

Veterans Health Administration Primary Care-Mental Health Integration Initiative

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The Veterans Health Administration has undertaken a large national initiative to integrate primary care and mental health services. A request for proposals was disseminated throughout the Veterans Affairs (VA) system inviting proposals for new programs to promote the effective treatment of common mental health and substance use disorders in the primary care environment. Both individual facilities and Veterans Integrated Service Networks (VISNs) were eligible to apply, and proposals could encompass activities at one or multiple VA facilities. Similarly, facilities within VISNs were free to use different evidence-based models for delivering integrated care. Program funding commenced during fiscal year 2007 (FY07).

The overarching rationale for the initiative is to integrate care for veterans' physical and mental health conditions, improve access and quality of care across the spectrum of illness severity, and allow treatment in mental health specialty settings to focus on persons with more severe mental illnesses.

The report of the President's New Freedom Commission on Mental Health emphasizes that mental health and physical health problems are interrelated components of overall health and are best treated in a coordinated care system.¹ That recognition also is embedded in the VA's Mental Health Strategic Plan and its goal to "[d]evelop a collaborative care model for mental health disorders that elevates mental health care to the same level of urgency/intervention as medical health care."²

The important context of integrated care recognizes several facts: primary care provides opportunities to screen for unrecognized disease; mental health and substance abuse conditions are common and are often treated by primary care practitioners; patients may prefer treatment in primary

care settings; an established relationship with a primary care practitioner fosters engagement in and adherence to treatment; and health conditions do not always fall neatly into "physical" and "mental health" categories. As former Surgeon General David Satcher said, "Primary care practitioners are a critical link in identifying and addressing mental disorders... Opportunities are missed to improve mental health and general medical outcomes when a mental illness is under-recognized and under-treated in primary care settings."³

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Approximately 20% of the 5 million veterans who received VA care in FY05 received mental health services. However, the number of veterans diagnosed with mental health disorders is even greater. While some have complex or severe conditions

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that require specialty services, others may benefit from receiving mental health treatment in the primary care setting, administered either by primary care practitioners who are given appropriate support or by mental health practitioners based in the primary care environment. Colocated collaborative treatment and care management are two evidence-based models for services that can promote patient engagement in and adherence to treatment and can avoid stigmatization and fragmentation of care. Furthermore, using these models allows providers to facilitate the coordination of care for mental health problems and other medical conditions which can translate into important patient outcomes. For example, one recent trial of an effective 2-year integrated care program for depression among older primary care patients demonstrated reduced all-cause mortality over a 5-year period.⁴

An example of the evidence base for integrated care models within VA is the Primary Care Research in Substance Abuse and Mental Health for Elderly (PRISM-E) study which VA and the Substance Abuse and Mental Health Services Administration (SAMHSA) of the US Department of Health and Human Services undertook to better understand what care delivery systems are effective for managing depression, anxiety disorders, and problem drinking in older primary care patients.⁵⁻⁷ The PRISM-E randomized controlled trial demonstrated that patients were significantly more likely to engage in mental health services that were integrated with primary care than to follow through on referrals to specialty services. For example, depressed patients in integrated care were 2.86 times more likely to have at least one contact with a mental health specialist than those in referral care.⁷ Findings like these led the President's New Freedom Commission to recommend important elements of integrated care such as expanded screening and collaborative care in primary care settings.

While much of the research evidence in this area has focused on depression, there also have been studies demonstrating the efficacy of an integrated approach for anxiety disorders⁸⁻¹¹ and problem drinking.¹²⁻¹⁶ Although there is no current evidence demonstrating the effectiveness of this approach for managing patients with posttraumatic stress disorder (PTSD), research is in progress.

Three major categories of integrated care models are being implemented in the Primary Care-Mental Health Integration Initiative: (1) colocated collaborative care; (2) care management; and (3) blended models that incorporate features of the other two.

Colocated collaborative care entails both mental health and primary care practitioners being physically present in the primary care setting with shared responsibility for evaluation, treatment planning, and monitoring outcomes. Episodes of care in this model can vary depending on the needs of the patient, ranging from a referral with a "warm hand-off" to informal consultation with primary care practitioners. A particular example of colocated collaborative care in VA is the White River Model of open access mental health treatment in primary care. This model has demonstrated significant increases in both the proportion of depression screen-positive patients receiving any treatment as

well as the proportion of patients receiving guideline-concordant treatment for depression.¹⁷

Care management models need not be physically located in the primary care setting, but care managers are actively involved in the process of delivering mental health treatment to primary care patients. Nurses constitute a core profession in care management, although social workers and psychologists perform the role of mental health care manager, too. Care managers interact directly with patients, facilitate ongoing evaluation, and maintain active communication that enables responsibility for mental health treatment to remain in the primary care setting. Two examples of care management models in VA are Translating Initiatives for Depression into Effective Solutions (TIDES) and the Behavioral Health Laboratory. The TIDES care management model uses registered nurses to provide guideline-based treatment support and has demonstrated high levels of treatment engagement among depressed primary care patients.¹⁸ The Behavioral Health Laboratory uses a software-based structured assessment for initial evaluation as well as on demand follow-up in support of primary care-based mental health and substance abuse treatment. Its implementation in a primary care setting led to a significant increase in the proportion of patients screening positive for depression as well as identification of substantial numbers of cooccurring mental health disorders and substance misuse.¹⁹

Finally, blended models combine elements of both care management and colocated, collaborative care. In a blended model, the mental health practitioner evaluates patients and offers psychosocial treatment when preferred or needed while the care manager provides complementary services including education, ongoing assessment, monitoring of adherence, algorithm-based use of medication, and referral management when necessary.

Irrespective of the structural form of the integrated care model, there are standard minimum requirements for the scope and process of services provided under the initiative. Foremost among these is a focus on prevalent conditions in primary care, namely depression, alcohol misuse and abuse, and PTSD. This is in keeping with the overarching rationale of integrated care being a complement rather than a substitute for mental health specialty services. Integrated care programs have an existing foundation upon which to build in that VA already screens primary care patients for depression, alcohol misuse, and PTSD on an ongoing basis. Important required components of evaluation, treatment, and follow-up include the following: risk assessment and appropriate action for suicidality among patients that screen positive for depression and PTSD; watchful waiting for subsyndromal conditions; availability of evidence-based treatments in primary care including brief treatment for problem drinking and pharmacological treatment for major depression; access to evidence-based psychotherapies; and ongoing monitoring for treatment adherence, medication side effects, and clinical outcomes. The fundamental aim of these processes is to support the primary care practitioner in addressing prevalent mental health concerns in a manner that is flexible and convenient for patients as well as centered on a patient's need for disease education and preferences for treatment.

As mentioned previously, the VA Primary Care-Mental Health Integration Initiative is a large national implementation effort presently composed of 92 integrated care programs. The sites for these programs include VA Medical Centers (VAMCs), Community Based Outpatient Clinics (CBOCs), and VISN-level groups of facilities. These sites are implementing diverse models of care including 24 colocated collaborative programs, 19 Behavioral Health Lab programs, 25 care management programs including sites using the TIDES model, and 24 sites with blended models of care. Annualized funding in FY07 was \$32 million representing 409 full-time equivalent positions. The program is continuing at a similar level of funding in FY08 and expansion of sites is anticipated in FY09.

In North Carolina there are 3 integrated care programs being funded through this initiative. A blended model consisting of colocated collaborative care and care management is being implemented at the Durham VAMC, the satellite Durham Clinic, and the Raleigh CBOC, which collectively represent a target population of 16 933 unique primary care patients. A similar blended model is also being implemented at primary care clinics in the Fayetteville VAMC serving a target population of 9600 veterans. Finally, the Salisbury VAMC is implementing a colocated collaborative model of integrated care in clinics serving 11 589 unique primary care patients.

The national program office for Primary Care-Mental Health Integration is undertaking a variety of activities in support of field implementation as well as evaluation of this important initiative. Program activities include national conferences attended by both primary care and mental health practitioners; monthly national educational teleconferences; policy development including procedures and tools for workload tracking, clinical utilization tracking, and performance measurement; collaboration on development and dissemination of automated decision

supports; and training and technical assistance to field sites. An important example of these activities in FY07 was the development of new performance measures, processes, and tools surrounding evaluation and follow-up of positive screens for depression, PTSD, and alcohol misuse. In particular, performance measures are in place for FY08 to track whether practitioners are following up on PHQ-2 screening for depression with a PHQ-9, risk assessment for suicidality, and pertinent clinical evaluation and follow-up of these assessments; pertinent clinical evaluation and follow-up of PC-PTSD screening for posttraumatic stress disorder including risk assessment for suicidality; and follow-up of AUDIT-C screening for alcohol misuse and abuse with appropriate patient-specific counseling and follow-up.

Finally, the national program office is actively collaborating with the Serious Mental Illness Treatment Research and Evaluation Center at the Ann Arbor VAMC to develop ongoing program evaluation of primary care-mental health integration. The major goals of this evaluation are (1) to assess the extent to which integrated care programs have been implemented across the VA system; (2) to assess patient-level access to care, receipt of services, and disease-specific outcomes; and (3) to determine what factors contribute to differences in mental health-related access and quality of care including variation related to specific integrated care models, model fidelity, and other site-specific program characteristics. This evaluation effort includes so-called formative evaluation components that will enable targeting of specific areas for attention. Ongoing availability of information from the evaluation team will greatly assist the program office in its overall goal of continuous quality improvement for veterans with mental health conditions by maximizing the successful implementation of integrated care programs throughout the VA system. **NCMJ**

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