

# Report on Integrating Mental Health Into PACT (IMHIP) in the VA

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## IMHIP Committee Chair

Lisa Rubenstein, MD, MSPH

*Director, QUERI Center for Implementation Practice and Research  
Co-Director, VA Greater Los Angeles HSR&D Center of Innovation  
Mental Health QUERI PCMH Workgroup*

## IMHIP Committee

Edmund Chaney, PhD

*Puget Sound VAMC  
Mental Health QUERI PCMH Workgroup*

Lisa Kearney, PhD, ABPP

*Senior Consultant for Technical Assistance,  
Office of Mental Health Operations  
Mental Health QUERI PCMH Workgroup*

JoAnn Kirchner, MD

*Director, VA Mental Health QUERI  
Mental Health QUERI PCMH Workgroup*

Praveen Mehta, MD, MBA

*Chief Medical Officer, VISN 12*

Maureen Metzger, PhD

*Program Manager, Primary Care –  
Mental Health Integration*

David Oslin, MD

*Director, VISN 4 MIRECC  
Chief of Behavioral Health, Philadelphia VAMC  
Mental Health QUERI PCMH Workgroup*

Andrew Pomerantz, MD

*National Mental Health Director, Integrated Services,  
Mental Health Services  
Mental Health QUERI PCMH Workgroup*

Edward Post, MD, PhD

*National Primary Care Director, Primary Care –  
Mental Health Integration  
Mental Health QUERI PCMH Workgroup*

Mona Ritchie, PhD(c), MSW

*Co-Implementation Research Coordinator, VA Mental Health QUERI  
Mental Health QUERI PCMH Workgroup*

Gordon Schectman, MD

*Chief Consultant, Office of Primary Care Services*

## Prepared by

Evelyn Chang, MD, MSHS

*VA HSR&D Greater Los Angeles Center of Innovation*

Alissa Simon

*VA HSR&D Greater Los Angeles Center of Innovation*



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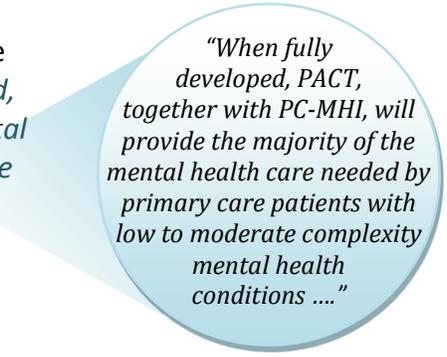
# EXECUTIVE SUMMARY

## **Mission Statement for the Primary Care-Mental Health Integration Initiative**

“To provide high quality, collaborative mental and behavioral health care to improve the health of both individual Veterans and the Veteran population as a whole.”<sup>1</sup>

## **Vision Statement**

The VA Primary Care-Mental Health Integration (PC-MHI) initiative aims to achieve seamless integration between mental health care provided through VA’s Patient Aligned Care Teams (PACT) and care provided through the full spectrum of VA Mental Health Services. *When fully developed, PACT, together with PC-MHI, will provide the majority of the mental health care needed by primary care patients with low-to-moderate complexity mental health conditions that have been shown to respond to brief, evidence-based interventions.* PC-MHI care for these conditions will be measurement based, proactive, and guideline concordant. For primary care patients with higher-complexity mental health conditions or those needing specialized resources, PC-MHI will link to the appropriate additional mental health services. Thus, PC-MHI will ensure high quality, accessible mental health care that meets the needs and preferences of all primary care patients with mental health concerns.



*“When fully developed, PACT, together with PC-MHI, will provide the majority of the mental health care needed by primary care patients with low to moderate complexity mental health conditions ....”*

To achieve its aims, the PC-MHI initiative provides integrated psychiatrists, psychologists, social workers and mental health trained care managers. These PC-MHI staff members work as an integral part of PACT, under the joint leadership of PACT and Mental Health Specialty at both local healthcare system (medical center) and division levels. As such, PC-MHI staff members work closely with, for example, PACT providers, generalist nurse care managers, pharmacists, social workers, coaches and other PACT team members. In addition, PC-MHI staff coordinates closely with the full range of non-PC-MHI Mental Health Specialty services, including psychiatry, psychology, chemical dependency, vocational rehabilitation and others, to meet the needs of patients requiring long term or specialized treatments.

PC-MHI staffing is guided by national standards. Within these standards, exact PC-MHI staffing patterns at individual sites will vary. For example generalist nurse care managers may be integrated into PC-MHI care, sites may engage specially trained care managers working at a distance, and collocated mental health providers themselves may provide measurement-based care and proactive follow-up. Clerical and nursing support for PC-MHI providers may be provided by primary care or by Mental Health Specialty. While collocation can facilitate integration, achieving PC-MHI aims require a level of collaboration that goes beyond and may be achieved without side-by-side practice. Whatever the exact configuration of staff, the result must be that each Veteran receives appropriate mental health care.

*“Target conditions for PC-MHI quality improvement are depression, anxiety, and alcohol misuse.”*

PC-MHI has a leadership role at each VA primary care site in improving the quality of care for primary care patients with mental health disorders. *Target conditions for PC-MHI quality improvement are depression, anxiety, and alcohol misuse.* The PC-MHI leadership role for these conditions includes: 1) assuring Veteran access to appropriate primary care-based, guideline-concordant treatment; 2) monitoring PACT and PC-MHI performance on relevant quality measures; and 3) training and supervision of PACT providers and

care managers in appropriate approaches to caring for the target conditions. *The PC-MHI leadership role also includes collaborating with primary care and other specialists to support primary care management of stress, sleep disorders, pain, obesity, tobacco use and other behaviorally-sensitive problems that impact health and wellness.*

*“The PC-MHI leadership role also includes collaborating with [others] ... to support primary care management of stress, sleep disorders, pain, obesity, tobacco use and other behaviorally-sensitive problems that impact health and wellness.”*

With education and support from PC-MHI, PACT primary care providers will be able to increasingly provide appropriate basic evidence-based interventions for the three target mental health disorders. The range of mental disorders treated in PACT can be expected to grow as new evidence supporting brief interventions emerges.

To ensure achievement of high quality mental health care in PACT, *the PC-MHI initiative is anchored at each local primary care site (division-level) by a lead integrated mental health specialist and a lead primary care provider, and is jointly supported by Mental Health and PACT resources.* These resources are designed to be appropriate for the size of the primary care population and the range of treatments that guidelines indicate should be available for the target conditions, including, for example, primary care based group psychotherapies and support for appropriate medication treatment by PACT providers.

*“The PC-MHI initiative is anchored at each local primary care site (division-level) by a lead integrated mental health specialist and a lead primary care provider, and is jointly supported by Mental Health and PACT resources.”*

## **Rationale for the PC-MHI Initiative**

First, as an integrated interdisciplinary program that provides each Veteran with comprehensive, accessible, high quality primary care through a single primary care continuity provider and his or her teamlet, PACT aims to promote emotional and mental well-being. Yet the quality of mental health care provided to the population of patients with mental health symptoms is lower than that of medical care provided to the population of patients with, for example, diabetes or heart disease.<sup>2</sup> About a quarter or more of VA primary care patients have mental health symptoms at a level consistent with a mental health diagnosis at any given point in time.<sup>3, 4, 5</sup> While nearly two-thirds of these symptomatic patients have received some mental health specialty care, the proportion of these Veterans who have received care at a level consistent with minimal guidelines for their mental health conditions is much lower.<sup>6, 7</sup> This is particularly true for alcohol misuse.<sup>8, 9</sup>

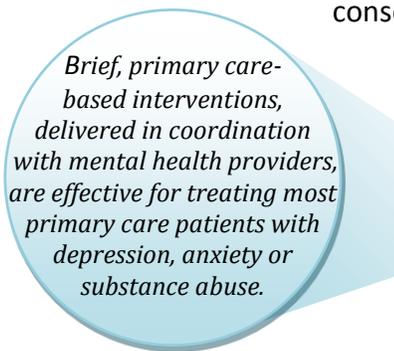
These gaps have remained, despite substantial VA work on bridging them. Such efforts include the PRISM-E project;<sup>10</sup> the collocated collaborative care model pioneered by the White River Junction (WRJ) VA;<sup>11</sup> the Behavioral Health Laboratory (BHL);<sup>12</sup> and the evidence-based quality improvement projects including the Translating Initiatives in Depression into Effective Solutions, or TIDES.<sup>13</sup> Each of

these projects contributed to the knowledge base underlying the 2008 VA mandate<sup>14</sup> to provide collocated collaborative care (the White River Junction model); or measurement-based assessment and care management using the Behavioral Health Lab (BHL) or TIDES approaches. By 2009, 47.5% of sites reported using collocation, 7.6% reported using BHL, and 17.3% reported using TIDES.<sup>15</sup> While the 2008 mandate resulted in substantially greater interactions between mental health specialists and primary care, evidence suggests that, of these approaches, sites found collocation of mental health specialists in primary care alone the easiest to accomplish. There is little evidence that collocation alone is effective, without the accompanying use of chronic disease management strategies, such as validated measurement tools, proactive care management, collaboration on jointly managed cases, and use of effective primary care-based short term therapies, including those delivered by telephone. On the other hand, widespread collocation can provide a strong basis for advancing PC-MHI, as suggested in this document.

The prior work on BHL, TIDES, and collocated collaborative care at White River Junction provide the basis for blended approaches that are adapted to local settings and designed to achieve high quality, high value mental health care for veterans in primary care.

Second, primary care-based treatments can prevent consequences of low-to-moderate level depression, anxiety, and alcohol misuse. These three conditions account for the large majority of mental health diagnoses in primary care, and treating these conditions in primary care improves outcomes. Research shows, for example, that primary care-based treatment of low-to-moderate complexity primary care patients with these disorders can minimize or prevent longer term

consequences such as job loss, marital stress, homelessness, medical hospitalizations, and even death.<sup>16-18</sup> Depression and alcohol misuse, in particular, are associated with poor medical illness outcomes such as emergency care and hospitalization for common chronic diseases such as diabetes or heart disease.<sup>19</sup> *Brief, primary care-based interventions, delivered in coordination with mental health providers, are effective for treating most primary care patients with depression, anxiety or alcohol misuse.*<sup>20-22</sup> If treatment is not provided in early stages, unnecessary suffering can occur, and both the mental and physical health care for these patients becomes complex and difficult.



*Brief, primary care-based interventions, delivered in coordination with mental health providers, are effective for treating most primary care patients with depression, anxiety or substance abuse.*

Third, detection of patients with mental health concerns is typically best achieved through primary care. Depression, anxiety and alcohol misuse are chronic or relapsing conditions that are likely to be most efficiently and effectively detected and monitored by a primary care continuity provider who already sees the patient typically two to six times a year for medical issues. It is for this reason that Veterans are screened yearly for depression and alcohol misuse in primary care. Subsequent attention to detected patients with target mental health conditions in primary care, however, requires enhanced access to integrated mental health resources for ensuring appropriate assessment and treatment of patients who screen positive.

Fourth, treating mental health conditions in the primary care setting can preserve access to more intensive mental health care for Veterans who need it. With PC-MHI support, PACT teams can deliver mental health care for uncomplicated mental health disorders, particularly for the three target conditions.

Fifth, primary care providers already provide a majority of psychoactive medications prescribed to Veterans. Yet evidence suggests that without PC-MHI education and support, primary care usage of

these medications is often not guideline-concordant.<sup>7,23</sup> Veterans may thus not be garnering maximum benefit from the use of these medications. PC-MHI can improve evidence-based psychoactive medication use in primary care particularly for its three target conditions.

Sixth, extensive literature exists for improving care for primary care patients with mental health conditions, such as with depression,<sup>21</sup> anxiety,<sup>24</sup> and alcohol misuse.<sup>25</sup> These evidence-based models should form the foundation for designing care pathways and flow.

## Core Recommendations for Enhancing PC-MHI

### Summary

- 1) Each VA facility appoints division-level (primary care site) PC-MHI leaders (one from PACT, one from Mental Health) to jointly manage the initiative at their site by FY 2014. These individuals should have sufficient authority, support from higher levels of leadership, and appropriate dedicated time to accomplish their leadership roles.
- 2) The PC-MHI initiative shows evidence of ongoing monitoring of PC-MHI goals and problems locally and nationally by 2015. This will require a national gap analysis and national implementation of quality measures for target PC-MHI conditions.
- 3) PC-MHI leaders, in collaboration with PACT and Mental Health, *design care pathways and flow* for target mental health conditions into a seamless, flexible, and patient-centered approach using stepped-care principles, by 2015.
- 4) Local Mental Health Specialty, PACT and PC-MHI sign and review/update regularly, *inter-service collaboration agreements* specifying a) what services will be provided for mental health conditions in primary care, b) what staff will be allocated to PC-MHI for how much time to provide these services, c) which mental health conditions will be primarily managed in PACT/PC-MHI and which in Mental Health Specialty, by FY 2014.
- 5) *Standardized electronic tools for providing symptom measure based care* for depression, alcohol misuse, and anxiety and for monitoring local PC-MHI program quality and productivity are in place by FY 2015 (depression and alcohol) and by 2016 (anxiety).
- 6) National Mental Health Specialty and Primary Care leadership develop *appropriate training for both integrated mental health staff and for PACT providers and team members*, with particular emphasis on incorporating *alcohol misuse* into curricula, by 2015. Local PC-MHI leaders systematically ensure appropriate training for site PACT providers and care managers through national programs and engage in supportive educational activities.

## Complete Core Recommendations

Based on our assessment of the current PC-MHI program, its accomplishments, and its challenges, we recommend that the following concrete, timely steps for promotion of the PC-MHI mission and vision be achieved:

1. Each VA facility appoints *division-level (primary care site) PC-MHI leaders* (one from PACT, one from Mental Health) to jointly manage the initiative at their site by FY 2014. These individuals should have sufficient authority, support from higher levels of leadership, and appropriate dedicated time to accomplish their leadership roles.
  - a. Facility and local (division -level) PACT and Mental Health leaders are jointly responsible for achieving PC-MHI goals through support for local PC-MHI leadership.
  - b. Each level of PACT and Mental Health leadership explicitly recognizes and supports the realignment of both PACT and Mental Health Services to support PC-MHI through an interdisciplinary, multi-level process for developing and implementing relevant agreements, policies and procedures (e.g., collaborative agreements).
2. The PC-MHI initiative shows evidence of ongoing monitoring of PC-MHI goals and problems locally and nationally by 2015. This will require a national gap analysis and national implementation of quality measures for target PC-MHI conditions.
  - a. Nationally, a formal gap analysis should assess the match between available resources and primary care patient needs using actual data and simulation of alternative care strategies (FY 2014).
  - b. Needs assessments should be undertaken regionally (VISN) and locally (healthcare system and primary care practice) as a necessary first step for PC-MHI improvement (FY 2014). The needs assessments should identify current local PC-MHI staffing, treatments offered, agreements in place, and organization.
  - c. National *quality measures* for depression (FY 2015), alcohol misuse (FY 2015), and anxiety disorders (FY 2016) should be developed and applied, consistent with evolving policy when available (i.e., Office of Mental Health Operations, Mental Health Services). These measures should address PC-MHI follow-up and monitoring of target conditions from detection through treatment completion for individual patients, based on routinely-collected PACT/PC-MHI clinical data.
  - d. National VA Clinical Practice Guidelines for anxiety disorders (FY 2015) are needed to support development of quality measures that address detection, treatment initiation and completion (FY 2016).
  - e. Local data on patterns of care (i.e., rates of screening, follow up from screening, treatment with brief intervention, specialty referral) for the population of Veterans screening positive for alcohol misuse should be used as the basis for regional and division-level PACT care redesign (FY 2014).
  - f. Locally, undertaking at least one data-driven quality improvement initiative annually, with appropriate dedicated time and resources, is a reasonable expectation. The quality improvement initiative should reflect local data on care for target PC-MHI conditions at individual primary care practices and should be directed at PC-MHI goals. Consideration

should be given to assessing disparities in mental health care for target conditions by race, gender, and rural/urban areas (FY 2014).

3. PC-MHI leaders, in collaboration with PACT and Mental Health Specialty, *design care pathways and flow* for target mental health conditions into a seamless, flexible, and patient-centered approach using stepped-care principles, by FY 2015. The design should:
  - a. Show awareness of and incorporate links to available PACT resources such as care managers, health coaches, social workers and classes (e.g., MOVE and smoking cessation).
  - b. Specifically incorporate support for patient self-management of common mental health symptoms and conditions through educational materials, sessions, or other modalities.
  - c. Facilitate communication and collaboration by ensuring PC-MHI staff attendance at PACT meetings as part of the PACT team.
  - d. Include timely and convenient access to mental health services according to patient preferences and clinical needs through telephone-based care and telemental health modalities, particularly in rural areas.
4. Local Mental Health Specialty, PACT and PC-MHI sign and review/update regularly, *inter-service collaboration agreements* specifying: a) what services will be provided for mental health conditions in primary care, b) what staff will be allocated to PC-MHI for how much time. c) which mental health conditions will be managed in PACT and Mental Health, by FY 2014.
  - a. Agreements between PC-MHI, mental health and PACT should encourage or assure availability of manualized short-term therapy, such as brief cognitive behavioral therapy and problem solving therapy, by PC-MHI or PACT staff in the primary care setting (FY 2015). Manualized therapies follow a written structure specifying patient and provider activities over a limited set of sessions.
  - b. Agreements should ensure that PC-MHI education and consultation supports psychopharmacologic prescribing by primary care providers as the primary prescriber, and the expectation that primary care providers take responsibility for prescribing psychiatric medications, when indicated, for their patients (FY 2014).
  - c. Agreements should ensure PC-MHI same-day availability for primary care patients with any mental health concern (FY 2014).
  - d. Agreements should facilitate inter-service PC-MHI staff performance review by PC-MHI, Mental Health, and PACT supervisors (FY 2015).
5. *Standardized electronic tools for providing symptom measure based care for depression, alcohol misuse, and anxiety and for monitoring local PC-MHI program quality and productivity are in place* by FY 2015 (depression and alcohol) and by 2016 (anxiety).
  - a. A systematic national information technology assessment, development and implementation effort is needed to identify or develop appropriate national tools, and to support tool dissemination to all sites (FY 2014).
  - b. Tools should use guideline-based templates to identify and proactively manage panels of patients over time (e.g., six months), and should store data and generate reports for quality monitoring (FY 2015).

- c. Tools should be based on enhancement of CPRS. CPRS alone, because of its kernel information storage structure, cannot support proactive panel management; the development of this capability across conditions should be a national priority (FY 2014). For example, currently, PC-MHI providers or care managers must track progress for over 100 patients at a time in different phases of treatment, based on serial measurements of clinical status. To carry out this tracking, registries are needed that identify the group of patients to be managed, what actions are due across these patients on any given date, and measured patient symptoms over time are needed. Unlike current VA CPRS-based registries, proactive panel management registries must include the ability to schedule future tasks. Such tools are currently available in VA through BHL (nationally approved external software), TIDES (CPRS and SharePoint based), or net DMS (approved external software). Each of these approaches currently has limited dissemination to individual sites
6. National Mental Health Specialty and Primary Care leadership implement appropriate training for both integrated mental health staff and for PACT providers and team members, with particular emphasis on incorporating alcohol misuse into curricula by FY 2015. Local PC-MHI leaders routinely and systematically ensure appropriate training for site PACT providers and care managers through national programs and engage in supportive educational activities by FY 2015.
    - a. National education and training activities should be designed to empower local PC-MHI education, training, and design (e.g., through train-the-trainer approaches, provision of and support for national tools for program design as well as for clinical care).
    - b. Local PC-MHI leaders should routinely carry out a variety of educational activities, such as case conferences, grand rounds, orientations for new staff or trainees, and informal discussions. These aim to improve the knowledge- base of site PACT providers and care managers on evidence-based guidelines, assessments, brief interventions, appropriate psychopharmacological care, and care management for target conditions. Education also focuses on knowledge of care pathways for appropriately accessing PC-MHI and Mental Health Specialty services.
    - c. Special attention in training should be given to alcohol misuse recognition and interventions. Targeted educational programs for clinicians and leaders concerning evidence-based alcohol interventions should be conducted throughout the VA by FY 2014.
    - d. Education/training should ensure PACT/PCMHI provider competence in and availability of materials and tools for patient self-management support for the three target conditions.
    - e. Education/training should ensure competence in and availability of materials and tools for operationalization of stepped care principles.

Some of the activities recommended above may be challenging for facilities to implement. VA Central Office leaders should consider the implications of these recommendations for supporting the field through access to education and training, toolkits, and facilitation of PACT and PC-MHI design. While sites have autonomy over local policies, clinical processes, and pathways, Central Office should provide broad expectations for the PC-MHI initiative and be responsive to the needs of the sites.

## Methods

In August 2012, the VA Primary Care Office charged an interdisciplinary group of 11 VA nationwide subject matter experts to participate in a workgroup to identify PC-MHI goals and objectives given the reorganization of VA primary care into PACT, and to make recommendations for integrating mental health into PACT. The charge to the IMHIP Workgroup focused on clarifying a vision and goals for PC-MHI built on the past but looking to the future. The charge also asked for expert assessment of the progress of the current PC-MHI initiative, achievements, and gaps. To accomplish this, the IMHIP expert panel, with the addition of 2 research support staff, convened monthly over the telephone in 1-2 hour sessions for a total of 10 sessions over 12 months.

The IMHIP group first identified literature on PC-MHI goals. Review of the identified sources resulted in identification of 251 relevant goals drawn from 3 VA and 7 non-VA resources (Appendix A: Resource List). The group also contributed 9 goals that had not been identified through the literature search. Research staff categorized the 260 goals into potential target populations, desired outcomes, desired processes, and quality improvement/redesign targets based on the Chronic Care Model framework. Through this process, the research staff consolidated the 260 goals into 14 categories and 159 mutually exclusive goals. The IMHIP expert panel members then rated the 159 goals using a web-based survey along four dimensions: **current level of implementation** in the VA system, **difficulty of implementation**, **impact on Veteran health**, and **overall value** to the PC-MHI program. *Value* was rated on a scale of 1-7, while *level*, *difficulty*, and *impact* were rated on an ordinal scale of low, medium, high. Response rate was 82% (n=9). The responses were aggregated and adjusted by respondent. These results (Appendix B) were then presented to the group for feedback and to obtain consensus during the monthly telephone calls.

The next expert panel activity was to answer a second web-based survey that aimed to assign to each of the three service lines (PC-MHI, PACT and MHS external to PACT) a recommended set of core responsibilities. The ratings reflect a level of responsibility (i.e., primary responsibility, collaborator, support role) for each service line for each recommended goal or activity identified through the prior consensus process. Specific responsibilities assessed included those pertaining to quality leadership, assessment, and management/treatment. Response rate was 55% (n= 6). The responses were aggregated (Appendix C) and presented to the group for feedback and to obtain consensus. This activity identified three highest-ranked target conditions for PC-MHI leadership (depression, anxiety, and alcohol misuse) as well as other conditions for which PC-MHI should have an active collaborative role but for which PACT or MHS should take leadership.

Finally, as a final step, the group came to consensus, again through a web-based survey and discussion, on a parsimonious set of recommendations that reflected high priority gaps in PC-MHI as currently implemented in the VA. The recommendations aimed to reflect PC-MHI goals and activities that were important to Veteran health, currently had not been fully accomplished, and that were feasible to accomplish within the next one to three years based on progress to date. Recommendations thus reflect workgroup deliberations and learning over the entire 12 month process.

These results were combined into the consensus report (see next section). The report has been reviewed, revised, and accepted by the entire workgroup; as a consensus document, however, it cannot be interpreted as reflecting the exact opinions of any one member. The Results section reports on the combination of survey and discussion results in detail, and summarizes the IMHIP assessment of current level of implementation of each goal. The Appendices show actual survey results.

# IMHIP CONSENSUS PROCESS RESULTS

## PC-MHI Initiative Recommended Core Responsibilities

### *Quality Leadership and Collaboration Structure and Responsibilities*

The PC-MHI initiative is dedicated to improving the quality of care for patients with mental health disorders that are detected or followed in the primary care setting. The quality leadership role for PC-MHI should be a collaboration between the Mental Health leaders and PACT leaders who appoint one or more clinicians to lead the local PC-MHI initiative. For example, the local PC-MHI leadership team might consist of a PC clinician, a MH clinician, and a care manager identified by the local MH and PACT chiefs. The leadership team is explicitly linked to a set of interdisciplinary providers, including the nursing, clerical, social work, pharmacy, and clinical staff needed to achieve PC-MHI goals. Some or all of the time of these individuals is identified as being under the purview of the PC-MHI leader and is committed to PC-MHI for an explicit period of time (e.g., a year or more) by written collaboration agreement. The leadership role includes directing and overseeing the overall delivery and quality of care received by primary care patients with diagnosed or suspected mental health conditions, particularly **depression, alcohol misuse and anxiety disorders**, as well as offering PACT staff their expertise with behaviorally-sensitive medical conditions. Leaders would be supported and guided by higher levels of VA leadership (Figure 1) and have dedicated time to complete tasks as outlined in the PC-MHI Functional Tool<sup>1</sup> (<http://go.va.gov/iitut>). **The major difference between current organizational structure and the proposed organizational structure is that each division or site must have an identified, explicitly named primary care local leader and a paired mental health local leader to lead the local PC-MHI initiative.**

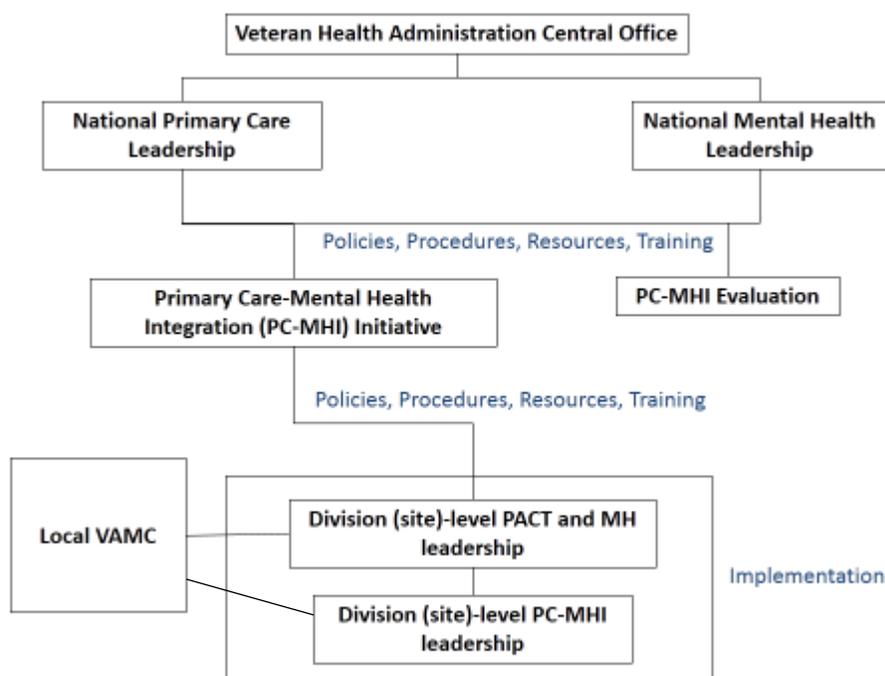


Figure 1. Proposed role of site-level PC-MHI leadership within larger context of VA leadership

### *Target Conditions for Which PC-MHI is Responsible*

Assuring and/or improving the quality of care for primary care patients with depression, alcohol misuse and anxiety disorders is a core PC-MHI responsibility. These three target conditions are the most common mental health conditions experienced by the population of patients seen in primary care settings.<sup>5</sup> Furthermore, these conditions require active mental health treatment that can often be most effectively delivered through an interdisciplinary primary care team that collaborates closely with mental health specialists (i.e., a collaborative care model that includes PCPs and PC-MHI staff).

PC-MHI also has an important collaborative role in managing other mental and behavioral health conditions that may present among primary care patients and may or may not require mental health specialist treatment. These include somatization, grief and bereavement, sleep disorders, and tobacco cessation. For these conditions, primary care has principal responsibility for assuring quality care with active support as needed from PC-MHI.

For complex, severe mental health conditions, PC-MHI integrated care providers have an important collaborative role with mental health specialists external to PACT. Mental health specialists have primary responsibility, with support from PC-MHI, for assuring appropriate mental health care for patients with the following conditions: psychiatric emergencies, severe depression, PTSD, severe or chronic anxiety, suicidal ideation with plan or risk factors, pathological grief, pathological responses to trauma, and patients who fail to respond to initial treatment in primary care.

At this time, little high-level evidence exists for PTSD treatment in primary care, and treatment is offered primarily in the specialty mental health setting outside of PACT. Nevertheless, patients with mild PTSD in combination with depression and/or alcohol misuse, are currently frequently treated in primary care with a focus on the treatment of comorbid depression and/or alcohol misuse through the care management program. PC-MHI has an important role in assessing patients who screen positive for PTSD in primary care and helping them to overcome barriers to care. As emerging evidence provides a foundation for primary care-based management, treatment in primary care may become the standard for mild PTSD in the future.

As part of quality leadership, the local PC-MHI leaders are responsible for engaging with PACT in system redesign, provider education, and performance evaluation. PC-MHI providers are expected to participate in PACT team meetings, in interdisciplinary PACT case conferences, and in curbside or electronic consultations, particularly when relevant to the three target conditions.

### *PC-MHI Responsibilities for Quality Measures*

PC-MHI leaders are responsible for monitoring the use of quality measures for target PC-MHI conditions. Achieving this goal requires implementation of quality measures based on routine clinical data gathering. Because current clinical data reflects symptom follow-up to only a limited degree (e.g., screen positive or negative; suicide assessment if indicated), initial quality measures may focus most on process of care. Over time, as tools to support standardized assessment and symptom follow-up for target PC-MHI conditions are deployed, additional measures based on these data can be developed.

Widely accepted tools currently exist for depression and alcohol use. While both PC and PC-MHI clinicians should administer assessment and symptom follow-up measures as part of routine care for their patients, PC-MHI staff in particular must have the expertise to administer the assessment tool if the tool cannot be self-administered, train others to administer the tool, and interpret the results. For instance, every Veteran in primary care with suspected depression should be followed-up with a PHQ-9 score to determine severity of depression symptoms.<sup>26</sup> This assessment would be helpful in

monitoring the patient and knowing what level of treatment is necessary. Furthermore, any Veteran with depression should have a PHQ-9 during and after treatment to assess response to this therapy.

### *PC-MHI Responsibilities for Quality Improvement*

To facilitate full integration of mental health into PACT, specific quality leadership responsibilities within a given local setting should be outlined and assigned to an individual (or position) or to the program itself, as appropriate. While the quality leadership role for each facility can be individually tailored based on available resources, feasibility and reasonable expectations, the local PC-MHI program should work collaboratively with the rest of the PACT at each site to ensure high quality care across the primary care population for patients screening positive for depression or alcohol misuse, or referred by primary care for anxiety or anxiety-related disorders. Ultimately, the PC-MHI initiative should demonstrate measurable improvements in health and healthcare outcomes among primary care patients for whom mental health care is indicated.

## **Largest Gaps in Achieving PC-MHI Goals for Target Conditions**

**Current Overall Level of Implementation (LOW, MODERATE, HIGH) of:**

### **Quality Care for Target Conditions**

The Panel judges the current overall level of achieving relevant PC-MHI goals for care for the target mental health conditions to be:

- Depression: MODERATE
- Anxiety disorders: MODERATE
- Alcohol misuse disorders: LOW

### *Treatment for Alcohol Misuse*

The panel judges the treatment of alcohol misuse, particularly risky or hazardous drinking, within the primary care setting to be the greatest current gap between current PC-MHI care and expected PC-MHI care. Treatment of alcohol misuse treatment is one of the most highly evidence based programs in mental health, and can often be delivered effectively in the primary care setting through any trained member of the PACT team. The impact of managing the continuum of alcohol misuse on the overall health status of our Veterans cannot be overstated. Yet, the implementation of these efficacious and effective interventions (i.e., brief intervention, motivational interviewing) has been limited. The availability of PC-MHI staff provides a unique opportunity to educate primary care providers on these interventions and fully implement these programs within VA.

### *Standardized Clinical Assessment and Follow-up Measures and Tools*

Another large gap with high impact on Veteran health identified by the Workgroup was in *availability* and, above all, *use* of standardized clinically generated clinical assessment and follow-up tools for the target conditions, including standardized symptom measures for use in initial assessment, follow-up, and knowledge of outcomes. Routine use of assessment and symptom measures is essential for developing individualized treatment plans, outcome measurement, and program evaluation. Furthermore, clinical use of these tools should generate data and reports for quality monitoring and improvement of PC-MHI.

### Quality Improvement Initiatives

Another critical gap was in local PC-MHI quality improvement initiatives. The Workgroup judged these to be high impact, but not routinely planned or implemented continuously. These activities should be based, whenever possible, on local assessment of quality of care for target conditions.

### PC-MHI Active Participation as Members of PACT

Collaboration within PACT or with specialty MH is essential for PC-MHI to provide quality care for Veterans. PC-MHI should be part of an integrated, team-based approach to management, characterized by collaboration and open communication between primary care and mental (behavioral health) providers. The team may include the patient’s primary care provider, PACT teamlet members, an integrated mental health care provider, a health behavior coordinator, and a care manager.

Please refer to Appendix D for various examples of PACT and PC-MHI collaboration for common clinical scenarios.

**Current Overall Level of Implementation** (LOW, MODERATE, HIGH) of:

#### Recommended Collaboration Activities

- Ongoing bi-directional learning between primary care and mental health staff (LOW)
- Interdisciplinary case discussions of problematic cases (LOW)
- “Curb-side” discussions, interdisciplinary team meetings, and joint treatment planning (LOW)
- Routine participation by mental health specialists in PACT team or teamlet meetings or huddles, upon request (LOW-MOD)
- PC-MHI management meetings (e.g., for performance improvement, team building, and oversight, that include interdisciplinary leaders) (LOW-MOD)
- Frontline provider/staff involvement (MOD)
- National, regional, medical system, and practice site leadership support and understanding of PC-MHI goals and processes (MOD)

### IMHIP PC-MHI Care Design Goals for Target Conditions

#### *Stepped Care: A Key Design Feature*

In order to achieve quality care for the target conditions, PC-MHI leaders at each site must collaboratively design or redesign care systems, with participation of front-line providers, to optimally deliver mental health care in the primary care setting. Rather than offering a “blended model,” fully functional PC-MHI programs should offer the full complement of PC-MHI services, as outlined in the PC-MHI Functional Tool<sup>1</sup> (<http://go.va.gov/iitut>). While specific design features may vary by site based on local resources and other contextual factors, the IMHIP Workgroup recommends that care design adheres to the following overarching principles:

- A stepped care program characterized by increasing intensity of mental health care based on patient need and preferences and on a PC-MHI-developed or -approved structured assessment, to include (1) (Low Intensity) watchful waiting with at least quarterly PC-MHI-developed or -approved structured re-assessment, self-management support; (2) (Moderate Intensity)

primary care-based, manualized short-term psychotherapy (group or individual), and/or medications in conjunction with guideline-concordant or PC-MHI-approved structured re-assessment, self-management support, and structured monitoring/follow-up; and (3) (High Intensity) medication, psychotherapy, or other counseling in the specialized mental health care setting.<sup>27-29</sup>

- Care delivery system is fluid and flexible enough to respond to patient needs and preferences while delivering high quality care. For example, while mild-moderate depression may be more appropriately cared for in primary care, Veterans with severe depression complicated by suicidal risk factors or treatment-resistant depression may be fully evaluated in specialty mental health outside of PACT and then followed by the PC-MHI integrated care providers along with the PACT team. Veterans whose symptoms do not improve in primary care need to be evaluated and followed in mental health outside of PACT after being initially evaluated and treated in the primary care setting.
- PC-MHI services are different from that of specialty MH services; PC-MHI services are not an extension of specialty mental health services within primary care.<sup>30</sup> Visits are shorter. Days may be structured differently to support open access. There may be multiple interruptions, depending on primary care needs. PC-MHI providers also do not practice in isolation but within the PACT team and should participate in PACT huddles and interdisciplinary team meetings or rounds. Services, such as psychotherapy and medication management, are intended to be short-term. PC-MHI integrated mental health care providers must be skilled and flexible enough to provide care at the appropriate level within primary care. While Veterans vary in need, services are terminated when a Veteran attains a specific goal or if the PC-MHI team determines that the Veteran requires transition to specialized or long-term therapy in mental health outside of PACT.
- PC-MHI serves as the cornerstone of the relationship between PACT and specialty mental health external to PACT. There should be seamless care among PACT, PC-MHI, and specialty mental health to provide coordinated care. If a Veteran requires high-intensity mental health care provided in the specialized mental health setting, PC-MHI should collaborate with specialty MH in the referral process. If a Veteran with serious mental illness requires high-intensity medical care provided in the primary care setting, specialty MH should collaborate with PC-MHI to assure continuity of care.
- In general, based on prior research, 60% to 80% of active treatments for screen-positive or referred patients should be carried out in the primary care setting, with PC-MHI support and monitoring of quality of care.<sup>11</sup>
- Providing this level of care for the screen-positive plus clinically-identified patient population will generally require structured, protocol-based care management, typically provided by a nurse, with weekly clinical review of caseloads by a mental health specialist. Monitoring the caseload for, and quality of assessment and follow-up provided by any primary care-based mental health care manager is a responsibility of the PC-MHI program (see core responsibilities above).<sup>11, 27</sup>
- Services should be as accessible to the patient as possible, and therefore should include *brief* psychotherapy services in primary care, telephone-based care<sup>31</sup> and telemedicine-based mental health<sup>32-34</sup> options.

- To achieve stepped care goals, PC-MHI programs should identify, based on flow charting, appropriate pathways from screening to assessment (including re-assessment), and then to treatment and follow-up care. Workflow should then be designed to efficiently and effectively connect patients who have PC-MHI target conditions to the appropriate level of care. In general, achieving these goals will require a quality improvement/system redesign approach locally.
- As a second step, flow charting and improving workflow to efficiently and effectively connect patients to specialized alcohol misuse treatment, vocational rehabilitation services, and housing services as indicated is highly desirable.

## Designing the Assessment

While a *screening* assessment for common mental health conditions among the Veteran population can be conducted at any point of care by PACT providers and staff in a given facility, *full initial assessment* of mental health problems to develop an appropriate care plan usually requires additional support, such as from a care manager or trained health technician who can administer appropriate standardized assessment tools. Full initial assessment may include treatment history, comorbid mental health conditions, and patient treatment preferences in addition to probable diagnosis and symptoms. Such assessments may take a half an hour or more, and require training to administer in a standardized manner. As such, full initial assessment is difficult to carry out within the typical PACT visit. On the other hand, consuming Mental Health Specialty resources with an initial assessment is similar to referring all diabetic patients to endocrinology. Involvement of care managers or health technicians enables these assessments to be carried out within the PACT framework, thus helping PC-MHI stepped care.

The full initial assessment can be brief but should include objective measures of distress or symptomatology (i.e., PHQ-9, PCL, SF-12, or quantification of standard drinks). The assessment should also be broad enough to assess safety and indicate whether or not a more comprehensive mental health specialty evaluation is necessary. Within the bounds of scope of practice and local policy, who does the assessment and how (in-person, telephone, virtual) is less important than completing the assessment. Each facility may need to consider multiple factors for the screening and assessment process, including who on-site is responsible, what level of training is necessary, and who is qualified to do it.

**Current Overall Level of Implementation (LOW, MODERATE, HIGH) of:**

### Care Design for the Target Conditions

Overall, the expert panel thought that the stepped care approach was underutilized for common, uncomplicated mental health conditions and had a LOW level of implementation. Pathways from screening to treatment were thought to have a MODERATE level of implementation. As the VA expands telemental health, PC-MHI services will be increasingly accessible; currently the VA is thought to have a LOW-MOD level of telephone, video or electronic services for PC-MHI conditions. Finally, the Workgroup identified full initial standardized assessment and reassessment of patients as part of the pathway from screening through treatment, and as a critical gap.

**Current Overall Level of Implementation** (LOW, MODERATE, HIGH) of:

### Screening Assessments for Target Conditions

The expert panel believes that the PC-MHI program currently has a HIGH level of implementation for screening assessments to identify *target conditions* across the primary care patient population, with the exception of anxiety disorders.

- Depression: Screening using the PHQ-2 and structured assessments using the PHQ-9 are currently in place.<sup>4</sup>
- Anxiety: No consistent standardized structured screening for anxiety (other than PCL) is currently used across VA facilities. The GAD-7 is a useful tool to screen for generalized anxiety disorder in primary care.<sup>35</sup>
- Alcohol misuse disorder: The VA implemented universal screening of alcohol misuse using the AUDIT-C in 2004.<sup>9</sup>

### Sustainability: The Challenges of Design that Accounts for PC-MHI Impacts

Integrated mental health providers are established within PACT to assist and to collaborate with the other PACT members. PC-MHI plays an important role in helping to achieve PACT performance measures by potentially reducing adverse outcomes and costs for *medical* conditions.<sup>8</sup> In doing so, this collaborative work may not be easily quantified. Important activities, such as PACT education, telephone-based care management, curbside consults, and engagement with PACT providers may not be accounted for in usual staffing and productivity measures. Also, some interventions, such as brief interventions for alcohol misuse, may be undervalued by RVUs as an evidence-based preventative intervention.

### Designing for Primary Care Based Mental Health Treatments

Management of target mental health problems within primary care is performed as a collaborative effort within the PACT. All assessed patients should have a documented guideline-concordant initial treatment plan. The treatment/management plan should accurately reflect initial assessment findings, yet be guided by the needs and goals of the patient. The plan may be as simple as offering someone in distress a few counseling sessions, a decision not to treat, or a more complex plan for patients suffering from an alcohol misuse disorder. Treatments such as brief counseling, education and medications for common mental health conditions should be provided by primary care providers with backup from PC-MHI team. If at all possible, psychotherapy or counseling should occur physically within the primary care setting. Treatment plans are aligned with the overall personalized health plan developed by the PACT.

**Current Overall Level of Implementation** (LOW, MODERATE, HIGH) of:

### **Management and Treatment of Target Conditions**

The PC-MHI initiative currently has a MODERATE level of provision for comprehensive treatment modalities for uncomplicated mental health disorders in the primary care setting. However, the expert panel believed that the PC-MHI providers could improve this area through, for example, increasing the availability of group psychotherapy to treat the target conditions.

Summarized below are the various treatment options for these conditions and the level of implementation at VA as determined by the expert panel.

- Depression: Antidepressants are routinely prescribed by primary care providers under PC-MHI guidelines (MOD-HIGH). While the group thought that PC-MHI providers often provide some level of psychotherapy targeted to depression (MOD-HIGH), manualized short-term therapy (e.g., brief cognitive behavioral therapy groups and brief problem solving therapy) are not routinely offered (LOW).
- Anxiety: Anti-anxiety medications are commonly prescribed by primary care providers (MOD). Similar to depression, manualized short-term therapy is not often used to manage anxiety (LOW).
- Alcohol misuse: Generally, the expert panel thought that the PC-MHI integrated care providers could offer a broader range of alcohol misuse treatments in the primary care setting, such as outpatient detoxification, medication-assisted abstinence, counseling, education, group therapy, and motivational interviewing. In 2008, the VA implemented an initiative that required primary care clinicians to follow-up with Veterans who screen positive for alcohol misuse by offering them brief advice, counseling, and/or referral to specialty SUD care.<sup>9</sup> However, the availability of brief alcohol interventions offered by PC-MHI (LOW-MOD), such as counseling, education, and in particular, motivational interviewing (LOW), could be improved. Care managers are often helpful in delivering interventions for alcohol misuse in appropriate patients (MOD).

### **Designing PC-MHI Follow-up and Monitoring of Target Conditions**

The most *critical* gap in the PC-MHI initiative was identified as the follow-up and *reassessment*. These activities were considered to be valuable for Veteran health but had the LOWEST level of implementation. The PC-MHI integrated mental health care providers should offer consistent follow-up assessments and monitoring of patient outcomes with appropriate adjustment in treatments to ensure patient improvement. Follow-up assessments for patients suspected to have or diagnosed with target mental health conditions should include tracking key symptoms, functional status, adherence to therapy and medications, side effects, and patient's treatment goals through structured re-assessment tools, such as validated questionnaires. Tools to track all PC-MHI patients longitudinally, such as a disease registry or panel management software (e.g., BHL), are helpful to monitor clinical and administrative outcomes. For any patient in which treatment is initiated (psychotherapy or pharmacotherapy) within primary care, an assessment should be ongoing during the initial stages of

treatment (e.g., the first few sessions) and should include objective measures of progress including adverse outcomes and adherence.

<b>Current Overall Level of Implementation</b> (LOW, MODERATE, HIGH) of:
<b>Follow-up and Monitoring of Target Conditions</b>
LOW for each reassessment activity described above

## Designing PC-MHI Care Management

Trained care managers can help PC-MHI and PACT providers coordinate and/or carry out the full range of PC-MHI activities (e.g., assessment, proactive follow-up and supported referral) for appropriate patients, using standardized tools and protocols. The PC-MHI integrated care manager may collaborate and coordinate with the PACT care manager to follow-up behavioral health problems as a team and to assess patient outcomes while maximizing efficiency through existing workflows. In the absence of care managers, PACT and PC-MHI providers themselves are responsible for implementing measurement-based, proactive care. This may limit the ability of PC-MHI to impact the full mental health needs of the primary care population.

Care management is an essential component of PC-MHI in all three currently sanctioned approaches to PC-MHI nationally (WRJ collocated collaborative care,<sup>11</sup> TIDES<sup>13</sup> and BHL.<sup>12</sup> While BHL initially emphasized the standardized assessment, and WRJ initially emphasized collocation with standardized assessment, all three models now include both standardized assessment and proactive follow-up. All three models can and do integrate trained care managers to assist with accomplishing these goals. It is therefore feasible to blend elements of these models to develop approaches that best fit local environments.

In the BHL and WRJ approaches, the initial assessment and supported referral to Mental Health Specialty may be carried out by a health technician, while the care manager focuses on proactive clinical follow-up for appropriate patients such as those treated with medications by a primary care provider. In WRJ, patients can self-administer assessment tools using a pre-programmed tablet. BHL uses special software to support these activities. In TIDES, assessment and follow-up are carried out by the care manager (typically a nurse or social worker) using a CPRS template with health factors, and a SharePoint adaptation for proactive task scheduling. Further work should be directed at understanding the advantages and disadvantages of each from the perspective of the adopting sites. Moving these initiatives forward may depend upon further understanding adoption rates and user responses. Workgroup members suggest moving away from these named approaches, and toward a blended model with local options.

In addition to their direct clinical care roles, care managers along with PC-MHI program leaders can play a key role in locally organizing the practice infrastructure that supports integrated care. This includes educational roles, liaison roles between mental health specialists and primary care, and promotion of the use and reporting of standardized mental health assessments by all members of the interdisciplinary PACT.

Care managers particularly target uncomplicated patients who could be cared for through provision of medications or brief psychotherapy in primary care. Because they are supervised by a mental health specialist, care managers promote communication and collaboration between primary care and mental

health specialists. Accordingly, care managers have the ability to deliver brief psychosocial interventions, provide outreach/education/decision support to PCPs on mental health issues, and support psychiatric medication management by PCPs for appropriate cases. In addition, they can address behavioral issues such as treatment adherence and alcohol misuse through motivational interviewing and other interventions.

**The expert panel agreed that TRAINED PC-MHI care managers could collaboratively assess, triage, and support management of the following conditions:**

- Mild-moderate depression
- Severe depression
- Mild-moderate situational anxiety (may include panic attacks)
- Mild to moderate alcohol-related problems or at-risk use
- Mild to moderate abuse or at risk use of substances other than alcohol
- Mild-moderate depression and mild-moderate PTSD
- Psychological response to trauma, whether single episode or chronic, repetitive trauma or other adjustment issues
- Poor adherence to lifestyle modification (e.g. for treating or preventing chronic medical conditions)
- Insomnia
- Suicidal ideation without indication of intent
- Poor adherence to medications (e.g. for chronic medical or psychiatric conditions)
- Mild-moderate post-traumatic stress disorder (PTSD) WITHOUT DEPRESSION §
- Psychiatric emergencies, including acute suicide or homicide intention, acute psychosis, or acutely deteriorated functional status such as depressed elderly patients not eating. §

§ Assessment only

**Current Overall Level of Implementation (LOW, MODERATE, HIGH) of:**

**Care Management for Target Conditions**

The expert panel believed that PC-MHI care management adequately addresses the intersection between medical and psychological/psychiatric conditions. The care management program predominantly utilizes staff members other than a prescribing mental health provider, such as nurses or social workers (MODERATE), but the number of care managers is suboptimal for PC-MHI functioning. Often, the care managers are funded and evaluated through mental health (HIGH) rather than primary care (LOW). While the care management program functions well, the expert panel believed that workflows and care delivery processes do not enable appropriate care management and treatment (including medication, psychotherapy, and alcohol misuse assessment and treatment) (LOW). The workgroup thought that there could be more emphasis of care management on delivering interventions for alcohol misuse (LOW-MOD).

## Designing Patient Self-management Support

Patient self-management is a key feature of the chronic care model, however support for self-management is not routinely provided in PC-MHI. Patient activation or motivational techniques should be systematically and efficiently integrated into each PC-MHI activity as appropriate (e.g., education, showing patients written information about their progress, developing goals, supporting patient self-monitoring of treatment adherence and outcomes, using motivational interviewing, individual or group therapy). PC-MHI staff should support shared decision making by discussing and providing the Veteran with materials to promote knowledge of mental health or alcohol misuse treatment options and their efficacy while appreciating the Veterans' values and choices. Care plans should be patient-centered and support the patient's own goals and preferences. PC-MHI staff should review the individualized care plan with the patient. The PC-MHI staff should provide patients with written and web-based patient education literature on all target PC-MHI conditions (i.e., depression, anxiety, alcohol misuse). Furthermore, policies should be developed that implement informed, patient-centered participation and decision making in treatment, illness self-management, and recovery plans.

As self-management IT applications become available, VA should actively evaluate and consider implementing them. These include tablet or computer based self-assessments as well as mobile phone and secure messaging applications.

**Current Overall Level of Implementation (LOW, MODERATE, HIGH) of:**

**Patient Self-Management of the Target Conditions**

LOW

## Designing PC-MHI Links to Community Resources

PC-MHI clinicians providing mental health or alcohol misuse treatment services should maintain effective, formal linkages with community resources to support patient illness self-management and recovery and help Veterans access existing community and family supports.

**Current Overall Level of Implementation (LOW, MODERATE, HIGH) of:**

**Links to Community Resources**

MODERATE

## Developing PC-MHI Policies and Procedures

PC-MHI has been implemented with substantial variation across the VA. Policies are based on accepted, evidence-based care models and the most current available evidence. The PC-MHI leadership should ensure that formal agreements at the local level between primary care and Mental Health specialty include:

- The management of care transitions between mental health specialists and primary care providers.
- Protocols for assignment of patients to the appropriate level of care, including 1) protocols for specialty mental health referral based on initial assessment, failure to progress, or other locally developed criteria, 2) protocols for acceptable treatment by primary care providers with appropriate mental health specialist back-up, and 3) protocols for transfer back to primary care following stabilization in specialty mental health.
- Standards for management of clinical care within the PC-MHI initiative, including screening, diagnosis, treatment use, periodic reassessment, and notification of results.

**Current Overall Level of Implementation** (LOW, MODERATE, HIGH) of:

### **Policies and Procedures**

Based on evidence-based models of care (LOW)

**Current Overall Level of Implementation** (LOW, MODERATE, HIGH) of:

### **Formal Agreements Between PACT and Mental Health**

- Management of care transitions between mental health and PACT providers (LOW)
- Protocols for assignment of patients to the appropriate level of care (LOW)
- Standards for management of clinical care within PC-MHI (MOD)

*“Because mental health and substance use problems are among the most common conditions seen in primary care settings and frequently co-occur with other medical problems, PCPs are often in the best position to identify, diagnose, and treat them. These facts alone make it clear that the PCMH will not reach its full potential without adequately addressing patients’ mental health needs.”*

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## Appendix A: IMHIP Goals Resource List

<p><b>Title:</b> Coordinating care in the medical neighborhood: critical components and available mechanisms.</p>	
<p>White Paper (Prepared by Mathematica Policy Research under Contract No. HHS290200900019I TO2). AHRQ Publication No. 11-0064. Rockville, MD: Agency for Healthcare Research and Quality. June 2011</p>	<p><b>Summary:</b> This paper examines the various “neighbors” in the medical neighborhood and how these neighbors could work together better, thus allowing the PCMH to reach its full potential to improve patient outcomes. It addresses 1) key components of the medical neighborhood and how the PCMH is situated within it; 2) existing barriers to achieving a well-functioning medical neighborhood; and 3) the approaches and tools available to achieve a well-functioning neighborhood, and the strengths and weaknesses of each.</p>
<p><b>Authors:</b> Taylor EF, Lake T, Nysenbaum J, Peterson G, Meyers D.</p>	
<p><b>Contributed by:</b> Evelyn Chang</p>	
<p><b>Title:</b> Integrating MH treatment into the PCMH</p>	
<p>AHRQ 2010 AHRQ Publication No. 10-0084-EF</p>	<p><b>Summary:</b> Efforts to improve the quality and efficiency of primary care have recently focused on the concept of the Patient Centered Medical Home. Given that primary care serves as a main venue for providing mental health treatment, it is important to consider whether the adoption of the PCMH model is conducive to delivery of such treatment. This paper identifies the conceptual similarities in and differences between the PCMH and current strategies used to deliver mental health treatment in primary care. Even though adoption of the PCMH has the potential to enhance delivery of mental health treatment in primary care, several programmatic and policy actions are needed to facilitate integration of high-quality mental health treatment within a PCMH.</p>
<p><b>Authors:</b> Thomas Croghan, Jonathan Brown, AHRQ</p>	
<p><b>Contributed by:</b> Evelyn Chang</p>	
<p><b>Title:</b> Integration of MH/ SU into PC</p>	
<p>AHRQ Publication No. 09-E003 October 2008</p>	<p><b>Summary:</b> Integrated care programs have been tested for depression, anxiety, at-risk alcohol, and ADHD in primary care settings and for alcohol disorders and persons with severe mental illness in specialty care settings. Although most interventions in either setting are effective, there is no discernible effect of integration level, processes of care, or combination, on patient outcomes for mental health services in primary care settings. Organizational and financial barriers persist to successfully implement sustainable integrated care programs. Health IT remains a mostly undocumented but promising tool. No reimbursement system has been subjected to experiment; no evidence exists as to which reimbursement system may most effectively support integrated care. Case studies will add to our understanding of their implementation and sustainability.</p>
<p><b>Author:</b> Mary Butler, Ph.D., M.B.A. Robert L. Kane, M.D. Donna McAlpine, Ph.D. Roger G. Kathol, M.D. Steven S. Fu., M.D., M.S.C.E. Hildi Hagedorn, Ph.D. Timothy J. Wilt, M.D., M.P.H.</p>	
<p><b>Contributed by:</b> Evelyn Chang</p>	

## Appendix A: IMHIP Goals Resource list

<p><b>Title:</b> Behavioral Health/Primary Care Integration and the Person-Centered Healthcare Home</p>	
<p>National Council for Community Behavioral Healthcare Apr 2009</p>	<p><b>Summary:</b> This paper addresses evidence-based approaches to a person-centered healthcare home for the population living with serious mental illnesses. It brings together current developments around the patient-centered medical home with evidence-based approaches to the integration of primary care and behavioral health.</p>
<p><b>Author:</b> Barbara Mauer</p>	
<p><b>Contributed by:</b> Evelyn Chang</p>	
<p><b>Link:</b> <a href="http://www.allhealth.org/briefingmaterials/BehavioralHealthandPrimaryCareIntegrationandthePerson-CenteredHealthcareHome-1547.pdf">http://www.allhealth.org/briefingmaterials/BehavioralHealthandPrimaryCareIntegrationandthePerson-CenteredHealthcareHome-1547.pdf</a></p>	
<p><b>Title:</b> Improving the Quality of Health Care for Mental and Substance-Use Conditions: Quality Chasm Series, 2006</p>	
<p>ISBN: 0-309-65460-2</p>	<p><b>Summary:</b> This paper examines the distinctive characteristics of health care for mental and substance-use conditions, including payment, benefit coverage, and regulatory issues, as well as health care organization and delivery issues. This new volume in the Quality Chasm series puts forth an agenda for improving the quality of this care based on this analysis.</p>
<p><b>Author:</b> Institute of Medicine</p>	
<p><b>Contributed by:</b> Evelyn Chang</p>	
<p><b>Link:</b> <a href="http://www.bbs.ca.gov/pdf/mhsa/resource/substance_abuse/iom_book_ch7_increasing_wkforce.pdf">http://www.bbs.ca.gov/pdf/mhsa/resource/substance_abuse/iom_book_ch7_increasing_wkforce.pdf</a></p>	
<p><b>Title:</b> Evolving Models of Behavioral Health Integration in Primary Care</p>	
<p>Milbank Memorial Fund, 2010 ISBN 978-1-887748-73-5</p>	<p><b>Summary:</b> This report also provides an orientation to the field and, hopefully, a compelling case for integrated or collaborative care. It provides a concise summary of the various models and concepts and describes, in further detail, eight models that represent qualitatively different ways of integrating and coordinating care across a continuum—from minimal collaboration to partial integration to full integration. Each model is defined and includes examples and successes, any evidence-based research, and potential implementation and financial considerations. Also provided is guidance in choosing a model as well as specific information on how a state or jurisdiction could approach integrated care through steps or tiers. Issues such as model complexity and cost are provided to assist planners in assessing integration opportunities based on available resources and funding. The report culminates with specific recommendations on how to support the successful development of integrated care.</p>
<p><b>Author:</b> Chris Collins, Denise Levis Hewson, Richard Munger, and Torlen Wade</p>	
<p><b>Contributed by:</b> Evelyn Chang</p>	

## Appendix A: IMHIP Goals Resource list

<p><b>Title:</b> PC-MHI Functional Tool (Version 1.0)</p>	
<p><b>Author:</b> PC-MHI Program Office</p>	<p><b>Summary:</b> The purpose of this tool is to outline the essential elements of a fully functional Primary Care-Mental Health Integration (PC-MHI) program within the VHA context. The introductory section of this tool (pp. 1-3) provides an overview and orientation to PC-MHI services. The main section (pp. 4-10) presents in checklist form the six specific functions of a fully operational PC-MHI program and details the elements necessary to achieve basic functionality in each. Additional desirable and optimal elements based on current best practices are also included.</p>
<p><b>Contributed by:</b> Maureen Metzger</p>	
<p><b>Title:</b> Veterans Affairs National Primary Care-Mental Health Integration Evaluation: Overview and Findings</p>	
<p><b>Author(s)</b> John F. McCarthy, Ph.D., M.P.H.</p>	<p><b>Summary:</b> This PowerPoint presentation presents the results of an evaluation of the VA PC-MHI implementation process. It discusses model fidelity and assesses impact of the implementation on the primary care patient population (e.g., access, quality), specialty mental health services (e.g., referrals, case-mix), provider behavior (e.g., diagnosis, prescription, referrals), quality of care (e.g., HEDIS depression measures), satisfaction (e.g., patient, provider), health care processes (e.g., treatment initiation, continuation), operations (e.g., workload, efficiency, communications), and patient outcomes (e.g., symptoms, function, treatment retention).</p>
<p><b>Contributed by:</b> Lisa Rubenstein</p>	
<p><b>Title:</b> VHA DIRECTIVE 2012-xxx: Mental Health in PACT</p>	
<p><b>Author(s)</b> Department of Veterans Affairs, Veterans Health Administration</p>	<p><b>Summary:</b> This Veterans Health Administration (VHA) directive establishes policy for assuring the goals of PC-MHI in PACT. (See goals 1 &amp; 2)</p>
<p><b>Contributed by:</b> Andrew Pomerantz</p>	

## Appendix B: Frequency Results for PC-MHI Goals Ratings

This rating form was developed based on the resource documents submitted by the workgroup (see document list in separate attachment). Two reviewers abstracted and categorized goals from these documents, then eliminated duplicates and grouped the goals. The form is divided into three sections and 15 subsections. An overall goal was created for each subsection, along with multiple sub-goals. Respondents were asked to consider these goals in relationship to Veterans and the VA in general, but to also rate each goal as it relates to the PC-MHI Program (i.e., the set of activities that are or should be undertaken jointly by primary care and mental health specialty at the national, regional and/or local levels). Therefore, a particular goal might be important to Veteran health, but might not particularly valuable as a focus for PC-MHI.

### Rating Domains

**Level of current goal achievement at VA:** The degree to which the current VA programs and primary care practices, with mental health or PC-MHI support, have achieved the goal. “Low” means that few primary care practices have met the goal; “Mod” (moderate) means that many, but not the majority of these practices have met the goal; “Hi” means that most VA primary care practices have met the goal.

**Difficulty of achieving this goal at VA:** The extent that barriers might impede (or might have impeded) an average VA primary care practice from achieving the goal, considering current resources such as PACT and PC-MHI (as they exist presently). “Low” means that there are few if any barriers to meeting the goal; “Mod” (moderate) means that an average practice would experience significant barriers but might achieve the goal; “Hi” means that substantial resources or facilitators are required beyond the capabilities of an average practice with typical PACT and PC-MHI support.

**Impact of goal on Veteran health:** The extent to which achieving the goal might impact (or has impacted) the mental and/or physical health status or quality of life of the population of Veterans with mental health conditions. “Low” means that achieving the goal would have little effect on the health of these Veterans with mental health conditions. “Mod” (moderate) means that a large fraction, but not the majority of these Veterans, would likely experience some improvement if the goal were met, or that a small fraction would avoid a major adverse outcome such as hospitalization or death. “High” means that achieving the goal would have substantial positive effects on the health of these Veterans, such as significant improvement in quality of life measures or avoidance of adverse outcomes.

**Overall Value for PC-MHI to target goal:** The value to PC-MHI, considering all relevant criteria, of commencing or continuing quality improvement (QI) initiatives to meet the goal, or once met, of sustaining goal-related performance. In other words, should this goal should be a key target of the PC-MHI program/strategic plan? A rating of high value would indicate that this goal should be a key driver of PC-MHI planning and activities.

**NOTE:** The original form rated “Level” “Difficulty” and “Impact” on a three-point scale (LOW-MODERATE-HIGH). In order to compare these ratings with the 7-point overall value rating scale, the mean was rescaled to 7 points. Also, we considered Overall Value to be the most important indicator of whether a goal should be pursued. Therefore, the table offers additional values for each rating (standard deviation, median value, minimum value, maximum value).

**Appendix B: Frequency Results for PCMHI Goals Ratings**

	Overall Value					Level	Difficulty	Impact
	Mean	SD	Med	Min	Max	Mean		
<b>Table 1: Goals or Standards for Maximizing the Mental and Physical Health of Veterans Through Primary Care/Mental Health Integration (PC-MHI) Activities or Programs</b>								
<b>PC-MHI Patient Populations</b>								
<b>2.0 The PC-MHI program optimizes overall (both physical and mental) health for Veterans with mental health conditions that occur commonly in primary care populations.</b>	6.22	0.67	6	5	7	3	5.83	6.61
<b>TARGETED MENTAL HEALTH PROBLEMS THAT NEED TO BE ADDRESSED INCLUDE:</b>								
2.1 Depression or suspected depression	6.89	0.33	7	6	7	3.5	3.5	7
2.2 Post-traumatic stress disorder (PTSD) or suspected PTSD	5.67	1.12	5	4	7	2.07	5	6
2.3 Substance abuse or suspected substance abuse	6.56	0.73	7	5	7	2.07	5.5	6
2.4 Serious mental illness (SMI) or suspected SMI (e.g., schizophrenia, severe PTSD, severe bipolar disorder, serious suicidality, or severe substance abuse/dependence) when care in mental health specialty is not feasible or not optimal	4.56	1.67	5	1	7	1.71	5.5	4.64
<b>OTHER TARGETED PSYCHOLOGICALLY-BASED OR INFLUENCED CONDITIONS THAT NEED TO BE ADDRESSED INCLUDE:</b>								
2.5 Poor adherence to medications (e.g. for chronic medical or psychiatric conditions)	5.56	1.01	6	4	7	2.43	4.5	5.5
2.6 Poor adherence to lifestyle modification (e.g. for treating or preventing chronic medical conditions)	5.56	1.42	5	4	7	2.07	6.5	6.5
2.7 Somatization	4.33	1.58	4	2	7	1.71	5.5	4.14
2.8 Grief, bereavement	5.22	1.56	6	2	7	2.93	3.14	3.79
2.9 Anxiety	6.67	0.71	7	5	7	2.79	3.94	5.5
2.10 Chronic pain	5.56	1.42	6	3	7	1.71	7	6.5
2.11 Difficult or disruptive behavior	3.67	1.41	4	2	5	2.43	4.94	3.64
2.12 Traumatic brain injury	3.22	1.72	4	1	5	2.93	5	4
2.13 Dementia	4.33	1.22	5	2	6	2.93	4.67	4.5
2.14 Psychological response to an episode of trauma, chronic, repetitive trauma or other adjustment issues	5.11	1.83	5	1	7	2.43	4.5	5
<b>PC-MHI RESPONSIBILITY FOR PATIENTS WITH A SERIOUS MENTAL ILLNESS (SMI) MAY BE CONSIDERED WHEN THE VETERAN:</b>								
2.15 Refuses mental health specialty care	5.11	1.36	5	2	7	2.43	5.14	4.14
2.16 Currently receives the majority of their care from primary care or is stable enough to transfer into primary care for their overall (mental and physical) care	6.11	1.27	6	3	7	3.29	4.14	5
2.17 Requires intensive primary care for a period of time to stabilize physical health problems	4.00	1.58	4	2	7	3.29	4	4.5

**Appendix B: Frequency Results for PCMHI Goals Ratings**

	Overall Value					Level	Difficulty	Impact
	Mean	SD	Med	Min	Max	Mean		
<b>Targeted Outcomes or Results from PC-MHI</b>								
<b>3.0 PC-MHI measurably improves health and healthcare outcomes among patients for whom PC-MHI care is indicated.</b>	6.22	1.09	7	4	7	2.39	4.78	6.22
<b>MEASURABLE OUTCOMES/RESULTS THAT MAY BE IMPROVED BY PC-MHI INCLUDE:</b>								
3.1 Economy of care for the PC-MHI patient population <b>Note:</b> for economy of care, consider the value, absolute costs to VA, cost-effectiveness, costs to patients and their families, or any other economically-related outcome.	5.00	1.07	5	4	7	2	5.83	4.83
3.2 Technical quality/appropriateness of mental health care in primary care setting	6.44	1.01	7	4	7	2.43	4.14	5.5
3.3 Continuity and/or coordination of care among primary care providers and mental health specialists	6.00	0.87	6	5	7	1.71	5.64	6
3.4 Humanistic care (e.g., patient care experiences and satisfaction)	5.89	1.17	6	4	7	2.43	5.5	5.64
3.5 Functional status	5.78	1.64	6	2	7	2.57	4.64	7
3.6 Status of relevant mental health symptoms	5.78	1.39	6	3	7	3.64	3.64	4.5
3.7 Status of disparities in mental health treatment (e.g., race, age, gender, ethnicity, geography)	5.67	1.00	6	4	7	2.57	4.14	5
3.8 Status of co-morbid chronic medical conditions (i.e., diabetes, congestive heart failure, chronic obstructive pulmonary disease)	5.78	1.39	6	3	7	2.21	4.14	6.5
<b>OUTCOMES/RESULTS ARE FACILITATED BY THE FOLLOWING:</b>								
3.9 Uniform PC-MHI implementation with similar availability and expectations across the nation	5.89	1.54	7	3	7	1.36	5.64	5.5
3.10 Technical assistance for facilities that require additional support, particularly smaller facilities or CBOCs	6.89	0.33	7	6	7	3.79	4.29	6.42
<b>SCREENING/INITIAL ASSESSMENT</b>								
<b>4.0 THE PC-MHI PROGRAM INSTITUTES SCREENING AND INITIAL ASSESSMENT FOR COMMON MENTAL HEALTH CONDITIONS AMONG ALL VETERANS IN THE PRIMARY CARE SETTING.</b>	5.33	2.12	6	2	7	5.56	3.33	4.5
<b>PC-MHI ENSURES THAT SCREENING AND INITIAL ASSESSMENT INCLUDE THE FOLLOWING:</b>								
4.1 Guideline-concordant <i>identification of target conditions</i> through appropriate screening and case finding across the primary care patient population	5.33	1.73	6	2	7	6	3.29	5.5
4.2 Guideline-concordant <i>initial comprehensive assessment</i> , diagnosis, and/or problem identification for all patients screening positive or referred for care for mental health symptoms	5.78	2.05	7	1	7	3.29	3.64	6

## Appendix B: Frequency Results for PCMHI Goals Ratings

	Overall Value					Level	Difficulty	Impact						
	Mean	SD	Med	Min	Max	Mean								
<b>THE INITIAL ASSESSMENT INCLUDES THE FOLLOWING CHARACTERISTICS:</b>														
4.3	They are of a limited scope, yet are broad enough to assess safety, to develop a treatment plan, and to indicate whether or not a more comprehensive evaluation is necessary.						6.56	0.53	7	6	7	3.5	4.5	5
4.4	They use structured assessment tools (e.g., PHQ-9).						6.78	0.44	7	6	7	1.71	4.14	6
4.5	They involve the patient’s family member, caregiver, or other personal support person, when that is acceptable/desirable to the patient.						5.00	1.41	6	2	6	2.57	3.79	4
4.6	They address behavioral health concerns (e.g., smoking, health management, pain).						6.00	1.00	6	4	7	2.57	4.5	7
4.7	They explore the meanings of illness from the patient’s perspective.						4.22	1.72	4	1	7	2.21	3.79	2.79
<b>TREATMENT &amp; MANAGEMENT</b>														
5.0	THE PC-MHI PROGRAM OFFERS COMPREHENSIVE TREATMENT MODALITIES FOR UNCOMPLICATED MENTAL HEALTH DISORDERS IN THE PRIMARY CARE SETTING.						6.89	0.33	7	6	7	2.39	5.44	7
<b>PC-MHI ENSURES THAT TREATMENT AND MANAGEMENT INCLUDE THE FOLLOWING:</b>														
5.1	A documented guideline-concordant initial treatment/management care plan for all assessed patients						6.25	0.71	6	5	7	2.67	3.5	5.25
5.2	A single treatment/management plan that reflects both behavioral and medical elements						5.89	1.17	6	4	7	1.36	4.64	5
5.3	A treatment/management plan that accurately reflects initial assessment findings						6.11	1.17	7	4	7	3.64	2.43	5.5
5.4	A treatment/management plan that reflects both primary care and mental health provider input or agreement						5.78	1.39	6	3	7	1.71	5.42	5.5
5.5	A treatment/management plan that reflects input from all relevant care team members for complex patients (e.g., those with multiple psychosocial and chronic medical conditions)						5.50	1.51	5.5	3	7	2.21	6	5.5
5.6	Documented guideline-concordant follow-up evaluations						5.89	1.27	6	4	7	1.71	6	5.5

## Appendix B: Frequency Results for PCMHI Goals Ratings

	Overall Value					Level	Difficulty	Impact	
	Mean	SD	Med	Min	Max	Mean			
<b>THE FOLLOWING TREATMENTS ARE AVAILABLE DIRECTLY THROUGH PC-MHI, AS INDICATED FOR OR PREFERRED BY THE PATIENT:</b>									
5.7	Brief Problem Solving Therapy (i.e., a cognitive-behavioral intervention to improve an individual's ability to cope with stressful life experiences)	6.11	0.78	6	5	7	1.71	3.42	5
5.8	Brief Cognitive Behavioral Therapy (i.e., a cognitive-behavioral intervention that focuses on examining the relationships between thoughts, feelings, and behaviors, useful for many mental illnesses, including mood and anxiety disorders)	6.00	1.31	6	3	7	1.36	3.79	5.5
5.9	Brief alcohol interventions (i.e., counseling, education, motivational interviewing)	6.78	0.44	7	6	7	2.57	4.29	7
5.10	Motivational Interviewing	6.00	1.00	6	4	7	1.71	5.14	4.5
5.11	Appropriate psychiatric medications	6.11	1.17	7	4	7	3.64	3.14	4.5
5.12	Recovery-oriented and illness self-management, including peer support, and other elements of a wellness recovery plan	5.67	1.00	6	4	7	1.86	4.25	5
5.13	Treatment for common mental health conditions by <i>primary care providers</i> with back-up from mental health	6.44	0.88	7	5	7	2.79	5	6
5.14	Treatment for common mental health conditions that occurs physically within the primary care setting	6.25	1.39	7	3	7	2.25	3.08	5.83
5.15	Integrative treatment modalities such as tai chi, acupuncture, low level exercise, and mindfulness meditation.	3.33	1.32	3	1	5	1.36	4.14	3.14
5.16	Eye Movement Desensitization and Reprocessing for PTSD that is evidence-based and endorsed by the VA and Department of Defense.	2.11	1.45	1	1	5	1.36	6	2.79
<b>FOLLOW-UP AND MONITORING</b>									
6.0	THE PC-MHI PROGRAM OFFERS CONSISTENT FOLLOW-UP ASSESSMENTS AND MONITORING OF PATIENT OUTCOMES WITH APPROPRIATE ADJUSTMENT IN TREATMENTS TO ENSURE PATIENT IMPROVEMENT.	6.67	0.50	7	6	7	1.56	5.44	6.22
<b>PC-MHI ENSURES THAT FOLLOW-UP ASSESSMENTS INCLUDE THE FOLLOWING:</b>									
6.1	Tracking of key symptoms, functional status, adherence to therapy and medications, and side effects.	6.56	0.73	7	5	7	1.71	5.5	7
6.2	Use of structured re-assessment tools	6.44	0.73	7	5	7	1.36	5.5	7
6.3	Use of valid and reliable questionnaires, when relevant	6.67	0.50	7	6	7	1.36	5.5	6.5
6.4	Use of a database or registry to track care	6.44	1.01	7	4	7	1	5.5	6.5
6.5	Tracking of "watchful waiting" for individuals who initially resist engagement in treatment	6.22	0.83	6	5	7	1.86	4.5	5
6.6	Tracking of primary care patients' missed referral appointments to specialty mental health or PC-MHI	5.67	1.50	6	3	7	2.07	4.5	5.5

## Appendix B: Frequency Results for PCMH Goals Ratings

		Overall Value					Level	Difficulty	Impact
		Mean	SD	Med	Min	Max	Mean		
6.7	Feedback on follow-up assessments to primary care providers	6.13	1.36	6.5	3	7	2.07	4.64	6
6.8	Monitoring based on patients' personal treatment goals	5.89	1.36	6	3	7	1.86	5.64	6.42
<b>PC-MHI ENSURES THAT FOLLOW-UP ASSESSMENTS LEAD TO TREATMENT ADJUSTMENTS CHARACTERIZED BY THE FOLLOWING:</b>									
6.9	They are based on lack of adequate symptom improvement, side effects, or poor adherence to therapy or medications.	6.63	0.52	7	6	7	2.67	4.67	5.6
6.10	They are based on discussion in PC-MHI team meetings, when the adjustment is complex.	5.71	1.11	6	4	7	1.5	4.9	4.2
6.11	They use warm handoffs or supported referrals to mental health specialists when appropriate.	5.89	1.45	6	3	7	2.07	4.14	5
6.12	They use brief motivational interviewing that focuses on patient experiences and attitudes to overcome ambivalence about referral or other treatments, when needed.	5.78	0.83	6	5	7	2.21	4.5	6
<b>Quality of Care</b>									
7.0	All PC-MHI activities reflect the attributes of timeliness, algorithmic or stepped-use of resources, and coordination of care.	6.22	0.67	6	5	7	1.56	5.83	6.22
<b>PC-MHI ENSURES THE FOLLOWING REGARDING CARE:</b>									
7.1	Care is timely, based on level of urgency of the patient's situation.	6.00	1.58	6	2	7	5.5	3.14	6
7.2	Care is stepped to reflect patient needs. A stepped care program is characterized by different treatment steps that are arranged in order of increasing intensity, such as (1) watchful waiting, (2) guided self-help, (3) manualized short-term psychotherapy, and (4) medication and/or specialized mental health care.	6.56	0.73	7	5	7	1.71	5.5	6.5
7.3	Care (1) causes the least disruption in the person's life, (2) is the least extensive needed for positive results, (3) is the least intensive needed for positive results, (4) is the least expensive needed for positive results, and (5) is the least expensive in terms of staff training required to provide effective service.	5.78	0.97	6	4	7	1.71	5	5.5
7.4	Care is delivered according to Veteran understanding and preferences.	6.11	0.78	6	5	7	2.93	4.64	5.5

**Appendix B: Frequency Results for PCMHI Goals Ratings**

	Overall Value					Level	Difficulty	Impact
	Mean	SD	Med	Min	Max	Mean		
<b>Table II: PC-MHI Program Features at the national, regional or medical center level for supporting PC-MHI goals</b>								
<b>Policies and Standard Procedures</b>								
<b>8.0 PC-MHI goals are supported by a comprehensive set of policies and standard procedures at national, regional and local levels.</b>								
8.1	5.38	1.41	5.5	3	7	1.94	4.63	4.81
8.1	4.78	1.56	5	2	7	2.67	5.25	3.43
8.2	5.11	1.05	5	4	7	2.07	4.94	3.14
8.3	4.56	1.51	5	2	7	3.64	4	3.14
8.4	6.00	1.20	6.5	4	7	2.83	4.08	4.67
8.5	6.00	0.87	6	5	7	2.57	5	5.83
<b>PC-MHI ENSURES THAT FORMAL AGREEMENTS BETWEEN PRIMARY CARE AND MENTAL HEALTH SPECIALTY INCLUDE THE FOLLOWING:</b>								
8.6	5.44	1.13	5	4	7	3.29	4	4.29
8.7	6.00	0.76	6	5	7	2.42	3.67	6.3
8.8	5.67	0.87	6	4	7	2.25	3.5	5.83
8.9	6.00	0.87	6	4	7	2.25	3.08	6.42

**Appendix B: Frequency Results for PCMHI Goals Ratings**

	Overall Value					Level	Difficulty	Impact
	Mean	SD	Med	Min	Max	Mean		
<b>LEADERSHIP</b>								
<b>9.0 Leadership supporting PC-MHI goals is interdisciplinary (or transdisciplinary).</b>	5.89	0.93	6	4	7	2.78	3.61	4
<b>LEADERSHIP IS INTERDISCIPLINARY ACROSS THE FOLLOWING:</b>								
9.1 Primary care and mental health specialty staff leaders, including nursing, clerical, physician, social work and pharmacy staff.	6.00	1.07	6	4	7	2.57	4.64	4.5
9.2 Mental health specialized treatment leaders, such as leaders of group therapies, substance abuse, or vocational rehabilitation services.	5.00	1.31	5	3	7	1.83	4.08	4.67
9.3 Specialty mental health and primary care providers/leaders such as physicians/psychiatrists, psychologists, social workers, nurse practitioners, and clinical nurse specialists.	5.67	1.22	6	4	7	2.43	3.64	4.5
<b>COLLABORATION/COMMUNICATION/CULTURE</b>								
<b>10.0 PC-MHI creates a culture of collaboration and open communication between and among primary care and mental (behavioral) health.</b>	6.56	1.01	7	4	7	2.39	4.78	5.83
<b>COLLABORATION/COMMUNICATION BETWEEN PRIMARY CARE PROVIDERS AND STAFF AND PC-MHI MENTAL HEALTH SPECIALISTS IS CHARACTERIZED BY:</b>								
10.1 Ongoing bi-directional learning between primary care and mental health staff	6.11	1.17	7	4	7	2.07	4.14	5.83
10.2 An integrated approach that utilizes “curb-side” discussions, interdisciplinary team meetings, and joint treatment planning	6.89	0.33	7	6	7	2.57	2.79	6.5
10.3 The use of E-consults to mental health specialty or the PC-MHI program when appropriate	5.00	1.41	5	2	7	1.71	2.21	3.08
10.4 A team-based approach to management. Team may include primary care provider, the patient’s PACT teamlet, mental health specialist, care manager.	6.44	1.01	7	4	7	2.79	4.64	6.5
10.5 Active communication, coordination, and collaboration around care transitions between providers and between healthcare settings.	6.33	1.00	7	4	7	2.43	4.64	6.5
10.6 Coordination of services through well-delineated, well-communicated points of access	5.78	1.30	6	3	7	2.07	4.14	6.5
10.7 Consistent use of collaboratively-developed decision support and educational tools	5.56	1.59	6	3	7	1.71	3.64	5.5
10.8 Medical record accessibility of mental health and primary care notes across disciplines	5.00	2.00	5	2	7	7	1.71	7
<b>PC-MHI COLLABORATION, COMMUNICATION, AND COORDINATION ARE SUPPORTED BY:</b>								
10.9 PC-MHI management meetings (e.g., for performance improvement, team building, and oversight, that include interdisciplinary leaders)	6.22	0.97	7	5	7	2.43	2.79	5.25
10.10 Routine participation by mental health specialists in PACT team or teamlet meetings or huddles	5.38	1.51	6	2	7	1.36	2.79	3.64

**Appendix B: Frequency Results for PCMHI Goals Ratings**

	Overall Value					Level	Difficulty	Impact
	Mean	SD	Med	Min	Max	Mean		
10.11 PC-MHI provider meetings to review progress of current cases as well as potentially problematic new consults/referrals	5.56	1.24	5	4	7	3.29	2.93	3.94
10.12 Interdisciplinary case discussions of substantially problematic PC-MHI cases	6.00	1.00	6	4	7	2.07	2.79	6.5
<b>CULTURE CHANGE TO PROMOTE THE IMPLEMENTATION AND SUSTAINABILITY OF THE PC-MHI PROGRAM IS FACILITATED BY:</b>								
10.13 Psychological safety among all staff	4.44	1.81	4	2	7	4.5	3.14	2.79
10.14 An open management style	5.44	1.67	6	2	7	2.43	6	5
10.15 Frontline provider/staff involvement	6.00	1.80	7	2	7	2.79	3.14	5
10.16 National, regional, medical system, and practice site leadership support and understanding of PC-MHI goals and processes.	6.33	1.12	7	4	7	2.79	4.14	4
10.17 Social marketing to promote quality improvement (QI) initiatives and staff involvement	5.56	1.33	6	3	7	2.43	3.79	4.5
<b>QUALITY IMPROVEMENT</b>								
<b>11.0 PC-MHI quality improvement initiatives are planned and implemented continuously.</b>	6.00	1.07	6	4	7	1.56	4.67	5.25
<b>QUALITY IMPROVEMENT INITIATIVES ARE CHARACTERIZED BY THE FOLLOWING:</b>								
11.1 Based on data	6.11	1.69	7	2	7	2.07	4.14	5.5
11.2 Involve all relevant disciplines	5.33	1.50	5	3	7	2.43	4.14	3.64
11.3 Directed at PC-MHI performance improvement goals	5.56	1.42	6	3	7	2.43	3.5	4.5
11.4 Provide opportunities for development and application of scientific evidence	5.56	0.88	6	4	7	2.43	5	5
11.5 Routinely review performance measures and adverse outcomes to assess the quality of care delivered to both identified PC-MHI patients and the full population of patients who screened positive for a mental health condition or who were referred to mental health	5.89	0.78	6	5	7	1.71	4.64	5.5
11.6 Routinely review utilization and quality for <i>psychiatric medications</i> across the primary care population	5.78	1.09	6	4	7	1.36	3.64	6
11.7 Routinely review utilization and quality for <i>psychotherapy</i> across the primary care population	5.56	0.73	5	5	7	1	5.14	4.5
<b>Patient Self Management Support</b>								
<b>12.0 Patient self-management support is routinely provided.</b>	6.44	0.53	6	6	7	2.11	4.39	6.22
<b>PATIENT SELF-MANAGEMENT SUPPORT INCLUDES THE FOLLOWING:</b>								
12.1 Patient education about the nature of the disorder and self-management	6.44	0.73	7	5	7	2.79	2.79	5.5
12.2 Identification and support of the patient's own goals and preferences	6.22	1.09	7	4	7	2.42	2.93	6.5
12.3 Review with the patient of his or her individualized care plan	6.33	0.87	7	5	7	2.57	2.79	6

## Appendix B: Frequency Results for PCMHI Goals Ratings

	Overall Value					Level	Difficulty	Impact	
	Mean	SD	Med	Min	Max	Mean			
12.4	Written patient education literature on all target PC-MHI conditions	6.11	0.93	6	5	7	2	1.71	5
12.5	Availability of <i>web-based</i> patient education on all target PC-MHI conditions	6.00	0.87	6	5	7	2.21	3.43	4.64
12.6	Availability of mental health education groups	5.50	1.31	5.5	3	7	2.07	2.43	4.64
12.7	Integration of patient activation or motivational techniques into each key PC-MHI activity as appropriate (e.g., education, showing patients written information about their progress, developing goals, supporting patient self-monitoring of treatment adherence and outcomes, using motivational interviewing)	6.00	1.00	6	5	7	1.71	4.64	5.5
12.8	Discussions and materials to ensure informed decision making by promoting patient knowledge of mental or substance use treatment options and their efficacy	5.33	1.12	5	4	7	1.36	5	4.5
12.9	Use of recovery-oriented practices including peer support and other elements of a wellness recovery plan	5.11	0.78	5	4	6	2.07	4.5	4.64
12.10	Use of policies that implement informed, patient-centered participation and decision making in treatment, illness self-management, and recovery plans.	6.00	0.87	6	5	7	2.43	5.83	6
12.11	Avoidance of coercion	4.22	1.09	4	3	6	5.5	2.07	4.14
<b>DELIVERY SYSTEM RE-DESIGN</b>									
13.0	DELIVERY SYSTEMS ARE DESIGNED TO FACILITATE OPTIMAL DELIVERY OF MENTAL HEALTH CARE IN PRIMARY CARE SETTINGS.	6.13	0.99	6	4	7	1.94	5.69	4.81
<b>PERSONNEL AND WORKFLOWS FOR CARRYING OUT PC-MHI ACTIVITIES ARE DESIGNED TO:</b>									
13.1	Minimize duplication of work and maximize coordination between individual providers and between mental health and primary care services	5.56	0.88	6	4	7	1.71	5	4.5
13.2	Reduce errors	5.00	1.22	5	3	7	4.5	4	5.5
13.3	Efficiently and effectively connect patients who have PC-MHI target conditions to PC-MHI primary care-based modalities when appropriate	6.44	0.73	7	5	7	2.79	5	6.5
13.4	Efficiently and effectively connect patients to non-PC-MHI mental health services when required, such as specialized substance abuse treatment, vocational rehabilitation services, and housing services.	6.13	1.36	7	4	7	3.14	4	6
13.5	Locate PC-MHI mental health services physically within the primary care setting	6.11	0.93	6	5	7	3.5	4.14	5
13.6	Locate PC-MHI mental health services as close to the patient as possible, such as through telephone care or telemental health	6.33	0.71	6	5	7	2.43	4.64	5.5
13.7	Create appropriate pathways from screening to assessment, and then to appropriate treatment and follow-up care.	6.38	0.92	7	5	7	2.79	3.5	6.5

## Appendix B: Frequency Results for PCMHI Goals Ratings

	Overall Value					Level	Difficulty	Impact
	Mean	SD	Med	Min	Max	Mean		
13.8 Enable appropriate care management and treatment (including medication, psychotherapy, and substance abuse)	6.89	0.33	7	6	7	1.71	5.5	7
<b>CARE MANAGEMENT DESIGN INCLUDES THE FOLLOWING FEATURES:</b>								
13.9 Predominantly utilizes a staff member other than a treating mental health provider	4.56	1.88	5	2	7	4.25	4.67	3.67
13.10 Predominantly utilizes nurses	5.00	1.94	6	2	7	3.67	3.83	3.83
13.11 Utilizes social workers	4.89	1.76	5	2	7	4.08	2.42	3.83
13.12 Targets uncomplicated patients who could be cared for through provision of medications or brief psychotherapy in primary care	6.33	1.12	7	4	7	4.08	2.83	5.83
13.13 Carries out or coordinates the full range of PC-MHI activities (e.g., assessment, proactive follow-up and supported referral) for appropriate patients, using standardized tools and protocols.	6.56	0.53	7	6	7	3.83	5.25	7
13.14 Addresses the intersection between medical and psychological/psychiatric conditions	5.89	1.05	6	4	7	5.25	4.25	5.25
13.15 Addresses treatment adherence	6.11	1.05	6	4	7	4.67	4.25	5.83
13.16 Provides outreach/education/decision support to PCPs on mental health issues	6.44	0.73	7	5	7	3.25	3.67	5.83
13.17 Promotes communication and collaboration between primary care and mental health specialists	6.22	0.97	6	4	7	3.67	3.67	5.83
13.18 Supports psychiatric medication management by PCPs for appropriate cases	6.56	0.53	7	6	7	4.25	3.08	7
13.19 Delivers brief psychosocial interventions	6.44	0.53	6	6	7	3.08	2.67	5.25
13.20 Delivers interventions for substance misuse or abuse in appropriate patients	6.44	0.73	7	5	7	3.25	3.67	6.42
13.21 Delivers interventions for PTSD in appropriate patients	5.56	1.13	6	4	7	1.83	4.67	4.25
13.22 Is supervised by a mental health specialist	6.67	1.00	7	4	7	4.08	2.67	5.83
13.23 Is funded and evaluated through primary care	3.56	2.35	4	1	7	1.83	4.83	2.42
13.24 Is funded and evaluated through mental health specialty	2.89	1.83	2	1	5	4.67	3.25	1.83
<b>MEDICATIONS FOR MENTAL HEALTH CONDITIONS THAT CAN BE PRESCRIBED BY PRIMARY CARE PROVIDERS UNDER PC-MHI GUIDELINES INCLUDE:</b>								
13.25 Antidepressants	6.78	0.44	7	6	7	4.67	2.67	6.42
13.26 Anti-anxiety medications	5.89	1.90	6	1	7	3.67	3.08	4.4
13.27 Pain medications	5.00	1.32	5	3	7	4.83	3.42	4.83
13.28 Medications for SMI, PTSD, or substance abuse, such as antipsychotics, when recommended by PC-MHI or another mental health specialist with a written care plan.	5.44	0.88	5	4	7	1.83	5.25	4.67
<b>PSYCHOTHERAPY IS ROUTINELY AVAILABLE THROUGH PC-MHI AND CHARACTERIZED BY THE FOLLOWING:</b>								
13.29 Available as group therapy	6.22	0.97	7	5	7	1.42	3.67	5.83

**Appendix B: Frequency Results for PCMHI Goals Ratings**

	Overall Value					Level	Difficulty	Impact
	Mean	SD	Med	Min	Max	Mean		
13.30 Available as individual therapy	6.00	1.12	6	4	7	3.67	4.42	4.67
13.31 Targeted to depression	6.11	1.17	7	4	7	5.42	2.67	7
13.32 Targeted to PTSD	5.11	1.62	5	3	7	2.67	5.25	5.83
13.33 Consistent with cognitive behavioral or other accepted manualized short-term therapy guidelines	6.56	0.53	7	6	7	1.83	5.83	5.25
13.34 Available through direct referral of uncomplicated patients by PC-MHI staff	5.67	1.22	6	4	7	2.67	3.25	4.08
<b>SUBSTANCE ABUSE TREATMENTS ARE ROUTINELY AVAILABLE THROUGH PC-MHI AND CHARACTERIZED BY THE FOLLOWING:</b>								
13.35 A full range of substance abuse treatments are available (i.e., outpatient detoxification, medication-assisted abstinence, counseling, education, group therapy, motivational interviewing) through the PC-MHI program.	4.67	2.40	6	1	7	1.42	5.25	6
<b>THE FOLLOWING APPLY TO EDUCATIONAL OPPORTUNITIES:</b>								
13.36 PC-MHI staff providing care management services receive formal training in care management protocols and skills.	6.67	0.71	7	5	7	3.08	3.83	5.25
13.37 PC-MHI seminars, case conferences, or other educational formats are routinely available.	6.25	0.89	6.5	5	7	3.08	3.25	4.08
13.38 PC-MHI educational activities target both mental health specialists and primary care participants.	6.44	0.73	7	5	7	1.42	4.42	5.25
13.39 The PC-MHI staff receives regular formal skills updates and/or ongoing continuing education to support integrated PC-MHI.	6.00	1.12	6	4	7	2.25	4.08	5.25
13.40 The PC-MHI program regularly trains primary care providers about the program and about the management of common mental health disorders, particularly in psychopharmacology.	6.22	0.67	6	5	7	1.42	4.08	5.25
<b>CLINICAL INFORMATION SYSTEMS</b>								
<b>14.0 Clinical information systems provide decision support and allow the PC-MHI program to monitor patient outcomes longitudinally and systematically.</b>	6.67	0.50	7	6	7	1.31	5.25	6.56
<b>CLINICAL INFORMATION SYSTEMS INCLUDE THE FOLLOWING:</b>								
14.1 The collection of process and outcomes data according to protocols, through the use of structured assessment tools and supportive software	6.44	0.88	7	5	7	1.42	5.25	5.83
14.2 Tools to track all PC-MHI patients over time (e.g., use of a registry or panel management software) for purposes of monitoring clinical and administrative outcomes	6.67	0.71	7	5	7	1.42	4.67	6.42
14.3 The ability to share clinical information needed for effective decision-making	6.22	0.83	6	5	7	3.25	4.83	6.42
<b>COMMUNITY RESOURCES</b>								
<b>15.0 Strong linkages with community resources are established to support the patient.</b>	5.00	1.00	5	4	6	3.44	3.88	4.81

**Appendix B: Frequency Results for PCMH Goals Ratings**

		Overall Value					Level	Difficulty	Impact
		Mean	SD	Med	Min	Max	Mean		
15.1	Clinicians providing mental or substance use treatment services maintain effective, formal linkages with community resources to support patient illness self-management and recovery.	5.11	1.05	5	3	6	3.67	2.67	4.67
15.2	Linkages may include both clinical (e.g., local vet center, community mental health clinic) and nonclinical services (e.g., personal care services, home-delivered meals, or school-based health care)	4.89	1.36	5	3	7	3.67	2.67	5.25
15.3	Collaboration with the local network of community behavioral health centers (i.e., community mental health clinic) is established to facilitate meeting the unmet mental health needs of Veterans.	4.88	1.55	5	2	7	2.83	3.25	4.42

## Appendix C: Program Role Recommendations for PC-MHI, Mental Health Specialty & Primary Care

- A checkmark (✓) means that for the indicated activity (Quality Leadership, Assessment, Management & Treatment), the program should have primary or shared responsibility for that condition/population, or that a Care Manager (CM) should have a role in assessing or managing the condition.
- A blank cell means that for the indicated activity, the program should not have primary or shared responsibility for that condition/population, or that a Care Manager (CM) should not have a role in assessing or managing the condition.
- A **yellow highlight** means the poll results did not indicate consensus for that particular item (i.e., that one or more team members disagreed with the recommendation).
- A red checkmark (✓) means that the recommendation was changed as a result of the team discussion. A comment explains this change further.

### Care-related activities are defined as follows:

<b>Quality Leadership (QL)</b>	Indicates which services have ownership over designing and monitoring effective care systems in each of the target goal areas.
<b>Assessment (Assess)</b>	Indicates which services are responsible for ensuring the completion of a post-screening assessment adequate for the purpose of management and treatment of the indicated condition.
<b>Management &amp; Treatment (M&amp;T)</b>	Indicates which services are responsible for ensuring appropriate management and treatment of the condition through direct per patient oversight or support (e.g., through a care manager) or through implementation of treatment.

	PC-MHI				PRIMARY CARE			MHS			COMMENTS
	QL	ASSESS	M&T		QL	ASSESS	M&T	QL	ASSESS	M&T	
			CM	CM							
Screening and case finding for mental health conditions					✓						
Women	✓				✓						
OEF/OIF Veterans	✓				✓						
Homeless persons	✓				✓						
Elderly persons	✓				✓						
Psychiatric Emergencies (acute suicide or homicide intention, acute psychosis, or acutely deteriorated functional status such as depressed elderly patients not eating).	✓	✓	✓					✓	✓	✓	
Multiple Psychiatric Illnesses (e.g., three or more mental health diagnoses, with at least one being severe)		✓						✓	✓	✓	

## Appendix C: Program Role Recommendations for PCMH, MHS & PC

	PC-MHI					PRIMARY CARE			MHS			COMMENTS
	QL	ASSESS		M&T		QL	ASSESS	M&T	QL	ASSESS	M&T	
			CM		CM							
Mild-moderate depression	✓	✓	✓	✓	✓	✓	✓	✓				Changed PC from having a collaborative role to having some primary responsibility for all three activities.
Severe depression	✓	✓	✓	✓	✓				✓	✓	✓	
Mild-moderate post-traumatic stress disorder (PTSD)	✓	✓	✓	✓					✓	✓	✓	
Severe PTSD		✓							✓	✓	✓	
Mild-moderate depression and mild-moderate PTSD	✓	✓	✓	✓	✓					✓	✓	
Mild to moderate alcohol-related problems or at-risk use	✓	✓	✓	✓	✓	✓	✓	✓				
Severe alcohol abuse or dependence									✓	✓	✓	
Mild to moderate abuse or at risk use of substances other than alcohol	✓	✓		✓	✓		✓	✓				
Severe abuse or dependence of substances other than alcohol		✓							✓	✓	✓	
Mild-moderate situational anxiety (may include panic attacks)	✓	✓	✓	✓	✓	✓	✓	✓				Changed CM role from 'No' to 'Yes'
Severe or chronic anxiety (i.e., Generalized Anxiety Disorder, Panic attacks)	✓	✓		✓					✓	✓	✓	
Mild-moderate dementia		✓		✓				✓	✓	✓	✓	
Severe dementia		✓						✓	✓	✓	✓	
Suicidal ideation, no indication of intent		✓	✓	✓	✓		✓	✓	✓			Changed MHS to a primary responsibility for leadership
Suicidal ideation, with plan or high risk factors	✓	✓		✓				✓	✓	✓	✓	
Previously diagnosed schizophrenia or bipolar disorder of any level of severity									✓	✓	✓	
Chronic pain managed with non-pharmacologic modalities (i.e., acupuncture)							✓	✓				
Chronic pain managed with prescription medications							✓	✓			✓	
Poor adherence to medications (e.g. for chronic medical or psychiatric conditions)		✓	✓	✓		✓	✓	✓				
Poor adherence to lifestyle modification (e.g. for treating or preventing chronic medical conditions)			✓		✓	✓	✓	✓				
Insomnia		✓	✓	✓	✓	✓	✓	✓				

**Appendix C: Program Role Recommendations for PCMHI, MHS & PC**

	PC-MHI					PRIMARY CARE			MHS			COMMENTS
	QL	ASSESS		M&T		QL	ASSESS	M&T	QL	ASSESS	M&T	
		CM	CM	CM	CM							
Somatization	✓	✓		✓		✓		✓				
Grief, bereavement (when not prolonged)	✓	✓		✓		✓		✓				
Prolonged grief	✓	✓		✓					✓	✓	✓	
Difficult or disruptive behavior		✓		✓		✓		✓		✓	✓	
Traumatic brain injury (TBI)								✓				
Psychological response to an episode of trauma, chronic, repetitive trauma or other adjustment issues	✓	✓		✓	✓			✓	✓		✓	
Patients who refuse mental health specialty care.	✓	✓		✓				✓				
Patients who are psychiatrically stable, and currently receive the majority of their care from primary care or wish to have primary care as their overall (mental and physical) care source.	✓	✓		✓				✓				
Patients who require intensive primary care for a period of time to stabilize physical health problems.	✓	✓		✓				✓				
Patients who fail to respond to initial medications or therapy.	✓	✓		✓					✓	✓	✓	
<b>Total ✓ (out of 38):</b>	<b>22</b> 58%	<b>27</b> 71%	<b>11</b> 29%	<b>22</b> 58%	<b>10</b> 26%	<b>14</b> 37%	<b>10</b> 26%	<b>21</b> 55%	<b>16</b> 42%	<b>16</b> 42%	<b>18</b> 47%	

## Appendix D:

### Examples of PACT and PC-MHI collaboration for common scenarios:

- Veteran screens positive for alcohol use disorder:

Before the scheduled visit with the primary care provider, the PACT nurse finds that the male Veteran has a positive AUDIT-C score of 5. The nurse alerts the primary care provider. During the visit, the primary care provider assesses the patient for alcohol abuse, dependence, and hepatotoxicity. The primary care provider feels uncomfortable with providing brief intervention but feels that the patient does not warrant a referral to a substance abuse specialist. After the visit, the primary care provider escorts the patient to the PC-MHI care manager, who engages the patient in brief intervention and motivational interviewing. The care manager also provides the patient with VA and community resources on alcohol misuse. The care manager then sets up the expectation with the Veteran for a telephone follow-up in two weeks.

- Veteran with chronic pain and stable major depressive disorder:

A Veteran with chronic lower back pain follows-up with a PC-MHI provider after having been diagnosed with major depressive disorder six months ago. Today, his PHQ-9 is 6, and he has been on the maximum dose of SSRI for two months. The patient has also been sporadically attending the chronic pain and mood disorders group therapy. The PC-MHI psychiatrist believes that the patient can be followed-up with primary care in the future, and the patient is amenable to that. The discharge note is written in CPRS with clear instructions of when the patient should be referred back to PC-MHI; therapies to continue, including the antidepressant and the group therapy; and side effects to monitor. During the following week's interdisciplinary joint case conference, the psychiatrist briefly discusses the case to handoff the patient to the PACT team. The PACT care manager calls the patient the same week to re-assess the PHQ-9 and set up a follow-up appointment with the PACT provider.

- Emergency situations:

The primary care provider follows-up on a Veteran with depression on a stable dose of SSRI, who has been seen by a PC-MHI provider several months ago. In interviewing the patient, the primary care provider finds that the PHQ-9 is 20 and the patient endorses suicidal ideation. Upon further questioning, the primary care provider assesses suicide risk and finds that the patient is not willing to divulge whether or not he has a plan. The primary care provider calls the PC-MHI care manager for available PC-MHI staff and walks the patient to the available PC-MHI provider for further evaluation.

- Routine communication between PACT and PC-MHI:

PACT and PC-MHI providers engage in active communication throughout the week through regularly-occurring meetings. PC-MHI providers may rotate through PACT teamlet huddles and participate in discussions to help PACT teamlets prepare for difficult or complex

## Appendix D: Examples of PACT and PC-MHI collaboration for common scenarios

patients, new consults to PC-MHI, or those recently discharged from PC-MHI. PACT and PC-MHI providers may meet during weekly interdisciplinary joint case conferences to review complex patients with comorbid mental disorders.

- Veteran has chronic insomnia:

The PACT provider sees a Veteran with chronic insomnia. The PACT care manager or nurse has already educated the patient on self-management strategies with sleep hygiene, and the primary care provider has already ruled out sleep apnea with a negative sleep study. After discussing patient preference for non-pharmacologic therapies, the primary care provider refers the patient to the PC-MHI provider for primary care based CBT-I and mindfulness groups and gives the patient a flier describing them. There are no more groups that day, and the patient does not wish to wait to talk to a PC-MHI staff. The PC-MHI staff receives the consult electronically and calls the patient the following day.

- Veteran with PTSD:

A Veteran has a screened positive for PTSD on the PCL-C on his first visit to primary care. The nurse alerts the primary care provider about the possible diagnosis. During the visit, the primary care provider brings up the possibility of PTSD and needing further specialized mental health care, and the Veteran acknowledges the severity of his symptoms but insists that he “will not see a shrink.” The primary care provider also assesses for suicidal ideation and finds that the Veteran is not suicidal. The primary care provider is worried that the Veteran will not follow up with specialty mental health and asks the Veteran if he can talk to a member of the team about his disturbing symptoms to get some relief. The Veteran accepts. The primary care provider calls the PC-MHI staff to find out who is available and walks the patient to the available staff member.

- Task sharing:

The PC-MHI lead has run through the registry of Veterans who had screened positive for alcohol misuse over the past year. The lead finds that 10% of them have not had any patient encounter in six months, including phone calls or visits. The lead shares the list with the PACT teams, and the PACT teams find that some names have been flagged by their registries as needing prescriptions renewed or follow-up labs. The PACT team care managers call the Veterans that need prescription renewals or follow-up labs and also re-assess and perform motivational interviewing on the patients during the same call. The PC-MHI care managers call the remaining Veterans to follow-up, re-assess with an AUDIT-C, and perform motivational interviewing over the phone.