The role of mental and behavioral health in the application of the patient-centered medical home in the Department of Veterans Affairs

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Cite this as: TBM 2011;1:624–628
doi: 10.1007/s13142-011-0093-4

ABSTRACT

The patient-centered medical home, which is termed the Patient Aligned Care Team (PACT) in the Department of Veterans Affairs (VA), is a transformational initiative with mental and behavioral health as integral components. Funding has been provided to VA medical facilities to assist with the transformation and process redesign of primary care into interdisciplinary teams focused on increased access, Veteran-centered care, and active incorporation of collaborative expertise from specialists within primary care. Primary care clinics are not simple machines that change by merely replacing parts or colocating additional resources. Rather, they are complex systems with a relationship infrastructure among members of the team that is critically important to the change process. Mental health professionals are integral, mandated members of the PACTs providing needed mental and behavioral health care to Veterans as an integrated component of primary care. They also work to catalyze a quality improvement process that encourages collaboration, innovation, and adoption of best practices that promote transformation based on patient-centered principles of care. The purpose of this article is to describe the evolution of VA primary care settings toward interdisciplinary teams that provide patient-centered care in collaboration with Primary Care–Mental Health Integration providers and Health Promotion Disease Prevention team members.

KEYWORDS

Primary care, Patient-centered medical home, Integrated care

The medical home has emerged as a critical tool in transforming United States health care into a coordinated, cost-effective, and patient-centered system [1]. The Department of Veterans Affairs (VA) has embraced this opportunity with the Patient Aligned Care Team (PACT) initiative. This initiative focuses on seven foundational principles: 1) creating *patient-driven* services, 2) offering *team-based* care, 3) increasing care *efficiency*, 4) providing *comprehensive* care including access to specialists, 5) developing *continuous* service across time, 6) im-

Implications

Practice: The incorporation of mental and behavioral health providers as change agents into primary care settings is critical to fully implementing the spirit of the patient-centered medical home, namely, the application of interdisciplinary approaches that address the full spectrum of health concerns.

Policy: Medical home resources should focus on the development and continuous improvement of collaborative interventions that broadly incorporate biopsychosocial needs and apply methods of registry-based care that track and optimize health and health conditions.

Research: Further research is needed in the evaluation of interdisciplinary clinical processes, as well as clinical outcomes, from care delivered through patient-centered medical homes.

proving *communication*, and 7) developing seamless *coordination* of care. With these overarching principles, VA has identified three long-term goals for PACT: 1) providing superb access including alternatives to in-person care, 2) providing seamless care coordination inside and outside VA; and 3) redesigning practices toward patient-centeredness. A central element is the Primary Care team, which includes the Core and Expanded Teams. The Core Team consists of a Primary Care Provider (PCP), RN Care Manager, Clinical Associate (LPN/LPN equivalent), and Clerk. The Expanded Team consists of a variety of specialty resources. Similar teams have been associated with improvements in efficiency, mortality, hospitalization, access, and coordination [2–8]. Figure 1 illustrates the relationship infrastructure of PACT team members.

Currently, 349 million dollars have been disbursed to transform primary care clinics into Patient Aligned Care Teams. The top funding priority has been the Core Team, followed by funding the Expanded Team including pharmacists, social workers, dietitians, mental and behavioral health

Fig 1 | Interdisciplinary PACT team. Note: reprinted with permission from the VA Primary Care Program Office and Primary Care Operations Office

providers, women's health clinicians, and health promotion/disease prevention staff. Funding also supports one Core Team per facility attending six week-long trainings to spearhead clinic transformation and assist local training. The remaining funding focuses on primary care space, PACT evaluation, and learning centers for ongoing education.

STATE OF AFFAIRS OF MENTAL HEALTH IN PRIMARY CARE IN VA: THE NEED FOR CHANGE

With approximately 30% of VA patients having a mental health diagnosis (J. McCarthy, personal communication, September 22, 2011), a critical issue for PACT is appropriate attention to these conditions. Across diverse settings, PCPs have historically underdiagnosed these conditions and been less likely to ensure provision of evidence-based treatments [9–11]. VA PCPs were frequently in separate locations from mental health providers, which inhibited consultation and decreased likelihood of successful referral. In one VA study, only 32% of direct referrals to specialty mental health from PCPs were successful, in contrast to over 70% of referred Veterans attending a specialty appointment after initially receiving care management services by an integrated mental health team [12]. Furthermore, though VA has achieved high rates for many preventive services (e.g., cancer screening), delivery of effective behavioral interventions remains a challenge. As primary care is the natural venue for accessing the population that VA serves, PACT provides the optimal platform for quality improvement in mental health across a continuum of condition severity (e.g., from treating uncomplicated

depression to identification of severe mental illness) and a locus for attending to the interplay of health behaviors and chronic conditions (e.g., decreased adherence) [9, 13–16].

While PACT funding is necessary, it is not sufficient to accomplish the systematic redesign needed to achieve the initiative's goals [1, 16]. Primary care clinics are not simple machines that change by merely replacing parts, revising procedures, or colocating additional personnel. These settings are complex systems built upon a relationship infrastructure among team members that requires careful attention during the change process [17, 18]. Mental health providers are integral PACT members providing not only direct consultation and care but also serving unique roles as transformational agents. Much as patients move through stages of change in learning self-management, provider teams must move through stages to fully implement PACT [1] and embrace a model emphasizing Veteran engagement. Two programs, described below, highlight the role of mental and behavioral health within PACT: the Primary Care–Mental Health Integration (PC–MHI) Program and the Health Promotion and Disease Prevention (HPDP) Program.

PRIMARY CARE–MENTAL HEALTH INTEGRATION (PC–MHI) PROGRAM

PC–MHI program description

The VA Offices of Mental Health Services and Primary Care began a joint initiative in 2007 at 94 facilities to integrate evidence-based mental health services in primary care [19, 20]. The principal aim is to support primary care-based treatment of

common mental health conditions, in particular depression, anxiety, and alcohol misuse. The effectiveness of collaborative, measurement-based approaches to integrated care is well-established, especially for depression [21, 22]. Given the prevalence of mental health conditions, their interaction with other conditions and health behaviors, and reluctance of patients to seek specialty care, primary care–mental health integration is central to fully achieving PACT goals [23].

PC–MHI program implementation

The initial success of PC–MHI led to its implementation beyond the initial cohort of facilities. The program was expanded in 2008 to be a routine expectation of care with larger VA primary care settings required to have blended programs incorporating both colocated collaborative care and care management [24]. Strong, preexisting research and quality improvement provided best practices that support PC–MHI including the White River Model for colocated collaborative care [25, 26], and Translating Initiatives for Depression into Effective Solutions (TIDES) and the Behavioral Health Laboratory for care management [27–29].

Colocated collaborative (CCC) providers practice within primary care with a focus on immediate consultation as a core element of transformation towards the interdisciplinary medical home. Clinical functions include “curb side” consultation, focused assessment, joint treatment planning, psychopharmacology expertise, brief therapies, and behavioral interventions such as brief alcohol counseling. Additionally, CCC providers may collaborate with PCPs and HPDP staff in providing behavioral health interventions and addressing chronic conditions like hypertension, dyslipidemia, and chronic pain. Care management functions encompass a package of protocol-based services that support primary care-based prescription of psychotropic medications, longitudinal follow-up, and behavioral interventions. These include patient education, activation, monitoring of medication adherence and structured, measurement-based assessment of progress with facilitation of treatment changes when necessary.

Facilitators of integrated care implementation include leadership support, a program champion, and understanding of the evidence base to avoid creation of colocated but separate (i.e., multidisciplinary) services. To assist with optimal program development, large interdisciplinary PC–MHI conferences were held in June 2007 in Denver, Colorado and April 2009 in Dallas, Texas to provide initial training to each cohort of facilities on the functional requirements of integrated care. Subsequently, multiple, focused trainings have provided PC–MHI providers and primary care and mental health leadership specific tools for facility level implementation. These include guideline-concordant training in care management, skills training for colocated collaborative care, and direction for

practical implementation strategies when working with local leadership. The national PC–MHI program office also provides monthly training calls, individual field consultation, quarterly newsletters, SharePoint resources, and a national electronic dashboard, which allows programs to track progress across common performance monitors. The Center for Integrated Healthcare, a VA national center of excellence in PC–MHI, provides additional support through research and educational efforts in integrated care.

The PC–MHI program presently has confirmed integration activities at 124 of 140 VA facilities and has recorded over 1.5 million encounters since late 2007. Zivin et al. demonstrated early PC–MHI program experience to be associated with greater case identification for depression, anxiety, PTSD, and alcohol abuse [30]. Active collaboration with PACT is ongoing to incorporate evidence-based practices; furthermore, well-functioning PC–MHI teams demonstrate leadership in how specialty services can seamlessly integrate into primary care [2, 17].

While the PC–MHI program has had many successes, facilities have faced challenges. Space for colocated providers continues to be problematic as it is for primary care overall with PACT staff expansion. Sites are challenged in blending care management and colocated collaborative care functions into unified programs. Sites may have one predominant function for a variety of reasons including staffing representation or having begun prior to the expectation of a blended program. Given current fiscal realities, major staff additions are unlikely; however, this presents opportunities for facility leadership to understand inherent efficiencies with integrated care and consider encouraging cross-functional staff rather than new hires to address each separately. Lastly, integrated care is not just a culture shift for primary care. Mental health providers are often foreigners in primary care with stated unfamiliarity with brief appointments, same-day access, frequent interruptions, and a population-based perspective. All PACT providers must embark together in revisiting how they define specific functions and in learning interdisciplinary collaboration improves not just physical or mental/behavioral care but overall health care for the Veteran.

HEALTH PROMOTION AND DISEASE PREVENTION (HPDP) PROGRAM

HPDP program description

The VA National Center for Health Promotion and Disease Prevention (NCP) aims to keep Veterans well by supporting health promotion, disease prevention, and patient health education. The HPDP Program provides support for preventive care, trains staff in patient-centered communication, and develops resources to accomplish these aims. It focuses on nine healthy living messages: increase your involvement in

health care, be tobacco-free, eat wisely, be physically active, strive for a healthy weight, limit alcohol intake, get recommended screening tests and immunizations, manage stress, and be safe (e.g., seat belt use). To assist implementation, funding available in 2010 supported hiring a Program Manager (HPDP-PM) and a Health Behavior Coordinator (HBC) at each facility with responsibilities that include the VA Medical Center (VAMC) and its associated community-based outpatient clinics (CBOCs). HPDP-PMs and HBCs collaborate with other HPDP staff (e.g., Veterans Health Education Coordinators–VHECs), PACT leaders, and Expanded Team members including PC–MHI staff, and in so doing enhance prevention services and the capability of PACT to provide collaborative behavioral interventions.

HPDP-PMs, typically nurses, dietitians, or health educators, are responsible for coordinating program development, implementation, monitoring and evaluation, and colead the HPDP Program Committee that directs facility prevention activities with the HBC. HBCs, typically health psychologists and social workers, advance program goals by providing training, coaching and support to PACT staff with some time devoted to direct clinical services (e.g., tobacco cessation counseling). Specifically, HBCs educate staff about the nonlinear process of behavior change [31], and develop providers' abilities and confidence in motivational interviewing [32] and brief counseling [33].

HPDP program implementation

Presently, implementation focuses on training PACT staff in health coaching via the TEACH for Success program and in motivational interviewing (MI). To that end, HBCs participate in a three-day MI training developed by a national expert panel and ongoing guidance through biweekly calls with experienced MI coaches. HBCs subsequently facilitate MI training (4 h over at least two sessions) for PACT staff (targeting RN Care Managers) at their local VAMC and CBOCs and provide ongoing clinic-based coaching in recognition of the limited influence formal training has on skill development and use. Similarly, HBCs attend a three-day TEACH training, and, in concert with VHECs, provide 7-hour trainings to local PACT Core Teams.

To date, over 98% of facilities have hired HPDP-PMs and HBCs. All facilities have developed HPDP committees and have initiated TEACH and MI training at local sites. Based on facility self-report, all facilities are on target for reaching current year training goals. While the HPDP program has reached many initial goals, key implementation challenges exist. These include hiring delays at some facilities and challenges in blocking time for training leading to staggered training that allows coverage of all primary care clinics. Finally, delivery of effective behavioral interventions requires more than training; it also requires a transformational shift

in how care is provided. This shift, from a clinician-centered disease-oriented approach to a more collaborative Veteran-centered wellness approach requires both PACT staff and Veterans to learn new skills, take on new roles, and participate in substantial process redesign. The full-time presence of HBCs and HPDP-PMs within each facility allows for opportunities for PACT members to receive ongoing education, support and consultation in the service of continued transformation.

CONCLUSION

In summary, VA has assumed a forward-looking leadership role in implementing the PACT patient-centered medical home. Consistent with the evidence base on quality improvement in mental and behavioral health care and institutional best practices, VA mental health providers are assuming key roles as leaders in promoting change including robust programs in primary care–mental health integration and health promotion and disease prevention. Researchers are encouraged to utilize this nationwide implementation to examine long-term outcomes including increased access to treatment and destigmatization of mental health concerns, prevention of chronic health conditions, and Veteran satisfaction, functioning, and quality of life.

1. Nutting PA, Miller WL, Crabtree BF, Jaen CR, Steart EE, Stange KC. Initial lessons from the first national demonstration project on practice transformation to a patient-centered medical home. *Ann Fam Med*. 2009;7(3):254-260.
2. Baicker K, Chandra A. Medicare spending, physician workforce, and beneficiaries' quality of care. *Health Aff*. 2004;4:184-97.
3. Counsell SR, Callahan CM, Clark DO, Tu W, Buttar AB, Stump TE, Ricketts GD. Geriatric care management for low income seniors: a randomized control trial. *JAMA*. 2007;298(22):2623-2633.
4. Dorr DA, Wilcox AB, Brunner CP, Burdon RE, Donnelly SM. The effect of technology-supported, multidisease care management on the mortality and hospitalization of seniors. *J Am Geriatr Soc*. 2008;56(12):2195-2202.
5. Leff B, Reider L, Frick KD, Scharfstein DO, Boyd CM, Frey K, Karm L, Boulton C. Guided care and the cost of complex healthcare: a preliminary report. *Am J Manag Care*. 2009;15(8):555-559.
6. Momany ET, Flach SD, Nelson FD, Damiano PC. A cost analysis of the Iowa Medicaid primary care case management program. *Health Serv Res*. 2006;41(4):1357-1371.
7. Reid RJ, Fishman PA, Yu O, Ross TR, Tufano JT, Soman MP, Larson EB. Patient-centered medical home demonstration: a prospective, quasi-experimental, before and after evaluation. *Am J Manag Care*. 2009;15(9):71-87.
8. Steiner BD, Denham AC, Ashkin E, Newston WP, Wroth T, Dobson LA Jr. Community Care of North Carolina: improving care through community health networks. *Ann Fam Med*. 2008;6(4):361-367.
9. Kessler RC, Demler O, Frank RG, Olfson M, Pincus HA, Walters EE, Wang P, Wells KB, Zaslavsky AM. Prevalence and treatment of mental disorders, 1990 to 2003. *N Engl J Med*. 2005;352(24):2515-2523.
10. Wang PS, Lane M, Olfson M, Pincus HA, Wells KB, Kessler RC. Twelve-month use of mental health services in the United States: results from the National Comorbidity Survey replication. *Arch Gen Psychiatry*. 2005;62(6):629-640.
11. Young AA, Klap R, Sherbourne CD, Wells KB. The quality of care for depressive and anxiety disorders in the United States. *Arch Gen Psychiatry*. 2001;58:55-61.
12. Zanjani F, Miller B, Turiano N, Ross J, Oslin D. Effectiveness of telephone-based referral care management, a brief intervention to improve psychiatric treatment engagement. *Psychiatr Serv*. 2008;59(7):776-781.

13. Almeida OP, Pfaff JJ. Depression and smoking amongst older general practice patients. *J Affect Disord.* 2005;86(2-3):317-321.
14. DiMatteo MR, Lepper HS, Croghan TW. Depression is a risk factor for noncompliance with medical treatment: results of a meta-analysis of effects of anxiety and depression on patient adherence. *Arch Intern Med.* 2000;160:2101-2107.
15. Merikangas KR, Ames M, Cui L, Stang P, Ustun TB, Von Korff M, Kessler RC. The impact of comorbidity of mental and physical conditions on role disability in the U.S. household population. *Arch Gen Psychiatry.* 2007;64(10):1180-1188.
16. Parchman ML, Pugh JA, Culler SD, Noel PH, Arar NH, Romero RL, Palmer RF. A group randomized trial of a complexity-based organizational intervention to improve risk factors for diabetes complications in primary care settings: Study protocol. *Implement Sci.* 2008;3(1):15.
17. Leykum LK, Pugh J, Lawrence V, Parchman M, Noel PH, Cornell J, McDaniel RR Jr. Organizational interventions employing principles of complexity science have improved outcomes for patients with type II diabetes. *Implement Sci.* 2007;2:28.
18. Heinemann GD, Zeiss AM. *Team Performance in Health Care: Assessment and Development.* New York: Kluwer/Plenum; 2002.
19. Zeiss AM, Karlin BE. Integrating mental health and primary care services in the Department of Veterans Affairs health care system. *Journal of Clinical Psychology in Medical Settings.* 2008;15(1):73-78.
20. Post EP, Van Stone WW. Veterans Health Administration primary care-mental health integration initiative. *N C Med J.* 2008;9(1):49-52.
21. Wang PS, Demler O, Kessler RC. Adequacy of treatment for serious mental illness in the United States. *Am J Public Health.* 2002;92:92-98.
22. Butler M, Kane RL, McAlpine D, Kathol RG, Fu SS, Hagedorn H, Wilt TJ. *Integration of mental health/substance abuse and primary care.* AHRQ Publication No. 09-E003. Rockville, MD: Agency for Healthcare Research and Quality; 2008.
23. Croghan TW, Brown JD. *Integrating Mental Health Treatment into the Patient Centered Medical Home.* AHRQ Publication No. 10-0084-EF. Rockville, MD: Agency for Healthcare Research and Quality; 2010.
24. Post EP, Metzger M, Dumas P, Lehmann L. Integrating mental health into primary care within the Veterans Health Administration. *Fam Syst Health.* 2010;28:83-90.
25. Pomerantz AS, Cole BC, Watts BV. Improving efficiency and access to mental health care: combining integrated primary care and advanced access. *Gen Hosp Psychiatr.* 2008;30:546-551.
26. Pomerantz AS, Corson JA, Detzer MJ. The challenge of integrated care for mental health: leaving the 50 minute hour and other sacred things? *Journal of Clinical Psychology in Medical Settings.* 2009;16(1):40-46.
27. Rubenstein LV, Chaney EF, Ober S, Felker B, Sherman SE, Lanto A, Vivell S. Using evidence-based quality improvement methods for translating depression collaborative care research into practice. *Fam Syst Health.* 2010;28(2):91-113.
28. Oslin DW, Sayers S, Ross J, Kane V, Have T, Conigliaro J, Cornelius J. Disease management for depression and at-risk drinking via telephone in an older population of veterans. *Psychosom Med.* 2003;65(6):931-937.
29. Oslin DW, Ross J, Sayers S, Murphy J, Kane V, Katz I. Screening, assessment and management of depression in VA primary care clinics: the Behavioral Health Laboratory. *J Gen Intern Med.* 2006;21(1):46-50.
30. Zivin K, Pfeiffer PN, Szymanski BR, Valenstein M, Post EP, Miller EM, Snedecor SM, McCarthy JF. Initiation of primary care-mental health integration programs in the VA health system: associations with psychiatric diagnoses in primary care. *Med Care.* 2010;48:843-851.
31. Prochaska JO, DiClemente CC. Toward a comprehensive model of behavior change. In: Miller WR, Heather N, eds. *Treating Addictive Behaviors: Processes of Change.* New York: Plenum; 1986:3-27.
32. Rollnick S, Miller WR, Butler CC. *Motivational Interviewing in Health Care: Helping Patients Change.* New York: Guilford; 2008.
33. Glasgow RE, Goldstein MG, Ockene JK, Pronk NP. Translating what we have learned into practice: principles and hypotheses for interventions addressing multiple behaviors in primary care. *Am J Prev Med.* 2004;27(2):88-101.