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Primary Care-Mental Health Integration in Healthcare in the Department of Veterans Affairs

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The U.S. Department of Veterans Affairs (VA) has been undergoing tremendous transformation in the past 15 years with regard to the delivery of health care. This special issue describes one aspect of this transformation of the largest health system in the U.S.; the system-wide efforts to integrate mental health treatment into the primary care setting in VA. This primary care-mental health integration (PC-MHI) is being accomplished through the central VA system support and implementation of three primary models developed in the field: the White River Colocated models, the Behavioral Health Laboratory, and TIDES (Translating Initiatives in Depression into Effective Solutions). The papers in this special issue describe the development of these models, local and regional efforts to prepare medical centers to adapt and implement PC-MHI, and the impact of the integration on mental health care in these settings. These efforts could represent a national model of PC-MHI implementation for health care systems throughout the U.S.

Keywords: primary care-mental health integration, primary care, mental health services, military veterans

In the past 15 years, health care delivery in the facilities of the Department of Veterans Affairs (VA) has undergone a gradual but dramatic transformation. This transformation has been driven by several factors, including responsibility for care of a growing diversity of patients ranging from aging World War II veterans through veterans from more recent conflicts in Iraq and Afghanistan. Another important stimulus was the New Freedom Commission on Mental Health (2003), a Presidential report that set new standards for delivery of mental health care. To meet these standards, VA has faced the same inevitability of adding a new venue for mental health and substance abuse services that has faced by the rest of health care delivery in the U.S. This special issue focuses on the resulting area of the transformation of VA care—the systematic integration of mental

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health care into the clinical setting in which most such care is delivered in the U.S., the primary care clinic.

THE VETERANS HEALTH ADMINISTRATION

With over 800 primary care clinics in all 50 states and Puerto Rico and over 5.7 million active patients seen in 75 million outpatient visits, the VA operates the United States' largest single health care system. Funded by Congress as part of the yearly federal budget, the Veterans Health Administration (VHA) is a risk-adjusted capitated single payer managed care organization. The VHA is largest component of VA; the other two components of VA are the Veterans Benefits Administration and the National Cemeteries Administration. The VHA is responsible for lifetime care of a cohort of patients, generally beginning in late adolescence or early adulthood. The VHA has traditionally served as a safety net for those veterans of military service disabled during their military duty or living near or below the federal poverty level. As such, its population has been noted to carry a higher illness burden and greater number of medical problems than most health systems. In recent years, it has also attracted an increasing number of more affluent patients, covered by other third party payers and drawn to the VA by its emphasis on prevention and quality of care.

The VHA has undergone a significant structural transformation in the past 15 years. It has decentralized from a single headquarters serving all facilities, to a system of 22 regional networks, known as Veterans Integrated Service Networks (VISNs). First described by the VA Undersecretary of Health as "22 experiments . . ." in health care delivery, the VISNs are responsible for assuring the provision and quality of health care services throughout each region. Each has a director and administrative structure, although there is variation between VISNs in how each is structured and functions. Funding for each medical center is apportioned based on patient enrollment and workload and is distributed from the VISN office, based each year on the budget appropriated by congress. Per-patient reimbursement is based on a formula that considers patient complexity and varies from ~$2,800 per year for basic care, with the highest level of reimbursement for complex mental illness being $39,000. Medical Centers are reimbursed $62,000 or more for total of all care for the most complex, catastrophically ill veterans. Although any facility may spend more or less on a specific patient, it is generally held to its year to year funding. In addition, some patients are covered by third party payers. Some of these veterans are responsible for insurance copays and charges for some medications. Patients treated for service-connected disability pay nothing for their care and pharmacy expenses and are reimbursed for their travel to the nearest VA medical Center or clinic that can meet their needs.

In addition to the structural transformation in the 1990s, the VA also transformed its service delivery, with the establishment of over 2000 Community Based Outpatient Clinics (CBOCs). Individual clinics treat from a few hundred to 20 thousand or more patients. This marked the change from VA as a hospital-based specialty provider to a community based primary care system, with broad access to specialty services (VA Office of Mental health Services, 2007). Each year, the VA opens more clinics as it moves further out from the 168 medical centers. Each CBOC is a subsidiary of a medical center. In recent years, VA has embraced telemedicine and home based primary care to reach further into the rural areas served by the CBOCs. More recently, VHA has embarked on a transition to the Patient Centered Medical Home model of care, a model that recognizes the key role of the primary care provider in overall management and coordination of a person's health care (American Academy of Family Practice, American Academy of Pediatrics, American College of Physicians, & American Osteopathic Association, 2007). The VHA is currently adjusting its resources to provide resources

for development of primary care teams in all of its medical centers and facilities.

From its earliest days in the 19th century, VA has been especially knowledgeable about illnesses related to military service and combat. The psychological sequelae of military service have figured prominently in VA medical care. Chronic pain, depression, substance abuse, traumatic stress, persistent mental illness, and other diagnoses have been have been important foci of VA care. In addition to treatment of mental illness, VA has long had an important health psychology focus, as veterans have long struggled with behavioral issues complicating their general medical care. Overseen for decades from Washington, DC, by the Mental Health and Behavioral Sciences Service (now called Office of Mental Health Services), mental health, substance use disorders, and health psychology have all been part of behavioral health care delivered in the VHA. These components of care have been integrated to a greater or lesser extent depending on decisions at the local medical center level.

THE CURRENT ISSUE

In many VA medical centers, primary care-mental health integration (PC-MHI) efforts have been in development for decades. From programs to treat morbid obesity to more recent collaborative care programs, VAs emphasis on mental health as part of overall health has always been strong. These early efforts in VA (i.e., Pomerantz et al., pp. 114–129, this issue) paralleled efforts in community (Blount, 1998) and military (Wilson, 2004) settings to increase access to behavioral health care, improve outcomes, and increase efficiency by integrating behavioral health care providers into the primary care setting.

As described in this issue by Post et al., (pp. 83–90) the VA recognized the integrated care programming by issuing a request for proposals for new programs in 2007. There are now 137 funded programs, in addition to many that developed without specific funding or spun off from funded programs. Initially, facilities applying for funding were asked to pick from among 3 core models, which had set the standard for integrated care in previous years. The three core models included:

1. Depression care management: Described in this issue (pp. 91–113) by Rubenstein and coauthors, the TIDES (Translating Initiatives in Depression into Effective Solutions) program brought the evidence based care management paradigm to VA primary care, using the Evidence Based Quality Improvement (EBQI) process to a selected group of clinics. This program has now spread throughout the system. Rubenstein and colleagues detail both the details of the program as well as its careful implementation in those sites.
2. Behavioral Health Laboratory: This unique program, developed out of primary care-based mental health research by Oslin and colleagues in Philadelphia also uses telephone care management, but addresses a number of mental health issues that occur in primary care, using detailed clinical algorithms that determine patient care—from watchful waiting to immediate referral to mental health. The model features a comprehensive telephone diagnostic assessment covering a number of domains. It is described in this issue (pp. 130–145) by Tew, Klaus, and Oslin.
3. Colocated collaborative care: Developed at the White River Junction VA medical Center in Vermont through a quality improvement process, this initiative rearranged mental health resources to embed a mental health team in primary care. The team provides open or same-day access to streamlined psychological and psychiatric assessment and treatment for all patients in primary care. It is described in this issue by Pomerantz and coauthors (pp. 114–129).

These programs differ on several dimensions and readers might make note of the features and benefits associated with these particular characteristics. In contrast to the White River Model, the Behavioral Health Laboratory (BHL) began as a telephone based model and TIDES was created with the flexibility of face-to-face or telephone delivery of care. Telephone based models have obvious benefits for care delivery in rural settings where the patients served are drawn from a geographically dispersed population. In addition, programs vary with respect to their focus—TIDES was originally developed to focus on care management of depression—and the White River colocated and BHL models focus on a broad range of mental health conditions and the behavioral components of medical conditions such as pain. Although there has been benefit through TIDES in developing an effective program to manage one condition well, most primary care settings benefit from having care available for a broad spectrum of conditions.

Another way that these core models differ is emphasis on different forms of care provided, from evaluation and triage (all three models), care management (TIDES and BHL), brief cognitive–behavioral interventions (White River colocation and to some extent BHL and TIDES), medication consultation (all three models), and primary care provider (PCP) education (White River colocation, TIDES, and to a lesser extent BHL). All three models introduce multiple disciplines into the treatment team, although the BHL and TIDES models may intrude less into the PCP-patient relationship because of the decreased emphasis on face-to-face separate clinical sessions that occur in the White River colocated model.

One omission from the components of all three models is a systematic way to include family members in the care of a veteran in primary care settings. Family members are integrally involved in the primary care of veterans, from medical decision-making to providing reminders to take medication (Sayers, White, Zubritsky, & Oslin, 2006). Currently, models of family involved treatment for medical patients require a high degree of specialization (McDaniel, Hepworth, & Doherty, 1992). Thus, the integration of family members into primary care-based mental health care awaits further development and maturation of the existing models.

Within a short time after funding the new programs, it became apparent that the most effective approaches to integrated care were those that blended the models together and now, after only 3 years, most programs blend models in a way that assures adaptation to local culture, resources and patient care needs. In the current issue, Kirchner and coauthors (pp. 161–174) describe a process using external and internal facilitation to implement a variety of different programs across the VAs largest single network. Funderburk and coauthors (pp. 146–160) describe the experience of another large network with a long tradition of colocated care. The paper by Brawer et al. (pp. 175–187) paper compliments the others in this issue of *Families, Systems and Health* by providing a description of an integrated care program in a single facility and its impact on primary care providers' treatment of mental illness. There is a natural tension between fidelity to a particular model and blending or transforming models to respond to local needs and preferences. The lessons that can be drawn from the success with which each program manages the issues of fidelity to and/or local modification of models makes the VA implementation a pilot for similar health care transformation in the U.S. as a whole.

Although there are many reasons to integrate mental health care, substance abuse treatment and behavioral psychology into primary care, all health care is local. The solutions developed in VA and outlined in this issue are best viewed as illustrating a number of principles of successful integration, rather than as a road map to be followed from point to point. It might be argued that VA is better able

to afford to invest its resources in what is a very difficult reimbursement environment for other systems of care. It is true that VA has invested a great deal of effort and financial resources in development of integrated care, but many of the most successful programs were developed by rearranging existing resources, questioning paradigms of care and thus better meeting the mental and behavioral health needs of its patients. Despite all the new funding for this endeavor, VA spends the same percentage of its yearly budget on mental health as does Medicaid.

Hopefully this special issue will help readers understand many effective ways that PC-MHI can be accomplished, as well as the efforts needed to make it a reality. A decade of research, as well as reports from the Surgeon General (Satcher, 1999), the Institute of Medicine (Institute of Medicine Board on Health Care Services, 2000), and the President's New Freedom Commission (New Freedom Commission on Mental Health, 2003) support the claim that such integration is an essential ingredient of quality health care and an integral part of the patient centered medical home.

REFERENCES

American Academy of Family Practice, American Academy of Pediatrics, American College of Physicians, & American Osteopathic Association. (2007). *Joint principles of the patient-centered medical home.* Retrieved from http://www.pcpcc.net/content/joint-principles-patient-centered-medical-home

Blount, A. (1998). Introduction to integrated primary care. In A. Blount (Ed.), *Integrated primary care: The future of medical and mental health collaboration* (pp. 1–43). New York: W W Norton & Co.

Brawer, P. A., Pye, P. L., Manwaring, J., & Tierney, A. (2010). St. Louis Initiative for integrated care excellence (SLI^2CE): Integrated collaborative care on a large scale model. *Families, Systems, & Health, 28,* 175–187.

Funderburk, J. S., Sugarman, D. E., Maisto, S. A., Ouimette, P., Schohn, M., . . . Strutynski, K. (2010). The description and evaluation of the implementation of an integrated healthcare model. *Families, Systems, & Health, 28,* 146–160.

Institute of Medicine Board on Health Care Services. (2000). *Improving the Quality of Health Care for Mental and Substance-use conditions: Quality chasm series.* Washington, DC: National Academies Press.

Kirchner, J., Edlund, C. N., Herderson, K., Daily, L., Parker, L. E., & Fortney, J. C. (2010). Using a multi-level approach to implement a primary care mental health (PCMH) program. *Families, Systems, & Health, 28,* 161–174.

McDaniel, S. H., Hepworth, J., & Doherty, W. J. (1992). *Medical family therapy: A biopsychosocial approach to families with health problems*: New York: Basic Books.

New Freedom Commission on Mental Health. (2003). *Achieving the promise: Transforming mental health care in America. Final Report.* Rockville, MD: New Freedom Commission on Mental Health.

Pomerantz, A. S., Shiner, B., Watts, B. V., Detzer, M. J., Kutter, C., Street, B., & Scott, D. (2010). The White River model of colocated collaborative care: A platform for mental and behavioral health care in the medical home. *Families, Systems, & Health, 28,* 114–129.

Post, E. D., Metzger, M., Dumas, P., & Lehmann, L. (2010). Integrating mental health into primary care within the Veterans Health Administration. *Families, Systems, & Health, 28,* 83–90.

Rubenstein, L. V., Chaney, E. F., Ober, S., Felker, B., Sherman, S. E., Lanto, A., & Vivell, S. (2010). Using evidence-based quality improvement methods for translating depression collaborative care research into practice. *Families, Systems, & Health, 28,* 91–113.

Satcher, D. (1999). *Mental health: A report of the Surgeon General.* Rockville, MD.

Sayers, S. L., White, T., Zubritsky, C., & Oslin, D. W. (2006). Family involvement in the care of healthy medical outpatients. *Family Practice, 23,* 317–324.

Tew, J., Klaus, J., & Oslin, D. W. (2010). The behavioral health laboratory: Building a stronger foundation for the patient-centered medical home. *Families, Systems, & Health, 28,* 130–145.

VA Office of Mental Health Services. (2007). *Uniform mental health services handbook.* Washington, DC: VA Office of Mental Health Services.

Wilson, P. G. (2004). The Air Force experience: Integrating behavioral health providers into primary care. In R. G. Frank, S. H. McDaniel, J. H. Bray, & M. Heldring (Eds.), *Primary care psychology* (pp. 169–185): Washington, DC: American Psychological Association.