John E. Herman Home and Treatment Facility Offers a Unique Hybrid Model of Residential Psychiatric Care

In an effort to treat patients with psychiatric illnesses who don’t require inpatient settings yet aren’t completely functional living independently, Mayo Clinic developed the John E. Herman Home and Treatment Facility, a residential psychiatric program opening in 2018. This home will offer residents an on-site, round-the-clock, supervised environment structured to support personalized treatment and community involvement.

“Rather than taking patients out of the community, this treatment model involves getting them into the community to get a job, go back to school, go volunteer — to begin putting in place, while in treatment, things that build meaningful lives,” says Brian A. Palmer, M.D., M.P.H., a psychiatrist at Mayo Clinic in Rochester, Minnesota, and the home’s medical director.

The care model is a hybrid: It represents an amalgam of models selected by John E. Herman Home’s directors, Dr. Palmer and Ajeng J. Puspitasari, Ph.D., encompassing clinical and vocational programs, and a setting and treatment duration designed to enhance residents’ success. Functional recovery is a key priority: developing skills necessary to live independently and care for oneself, attend to household responsibilities, and become a productive society member. This emphasis was patterned after ClearView Communities in Maryland, whose founder, Sylvan C. Herman, provided funding for Mayo Clinic’s program.

Clinical program
The clinical program is designed for customization to residents’ needs and includes behavioral health care as well as care for all facets of an individual’s health, knowing there are often comorbid psychiatric and medical conditions. This includes Mayo Clinic primary and specialty care as well as psychiatric care, including psychiatric diagnoses, customized treatment plans and psychopharmacologic reviews. Each resident will receive individual and group psychotherapy, including cognitive and behavioral therapies such as acceptance and commitment therapy, dialectical behavioral therapy and behavioral activation.

Vocational program
John E. Herman Home will utilize the Individual Placement and Support (IPS)-supported education and employment model — a vocational model rare in residential treatment programs — pioneered at Dartmouth-Hitchcock Medical Center and employed at ClearView Communities.

This model supports employment promoting healing and is associated with better functional improvement than other models, according to Dr. Palmer. An employment specialist will assist residents in developing career or educational plans, and then executing plans with support through resume writing, applications and interviews. Continued coaching will be provided after securing employment.

The employment specialist will encourage residents to pursue their own vocational goals, rather than underemployment while dealing with mental illness. Some residents’ plans will include...
Increasing the Happiness of Health Care Workers

For years, stress management programs have looked at how to manage the negative: targeting stress and burnout for turnaround. Thus, when Matthew M. Clark, Ph.D., L.P., a psychologist at Mayo Clinic’s campus in Rochester, Minnesota, was asked to work with Dan Abraham Healthy Living Center (DAHLC) — Mayo Clinic’s employee wellness center — he led the stress management domain to focus on positive functioning.

Dr. Clark’s DAHLC role involves researching and implementing stress alleviation programs such as wellness coaching and stress management groups. Research from this work, such as a DAHLC member cohort study observing employee stress and health behaviors, published in the September 2016 *Journal of Occupational and Environmental Medicine*, found high stress in one-sixth of participants. While each survey year those experiencing high stress changed, having high stress was associated with negative health behaviors, such as fewer DAHLC visits, impaired mental health, poor nutritional habits and lower perceived overall health.

Over time, Dr. Clark and colleagues began turning the paradigm to the positive, asking, “What if, instead of trying to manage employees’ negative life aspects such as stress and burnout, we looked at building positive life aspects, good things we want to see grow?”

Rather than focusing solely on becoming stress-free, this wellness model targets resiliency: the ability to achieve and have a good quality of life (QOL), something that employees could work on daily. This emphasis change led to Dr. Clark’s DAHLC title becoming resiliency domain leader.

### Treatment duration

Residents will spend an average of six months at the John E. Herman Home, as symptom control and securing employment take time. “There’s a push for rapid treatment,” says Dr. Palmer. “We don’t want to keep people longer than necessary, yet residential treatment has become part of the ‘revolving door’ of psychiatric treatment. We think longer treatment plays a role in changing that pattern.”

While some residents will return home after six months, treatment may extend longer, with residents stepping down into lower level care. Staff will conduct follow-up after program completion.

True to the care model, Dr. Palmer defines residents’ recovery in functional and psychological terms. “Recovery is living a meaningful life, where you find work, build relationships, make a contribution and are challenged at the top of your capabilities,” he says.

### A novel study

Dr. Clark and colleagues noted a dearth of research on happiness’s role in bolstering health care employees’ workplace function. Researchers posited as individuals’ happiness relates to willful choices, a study designed to boost intentionality could increase happiness and other well-being measures.

Amit Sood, M.D., a Mayo Clinic internist in Rochester, Minnesota, had designed such an intervention, Stress Management and Resiliency Training (SMART), with demonstrated effectiveness improving various QOL domains, yet not happiness specifically. The researchers designed a study observing SMART efficacy for increasing health care worker happiness and well-being.

DAHLC members volunteered for this study — a prospective, nonrandomized, single-arm trial — and received the SMART intervention between 2013 and 2017. It involved six months’ participation: three months’ in-person SMART intervention and three months’ post-intervention follow-up. Investigators used these tools to determine outcome at baseline, intervention end and three months’ post-intervention:

- Functional Assessment of Chronic Illness Therapy—Spiritual Well-Being
- Gratitude Scale
- Mindful Attention Awareness Scale
- Perceived Stress Scale
- Subjective Happiness Survey
- Satisfaction With Life Scale

Researchers found statistically significant improvements in all domains, including subjective happiness, gratitude, life satisfaction, mindfulness, spiritual well-being and stress levels. They also
noted strong engagement rates, indicated by few participant dropouts. Findings were published in Mayo Clinic Proceedings: Innovations, Quality & Outcomes’ December 2017 issue.

Practice application
Dr. Clark believes these findings also may apply in depression treatment. Many patients reported as depression worsened, their health behaviors became more negative. Therefore, part of a depression recovery plan may include a wellness intervention. While patients can start feeling better through depression treatment, their lifestyles may have fallen apart, prompting behaviors such as missing yoga because they feel bad or eating junk food for comfort. At some recovery juncture, however, actively working on wellness and resiliency could be appropriate as part of a comprehensive depression relapse prevention plan, says Dr. Clark.

To examine how resiliency programs could complement depression treatment, the Mayo Clinic Depression Center is conducting a single-arm pilot study providing SMART to patients being treated for depression, observing recovery impact and ability to benefit from SMART.

For future research
Dr. Clark indicates a randomized, controlled study of increasing health care workers’ happiness and additional studies investigating resilience programs for patients with depression should be explored.

Though he feels stress groups are useful, Dr. Clark notes such programs aren’t scalable for thousands of medical center workers, since these groups only facilitated 300 participants yearly at Mayo Clinic. To broaden the scope, he’s now looking at large participant group interventions. One possible avenue for resiliency improvement at the workplace is a wellness champions program, where individual employees volunteer to promote wellness with co-workers. This program, discussed in a 2016 issue of American Journal of Health Behavior, has demonstrated benefit and is a future research focus.

For more information


Patient-Centered Medical Home Membership Affects ED Admissions for Behavioral Health Patients

In a time when over 80 percent of psychiatric medications are prescribed by primary care providers due to factors such as stigma associated with psychiatry visits, lack of available psychiatrists and long specialist waitlists, the patient-centered medical home (PCMH) has filled a void. The PCMH is a model embedding specialty services into primary care, providing general practitioners support through teaming with specialists—a concept developed in the 1960s and re-evaluated in the 2000s.

Though initially the PCMH model didn’t include behavioral health, over time the medical community realized addressing all patients’ needs in primary care couldn’t be accomplished without mental and behavioral health care. Further, this approach and its emphasis on care integration and coordination aligns with the Institute for Healthcare Improvement’s Triple Aim to improve population health and patient experience, and to lower per person health care costs.

While most patients with behavioral health problems are seen in primary care, another major entry point has been hospital emergency departments (EDs). Some seek ED care due to psychiatrists’ unavailability to see them promptly, primary care not being well-equipped to listen to behavioral health issues, belief the ED has psychiatric expertise, lack of insurance for mental health appointments or urgent need when primary care resources aren’t available.

“Patients with behavioral health problems tend to deteriorate quickly, and the next port of call is the ED,” says Akuh Adaji, M.B.B.S., Ph.D., a Mayo Clinic psychiatrist based in primary care at Mayo Clinic Health System in Austin, Minnesota, and Integrated Behavioral Health at Mayo Clinic’s campus in Rochester, Minnesota. Dr. Adaji came from Australia to train at Mayo Clinic to be part of a PCMH embedded in primary care. High ED usage by patients with behavioral health issues has been a concern from a health care utilization perspective.%

Figure. Conceptual framework for the effectiveness of the medical home. Graphic reprinted with permission from Agency for Healthcare Research and Policy, U.S. Department of Health and Human Services.
standpoint. However, a greater cost-containment concern has been patient hospital admissions resulting from ED visits. Thus, Dr. Adaji and team embarked on an observational study looking at whether PCMH membership affected admissions or return ED visits for patients seeking ED care for behavioral health concerns.

The study
The study’s setting was Mayo Clinic, one of the most highly integrated health care systems worldwide and a PCMH model early adopter (Figure). Patients with Mayo Clinic PCMH primary care providers were considered PCMH members, and they became study subjects by visiting the ED at Mayo Clinic Hospital, Saint Marys Campus, in Rochester, Minnesota, for behavioral health concerns.

Investigators looked at all patients presenting to the ED from 2012 to 2013 who underwent psychiatric evaluation and provided research authorization. To determine patient health care utilization, researchers used ED hospital admissions and return ED visits within 72 hours as outcome measures. Of 3,815 patients studied, 5,398 ED visits occurred, and 2,983 of these led to inpatient admission. Of non-PCMH patients, 57 percent were admitted, while only 53 percent of PCMH patients were admitted. Though PCMH patients were less likely to be hospitalized, investigators didn’t discern significant difference in 72-hour ED return rates between the groups.

Study significance and care applications
Per Dr. Adaji, this study’s findings, published in the May 9, 2017, Population Health Management issue, imply hospitalization costs for patients with behavioral health problems can be reduced through a PCMH.

One theory investigators postulated for reduced PCMH patient admissions for those seen in the ED for behavioral health problems is ED physicians may be more likely to dismiss patients having PCMH access, feeling more confident in their support. If patients aren’t PCMH members, investigators hypothesize ED physicians may be more likely to admit them due to uncertainty regarding safety and support.

Dr. Adaji feels a PCMH model can benefit psychiatrists by providing opportunity to lend expertise to primary care colleagues, lightening these physicians’ burdens and making a difference in patients who may never see a psychiatrist.

Integrating with primary care colleagues also can promote referrals, paving the path for psychiatrists with concerns about their patients’ nonbehavioral health aspects to reach out to their primary care providers.

Although the PCMH model has more limitations in less integrated medical systems, Dr. Adaji believes it’s adaptable to any medical center, provided it’s customized, such as use of virtual consults.

“Every organization, in one shape or form, will benefit from the PCMH model. I think it’s the future of psychiatry, and clinically, it’s showing it’s making a difference.”

For more information