
Applying the Interprofessional Patient Aligned Care Team in the Department of Veterans Affairs

Transforming Primary Care

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The Veterans Health Administration (VHA) is the largest integrated health care system in the United States, serving more than 8 million veterans. VHA is currently undergoing extensive changes to its health care delivery model, moving toward the full implementation of the patient-centered medical home. Mental health providers, including psychologists working in primary care, are playing key roles in this transformation to interprofessional teams and systems—as clinicians, researchers, program evaluators, and educators. Moreover, VHA mental health staff serves critical leadership functions supporting primary care in the broad transformation that is required to implement the medical home. In this article, we review the implementation of mental health integration into this new model of care.

Keywords: patient-centered medical home, integrated care, primary care, veterans

The Veterans Health Administration (VHA) of the Department of Veterans Affairs (VA) provides health care to more than 8 million veterans in 140 health care systems and more than 800 community-based outpatient clinics. In the late 1990s, VA health care underwent expansion from a hospital-based system, providing secondary and tertiary care, to a system providing primary and multispecialty care, supported by a modernized hospital system (Kizer & Dudley, 2009). To better align resources, funds for direct costs of medical care are disbursed regionally through risk-adjusted capitation based on the number of veterans served and the complexity of their conditions. One goal of this transformation to a primary-care-based system was a commitment to provide comprehensive treatment to veterans across their life span (Kizer & Dudley, 2009). Now, VA is evolving its primary care services to the patient-centered medical home model of care, known in VA as the Patient Aligned Care Team (PACT). Within this model, an interprofessional team of providers not only focuses on treatment of medical condi-

tions but also addresses prevention and improvement of functional outcomes, thus providing proactive care consistent with patient goals. In this article, we describe the implementation of PACT, focusing specifically on the role played within these teams by mental health professionals.

Veterans enrolled in VA are now assigned to PACTs and receive interprofessional care. The core PACT consists of a primary care provider (PCP), a registered nurse (RN) care manager, a licensed practical nurse (LPN or similar “clinical associate”), and a clerk or “clerical associate.” These core teams are supported by an expanded team that includes clinical pharmacists, social workers, health psychologists, and mental health professionals to address mental illness (Primary Care–Mental Health Integration [PC-MHI] providers). Other members may include podiatrists, audiologists, and physical therapists. During transition to

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the PACT model, mental health has emerged as a critical service for veterans, and psychologists have been identified as key partners in primary care—not only as direct care providers but also as trainers/educators, program leaders, program evaluators, and researchers.

The Clinical Role of Psychologists and the Mental Health Team in PACT

History of VA Primary Care–Mental Health Integration

In 2007, the PC-MHI initiative began as a joint effort between primary care and mental health services (Post & van Stone, 2008; Zeiss & Karlin, 2008) to address common conditions in the primary care population, such as depression, anxiety and substance misuse. Funding proposals were solicited from VA facilities to implement evidence-based practices in PC-MHI into routine clinical care. Since the earliest studies of integrated care, this translation of research findings into implemented practice has been a critical concern (deGruy, 2006; Goldberg, 2002). VHA research had already shown that integrated care results in improved depression remission rates, decreased alcohol misuse, and increased adherence to antidepressant regimens in primary care (Oslin et al., 2003; Rubenstein et al., 2010). Others have demonstrated that having integrated mental health services available not only increases the likelihood of being seen by a mental health care clinician in primary care but also increases engagement and decreases no-show rates at specialty mental health services when needed (Zanjani, Miller, Turiano, Ross, & Oslin, 2008).

Integrating care reduces stigma for accessing mental health services (Chen et al., 2006). This is a critical goal for VHA: to assist veterans by making mental health services

a normal part of their primary care experience. While the request for PC-MHI funding proposals did not require specific disciplines, most submissions incorporated psychologists. Approximately two thirds of VA facilities successfully attained program funding, with these initial efforts focused on system leadership and primary care at the central medical center, rather than associated community-based outpatient clinics (CBOCs). Prior to initiative funding, models of mental health integration had emerged in VA through innovation projects, either as research or as performance improvement.

As a result of these efforts, mental health providers in many VA locations expanded their service as key clinical partners within primary care by providing both co-located collaborative care (CCC) and care management (CM; Oslin et al., 2003, 2006; Pomerantz, Cole, Watts, & Weeks, 2008; Pomerantz, Corson, & Detzer, 2009; Rubenstein et al., 2010). CCC embeds at least one mental health professional—a psychologist, psychiatrist, advanced practice nurse practitioner, and/or clinical social worker—in the primary care team, working collaboratively with PCPs to establish a shared treatment plan to address both general medical and mental health problems (Pomerantz et al., 2008, 2009). For example, a veteran who screens positive for depression requires further evaluation, which may be completed by the PCP or the co-located PC-MHI provider. The co-located provider will also work with the patient, using behavioral activation strategies, brief therapy interventions, problem-solving therapy, or other evidence-based approaches. If psychotropic medications are indicated and the veteran accepts, a PACT team member may offer to enroll the patient in telephone CM along with an initial prescription. The CM function is performed in many instances by RNs, usually by telephone. For example, a PACT team member calls the patient at prescribed intervals and follows an evidence-based CM protocol that includes medication monitoring, outcome assessment, behavioral activation, teaching cognitive behavioral skills for managing symptoms, and incorporating motivational interviewing strategies to assist with behavioral changes (Oslin et al., 2003, 2006; Rubenstein et al., 2010). CM includes ongoing case supervision by licensed independent providers and active involvement of PCPs when a treatment change (e.g., titration of an antidepressant) is indicated.

Newly funded PC-MHI programs were established as either CCC, CM, or a unique blending of both programs. Shortly thereafter, a groundbreaking directive emerged related to the expansion of mental health services across VA: the Uniform Mental Health Services Handbook (VHA, 2008). This handbook defined expectations for mental health services at all VA sites and recognized a crucial concept—namely, that appropriate care requires a full continuum of mental health services from the earliest intervention stages in primary care to the most intensive mental health programs provided in residential rehabilitation and inpatient units. As a result of this policy, larger VA primary care settings were now required to have a program that incorporated the expertise of CCC providers along with the longitudinal, registry-based monitoring afforded through



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CM (Post, Metzger, Dumas, & Lehmann, 2010). An additional round of initiative funding allowed for expansion of integrated care to all VA health care systems, and subsequently funding was incorporated directly into the VA capitation system.

To date, PC-MHI in VA is the largest effort of its kind ever undertaken. Since late 2007 when program tracking began, PC-MHI programs have collectively recorded more than 2.2 million veteran encounters, and during Fiscal Year 2012 they provided care to 5.9% of all VA primary care patients (see Figure 1). Psychologists in these settings provide same-day care for veterans that includes screening and evaluation for mental health concerns; treatment of mild to moderate depression, anxiety, and substance misuse; as well as behavioral interventions for medical disorders. Aggregate staffing data demonstrate that, as of November 2011, 345 psychologists contribute 269 full-time equivalents (FTEs) to the program, out of a total PC-MHI clinical staff of 1,469 clinicians and 950 FTEs.

Introducing the Patient-Centered Medical Home in VHA

In 2010, transformation of VA primary care into PACT teams emerged as a top VA priority. One critical component of the PACT initiative is addressing both mental illness and health behaviors as an integral part of primary care. Primary care has traditionally served as the de facto mental health care system, yet has done so largely without access to mental health expertise (deGruy, 1996; Regier et al., 1993). Teams integrating mental health in primary care were established prior to the PACT initiative, thus laying a strong foundation for collaboration in improving evidence-based treatment practices for most common mental disorders. Integrated mental health providers assisted with con-

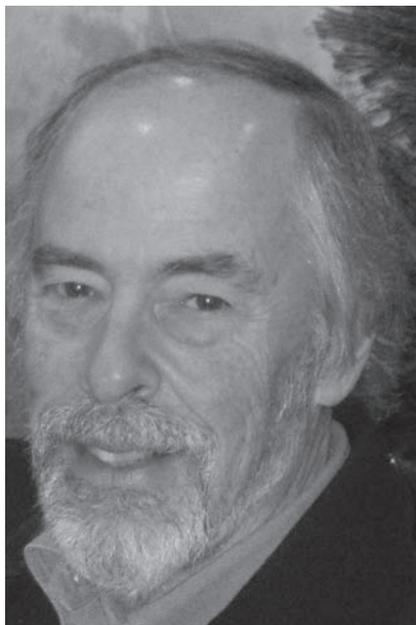
ceptualization and development of a stepped-model of care, wherein mild to moderate severity mental health disorders are managed within PACT, thereby conserving more intensive specialty mental health services for those in need of complex treatment. This approach is consistent with consensus screening recommendations in primary care, wherein PCPs require expertise in the practice to be both comfortable and effective in identifying, treating and following up on mental health disorders (U.S. Preventive Services Task Force, 2009). Prior to this collaboration, PCPs may have referred directly to specialty mental health whenever the smallest concern arose, adding to the burden of mental health clinics. These delays between referral and an initial appointment date have been demonstrated to decrease referral attendance and limit treatment engagement, leaving uncomplicated mental disorders untreated (Zanjani et al., 2008). Now, veterans work closely with mental health providers in primary care, and this has demystified mental health treatment for many. In addition, health behavior change interventions for medical disorders have become a common role for integrated care providers. Thus, VA's experience with mental health integration in primary care has demonstrated how specialist expertise can be seamlessly integrated (Leykum et al., 2007; Nutting et al., 2009), and the medical home is realized as integrated care providers begin viewing themselves as much a part of primary care as of mental health.

The success of mental health integration also played a role in the Department's decision to hire a health behavior coordinator (HBC) at each VA health care system, as part of the Health Promotion and Disease Prevention Program. HBCs, a great majority of whom are health psychologists, add a dedicated programmatic focus to health behaviors that is complementary to the principal focus of PC-MHI on treatment of mental disorders. HBCs provide assistance by helping PACT team members apply clinical interventions for health promotion and disease prevention, and thus extending the reach of mental health integration in improving management of chronic health conditions (e.g., Buysse et al., 2011; Cully et al., 2010; Lamers, Jonkers, Bosma, Knottnerus, & van Eijk, 2011). Examples include development of shared group medical appointments; motivational interviewing with veterans; and applying brief counseling to effect improvements for behaviorally sensitive conditions, such as hypertension, diabetes, and nicotine dependence. They also co-lead the Health Promotion Disease Prevention hospital-wide committee to help coordinate broader interventions across the system.

The Emerging Role of Psychologists in Integrated Care

A key factor in the expansion of these integrated services is the role of psychologists as part of the interprofessional primary care team. One key finding from early implementation relates to the relative comfort and facility of different mental health disciplines with both CCC and CM functions. Integrating mental health and primary care has proven to be a large paradigm shift for the current generation of mental health clinicians not previously exposed to

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these evidence-based models of care. It requires a shift to population-based care, tending proactively to the needs of a cohort of primary care patients, rather than just a caseload of patients who have been referred and then present for psychological care (McDaniel, Belar, Schroeder, Hargrove, & Freeman, 2002). Notably, many psychologists and in particular health psychologists have adapted readily in VA to the fast-paced environment of the primary-care setting. Here, the focus is on the patient's goals and providing rapid interventions related to immediate concerns: This is the strength of having psychology involved in medical homes (McDaniel & Fogarty, 2009). The familiarity of health psychologists with diverse treatment settings greatly assists their transition to PACT care (McDaniel & Fogarty, 2009; McDaniel, Hargrove, Belar, Schroeder, & Freeman, 2004).

While psychologists, social workers, and therapists are central to integration within VA primary care settings, psychiatrists and advanced practice psychiatric nurses also play unique roles on most VA integrated care teams. They complete the biological portion of the biopsychosocial assessment and, in providing this assessment, support and enhance the entire team's ability to care for veterans' mental illnesses. They also provide direct care for those whose problems are more complex but remain manageable within primary care, as well as those who decline or are in transition to specialty mental health care. Psychiatrists assist PCPs in selecting psychopharmacological interventions, either at the outset of treatment or in treatment-resistant cases. PCPs are generally willing to treat more complex and severe psychiatric conditions if specialty expertise is immediately available. Psychiatrists also play a key role in ruling out general medical conditions, as behavioral and psychological symptoms can make detection of such illnesses difficult for the PCP.

Together, integrated mental and behavioral health providers manage diverse care needs of the primary care population, with psychology collaborating with all inter-professional PACT members. Interventions focus on functional assessments and brief, problem-focused treatments transformed to fit the pace of primary care (Pomerantz et al., 2009). Most programs use open or advanced access scheduling to ensure patients can receive assessment and care at the same time, or at least on the same day as the primary care appointment. This service may reduce stigma and help enhance access for veterans seeking mental health services by providing nearly immediate service within a nonmental health setting.

One psychologist provider relays her experience in PACT teams as follows:

Being the PC-MHI part of the PACT team has been a rewarding and challenging position. We are able to assimilate into the primary-care culture and be part of the natural flow of health care. When risk assessments are needed and/or emotionally labile patients are in the primary-care-clinic setting, the PC-MHI staff is there on hand to help address and assess the situations via warm-handoffs. It also allows immediate access for patient-centered care to take place, meeting the veteran where they are (literally) and how they need their needs met without waiting for consults, scheduling phone calls, or future appointments. This reduces stigma felt by the veterans and allows learning opportunities between disciplines on a daily incremental basis with lasting results.

Transforming Primary Care: Training and Education Roles

Putting Veterans First: Changing the Model

Psychologists in PACT serve not only as clinical providers but they also serve in critical roles as facilitators, educators, and change experts. The changes necessary to adopt the medical home model cannot be brought about by mandate or funding alone (Leykum et al., 2007; Nutting et al., 2009) but rather involve transformation in how providers and patients view, experience, and participate in health care. Shifting from a single provider-patient-diagnosis paradigm to a team-based model of patient-centered care is foreign to many practicing clinicians. Accordingly, programs moving toward this model must address implementation challenges at various levels, helping providers adopt a patient-centered care model where veterans drive care experiences by identifying their own personalized health goals. A critical part of this transformation is engaging veterans in voicing their own desires for treatment, with attention placed on veterans' values, preferences, and selections for care in the development of a personalized health plan, a core component for recovery-oriented treatment (VHA, 2008). In integrated care settings, this involves moving from a provider-driven interview to a functional based assessment.

The primary care setting is a complex system with a relationship infrastructure among all core and expanded members of PACT teams. This relationship infrastructure is critically important to any change or transformation effort (Leykum et al., 2007). Much like a patient moves through stages of change in learning to manage his or her



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own newly diagnosed medical condition, teams and individual providers must move through their own development stages to fully implement the PACT model of care (Nutting et al., 2009). Psychologists play a crucial role in establishing these patient-centered models of primary care by collaborating with other health care providers in PACT teams, increasing patient engagement as a partner in their own care, and putting the “home” in the patient-centered medical home model (Holleman, Bray, Davis, & Holleman, 2004; McDaniel & Fogarty, 2009).

Veteran Engagement: Case Example 1

A 40-year-old female veteran presented to her PCP with concerns about decreased work productivity and feelings of difficulty focusing on tasks. She noted feeling increasingly stressed and wondered whether she might need stress management skills to assist with workplace performance. Her Patient Health Questionnaire–2 (PHQ-2; Kroenke, Spitzer, & Williams, 2003) screening was positive for depression, and the PCP engaged her in a discussion about treatment options, leading to a warm-handoff to the co-located psychologist, as she elected to have brief therapy for stress management and declined pharmacological interventions.

The primary care psychologist completed a brief functional assessment focused on stress concerns. The veteran’s Patient Health Questionnaire–9 (PHQ-9; Kroenke, Spitzer, & Williams, 2001) score fell in the mild range; however, the veteran noted she had times when she was severely depressed. She informed the psychologist that her mother and sister were both diagnosed with bipolar disorder, and she did not think she was “crazy” like them. Time was allotted in the session to discuss the veteran’s concerns, including her thoughts about diagnoses and fears related to being “labeled.” Motivational interviewing techniques

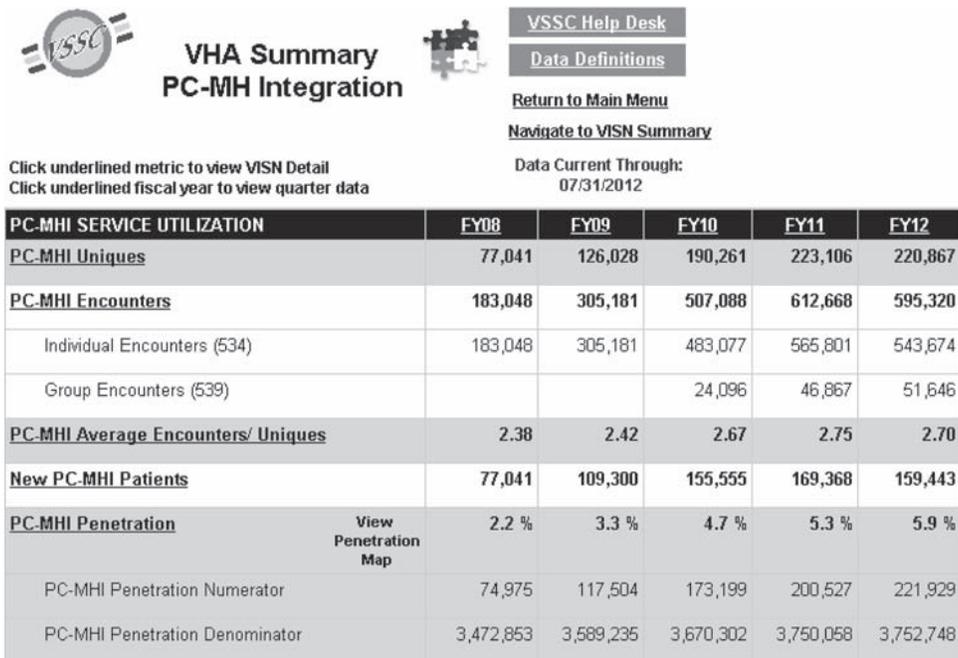
were employed to discuss the benefits and detriments of exploring diagnoses. This led to a collaborative decision to participate in a brief screening for bipolar disorder, the Mood Disorder Questionnaire (Hirschfeld, 2002), and results indicated that a bipolar disorder diagnosis should be considered. However, the veteran voiced concern about being labeled with such a diagnosis, and she declined to pursue this further, which the psychologist respected. The veteran subsequently engaged in three biweekly sessions of treatment utilizing stress reduction and behavioral activation strategies, relaxation training, and brief cognitive behavioral treatment, leading to improvement in stress levels and PHQ-9 scores. Despite this improvement, the veteran continued to complain of concentration difficulties, difficulty sleeping but not feeling tired, feeling extremely hyperactive and energetic without being able to accomplish much, and other symptoms possibly indicative of bipolar disorder. When the psychologist pointed this out to her, she agreed to read some introductory psychoeducational materials on the topic. The psychologist met again with the PCP to discuss progress as well as possibilities for treatment and methods of supporting the veteran’s choices in care.

At the next appointment, the veteran reported willingness to discuss her symptoms further after reflecting on her own progress, indicating that while she felt less “stressed,” she was not gaining the productivity she wanted at work. With a more thorough interview, the psychologist discussed with the veteran the likely diagnosis of bipolar disorder and evidence-based treatments for the disorder, including medication. Motivational interviewing techniques were employed to review her concerns about treatment. The veteran agreed to an introduction to the psychologist’s colleague in specialty mental health who subsequently met with them, discussed options for care, and answered the veteran’s questions. In doing so, the psychiatrist normalized the treatment while simultaneously supporting the veteran in her quest for more information. The psychologist and psychiatrist collaborated with the PCP after the appointment to discuss methods of continuing to support the veteran as she dealt with her own concerns about seeking treatment in a specialty clinic. Through two more sessions of therapy with the psychologist, she was able to build her comfort as she initiated treatment with the psychiatrist at the same time. After these two sessions, the veteran reported she felt at ease transferring care to her new provider and expressed appreciation for the initial work in primary care. Six months later, she returned to primary care, reporting significant improvements in productivity and overall mood. The PCP reported to the integrated psychologist about this progress, who offered continued support if future needs arose for the veteran’s care.

This case example illustrates the need to work with patient preferences for care. Had she been immediately referred to specialty mental health without the veteran accepting this choice, the veteran likely would not have engaged in specialty mental health treatment. Prior research has shown that referrals after engagement in brief integrated care double the likelihood of engagement in

Figure 1

Webpage From the Veterans Health Administration (VHA) Primary Care–Mental Health Integration (PC-MHI) Dashboard



Note. "Uniques" refers to the number of individual veterans seen in the integrated care setting. Data presented for Fiscal Year (FY) 12 still has two months remaining in the year. VSSC = VHA Support Service Center; VISN = Veterans Integrated Service Network.

specialty mental health treatment (Zanjani et al., 2008). By working with the veteran's initial goals and having her see the progress as well as lack of progress in some areas, the interprofessional care team supported her as she concluded that further education and treatment may be needed. In order to do this, the providers had to be comfortable with allowing the veteran to lead the treatment.

Ideally in the above scenario, psychiatry also would be co-located in primary care and the veteran would have been fully managed within the primary care clinic, an ideal method of meeting the full preferences of the patient without having to refer to specialty mental health. VA is moving toward having more integrated psychiatrists; the case that follows below illustrates how having both psychology and psychiatry co-located together in primary care provides an ideal situation for a richer, interprofessional model of care.

Veteran Engagement: Case Example 2

A 55-year-old veteran with a history of multiple sclerosis and hypertension reported increasing difficulty with his mood and feeling overwhelmed with many ongoing obligations at home. He reported three weeks of depression, a mounting stack of unpaid bills, concerns about his daughter's social life, and worries about his wife's increasing irritation with him. He screened positive for depression and

posttraumatic stress disorder (PTSD) with the primary care team and told his provider, "I don't know if I can take any more."

The PCP asked the veteran about his willingness to learn about potential options to help with these symptoms, and the veteran agreed to be seen by another member of the PACT team with expertise in this area. The PCP provided a warm-handoff to the psychologist across the hall after discussing briefly the veteran's concerns about his family and his increasing depression symptoms. Further evaluation of the veteran identified that depression symptoms were the primary concern while the PTSD diagnosis was ruled out. The psychologist suggested he could be of help in "sorting out all those problems you are dealing with," with a focus on problem-solving therapy. However, the psychologist wished to clarify the contribution of multiple sclerosis to the depression and reviewed the biological aspects of the case with the integrated care psychiatrist, who then met with the patient for further assessment. The psychiatrist confirmed the presence of the diagnostic criteria for major depressive disorder but perceived the symptoms could be caused by or worsened by medications he was taking for hypertension. The psychologist provided a brief course of problem-solving therapy while the psychiatrist discussed the link between multiple sclerosis and antihypertensive medications in patients with depression

during the next PACT teamlet huddle, which included the PCP, psychologist, and nurse. A joint decision with the PCP was made to adjust the medications noted to be potentially exacerbating the depressive symptoms. After the problem-solving therapy and a change in medications, most of the depressive symptoms resolved, and active treatment with the co-located mental health providers concluded. Since then, the PCP continues to screen for depressive symptoms and reviews the case in team meetings from time to time.

In the absence of an integrated care program, this patient would likely have been referred directly to a specialized PTSD program. This would not only have delayed the patient's receipt of appropriate care but would also have consumed scarce subspecialty resources and potentially risked the loss of the patient to care if he did not attend this follow-up appointment (Zanjani et al., 2008).

Putting Veterans First: Transformation Through Education and Training

When the VA took on the large task of transformation to interprofessional care, health care leadership realized that a large educational initiative would be required to guide and support change at all levels of care. On a national level, PACT implementation traces its roots to an educational conference attended by over 3,000 clinicians and administrators in Spring 2010. Under the guidance of the VA Office of Systems Redesign, a subsequent series of six meetings within five distinct regions of the country (regional learning collaboratives) were held, concluding in January 2012. The serial meetings were designed to train an interprofessional team from each VA health care system, including psychologists and other mental health providers, in primary care transformation.

The first four collaboratives catalyzed development of the core PACT structure, including role differentiation of providers, administrative requirements, and other general operational and design elements of the new practice model. Each of the PACT providers, including the integrated care team members, is expected to function at the top of his or her license or skill set. For example, a variety of tasks previously performed by the PCP can be effectively and appropriately accomplished by RNs. Likewise, many traditional RN tasks can be performed by LPNs or health technicians, and psychologists and psychiatrists can collaborate more closely with master's level clinicians to most efficiently utilize each team member's unique skills. The clerical role is also expanded, to assume tasks that do not require professional or clinical expertise. Anecdotally, these new roles have led many staff to report a new sense of meaning in their work. For example, when the housekeeping staff begins to view their work as critical interventions in infection control, their own sense of purpose is enhanced. The fifth collaborative session focused on the role of the expanded PACT team that includes integrated mental health services, HBCs, and health promotion/disease prevention program managers. The sixth and final collaborative was devoted to developing the relationship between PACTs and medical specialties and subspecialties,

including specialty mental health care. Workshops and plenary sessions addressed the role of integration of mental health services, specifically both the mental health component of the primary care team as well as the critical link between primary care and specialty mental health programs. These learning collaboratives have been followed by smaller regional learning initiatives to continue the transformation and extend formal training and coaching to additional staff.

In addition to training primary care teams in the PACT model of care, VA has demonstrated commitment to the education and training of mental health and PCPs and leaders in the delivery and implementation of integrated services. The PC-MHI Office, comprised of individuals from both primary care and mental health, along with VA's Center for Integrated Healthcare (CIH), have partnered with experts nationwide in providing local, regional, and national trainings on integrated care services over the past five years. Psychologists have played key roles in teaching brief interventions in primary care settings and have provided subject matter expertise in the cultural transformation of primary care settings. Large national trainings are now being replaced by other virtual and in-person training modalities to refine further local program development and clinical skill training, including expanded utilization of personalized facilitation models, technical assistance, SharePoint resources, and video teleconference training. Psychologists are playing key roles on work groups assisting with the development of these new modalities.

Formal education efforts, while necessary, will not be sufficient in producing long-term cultural shifts in care at the point of service delivery. Specifically, HBCs have been providing ongoing, hands-on training at the local level for PACT staff, helping them to learn the principles of motivational interviewing and communication enhancement skills, both with patients and within the team. In addition, mental health providers are regularly serving on local PACT transformation teams to assist with the strategic planning necessary to help move facilities forward with the necessary systems-level processes that will accomplish the overall goals of PACT transformation. Additionally, psychologists aid PACT teams in moving through their own developmental stages to implement fully the spirit of the patient-centered medical home (Nutting et al., 2009). Psychologists, sensitive to the nuances of change both individually and organizationally, have proven to be of assistance in helping teams to continue moving forward in adopting the PACT model.

PACT/PC-MHI Research and Program Evaluation: Contributions by Mental Health

While VA embraces the application of patient-centered medical home principles on a large scale, evaluating this transformative process remains essential—to not only assess whether and how its efforts make meaningful change but also to provide feedback on altering pathways when necessary during the implementation process to improve

outcomes. Psychologists play critical roles alongside their colleagues in both program evaluation and research efforts related to this initiative. VA is a complex, yet coordinated, system with systematized measurement in place, and it is therefore able to perform many program evaluation tasks from national databases. Additionally, it has two different offices dedicated to program evaluation and research focused on integrated mental health care: the PC-MHI Evaluation Office and the CIH.

Dashboard Utilization for Program Evaluation

Prior to the rollout of the PACT initiative, the Office of Primary Care Services created an extensive database, named the “PACT Compass,” to assist with the evaluation of PACT implementation efforts. The Compass, available from any workstation or computer connected to the secure VA intranet, combines a series of administrative and clinical metrics from a variety of sources to provide data on a national, regional, and individual facility basis. These metrics reflect the many dimensions and core principles of PACT. The Compass is continually updated and presents data on many programmatic outcomes, such as enrollment, use of telemedicine, home-based care, emergency room visits, hospitalizations, panel management, timely scheduling, utilization of group medical appointments, and secure messaging. Used by local or regional management, the Compass assists in monitoring program operations and outcomes locally as well as in benchmarking against other programs or regions.

In addition to general PACT measurement, VA has created a PC-MHI Dashboard, whose purpose is to evaluate integrated mental health care implementation by tracking staffing, compliance with key program components, service utilization, diagnostic data, and performance measure outcomes at the national, regional, and local level. Through use of this Dashboard, one can quickly assess an individual program by reviewing information as to whether a program is present, and if so, whether it has both of the required components: CM and CCC. With respect to staffing levels, the Dashboard reflects the number of staff (by discipline) dedicated to integrated mental health care in PACTs across the nation, with the capability of drilling down to the local facility level. Service utilization data assess the number of veterans served in a given time period, the number of appointments utilized by each veteran, the number of new veterans seen in a program, and the “penetration rate”—which is the number of veterans served by PC-MHI staff in primary care, compared to the overall number of veterans in primary care in a given setting. Figure 1 demonstrates the overall look of the Dashboard by displaying a webpage with the aforementioned service utilization data (in the aggregate) since the advent of formal tracking of the PC-MHI program. Diagnostic data reveal the mix of mental disorders seen in this setting, grouped by the major diagnostic categories of depression, anxiety, alcohol misuse, and PTSD. Finally, the PC-MHI Dashboard reports data on performance metrics specifically related to completion of required mental health screening (depression, PTSD, and

alcohol misuse) as well as initial follow-up processes after a positive assessment on any of these screenings. In addition to this PC-MHI Dashboard, VHA’s Office of Mental Health Operations (OMHO) has created the Mental Health Information System, which reflects the full continuum of mental health services mentioned previously; it includes a component related to integrated care, and the system is presently being disseminated for use. At this time, a direct linkage between the PC-MHI Dashboard, the PACT Compass, and the OMHO Mental Health Information System remains an aspirational goal.

Program Evaluation and Research Centers

The National PC-MHI Evaluation Office has the responsibility of evaluating the extent of mental health integration across the VHA, with particular attention paid to the extent and the quality of integrated care services, as evidenced by access, engagement, and outcomes. On a yearly basis, the Evaluation Center undertakes a large national survey of VA integrated mental health programs, involving more than 300 VA medical centers and larger community-based outpatient clinics. The survey focuses not only upon the characteristics of the program (e.g., staffing) but also diagnostic categories of veterans seen in the program, referral and engagement practices, types of clinical services provided, assessment tools utilized, compliance with CM and CCC standards, quality improvement practices, training involvement, program policies, barriers and facilitators of integrated care, and impact of integrated care.

Several publications from the early implementation experience of PC-MHI have come forth from the PC-MHI Evaluation Office’s efforts, many in collaboration with psychologists (Pfeiffer et al., 2011; Wray, Szymanski, Kearney, & McCarthy, 2012; Zivin et al., 2010). Findings suggest that, on a national level, integrated care has not yet significantly reduced specialty mental health care services (Pfeiffer et al., 2011); however, patients who received integrated care services were significantly more likely to stay engaged in specialty mental health treatment when referred, compared to those who did not receive integrated care services (Wray et al., 2012). This finding suggests that much of the time previously wasted by no-shows and patients who left treatment after only one session is now available to enhance specialty care services.

The CIH was established in 2004 as a VHA Center of Excellence whose mission is to improve veterans’ health care by enhancing integrated care services through clinical, education, and research activities. Research from CIH has focused on the description of behavioral health problems in primary care, effectiveness of integrated care interventions, and the identification of key processes involved in optimal integrated care practices. These efforts have culminated in a number of publications, which have expounded upon such critical areas as the content of brief interventions in integrated care (Funderburk et al., 2011); perceptions of integrated care by PCPs, patients, and integrated care staff (Funderburk et al., 2010); the critical importance of addressing multiple risk factors in the primary care setting (Funderburk, Maisto, Sugarman, & Wade, 2008); and the

treatment of PTSD in primary care settings (Possemato et al., 2011). Chart reviews from primary care settings with integrated care found the most common interventions utilized were pharmacological intervention, psycho-education, supportive psychotherapy, and cognitive-behavioral therapy interventions (Funderburk et al., 2011). A review of PTSD treatment in primary care found that the majority of veterans (69%) were treated in specialty mental health for PTSD, followed by treatment with integrated care providers (19%), and finally treatment solely by their PCPs (12%; Possemato et al., 2011).

Conclusion

VA has emerged as a leader in the transformation of primary care clinics into truly patient-centered medical homes. VA also recognizes that providing the resources for implementation is necessary but not sufficient. Rather, the engagement of each individual involved in the transformation remains a critical element. At the core of this engagement is the contribution of mental health providers. In particular, psychologists are proving invaluable not only in demonstrating leadership by example in their clinical practices within primary care but also in adding value by assisting PACT teams in the difficult and systematic change process that begins with a paradigm shift of how staff view and provide care to our nation's veterans. Enabling the veteran to be the centerpiece, empowered to steer the course of his or her integrated care, is the essential element upon which all other aspects of primary care transformation must be built. When this goal is achieved through the contributions of psychologists in primary care (McDaniel & Fogarty, 2009), the veteran will truly feel at "home" in PACT, the implementation of the patient-centered medical home model in VA.

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