

VA



U.S. Department
of Veterans Affairs

Defining minimally adequate care: The VA Integrated Care Experience

Andrew S. Pomerantz, MD

National Mental Health Director, Integrated Services

VA Office of Mental Health and Suicide Prevention

Associate Professor of Psychiatry

Geisel School of Medicine at Dartmouth

Disclosures

- As a Federal employee, I am public domain
- I have no financial or non financial conflicts of interest to disclose
- We begin with the assumption that those listening already agree with NASEM that integrating care for mental health conditions (which include substance use disorders) in primary care will help us all provide cost effective care that improve outcomes and patient and provider satisfaction.

If not, please refer back to the IOM “Crossing the Quality Chasm” reports (National Academies Press, 2005)

This is about translation of evidence into practice

What does the evidence from systematic research tell us?

- Screening alone is (at best) inadequate to improve care
- Collaborative Care Model Improves outcomes with limited initial cost
- Health Psychology improves outcomes for many conditions
- Co-Location of MH/SA in primary care is necessary but not sufficient to improve care
- Measurement based care Improves clinical outcomes at same or reduced cost
- Peer support improves engagement in treatment

Statement of the Problem: Most MH conditions in the US are unrecognized, untreated or undertreated

- With Impact and cost to:
 - Patient, family, community and Society
 - Business and Industry
 - The healthcare system
- Many variables drive this problem; a few are:
 - Stigma
 - Wait times for nonemergent care
 - Limited Access (particularly in rural areas)
 - Limited Mental Health training in medical education; even less for Substance Use Disorders

Another part of the problem is our approach

- Common premise: Patients do not really know what is wrong. The symptom (“chief complaint”) is merely a manifestation of a myriad of complex intrapsychic, social, spiritual and biologic mechanisms. Understand the “real” problem requires an extensive exploration
- Less common premise: Most patients know what is wrong and want/need problem-focused treatment.

Targeting evaluation and treatment to level of need: A stepped care approach

- Primary: MH care can be delivered in the same setting as general Primary Care by primary care teams with the support of expert clinicians with mental health expertise.
- Secondary: Those whose problems are more complex require more specialized care which may be more difficult to provide within primary care
- Tertiary: Many specific conditions require a more specialized team
 - Does every patient with SUD need referral to a SUD program after brief intervention or are there other steps in between?

Mental Health Services and the Medical Home

“... the Patient Centered Medical Home will not reach its full potential without adequately addressing patients’ mental health needs. Doing so, however, will likely shift responsibility for the delivery of much mental health care from the mental health sector into primary care... *a change that many stakeholders will likely oppose.*”

(italics added)

Croghan TW, Brown JD. Integrating Mental Health Treatment Into the Patient Centered Medical Home. AHRQ Publication No. 10-0084-EF. Rockville, MD: Agency for Healthcare Research and Quality. June 2010.



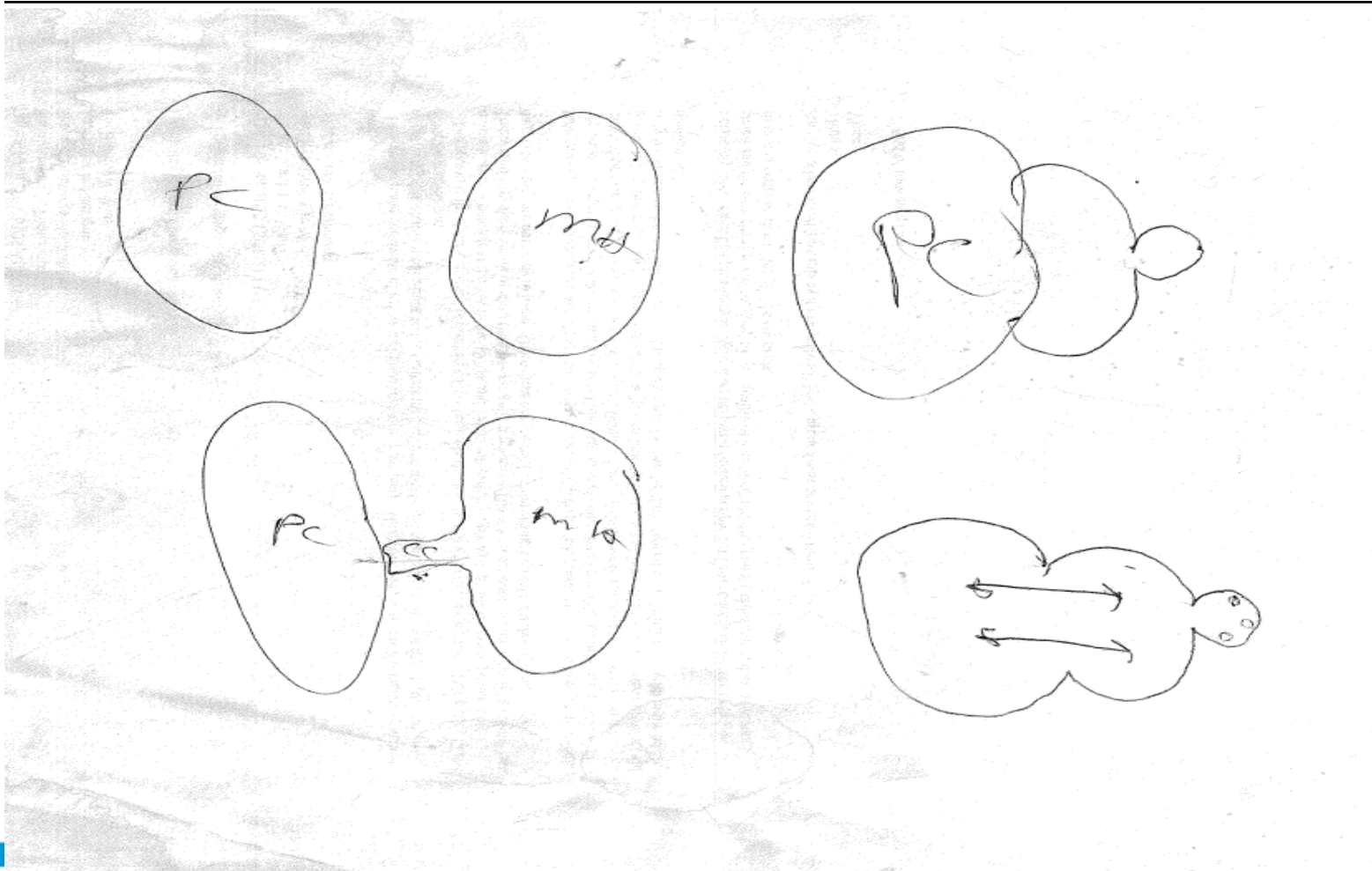
U.S. Department
of Veterans Affairs

Integrated care: consensus definition

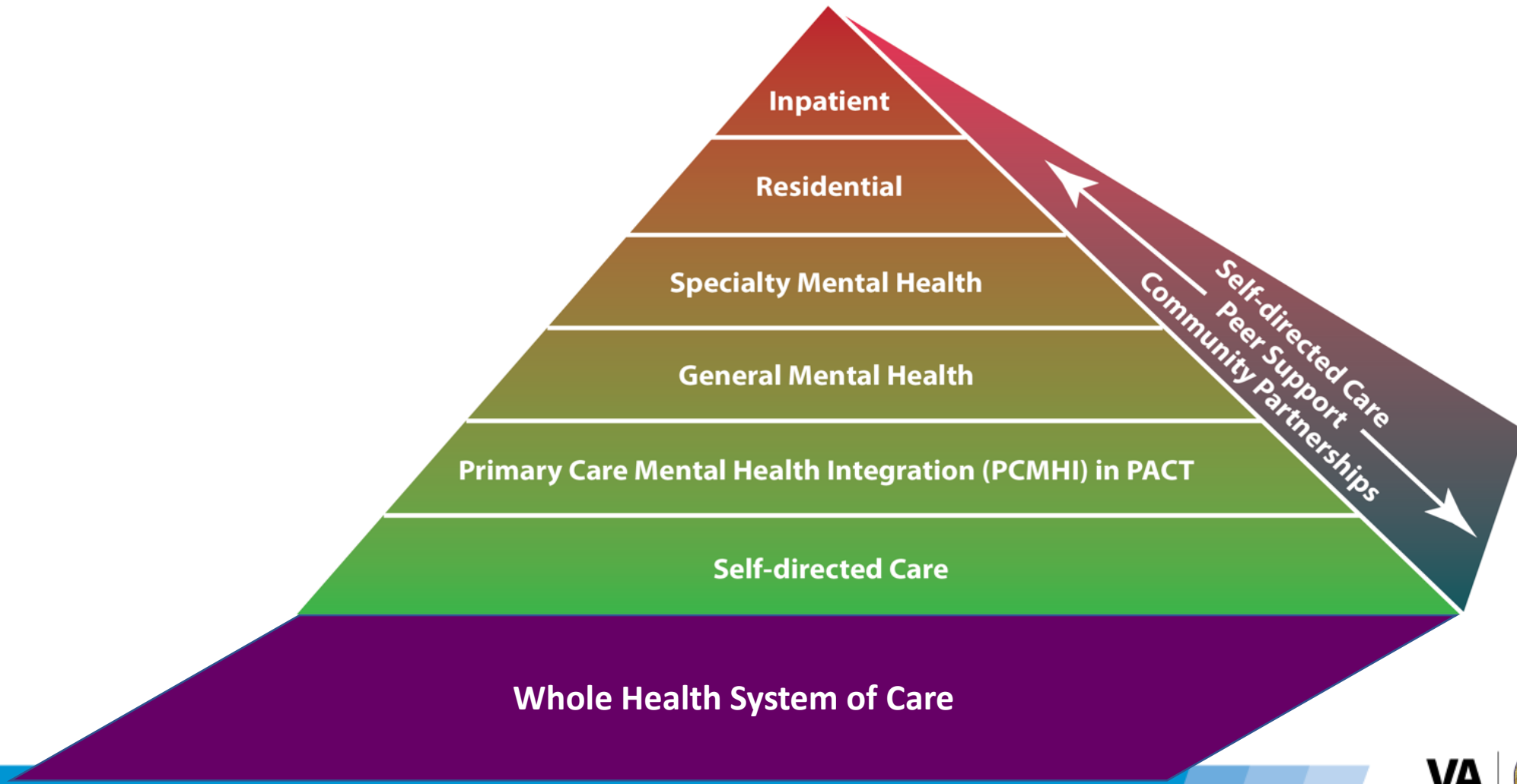
- The care that results from a practice team of primary care and behavioral health clinicians, working together with patients and families, using a systematic and cost-effective approach to provide patient-centered care for a defined population. This care may address mental health and substance abuse conditions, health behaviors (including their contribution to chronic medical illnesses), life stressors and crises, stress-related physical symptoms, and ineffective patterns of health care utilization.

Peek CJ and the National Integration Academy Council. *Executive Summary--Lexicon for Behavioral Health and Primary Care Integration: Concepts and Definitions Developed by Expert Consensus*. AHRQ Publication No.13-IP001-1-EF. Rockville, MD: Agency for Healthcare Research and Quality. 2013. Available at: http://integrationacademy.ahrq.gov/sites/default/files/Lexicon_ExecSummary.pdf

Organizing Integration on a Napkin (circa 1995)



Formalizing the napkin in VA: The stepped care approach



VA Primary Care Mental Health Integration in the Patient Aligned Care Team (VA medical home)

- Clinical pathway following universal screening
- Support Patient Self-Management
- Provide brief assessment and interventions
- Support MH treatment provided by primary care team
- Support self management/self care
- MH subject matter expert in PACT
- Support PACT after MH episode of care completed and care returned to primary care team
- Serve as link between PACT and specialty mental health programs for those in need of more specialized MH care,

VA Integrated care has two key components

1. Co-located Collaborative Care

- Builds on the “Behavioral Health Consultant.” Embedded mental health clinicians are part of medical home team
- Provide consultative advice, focused assessment, brief interventions (usually 1-4 30 minute visits)
- Population based care for uncomplicated mental illness, Substance Use Disorders, health-related behavior change
- Evidence based treatments adapted (and tested) for use in primary care

- ## 2. Care Management (the Collaborative Care Model-CoCM)
- Typically done by telephone contact
 - Second level screening/assessment to confirm diagnostic impression
 - Proactive follow-up & tracking using Patient Reported Outcome Measures)
 - Assess treatment adherence/side effects
 - Education
 - Behavioral Activation / Problem Solving
 - Psychiatry Consultation/oversight
 - Specialized care for treatment nonresponders

But this is not your typical MH care

- Problem focused-based on what matters to the patient
- 30 minute sessions
- National average 2-3 appointments
- Evidence based brief interventions developed specifically for use in primary care
 - Problem Solving Training
 - CBT for Chronic Pain
 - Brief exposure for PTSD
- Relies on patient reported outcome measures to guide initial assessment as well as ongoing treatment decisions

Current Integrated Care Metrics

- PACT 15 (percentage of PC patients with a PCMHI encounter): 9.05%
- PCMHI-5 (Same day access): Percent of patients whose first visit is on same day as a primary care encounter: 51%
 - Strong association with fidelity to the model of care assured by national competency training/certification and ongoing monitoring of provider performance.
- Methodology for both measures are under revision at this time.

Published national and facility outcomes

- Improved identification and treatment in the primary care population
- Improved engagement/continuation in care if referred to more intensive level
- Reduced demand for more specialized MH care
- High patient and provider satisfaction
- Increased likelihood of guideline concordant care
- Improved use of antidepressants by primary care providers
- Reduced no-shows

Sustainability through efficiency

- Shifting more MH care to PC
- Brief assessments and brief interventions save time and are often preferred by patients
- Reliance on self report tools to streamline evaluation, monitor outcome and guide treatment
- Brief, problem oriented treatment plans
- Improves no-show/nonengagement rates and other wasted time in system
- Anticipating long term savings in cost of care due to early identification and treatment
- Initially funded with protected funding in 2007. Steady growth in past 5 years due to shifting of resources

Challenges

- Reimbursement issues (productivity in VA)
- Space: Quantity and Design (onstage/offstage model)
- Training
- Maintaining advanced clinical access
- Development of the evidence base for brief treatments
- Cost effectiveness versus cost offset
- Improve integration with the rest of MH
 - Stepped care requires culture change
 - Defining the limits of what can be done in primary care (moving toward increasing complexity)

Common Issues across systems

- Team care vs autonomy
- Distrust of the model (CM and/or CCC)
- “MH-lite”
 - Doesn’t address the “real problem”
 - “Going to miss something”
 - “I cant give an opinion without seeing the patient in person”
 - “more work for PCP”
- Staffing/Space
- “No evidence for that”

Important facilitators

- Role clarification and the right people in the right roles
- Leadership support and understanding of the model of care
- TRAINING (APA, SAMHSA/CIHS)
- USE OF PATIENT FACING RESOURCES, INCLUDING SELF REPORT TOOLS
- Operational processes that support open access
 - Demand management
 - Managing constraints/predicting flow
 - Coordinating/planning
- Thoughtful implementation and sustainment efforts
 - Avoidance of “premature orthodoxy”

Future directions

- Expand telehealth
 - Already in use in some areas for remote clinics as well as telehealth to home
- Mobile technology
 - Clinician directed/supported self care/self management
- Innovations in Collaborative Care Model
 - E.g. Opiate Use Disorder
- Addressing more complicated illness in primary care
 - Enhance capability to provide healthcare for individuals with serious mental illness
 - Provide additional mental health resources to PC rather than add PC to mental health clinics
- Coordination with NonVA care

Bottom line: Many (most) patients can be adequately treated in Primary Care if we do a few things differently

- Accept that most mental health conditions are straightforward and need a stepped approach
- Bring more MH/SA care into primary care (including Medication Assisted Treatment for SUD)
- Abandon requirements for “full” evaluations for any individual with a MH condition
- Embrace Patient Reported Outcome Measures (PROMs) to improve assessment/triage and guide treatment
- Build clinical pathways to follow-up positive screens
- Adopt shared decision making as the norm. Though individuals may have multiple problems that could be addressed, they are experts in their own lives and can prioritize
- Continue development of brief, problem focused interventions that can be used in primary care
- Improve reimbursement/credentialing for telehealth to expand access
- Eliminate the waiver requirement for buprenorphine prescribing
- Universal adoption of payment for collaborative care
- Bundled payment based on outcomes
- Incentivize “non medical” approaches; e.g. Supported Employment

A promising example

SCOUTT: Stepped Care for Opiate Use Disorder

- 107% increase in the number of patients with Opiate Use Disorder who were prescribed buprenorphine in implementation clinics from August 2018 to June 2019.
- A 68% increase in the number of buprenorphine prescribers in implementation clinics from August 2018 to June 2019.
- On average, 70% of patients retained in buprenorphine treatment for 90 days or longer.

References (from VA)

- Primary Mental Health Care Clinic at the White River Junction VA Medical Center, Vermont. 2005 APA Gold Award: Improving Treatment Engagement and Integrated Care of Veterans. *Psychiatr Serv.* 2005;56(10):1306-1308.
- Bohnert, K. M, Pfeiffer, P. N., Szymanski, B. R., & McCarthy, J.F. 2013. Continuation of care following an initial primary care visit with a mental health diagnosis: Differences by receipt of VHA primary care–mental health integration services. *General Hospital Psychiatry*, 35, 66–70.
- Brawer PA, Brugh AM, Martielli RP, et al. Enhancing entrance into PTSD treatment for post-deployment veterans through collaborative/integrative care. *Transl Behav Med.* Dec 2011;1(4):609-614.
- Cigrang, J.A., Rauch, S.A., Mintz, J., Brundige, A., Avila, L.L., Bryan, C.J.,...STRONG STAR Consortium (2015). Treatment of active duty military with PTSD in primary care. *Journal of Anxiety Disorders*, 36:110-4. doi: 10.1016/j.janxdis.2015.10.003. Epub 2015 Oct 22
- Brawer, P. A., Brugh, A. M. T., Martielli, R. P., O'Connor, S. P., Mastnak, J., Scherrer, J. F. & Day, T. E. (2011). Enhancing entrance into PTSD treatment for post-deployment Veterans through collaborative/integrated care. *Translational Behavioral Medicine*, 1(4), 609-614.
- Felker, B. L., Chaney, E., Rubenstein, L. V., Bonner, L. M., Yano, E. M., Parker, L. E., & Ober, S. (2006). Developing effective collaboration between primary care and mental health providers. *The Primary Care Companion to the Journal of Clinical Psychiatry*, 8, 12–16.
- Kearney, L.K., Post, E.P., Pomerantz, A.S., Zeiss, A. (2014). Applying the interprofessional patient aligned care team in the Department of Veterans Affairs: Transforming primary care. *American Psychologist*, 69(4), 399-408 PMID 24820689

- Hoerster, K.D., Jakupcak, M., Stephenson, K.R., Simons C.E., Dwight-Johnson, M>, Chaney, E>, Felker, B.L. (2015). A Pilot Trial of Telephone-Based Collaborative Care Management for PTSD Among Iraq/Afghanistan War Veterans, *Telemedicine and eHealth*, 21(1), 42-47
- Johnson-Lawrence, V., Zivin, K., Szymanski, B. R., Pfeiffer, P. N., & McCarthy, J. F. (2011). VA primary care–mental health integration: Patient characteristics and receipt of mental health services, 2008–2010, *Psychiatric Services*. 63, 1137-1141
- Johnson-Lawrence, V. D., Szymanski, B. R., Zivin, K., McCarthy, J. F., Valenstein, M., & Pfeiffer, P. N. (2012). Primary care–mental health integration programs in the Veterans Affairs health system serve a different patient population than specialty mental health clinics. *Primary Care Companion for CNS Disorders*, 14(3), pii. doi:10.4088/PCC.11m01286.
- Kearney, L.K., Post, E.P, Zeiss, A, Goldstein, M.G. & Dundon, M. (2011). The role of mental and behavioral health in the application in the application of the patient centered medical home in the Department of Veterans Affairs. *Translational Behavioral Medicine*, 1(4), 624-628.
- Oslin, D. W., Ross, J., Sayers, S., Murphy, J., Kane, V., & Katz, I. R. (2006). Screening, assessment, and management of depression in VA primary care clinics. The behavioral health laboratory. *Journal of General Internal Medicine*, 21, 46–50
- Pomerantz, A.S., Kearney, L.K., Wray, L.O., Post, E.P., McCarthy, J.A.(2014) Mental health services in the medical home in the Veterans Health Administration: Critical factors for success. *Psychological Services*. 11(3), 243-253 PMID 24841512
- Pomerantz, A.S. (2017). Treating PTSD in Primary Care: One small step is one giant leap. (invited commentary). *Families, Systems and Health*. 35(4), 505-507

- Pfeiffer PN, Szymanski BR, Zivin K, Post EP, Valenstein M, McCarthy JF. Are primary care mental health services associated with differences in specialty mental health clinic use? *Psychiatr Serv.* Apr 2011;62(4):422-425.
- Pomerantz, A. S., Corson, J. A., & Detzer, M. J. (2009). The challenge of integrated care for mental health: leaving the 50 minute hour and other sacred things. *Journal of Clinical Psychology in Medical Settings*, 16(1), 40-46.
- 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 and Health*, 28(2), 114–129.
- Post, E. P., Metzger, M., Dumas, P. & Lehmann, L. (2010). Integrating mental health into primary care within the Veterans Health Administration. *Families, Systems and Health*, 28, 83-90
- Watts, B. V., Shiner, B, Pomerantz, A. S., Stender, P. & Weeks, W. B. (2007): Outcomes of a quality improvement project integrating mental health into primary care. *Quality and Safety in HealthCare*, 16, 378-381
- Leung, L.B., Rubenstein, L.V., Yoon, J., Post, E.P., Jaske, E., Wells, K.B.& Trivedi, R.B. (2019). Veterans Health Administration investments in primary care and mental health integration improved care access. *Health Affairs* 8:1281-1288
- Trivedi, R., Post, E.P., Sun, H., Pomerantz, A., Saxon, A.K., Pietti, J.D., Maynard, C. Arnow, B., Curtis, I., Fihn, S.A., Nelson, K. (2015). Prevalence, comorbidity and prognosis of mental health among U.S Veterans. *American Journal of Public Health*. [Am J Public Health](#). 2015 Dec;105(12):2564-9. doi: 10.2105/AJPH.2015.302836. Epub 2015 Oct 16

Contact Information

Andrew S. Pomerantz, MD

Andrew.Pomerantz@va.gov

802-280-5681