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Integrating Mental Health and Primary Care Services in the Department of Veterans Affairs Health Care System

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Abstract Integrating mental health care in the primary care setting has been identified in the literature as a model for increasing access to mental health services and has been associated with enhanced clinical and functional patient outcomes and higher patient satisfaction. The Department of Veterans Affairs (VA), which operates the nation's largest integrated health care system, has taken a leadership role in creating a health care system in which mental health care is provided in the primary care setting. This article examines VA's efforts and progress to date in implementing evidence-based models of integrated mental health services nationally in community based outpatient clinics, home based primary care, and outpatient primary clinics at medical facilities. Psychology plays an important role in this progress, as part of an overall interdisciplinary effort, in which all professions are crucially important and work together to promote the overall well-being of patients.

Keywords Primary care · Mental health · Veteran's Affairs

The integration of mental health care in the primary care setting is a high priority goal for the Veterans Health Administration (VHA), the component of the Department of Veterans Affairs (VA) that plans, has oversight of funding, and evaluates health care service provision to veterans. Significant efforts have been made in the last year and a half to accomplish this goal, and continued efforts are underway. Integration of mental health care in the primary care setting is a goal for VHA for the same reasons as in other health care settings. While there are a large number of reasons to prioritize this change in the health care system, five particularly important reasons stand out.

First, patients prefer it—most selectively take mental health problems to their primary care providers, and they often express the preference that mental health care be provided in that setting (e.g., Areán et al., 2002; Chen et al., 2006). Second, mental health problems are often missed or misattributed to physical illness in primary care, particularly with older patients (Karlin & Fuller, 2007; Tai-Seale et al., 2005). Integrating mental health care in primary care can significantly increase detection and diagnostic accuracy. Third, patients are more likely to receive care for mental health problems when the issues are identified in primary care, and when it is possible to provide care in that setting (Bartels et al., 2004). In particular, they are less likely to be lost in the referral process to another provider in a specialty mental health setting. For example, some studies show up to 75% of patients get lost in referral to the specialty mental health setting, whereas up to 90% are seen when mental health attention is sought in primary care (Speer & Schneider, 2003). Fourth, receiving care in the primary care context enables better integration of care, in which the primary care provider and the mental heath provider(s) can share diagnostic information, collaborate on treatment plans, and follow the overall health and well-being of the patient (Skultety & Zeiss, 2006). In this way, the complex relationships between physical and

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mental health can be recognized and handled sensitively and effectively. In fact integrated mental health care has been shown to enhance clinical and functional outcomes (Hedrick et al., 2003; Katon et al., 2002; Unützer et al., 2002). Finally, treating mental health problems in primary care could have important impact on destigmatizing mental illness and mental health care. If mental health concerns are treated as a natural part of the concerns of the health care system, including the central component of primary care, patients are more likely to understand and accept that mental health is an integral part of overall health.

While there have been increasing efforts in recent years to incorporate mental health screening (e.g., for depression) into primary care settings, implementing screening without specific practices and procedures in place for effective treatment and follow-up has consistently been shown to yield little benefit (Pignone et al., 2002). In fact, the United States Preventive Services Task Force (USPSTF) only recommends screening adults in primary care for depression when coordinated systems for treatment and follow-up are in place, which have been shown to have large effects (Pignone et al., 2002).

Integrated mental health care has yielded a number of significant service as well as patient outcomes. Integrated care is associated with increased mental health care access and rates of treatment (Bartels et al., 2004; Hedrick et al., 2003; Liu et al., 2003), improved treatment adherence (Katon et al., 1999; Katon et al., 2002; Roy-Byrne et al., 2001), enhanced clinical and functional outcomes (Katon et al., 2002; Rollman et al., 2005; Roy-Byrne et al., 2001; Unützer et al., 2002), and greater cost-effectiveness (Liu et al., 2003).

This is only a capsule view of the literature on the value of the integration of mental health services into the primary care setting. While further review could be extensive, the goal of this article is, instead, to explore two related issues. The first issue concerns how, if such integration is to occur, can it be done systematically and on a large scale? VA supplies an ideal context to review how a large health care system can reorganize to supply such care, and what the nature of the resources needed would be. The second issue is to explore the potential role of psychology in such integrated care sites. We focus on psychology in this review in order to address a specific audience. Integrated care is intrinsically interdisciplinary, and a large number of providers are relevant—primary care physicians, nurse practitioners, physician's assistants, social workers, staff nurses at the RN level, etc. A full review of the interdisciplinary coordination and the decisions needed to determine the relevant professions and their roles is beyond the scope of this article, but this review of VA's efforts with a focus on psychology must be understood in that larger context.

Achievements to Date to Create an Integrated Care System in VHA

The VHA, within the VA, is the largest integrated health care system in the United States. It serves over five million veterans annually, and provides both inpatient and outpatient care at over 150 full-service health care facilities, ranging from primary care to complex tertiary care; and at over 800 community based outpatient clinics, which primarily offer primary care services. VHA serves almost one million veterans with mental health concerns annually, and over $3 billion per year are provided for mental health services in VHA's budget.

Intensive enhancement of VA mental health services was triggered by the development in 2004 of VA's comprehensive Mental Health Strategic Plan (MHSP). This plan was created as an adaptation of the report of the President's New Freedom Commission on Mental Health,—"Achieving the Promise: Transforming Mental Health Care in America." In their Final Report, the New Freedom Commission concluded:

> Our country must make a commitment. Americans with mental illness deserve our understanding, and they deserve excellent care. They deserve a health system that treats their illness with the same urgency as physical illness.

To improve access to quality care and services, the Commission recommended "fundamentally transforming how mental health care is delivered in America."

VA's MHSP, based on the Commission's report, but with major adaptations to address our mission, opportunities, and challenges, was approved by the Secretary of the Department of Veterans Affairs in November, 2004, and implementation began early in 2005. Full implementation of the plan is designed to be completed in five years, through a process of phased implementation of its 265 action items over that period. Five major components capture most of the essential elements of those action items. One of those major components is to facilitate the integration of mental health services with primary care. Thus, integration of mental health services into the primary care context is one of the main priorities of VA mental health enhancement efforts currently and over the last three years.

In VA, primary care occurs in three main settings: Primary Care Outpatient Clinics in VA medical centers, Community Based Outpatient Clinics, and Home Based Primary Care. Actions in each of these settings are addressed below in the order in which they have been implemented.

Community Based Outpatient Clinics

Community Based Outpatient Clinics (CBOCs) offer services closer to the veteran's home than the tertiary care

medical centers. CBOCs all offer primary care services; other direct care is generally limited. However, each CBOC is administratively under a parent medical facility, and staff at the CBOC can consult with, refer to, and otherwise utilize the expertise in the parent facility. The CBOC is more accessible for many veterans and is the primary locus of care for a large number of veterans. From the start of the CBOC program, many sites co-located at least one mental health provider, especially in larger CBOCs. Beginning in 2005, VA's Office of Mental Health Services (OMHS) began to provide funding to co-locate at least one mental health provider in CBOCs that did not have such staff. Funding has been provided for 294 sites for such mental health staff to date; additional sites are funded each year. Of those funded to date, 86 of the new staff members are psychologists; other sites have funding for psychiatry, social work, or nursing instead of or in addition to psychology. In these sites, the mental health staff works closely with primary care and other program staff to serve the physical health and mental health needs of veterans.

Home Based Primary Care

Home Based Primary Care (HBPC) is a program designed to ensure primary care and related healthcare services to veterans who are homebound because of health problems and thus cannot routinely visit either a VA medical facility or a CBOC for care. HBPC enables the veteran to continue to live at home rather than needing to be placed in a long term care setting. This method of care is preferred by most veterans and their caregivers, and this program has been extremely effective at maintaining quality of life for the veterans served and their families. Funding for a mental health provider in all certified HBPC programs began in March 2007; the targeted profession for hiring is psychology, unless there are special local circumstances that lead to a need for hiring of another of the core mental health professions. To date, a mental health provider has been funded for 125 HBPC teams and most have been hired and trained.

The role of the HBPC psychologist is to work closely as an integral member of the HBPC interdisciplinary team, which also consists of a physician, nurses, a social worker, and often other professionals such as a dietitian, occupational therapist, physical therapist, pharmacist, or others as needed for the specific population served by the HBPC program. The mental health provider conducts psychological assessment, cognitive screening (including dementia screening and capacity assessments), and provides evidence-based psychosocial intervention and prevention services to veterans enrolled in the HBPC program. The HBPC psychologist also has an important role in providing treatment for health-related conditions, such as sleep disturbance and pain, as well as in supporting caregivers in managing veterans at home, and in promoting communication between HBPC team members, patients, and their families to facilitate the medical treatment process.

Mental Health in Primary Care Clinics

Three models of integrated care have been implemented in primary care clinics in VA medical centers: co-located/collaborative care, care management, and a blended model combining these two approaches.

In the co-located/collaborative care model, a mental health provider is embedded in the primary care clinic. This is often a psychologist, but could be another mental health professional. The mental health provider does immediate follow-up of positive screens for mental health problems. In VA, routine screening is mandated for all veterans for depression, problem drinking, post traumatic stress disorder (PTSD), and military sexual trauma (MST). If the veteran's response indicates a possible problem, evaluation can be done immediately in the primary care setting. The co-located mental health provider also can assess any veterans who are identified in other ways by the primary care provider (PCP) as likely to benefit from mental health services Mental health treatment, including evidence-based psychotherapy, can be provided in the primary care clinic, and such mental health treatment can be integrated with other health care received. The mental health provider also offers consultation to the PCP concerning optimal ways to work with veterans whose behavior is difficult, usually because of mental health problems. Finally, the mental health provider may provide behavioral medicine services to help with broader health issues. Psychologists are particularly likely to have training to provide this component of care.

In the care management model, a mental health staff person is designated as a care manager; this is typically a Registered Nurse (RN). The PCP refers patients to the care manager for telephone evaluation and triage of possible mental health problems, most commonly depression. The care manager provides follow up by phone regarding the patient's adherence to the PCP's treatment plan for depression or other mental health problem(s). The care manager reinforces the patient's knowledge regarding the diagnosed mental health problem(s), provides psychoeducation about the diagnosis, and facilitates appropriate treatment. The care manager is responsible for re-referral to the PCP if the patient does not improve or has negative side effects of medication. In making those decisions, the care manager has a supervising psychiatrist available as needed, who can communicate with the PCP, when necessary.

Translating Initiatives for Depression Into Effective Solutions (TIDES) is a care management program for

depression that has been implemented and evaluated in select primary care sites within VHA (Felker et al., 2006). TIDES has been found to improve quality of care and outcomes for older and younger primary care patients.

The Behavioral Health Laboratory (BHL) is another model for care management clinical service (Oslin et al., 2006). The BHL includes a brief, structured interview that assesses mental health and substance abuse symptoms in primary care patients. Results and treatment recommendations are communicated to primary care providers and appropriate treatment decision support is provided, tailored to the patient. Following the core assessment, the BHL may help to implement a range of services, including psychoeducation, watchful waiting, treatment monitoring, disease management, and referral management. Unlike other care management programs that address only depression, the BHL addresses a range of mental health problems, including depression, anxiety, and alcohol use disorders.

Given the value of both co-located collaborative care and care management, VA ultimately plans to provide a blended model, incorporating both of these approaches, throughout the system. The care management component emphasizes follow-up (usually by phone) for patient assessment and education and medication management of mental health problems. The co-located/collaborative care model emphasizes immediate face-to-face connection with patients identified with mental health needs in a primary care visit and the use of evidence-based psychotherapy and health behavior management.

To date, VA has taken major steps toward accomplishing the ultimate goal of implementing the blended model throughout the system, In the 1990s, many VA facilities developed either care management or collaborative care models. Examples of such efforts include development of a model co-located, collaborative care program in White River Junction; development of an integrated care Center of Excellence covering all of up-state New York; development of co-located, collaborative care at the VA Palo Alto Health Care System; and development of the Behavioral Health Lab at the Philadelphia VA. In 2006, VA funded 90 new programs at VA medical center primary care clinics. Overall, these newly funded programs cover over 110 specific sites of care. Sites either received funding to begin work toward a blended model by initiating either a co-located collaborative care program, a care management, or they received funding to expand a current program of one of these types to become a blended model. A small number of sites (24) received funding to initiate a blended model; this was done only where it was clear that there was a strong institutional commitment to supporting this full development of integration of mental health and primary care.

Psychology has clearly been included in VHA's integration of mental heath services into primary care. To date, 99 psychologists have been approved for hiring, all in co-located, collaborative care or blended model programs in general primary care. Most of these psychologists have been hired and are providing the array of assessment, consultative, and direct treatment services already described. Numerous other professionals also have been hired, from psychiatry, social work, and nursing in particular. As noted initially, these integrative efforts need to be interdisciplinary, and VA has approached this transformative process as an interdisciplinary effort.

Overall, combining across the three care settings—CBOCs, HBPC, and primary care clinics in VA medical centers—a total of 509 programs, serving at least 530 sites of care, have been funded for integration of primary care and mental health. Across these sites, 310 psychology positions have been funded; most have been hired and are providing services to veterans.

Plans for Monitoring Impact

Measurement and evaluation of services are important components of health care delivery within VHA. This emphasis on evaluation and broad adoption of performance measures has helped distinguish VHA as a leader in evidence-based health care (Longman, 2007). Evaluation activities are especially central to the initiatives underway designed to transform mental health care delivery in the VA health care system, including particularly the integration of mental health services in primary care. Although the sweeping changes described throughout the whole VA system and at multiple levels of care cannot be evaluated using traditional randomized, controlled trial methodology, formative and summative evaluation is critical to create a process in which implementation of integrated care becomes a reality, problems in implementation are identified and addressed, and data are generated to demonstrate to higher level decision makers that better outcomes for veteran patients result from these efforts. Evaluation efforts also should guide the next generation of decisions for funding, training, and emphasis areas. Performance measures for other aspects of effective integrated care are planned. A next target of measurement will focus on mandated mental health screening and appropriate follow-up of positive screens in primary care. Placing mental health staff in the primary care setting should result in improved rates of screening, follow-up, and initiation of treatment for veteran patients.

Broadly, VA evaluation plans include monitoring a wide variety of indicators of effective implementation of the integrated care initiative. One component is monitoring staffing levels; VA facilities report monthly on hiring efforts to ensure progress is made to full hiring of all

positions funded. When staff have been hired, facilities also report on the productivity of staff in providing services to veteran patients.

In addition to basic monitoring, VA has a system of national performance measures. These are applied system-wide, with mandated targets for performance. The outcomes on these measures determine the bonuses of VA managers. Performance measures are designed to capture high priority areas of service delivery. In relation to integrated care, one example of a performance measure captures mental health service delivery in CBOCs. The measure evaluates the percentage of outpatient visits in CBOCs in which mental health services are delivered. It targets only larger CBOCs, serving over 1,500 unique veterans, and the target level of mental health service is 10% of all visits. Each region of care is reviewed, and the region is considered to meet the measure if all CBOCs in the regions meet the target level of 10% of visit being for mental health. When the performance measure was first created in 2005, only 73% of the regions met the criterion. By 2007, over 94% of the regions were meeting the measure. This change reflects both the period when resources were being provided to hire new mental health providers in CBOCs, as described above, and the period when regions were getting feedback, with financial contingencies for managers, about their region's performance. As noted above, more detailed performance measures are being developed for monitoring integrated mental health services provided in primary care clinics.

Summary: Achieving the Promise

VA has taken a lead role in creating a healthcare system in which mental health care will be provided in the primary care setting. As a national system with the ability to make policy decisions that affect care throughout all facilities in the system, and in which financial resources can be planned to support such policy, VA has advantages for achieving systematic change that are not immediately available to the private sector. Nonetheless, the VA experience demonstrates that integrating mental health into primary care is possible. Moreover, we believe the VA model provides a workable, if somewhat aspirational, paradigm for other private and public sectors. Significant progress has already been made to achieve integrated mental health and primary care in community based outpatient clinics, in home based primary care, and in outpatient primary clinics at medical facilities. Psychology plays an important role in this progress, as part of an overall interdisciplinary effort, in which all professions are crucially important. In the years ahead, VA will continue to develop and evaluate integrated mental health services and change the mental health care landscape, bridging science, practice, and innovation to most effectively meet the mental health needs of veterans.

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