonphysician clinicians and peer support specialists, could also help increase the staffing capacity of community-based specialty mental health services (McGinty et al., 2021). Initial research findings suggest that Medicaid BHHs which include elements of peer support are where the greatest reduction in cardiometabolic risk factors in the population with SMI are found (Fortuna et al., 2020). Peer workers are increasingly trained and hired in the French mental healthcare system (Coldefy and Gandré, 2020) and could provide useful support for the management of somatic care. Furthermore, in Medicaid BHHs, the primary care providers involved can be nurse practitioners, and coordination is systematically ensured by nurse care managers. In France, while nurses generally have limited responsibility compared to other countries (Or et al.,

2023), this situation is slowly evolving, especially for the management of chronic physical illnesses. Since 2004, pilot projects (*Action de santé libérale en équipe, Asalée*) have been established in which nurses are allowed to perform new procedures and tasks that were usually provided by GPs, including screening and therapeutic education for patients with some chronic diseases (such as diabetes), in cooperation with a primary care physician with a national extension that started in 2012 (Fournier et al., 2018). One "Asalée" nurse is already part of the innovative integrated care model described in Inset 2. Furthermore, an advanced nurse practice position (*Infirmier en pratique avancée, IPA*) that broadens nurses' responsibilities and facilitates task shifting following specific training was introduced in 2019 and can follow up patients with common chronic conditions. These health professionals could therefore oversee primary care and systematic health prevention actions for people with SMI within CMPs, a role that is filled by sim-

ilar nurse practitioners in the Medicaid BHH model and was recently encouraged in France (ANAP, 2021). However, thus far, the number of individuals trained in advanced nurse practice remains very limited. The attractiveness of this profession should be supported by dedicated health policies before it can be a lever on a nationwide scale (National Court of Auditors, 2023).

Finally, the U.S. experience of Medicaid BHHs demonstrates that in addition to sufficient workforce capacity, involved staff need to be adequately trained. The mental health workforce should be supported in gaining general medical competencies and the primary care workforce should acquire basic mental health skills, which could be part of initial or continuous education. Similarly, specific competencies in team-based care and care coordination, which are rarely addressed in health training, should be reinforced (McGinty et al., 2021).

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The example of an integrated model between a CMP and a primary care healthcare center in the Auvergne-Rhône-Alpes region of France

The outpatient mental healthcare center (CMP) of Bron, which is linked to the hospital Le Vinatier in the Auvergne-Rhône-Alpes region of France, provides ambulatory care to adult individuals with mental illnesses. It includes psychiatrists, nurses, a social worker, a health executive, and a medical secretary. Since 2022, this CMP has shared its practice space with a primary care healthcare center named "Le Jardin" ("The Garden"). This healthcare center has an associative status and is multidisciplinary, involving primary care physicians, medical assistants, a health mediator, a nurse specializing in the care of chronic disorders ("Asalée" nurse) [see Fournier et al., 2018], and two project coordinators. Its health project is organized around the principles of community health with a focus on addressing health inequities and the involvement of service users in care pathways complemented by an innovative environmental approach (e.g., deprescribing, limitation of waste) and specific attention to gender issues in health.

The CMP and the primary care healthcare center collaborate in the framework of an integrated model with the collocation of services. In practice, this collaboration takes several forms:

- clinical exchanges with standardized protocols to refer patients, multiprofessional clinical meetings, and electronic

transfers of information through a secure messaging system (MonSisra regional system for exchanging and sharing health information);

- shared consultations for persons who are followed in the CMP and need somatic care (for those who do not have a referring GP, physicians of the healthcare center commit to taking on this role), as well as for patients of the primary care healthcare center who require a psychiatric assessment;
- a jointly established common code of conduct for working in a shared space;
- a working group on how to best receive service users with a focus on the destigmatization of mental disorders and the inclusion of individuals living with a disability;
- the co-facilitation of therapeutic groups (e.g., for depression, sleep, physical activity);
- joint training for all health professionals;
- informal exchanges in the shared practice spaces.

This initiative, which received financial support from the *Fondation de France* (notably for group activity and equipment), is a form of shared practice between CMPs and primary care healthcare centers, of which there are other examples in France, such as since 2016, in the city of Marseille, with the André Roussin healthcare center.

Investing in data infrastructure for the collection and exchange of health data

Insufficient health information technology (HIT) infrastructure has been identified as another main barrier to the implementation of Medicaid BHHs. In the U.S., the mental health sector has lagged behind in the adoption of EHRs, and systems implemented in this sector are not always compatible with those used in the general medical sector. This has been identified as a key implementation challenge for the BHH model (McGinty et al., 2021; Stone et al., 2020). In France, the situation is opposite to that observed in the U.S. The French public community-based mental health system is managed by the hospital sector, which has developed shared EHRs and comprehensive claims data, while the primary care sector has lagged behind in HIT development. In these two national contexts, specific financial incentives to help different health providers invest in data infrastructure, particularly in interoperable EHRs, remain necessary. In France, inspiration can be obtained from the lump sum provided to MSPs in return for developing shared HIT infrastructure or from systems that support the secured exchange of health information between all healthcare professionals on a territory regardless of their place of practice or usual numerical tools, such as the MonSISRA system developed in the Auvergne-Rhône-Alpes region.

The U.S. experience of Medicaid BHHs also supports a proactive strategy to facilitate population health management, which remains insufficient, through specific registries that allow targeted person-centered interventions (e.g., identifying which people in a patient panel have diabetes and other comorbid chronic conditions or uncontrolled physical health conditions or present risk factors for which specific prevention measures can be developed) [McGinty et al., 2021].

In France, bottom-up initiatives are emerging from the field within CMPs

Many of the barriers to implementation encountered in the U.S. in reverse integrated care models for people with SMI require careful anticipation and planning through dedicated policies in the French context, where they are also likely to be present. However, measures that address these barriers may be easier to develop in France considering the somewhat simpler organization of its health system. It includes universal healthcare coverage (*Protection universelle maladie*, PUMA), with an additional state-funded complementary health insurance scheme for people with low incomes, *Complémentaire santé solidaire*, C2S) and a single public payer model (vs. multiple public and private payers in the U.S.). This can facilitate the development of new funding models and guarantee a lack of out-of-pocket (OOP) payments and the finan-

cial accessibility of CMPs, which could be extended to primary care coordination actions (whereas OOP costs are possible in Medicaid BHHs, with variation across states). Characteristics of the French health system also include strong national steering (vs. a federal system in the U.S.), which can support the implementation of coordinated policies throughout the country. Finally, there is a form of homogeneity in community-based specialty mental health services (CMPs organized according to a similar model and with teams that have a strong history of multidisciplinary work vs. community-based services where Medicaid BHHs are implemented that may differ greatly between states) [Or et al., 2023; Rice et al., 2020].

Local initiatives are starting to develop in a few CMPs in France according to several types of organizations (Insets 2 and 3), although an exhaustive inventory is not available. They mainly rely on health professionals' good will without the support of a coordinated national strategy to ensure that the momentum generated is sustained and covers all territories. These initiatives provide opportunities for further learning considering the specificities of the French context, and their thorough evaluation should be encouraged. The U.S. example highlights the numerous insights that can be drawn from exploring new delivery system models in real-world settings at a time when innovations are increasingly pilot tested in the French health system (e.g., Article 51 of the Social Security Financing Law, which provides a consolidated budget

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The Psysom model in the Parisian area linking ambulatory psychiatric care in CMPs with external GPs in the community

Psysom represents an innovative model for coordinating psychiatric and physical care in the Parisian area, launched in 2020 at the initiative of the University Hospital Group Paris Psychiatry & Neurosciences, and initially financed by the Fund for Organizational Innovation in Psychiatry. Its main aim is to harness the synergy of healthcare professionals' skills to provide comprehensive care for people with SMI. Since 86% of the patients of this university hospital group are followed on an outpatient basis, the model targets adults seen in its CMPs who are receiving antipsychotic drugs. The Psysom team, which includes two nurse coordinators and two assistant nurses, establishes partnerships between these CMPs and external primary care structures in the community close to where patients live.

Specifically, Psysom focuses on several areas:

- assigning a referring GP (for example, practicing in a primary care healthcare center) to patients who had none previously;
- resuming somatic healthcare follow-up if this had been suspended;
- accompanying patients to consultations with somatic healthcare

professionals, if required;

- regular physical health exams, ideally including two annual check-ups;
- formalized and systematized exchanges between CMPs and external GPs involved in the model;
- a therapeutic education program focused on raising awareness, informing and empowering patients that highlights the value of visiting GPs to promote overall health.

This initiative is an illustrative example of the involvement of CMPs in connection with GPs in the community for the somatic follow-up of their patients. There have been other similar initiatives in France, notably the Coreso model (*Centre hospitalier Le Vinatier*, 2019; Fau et al., 2017) and in the Paris 13 health cluster (<https://sante.gouv.fr/systeme-de-sante/parcours-des-patients-et-des-usagers/projet-territorial-de-sante-mentale/illustrations/article/partenariat-asm-13-et-pole-de-sante-paris-13-sud-est>).

for local pilot studies to support innovative care models and funding methods in the health sector since 2018, Fund for Organizational Innovation in Psychiatry since 2019). The emergence of these bottom-up initiatives within CMPs in France opens up the possibility of integrating research with the real-world implementation of systems designed directly by those working on the ground. These systems are often more acceptable and sustainable and therefore are ultimately more widely applicable because they account for the reality of healthcare practices (McGinty et al., 2024).

The persistent excess mortality of people with SMI, for which the gap with the general population is widening, should no longer be seen as an unavoidable phenomenon. It is partly explained by the inadequate provision of somatic care, which requires the timely development of new delivery system models.

Actionable insight for France emerges from the implementation of Medicaid

BHHs in the U.S., which represent one of the most advanced forms to date of models that integrate primary care delivery or coordination within community-based specialty mental health services. A positive impact was found on increasing access to general medical care for individuals with SMI, which calls for a new national paradigm that reinforces the pivotal role of French CMPs at the heart of a comprehensive approach to health for these individuals.

Nevertheless, these models of care integration face significant barriers to implementation in real-world settings, which may limit the extent and durability of their effects and require anticipation. Additional lessons for upstream planning may be drawn from initiatives emerging within CMPs in France, which must be supported by policies designed to ensure that they are evaluated, generalized and sustained. The challenge is to prevent the current momentum from relying solely on the strong involvement of health professionals in a national context where the health system lacks maturity with regard to an integrated and person-centered

approach. The mental health field is ideally placed to be a forerunner of this type of approach, as it has been in the past (e.g., for the development of ambulatory care, outreach services, peer support).

Future prospects should include the development of models that support the integration of healthcare with the social sector, which is also key to meeting all the needs of people with SMI in accordance with their life plans. Finally, the inclusion of persons with lived experience in the design of new models of care delivery dedicated to them should not be forgotten. ♦

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