

Psychologists in Patient-Centered Medical Homes (PCMHs): Roles, Evidence, Opportunities, and Challenges

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The patient-centered medical home (PCMH) is an increasingly common model of health care delivery with many exciting opportunities for psychologists. The PCMH reflects a philosophy and model of care that is highly consistent with psychological science and practice. It strives to provide patient-centered, comprehensive, team-based, coordinated, accessible, and quality and safety-oriented health care delivery to individuals and families. Moreover, in keeping with changes in the health care system more broadly, the PCMH model prioritizes the integration of behavioral and physical health care, and this emphasis lays the foundation for active and full engagement of psychologists in this context. This article provides an overview of the PCMH and the evidence and roles for psychologists across a range of pediatric, adult, and geriatric health care populations and settings. Current challenges to the necessary expansion of psychology in the PCMH are discussed, with particular attention to the needs for training and advocacy to support the contributions of behavioral health care in the PCMH. Psychology must embrace its rightful place as a health profession and appreciate and highlight the ways in which psychologists can play unique and critical roles in transforming present and future health care delivery models.

Keywords: patient-centered medical home, psychology, health care delivery

Dissatisfaction with health care systems in the United States, combined with rapid changes in how care is delivered and uncertainty about the implications (for patients, families, providers, and payers), have created valuable op-

portunities and significant challenges for psychology.¹ This article focuses on one model of integrated care that aims to improve delivery and patient outcomes—the patient-centered medical home (PCMH)—which offers excellent prospects for workforce growth for psychologists (Beacham, Kinman, Harris, & Masters, 2012). This article offers the first in-depth examination of the roles, evidence, opportunities, and challenges for psychologists engaging in leadership, clinical care, research, and education/training in PCMHs. After overviewing the relevant background and definitions, this article focuses on opportunities for psychologists in the PCMH, examines the impact of behavioral health issues on care delivery and patient outcomes, and discusses how psychologists can provide models of effective integrated care. Challenges in integrating psychology in the PCMH also are considered, such as our current low level of visibility, the need for interprofessional collaboration, and workforce issues. General strategies are offered to ad-

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¹ We refer frequently to psychologists, appropriate to the primary intended audience for this article. However, the authors intend that the article be relevant to a broader audience of behavioral healthcare providers and consistent with the necessity for interprofessional collaboration in the PCMH.



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dress these concerns in order to optimize psychologists' engagement, roles, and responsibilities in PCMHs.

The Patient-Centered Medical Home (PCMH)

Key Definitions, Structure, and Functions of the PCMH

The Agency for Healthcare Research and Quality (n. d.) is characterized in the definition from the Patient-Centered Primary Care Collaborative (PCPCC, n. d.) and by its five functions and attributes put forth by the Agency for Healthcare Research and Quality (AHRQ, n. d.). Based on the PCPCC's definition, the PCMH is not a physical location, but is

a model or philosophy of primary care that is Patient-centered, Comprehensive, Team-based, Coordinated, Accessible, and focused on Quality and Safety . . . a philosophy of healthcare delivery that encourages providers and care teams to meet patients where they are, from the most simple to the most complex conditions . . . a place where patients are treated with respect, dignity, and compassion and enable strong and trusting relationships with providers and staff . . . not a final destination . . . a model for achieving primary care excellence so that care is received in the right place, at the right time, and the manner that best suits a patient's needs.² (www.pcpcc.org)

The PCPCC (n. d.) definition incorporates many of the PCMH functions and attributes that are delineated by the AHRQ. *Patient-centered* underscores the partnerships essential to the PCMH and a focus on respect for patients' personal, family, and cultural backgrounds, and attention to

care that has value to patients and families. *Comprehensive care* includes addressing behavioral as well as physical health, with care requiring a team of interprofessional providers. *Coordinated care* indicates that providers communicate with one another and assure the integration of all services and treatments provided within and beyond the walls of the medical setting. *Accessible services* means that PCMH appointments are available in a timely and convenient manner and that alternative delivery approaches are used when they can facilitate patient engagement (e.g., home-based services). Finally, *quality and safety* highlight the importance of monitoring outcomes and conducting quality improvement projects.

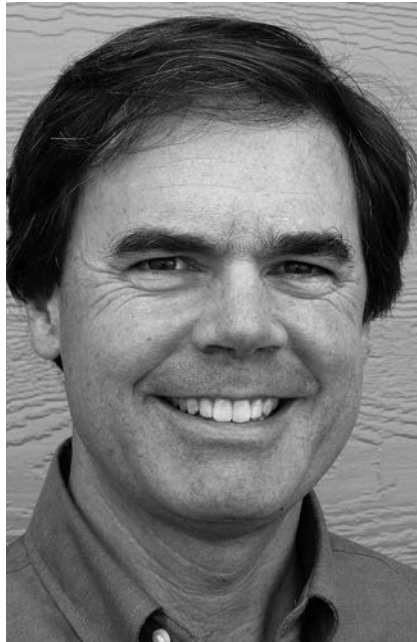
Background of the PCMH

The medical home concept came initially from pediatrics when it first appeared in the Standards of Child Health Care, published by the American Academy of Pediatrics Council on Pediatric Practice (1967). The concept was next highlighted internationally in the 1978 World Health Organization conference at Alma Alta (World Health Organization, 2008), which described primary care using language that is incorporated into the PCMH model, but did not use the term itself. In 1996, the Institute of Medicine specifically used the term "medical home" (Institute of Medicine, 1996). In the beginning of the 21st century, the PCMH became recognized as a model to address the extensive overhaul and redesign of the health care system in the United States that was cogently articulated in the Institute of Medicine report, *Crossing the Quality Chasm* (Institute of Medicine, 2001).

In 2006, the National Demonstration Project was the first test of an innovative PCMH model in 36 family practices in the United States, with findings guiding policy and implementation efforts (Crabtree et al., 2010). In 2007, the Veterans Health Administration launched the Primary Care Mental Health Initiative (PC-MHI) to integrate the care of common behavioral problems (depression, anxiety, substance use; Zeiss & Karlin, 2008). That same year, the PCMH concept was endorsed by the major primary care professional organizations in a joint statement that delineated the primary principles of the PCMH (American Academy of Family Physicians, American Academy of Pediatrics, American College of Physicians, & American Osteopathic Association, 2007).

The National Committee for Quality Assurance (NCQA, n. d.) has transformed 7,000 primary care practices into medical homes (www.ncqa.org/HomePage.aspx). Many commercial insurers pay higher reimbursement rates to practices that have earned NCQA PCMH recognition. More

² Although the PCPCC definition focuses on primary care, the PCMH is broader. Our discussion reflects the important roles of psychologists across settings. The definition is also individually focused ("the patient"). We endorse an approach that is inclusive of families and is family-centered.



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recently, the American College of Physicians extended the PCMH concept to the patient-centered medical home neighbor (PCMH-N), acknowledging that the PCMH does not exist in isolation but must coordinate care across acute and post acute care, ambulatory specialty practices, and community and social service resources, including behavioral health programs (AHRQ, 2011; American College of Physicians, 2010). In 2013, the NCQA began designating specialty practices as patient-centered specialty-practice programs. The PCMH is informed by and influences broader movements in health care, such as the Triple Aim and the Affordable Care Act (ACA, 2010). Patient Protection and Affordable Care Act (2010).

The Triple Aim (improving patient experiences, promoting the health of populations, and reducing the per capita cost of care) exemplifies the paradigm shift that undergirds changes in health care and guides objectives in the PCMH (Berwick, Nolan, & Whittington, 2008). The consideration of patient experiences is a major entry point for psychologists. Although patient experience is sometimes simplified to mean *patient satisfaction*, it is appropriately inclusive of a broader range of factors, such as safety, effectiveness of treatments, implementation of patient-centered care, timeliness, efficiency, and equity in care delivery. The patient experience must also include the family members' experience, as family-centered outcomes are critically important for optimizing care. These are broad constructs for which psychological theory and practice are quite relevant.

Population health, the second component of the Triple Aim, necessitates a shift from conceptualizing health at the level of individuals to that of a defined group of people (Kindig & Stoddart, 2003). A population health

perspective rests on a broad vision of determinants of health, interventions, and outcomes on a continuum ranging from epigenetic to cultural (Halfon, Larson, Lu, Tullis, & Russ, 2014). It underscores the importance of utilizing behaviorally oriented approaches, such as those promoting health behaviors, preventing maladaptive lifestyle problems, and engaging the community. The incorporation of such approaches facilitates the coordination of systems, as well as the access to and delivery of comprehensive health care. It also requires that essential research questions are addressed, including those in the realm of behaviorally oriented approaches, such as developing and testing interventions that positively impact health, understanding health risks across the life span, and developing and using measures that assess outcomes associated with population health. Psychologists have many competencies and associated components that are relevant for population health, including health promotion and prevention, behaviorally oriented approaches, consultation, research methods and statistical methods, and social ecologically and systemically oriented research and practice.

Finally, the Triple Aim requires reducing per capita health care costs. Measuring cost (and value for cost) is critical. The electronic health record is central to the PCMH as a tool for controlling cost as well as improving population health. Of relevance to psychologists, this includes collecting information from patients about health behaviors, preferences, and psychosocial functioning (Glasgow, Kaplan, Ockene, Fisher, & Emmons, 2012). Psychologists' knowledge, skills, and attitudes can be applied as part of larger efforts in PCMH practices to reduce per capita cost, especially when addressing costly behavioral health problems, conducting program development and evaluation, and using psychometrically sound approaches to assess impact on cost. Indeed, a review of studies has demonstrated the cost effectiveness of integrating behavioral health into primary care settings (Tice et al., 2015).

The PCMH is important to primary and integrated care, in keeping with the 2010 Patient Protection and Affordable Care Act (ACA, 2010; <http://housedocs.house.gov/energycommerce/ppacacon.pdf>). The ACA mandates broad changes in health care delivery, access to care, preventative care, patient choices, payment models, and coverage of preexisting conditions and young adults. However, as with any change of this magnitude, much remains unclear about how the ACA will be actualized, managed, and monitored. Several key components of the ACA are relevant to psychology and the PCMH. In particular, psychologists are more valuable members of the PCMH team because they can play key roles in offering services that are now available because of people's increased access to care, the implementation of parity and associated coverage, and the growing focus on integrated care models (McDaniel & deGruy, 2014).



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Opportunities for Psychology in the PCMH

There are many compelling reasons to integrate behavioral health in the PCMH in order to help achieve the Triple Aim. Behavioral health problems in primary care patients are very common; up to 30% of primary care patients meet diagnostic criteria for behavioral health problems, including anxiety, mood, somatoform, and substance use disorders (Serrano-Blanco et al., 2010). These problems often go unrecognized and/or are undertreated (Wang et al., 2005), even in the traditional PCMH model (Massa, Miller, & Kessler, 2012). This, in turn, increases costs in multiple domains, including lost wages from sick days, increased unemployment related to disability, and frequent hospitalizations. Psychologists are well trained and well suited to provide behavioral health assessments, interventions, and consultations for individuals with significant behavioral health problems who present to the PCMH.

The costs of managing chronic disease increase significantly when comorbid behavioral health conditions exist, and multiple chronic medical conditions have high rates of co-occurring depression. Research using mortality data from the Centers for Disease Control and Prevention found that largely preventable and modifiable health behaviors and risk factors (e.g., tobacco use, poor diet, alcohol use) contributed to nearly half of all premature deaths (Mokdad, Marks, Stroup, & Gerberding, 2004). Limited availability of patient education and coaching for health-promoting activities (e.g., diabetes management, pain management, tobacco cessation) also contributed to increased morbidity and mortality. Psychological services in the PCMH can help reduce the high costs associated with chronic diseases by identify-

ing and actively intervening with individuals with comorbid behavioral and physical illnesses, such as by enhancing their health behaviors and improving their chronic illness self-management efforts. Indeed, behavioral health interventions within medical settings facilitate improved self-management of chronic diseases, ultimately decreasing frequency of hospitalizations and number of high utilizers of health care services. These proximal and distal effects subsequently bolster patient satisfaction with services and allow for greater panel sizes by decreasing repeat visitors, which contribute to decreased provider burnout and higher reimbursement. As discussed later, workforce development efforts are needed to assure primary care competencies for psychologists in the PCMH.

Barriers to accessing services can complicate help seeking among patients and increase attrition (Institute of Medicine, 2006). Embedding psychologists in the PCMH helps patients overcome barriers to accessing services, including stigma of seeking services in behavioral health settings and long wait times due to a limited supply of providers. Individuals from ethnic/racial minority backgrounds tend to seek behavioral health services through primary care rather than traditional behavioral health clinics (Gum, Iser, & Petkus, 2010), further supporting the importance of behavioral services in the PCMH. This level of integration with a focus on whole-person care can enhance patient experience and outcomes, quality of care, and reduce provider burnout (Reid et al., 2010).

Support for Increased Integration of Behavioral Health in the PCMH

Professional organizations and regulatory agencies have called for increased integration of behavioral health in the PCMH. Recent years have witnessed historic progress in this regard. Integration efforts are supported by the creation of the "Joint Principles: Integrating Behavioral Health Care into the Patient-Centered Medical Home" (Baird et al., 2014, hereafter, Behavioral Joint Principles) and the release of new behavioral health standards by the NCQA.

Joint Principles: Integrating Behavioral Health Care into the Patient-Centered Medical Home. Representatives from six national family medicine organizations, with psychologists accounting for nearly one third of the representatives, convened as the Working Party Group on Integrated Behavioral Health Care (Baird et al., 2014). The group recognized that comprehensive whole-person care was not being achieved because many of the transformation efforts in primary care practices nationally were not incorporating behavioral health care. Trying to retrofit existing PCMH programs to include behavioral health is possible, but more difficult and less effective than prospectively building it into the original design.



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The Behavioral Joint Principles (see Table 1) call for behavioral health care to be incorporated into primary care practice settings to ensure patients have access to the full benefits of the high quality of care delivered in the PCMH. The Behavioral Joint Principles serve as a separate, supplementary document to the original Joint Principles of the Patient-Centered Medical Home (American Academy of Family Physicians, 2007). The principles recognize the centrality of behavioral health care as part of the PCMH, following the order and language of the original principles while emphasizing steps to incorporate behavioral elements. The members of the team—including the physicians and behavioral health professionals—working within defined roles and using complementary skill sets, engage the patient

and family in articulating the patient's needs and in developing a care plan.

The principles emphasize access to behavioral health care in the PCMH, primarily through physical integration and coordination of behavioral health and primary care, especially if the patient accesses behavioral health services that are separate from the PCMH. Considering the challenge of payment for integrated behavioral health services, the principles stress that appropriate payment recognizes the added value of behavioral health care as part of the PCMH. Since its release, the Behavioral Joint Principles received endorsement from a number of organizations, including the American Psychological Association (Anderson et al., 2014).

NCQA behavioral health standards. Another important development for behavioral health integration is the emphasis of behavioral health in the NCQA medical home standards (NCQA, 2014). The expectation in these standards is that primary care practices support patients' behavioral health. Practices are to disclose the range of the behavioral health services they offer, and when services are not part of the practice, the standards require that referral agreements be established with behavioral health providers. The 2014 standards also update the 2011 standards by emphasizing team-based care, focusing care management on high-need populations, and aligning quality improvement efforts with the Triple Aim objectives (NCQA, 2014). Psychologists in the PCMH are well prepared to favorably influence each of these areas (Nash, Khatri, Cubic, & Baird, 2013). For example, psychologists' team facilitation skills can enhance the effectiveness of team-based care. In addition, the assessment and other research-based abilities psychologists have can be used to identify and monitor high-need patients. Psychologists also have the ability to develop plans to address the social determinants of health that can be part of the care management focus.

Table 1
Synopsis of Joint Principles: Integrating Behavioral Health Care in PCMH

Principle	Principle description
Personal physician	Every patient in the PCMH has a personal physician committed to the patient's well-being
Physician-directed medical practice	Practice has a team of health care professionals acting together to integrate the physical, emotional, and social aspects of the patient's health care needs
Whole person orientation	Practice relies on a coordinated team of health care professionals to integrate the physical, emotional, and social aspects of the patient's health care needs
Care is coordinated or integrated	Behavioral health care is fully incorporated including the behavioral together with the physical
Quality and safety	Across all elements of the health care system, care is coordinated and integrated via shared registries, medical records, decision making, revenue streams, and responsibility for the patient's care plan
Enhanced access	Behavioral health clinicians included in care planning process; information technology incorporates behavioral health elements
Payment:	Payment recognizes the added value of behavioral health care as part of the PCMH, and the behavioral health clinicians as members of the team
Access	Access to behavioral health care resources is provided for patients, families, and physicians

Note. PCMH = patient-centered medical home. Adapted from "The Development of Joint Principles: Integrating Behavioral Health Care Into the Patient-Centered Medical Home," by M. Baird, A. Blount, S. Brungardt, P. Dickinson, A. Dietrich, T. Epperly, . . . F. Degruy, 2014, *Annals of Family Medicine*, 12, p. 183. Copyright 2014 by the Annals of Family Medicine, Inc.

Although NCQA recognition has historically focused on primary care settings, in 2013, NCQA launched a program for patient-centered specialty practices (PCSPs). These recognition standards explicitly state that practices, including behavioral health practices, demonstrate patient- and family-centered care, successful care coordination, effective communication between specialty and primary care teams, timely access to services, and continuous quality improvement efforts can be recognized as PCMHs. Practices with doctoral- or master's-level psychologists, as well as other behavioral health care professionals, are eligible for PCSP recognition. This offers new and significant opportunities for behavioral health providers who practice together in a fashion guided by the PCMH. Psychologists have a long-standing history of participation on interprofessional teams within specialty contexts across the life span, and as these specialty clinics gain PCSP designation, psychologists' roles will likely expand and shift. Over time, it is hoped that the PCSP standards explicitly will include the integration of behavioral health care into the specialty care programs for them to gain recognition.

Psychology Practice in PCMH

There are many examples of behavioral practice in the PCMH, and increasing data support the efficacy of integrated care within the PCMH. Roles for psychologists in the PCMH are broad and wide-ranging (Kaslow, Kapoor, Dunn, & Graves, 2015). Beyond providing direct clinical

assessment and interventions as clinicians, psychologists often serve as consultants to the team, program developers and assessors, team leads, teachers/supervisors (to psychology and nonpsychology trainees), and researchers (Nash et al., 2013). The varied competencies that psychologists possess enable them to be well suited to the myriad roles and responsibilities for behavioral health providers in the PCMH. An extensive review of these roles, associated activities, and competencies exceeds the scope of this article, but these are briefly outlined in Table 2.

The PCMH encourages providers to practice broadly, often placing psychologists in clinical practice, consultative, supervisory, management, and leadership roles (Nash et al., 2013). Psychologists often work in tandem with primary care providers to address behavioral health issues affecting patient health care (e.g., medication adherence, behavior problems, health literacy). This can take the form of hallway conversations to prompt the provider with clarifying questions to identify underlying behavioral health concerns, brief sessions with the patient (and family members) to hone the diagnostic understanding (shortness of breath due to anxiety or a medical problem), or more intensive behavioral health assessment to address suicidality or other risks (Vogel, Kirkpatrick, Collings, Cederna-Meko, & Grey, 2012). Psychologists may refer the patient back to the primary care provider for further follow-up and treatment planning, provide several brief individual or group therapy sessions to prepare them for specialized care (e.g., intensive outpatient

Table 2
Roles, Responsibilities, and Activities of Psychologists in Patient-Centered Medical Homes

Roles	Responsibilities	Activities
Clinician	Provides whole-person assessment, diagnosis, referral-specific conceptualization; evidence-based interventions	Screen for psychosocial and behavioral health problems; change health behaviors; implement brief evidence-based interventions; provide preventive interventions; treat couples/families; manage complex patients in collaboration with team to address complex biopsychosocial needs
Consultant	Responds to requests for patient care issues promptly with practical recommendations	Coach primary care provider on methods to facilitate health behavior change; provide treatment recommendations
Teacher/Supervisor	Teaches and provides supervision to trainees in psychology and other fields	Train psychology and other healthcare providers (e.g., medicine, nursing, pharmacy) by developing curricula and providing supervision and training; foster collaborative team work
Administrator/Team Lead	Facilitates management of behavioral and behavioral health service; promotes collaboration between/across sites, and enhances team functioning	Lead efforts to build behavioral health services within PCMH; network with outside agencies to foster collaborative care in the medical neighborhood; provide interventions to enhance team functioning; increase access to care; develop interprofessional behavioral health group protocols in chronic pain, depression, diabetes management; collaborate in system redesign
Researcher	Applies research methods to quality improvement practices in support of PCMH goals	Lead quality improvement projects; review cultural sensitivity of approaches to determine the sensitivity and specificity for a given population; develop program evaluation tools to determine efficacy of interventions; evaluate efficacy of PCMH model and attend to implementation and dissemination of care models

Note. PCMH = patient-centered medical home.

treatment for depression), offer couples/family work, consult and link them to community resources (e.g., schools, Alcoholics Anonymous, support groups), and/or collaborate with the patient and his or her care team in developing a treatment plan for self-management of chronic disease (Fisher & Dickinson, 2014; Katon et al., 2010). Behavioral health providers within the PCMH have multiple roles and responsibilities, which vary depending on the population served and the types of problems encountered.

Although psychologists in the PCMH are helpful to patients with mild or acute behavioral health needs, they must devote their attention to patients who account for higher costs or who are in need of higher levels of care (e.g., diabetes, chronic pain, coronary heart disease, depression, serious mental illness [SMI]; Pourat, Lavarreda, & Snyder, 2013). For patients with chronic health conditions, the PCMH reduces the number of in-person visits and hospitalizations, thus lowering health care costs and increasing access for new patients (Katon et al., 2010; Liss et al., 2013).

Psychologist Contributions in PCMH to Specific Populations and Settings

Pediatric Populations

Early adoption of the PCMH model in pediatrics is consistent with the specialty's focus on families. Children with complex health conditions often require intensive treatment and coordination of care over many years and developmental stages. The PCMH initially provided a means by which medical records could be centralized to facilitate communication among patients, families, health care providers, schools, and community agencies. Over time, the model has continued to be utilized in complex care, including the transition from pediatric to adult care in youth with chronic medical conditions, in which patients, families, and providers must partner to develop a plan that will assure that the child's health care needs are met as they enter adulthood and must assume more independence for that health and well-being. Pediatric psychologists are trained to work in settings with other health providers and have an established track record in collaborating in pediatric subspecialties addressing behavioral aspects of care (e.g., adherence to treatment, pain, quality of life, behaviors that affect treatment outcomes) with a range of evidence-based treatments (see the 2014 *Journal of Pediatric Psychology* special issue with systematic reviews of a range of treatments appropriate to pediatric health conditions, including pain, elimination disorders, disease-related symptoms, and adherence; Palermo, 2014).

Pediatrics illustrates the application of the PCMH for specialized (as in the examples given here) and primary care. Parents historically have shared concerns about their

child's development or behavior with pediatricians. The top parental concerns about children's health, across racial and ethnic groups, are behavioral and related to topics for which there is considerable psychological research (e.g., stress, attention-deficit disorder, anxiety and depression, childhood obesity, substance use, bullying, school violence, Internet safety, gun-related injuries, teen pregnancy; C.S. Mott Children's Hospital National Poll on Children's Health, 2013). Therefore, there are many opportunities for psychologists to partner with pediatricians to address these concerns and there is evidence for the impact of these interventions from meta-analyses (Asarnow, Rozenman, Wiblin, & Zeltzer, 2015) and randomized clinical trials (Asarnow, Kolko, Miranda, & Kazak, 2015).

Geriatric Populations

Geriatrics involves the patient and family members in integrated, whole-person care due to the high prevalence of medical and behavioral comorbidities and the frequency of transitions in care for frail older adults who may have limited resources to coordinate care. Geropsychologists train in interprofessional care settings and provide a range of services, including brief and longer term psychotherapy, cognitive testing, behavioral and environmental interventions, and consultation with medical providers and teams (e.g., nursing home staff; American Psychological Association, 2013; Knight, Karel, Hinrichsen, Qualls, & Duffy, 2009).

Geriatric care demonstrates the application of the PCMH across settings (primary care, residential facilities, patients' homes) and in transitions of care (Coleman, 2003). Those in long-term care environments living with dementia benefit from team-based collaborative care models with embedded behavioral health services that include nonpharmacological approaches (Maurer, McKeith, Cummings, Ames, & Burns, 2006). Similar collaborative care models have existed for decades for older adults living in nursing homes and other long-term care environments, and for those receiving non-curative palliative care or end-of-life hospice care (Haley, Larson, Kasl-Godley, Neimeyer, & Kwilosz, 2003). However, most community-dwelling older adults seek behavioral health services through primary care settings and prefer nonpharmacological interventions for behavioral health conditions (Gum et al., 2006). Recognizing underlying behavioral health concerns is critical given older adults' elevated risk for suicide and tendency to have seen their primary care providers within one month of suicide. Moreover, when working with older adults, providers' and patients' attitudes and beliefs toward aging must be attended to; these can cause misdiagnosis, treatment delays, and reduced survival rates (American Psychological Association, 2013). Additionally, health care providers must bolster their cultural sensitivity in the care they provide, as older

adults are embracing aspects of their identities that historically have been ignored (e.g., self-identifying as LGBT).

Department of Veterans Affairs (VA) Medical Centers

The VA made major efforts to develop and implement the PCMH in 2010 via the PACT Initiative (Kearney, Post, Pomerantz, & Zeiss, 2014). This stepped model of care allows the team to manage mild to moderate behavioral health problems and reserve specialty behavioral health services for veterans requiring or requesting more intensive treatment. It aims to reduce delays in treatment, which ultimately reduces attrition and increases treatment engagement. The PC-MHI team provides these services through colocated collaborative care, care management, or a combination of both (Kearney et al., 2014; Pomerantz, Kearney, Wray, Post, & McCarthy, 2014). Providers coordinate care with other specialty services, while also providing time-limited interventions to support the veteran and the care team (e.g., motivational interviewing for substance use; suicide risk assessment and safety planning). This approach incorporates interprofessional training to empower nonbehavioral health providers (primary care nurses, physicians, dietitians, pharmacists, and medical social workers) with the requisite skills to facilitate health-promoting behaviors. In addition, the Home-Based Primary Care (HBPC) program offers a collaborative, interprofessional approach for veterans with complex medical, and often psychiatric, needs, with behavioral health providers offering in-home services. It prevents hospital readmissions, which decreases costs, improves health-related quality of life, and enhances self-management of chronic illnesses. With the mandate for HBPC teams to have behavioral health providers, veterans have access to services they may not have sought or received due to logistical or cultural barriers (Zeiss & Karlin, 2008).

Individuals With SMI

The PCMH model is informing new integrated care initiatives to address the challenges of SMI (Ward, Miller, Marconi, Kaslow, & Farber, 2016). Individuals with SMI die prematurely, 25 years earlier on average than the general population, in part due to higher rates of cardiovascular and pulmonary disease, obesity, and smoking (Croghan & Brown, 2010). There are challenges in caring for individuals with SMI, considering the complexity of co-occurring chronic disease, substance use, poverty, and other sources of vulnerability. Medicaid, which has a large role in covering individuals with SMI, recognizes these challenges, and the need to address fragmented care is accounting for some of the poor quality and high cost of care (Croghan & Brown, 2010). Individuals with SMI who are connected to

community-based behavioral health services may not receive adequate medical care, and those connected to primary care may lack effective behavioral health care.

Medicaid integration efforts for SMI focus on reaching the patient in their “home,” which can be primary care or community behavioral health contexts. Some initiatives are integrating behavioral health services in the PCMH in which patients with SMI are connected (e.g., Federal Qualified Community Health Centers; Alakeson, Frank, & Katz, 2010). Medicaid also supports initiatives to incorporate primary care services into community behavioral health settings (i.e., reverse colocation; Druss et al., 2010). Another Medicaid initiative established by the Affordable Care Act, the “Health Home,” employs teams of primary care and behavioral health providers that connect with patients in the community, and coordinate and integrate whole-person services and supports needed by patients. Although mechanisms for providing integrated care for people with SMI are not yet established, the essential elements are likely to include aspects of care planning and management, evidence-based treatments, consistent measurement and outcome tracking, and medication adherence (Croghan & Brown, 2010).

Underserved Populations

Many PCMH transformation efforts, particularly those funded by the government (e.g., Federally Qualified Health Centers), are based in underserved communities. Individuals in underserved communities have complex health and behavioral health issues that result in part from social determinants (e.g., housing, transportation). Health disparities are more common in the underserved and resource poor. Given psychologists’ expertise related to reducing health disparities associated with behavioral and physical health challenges, and the growing emphasis on creating patient-centered care models in communities in which high levels of health disparities exist, psychologists must be at the center of these unfolding efforts (Farber, Ali, Van Sickel, & Kaslow, 2015). Psychologists must communicate about the ways they are indispensable to such efforts; engage in the PCMH as leaders, clinicians, educators, and researchers; and use data to demonstrate the value added by health care integration (Kessler, Stafford, & Messier, 2009).

Challenges for Psychology in the PCMH and Proposed Solutions

Along with the growing opportunities, there are challenges for psychologists to contribute more significantly. Psychologists play important and meaningful roles, but they typically are less integrated and less visible than would be expected considering the increased demand for behavioral health in the PCMH. In contrast to academic health centers

and VA Centers, psychologists are less likely to be located in community health centers where many PCMH transformation efforts have occurred. In these settings, master's-level clinicians are present and may be favored due to cost concerns. Determining complementary roles that will further accelerate the integration of collaborative behavioral care is an important step to overcome this challenge.

Although psychologists have many competencies that transfer to the PCMH, the current workforce may not be adequately prepared for the changing health care environment, highlighting the need to develop an appropriately trained workforce (Kessler et al., 2009; Runyan, 2011). A workforce analysis with current information about the diversity and nature of psychologists' roles in the health care context will enable strategic planning for training (Cubic, Mance, Turgesen, & Lamanna, 2012). This training must include interprofessional education (Institute of Medicine, 2003; Rozensky, 2012) and focus on the associated core competencies (Interprofessional Education Collaborative Expert Panel, 2011). Interprofessional education at all levels, including experiential training in PCMHs, will help ensure mutual respect about disciplines, shared values and goals, more integration of physical and behavioral health care, and greater dedication to patient-centered initiatives (Cubic et al., 2012). It will help ensure that psychologists and their interprofessional colleagues utilize an integrated, collaborative, team-based approach to delivering high-quality, continuous, comprehensive, compassionate, evidence-based, and culturally relevant care to individuals across the life span, as well as their families (McDaniel & Fogarty, 2009; Rozensky, 2014b).

Graduate students, interns, and postdoctoral fellows who train in the pertinent competencies in pediatric psychology, geropsychology, rehabilitation psychology, and other health services psychology, as well as primary care psychology, and those with experience in translating research into health care settings will be best prepared to enter the PCMH workforce (Beacham et al., 2012, 2015; Health Service Psychology Education Collaborative, 2013; McDaniel et al., 2014; Nash et al., 2013). Efforts are needed to expand training opportunities, especially at the graduate level. Knowing that psychologists are transitioning from other settings to work in PCMHs underscores the need for creating pertinent continuing professional development models. In reality, the training models at all levels of development must broaden their focus and attend more to data on the effectiveness of the integrated care model, workforce analysis and development, finances (e.g., reimbursement, health care cost offset), professional accountability (e.g., specialization), and advocacy and leadership (Rozensky, 2014a). Such education and training across the professional life span will help ensure that our workforce is well prepared and ready to not just serve as frontline service providers, but also as leaders of and on PCMH teams.

Reimbursement for psychologists' services has been challenging, especially in the context of service delivery. This partly reflects a lack of fit between the models for coding and reimbursement vis-à-vis the delivery of physical versus behavioral health care and challenges with the health and behavior codes (Kessler, 2008). In the PCMH, the fee-for-service model does not support the many nonreimbursable activities that psychologists engage in to support the most important PCMH initiatives. For example, team-based consultation, program development, and program evaluation are all key for improving care and controlling costs, but are not supported financially under the predominant pay structure. Psychologists need to build a more convincing evidence-based case for their financial relevance in the new health care finance climate (Miller et al., 2015). They must be active participants in the ongoing efforts focused on the reimbursement of behavioral health services in primary and specialty care settings (Kautz, Mauch, & Smith, 2008). As we shift from a system of care structured around reimbursement to one that is patient-centered and related to care integration, performance, and quality, psychologists must be at the table to build the case for appropriate reimbursement for behavioral health services. We must negotiate with payers and policymakers about performance criteria that would indicate the value-added of our services and the ways in which these should be compensated (Kessler et al., 2009).

There are major possibilities for psychologists locally and nationally to partner with colleagues from other professions and organizations to ensure full inclusion of behavioral health care in the PCMH. Psychologists must shape the future of PCMHs by advocating for more inclusive terms (e.g., health care home; clinician rather than physician as the point person; Anderson et al., 2014); such terms convey that this model does not have to be medically or physician centered. The PCMH model suggests that the entire team shares the responsibility for actualizing patient-centered care, with the term "patient" being loosely defined depending on the setting and cultural context. These interprofessional partnerships will be most successful if they focus on integrated care in the PCMH context that is fully collaborative in nature.

Conclusion

The time is now for health care professionals, including psychologists, to advance health care reform from the "inside out" (Berwick, Feeley, & Loehrer, 2015). Current changes in health care delivery offer many opportunities for psychologists, particularly given the many prior and ongoing contributions of behavioral science to health outcomes across patient groups. Psychologists now have the opportunity to apply this knowledge and assume greater leadership roles as the focus of health care shifts from patient-centered care to patient- and family-centered care and a systemic and

collaborative approach to such care delivery. People live in a family context, and families are critical to their loved one's health and well-being, as well as their care when they are ill and approach the end of life. Psychologists can and should give meaning to the word "home" in the PCMH model (McDaniel & Fogarty, 2009).

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