Improving Treatment Engagement and Integrated Care of Veterans

The Primary Mental Health Care Clinic at the White River Junction VA Medical Center, Vermont

The effectiveness of integrated and collaborative care models has been demonstrated by an evidence base developed in the 1990s. But even before then—in 1989—the mental health service of the Department of Veterans Affairs (VA) Medical Center in White River Junction, Vermont, began experimenting with the delivery of mental health services within a primary care setting. This initiative was in response to long waiting times for mental health care appointments and a reluctance on the part of many veterans to seek mental health services because of stigma. In addition, the geographic isolation of the rural patients of this medical center was an access barrier to services.

Over the following 16 years, the mental health service developed a new model based on the Performance Improvement model now promulgated by the Institute for Healthcare Improvement and the Institute of Medicine. This model is encouraged throughout the VA as well as throughout the health care sector more generally. As this new model was developed, mental health services at the White River Junction medical center were transformed through a series of innovative changes designed to improve patients' access to treatment and enhance collaboration between providers.

In recognition of its success in increasing collaboration between mental health care clinicians and primary care providers and in dramatically improving the treatment engagement of this population of veterans, the primary mental health care clinic at the White River Junction VA Medical Center in Vermont has been selected by the American Psychiatric Association as winner of the 2005 Gold Achievement Award in the category of academically or institutionally based programs. The winner for community-based programs is described on page 1303**.** The awards will be presented on October 5 during the opening session of the Institute for Psychiatric Services in San Diego. Each winning program will receive a plaque and a $10,000 prize made possible by Pfizer, Inc.

Emergence of a new system

Mental health services at the medical center have been reconceptualized under a new model of care—the White River Model—that now provides immediate access to comprehensive psychiatric care for any patient, regardless of the level of acuity of illness, at any time, with no need for an appointment. The model was developed through a paradigm shift to an understanding that most mental health problems do not require the intensity of treatment that traditionally has been associated with specialty mental health outpatient care but, rather, are best treated by mental health experts practicing within a primary care setting. The model blends evidence-based approaches of integrated care, collaborative care, and traditional consultation-liaison into a single entity with the agility to quickly shift among those approaches for each individual patient who needs care.

The White River Model was developed with the understanding that bringing all primary care patients into specialized mental health programs at the outset of treatment increased the likelihood that scarce resources would be spread too thinly. It was recognized that the resources that had previously been earmarked for specialty mental health services would be better reserved for the 20 percent or so of patients who truly needed them.

Between 1989 and 1993, various health service delivery methods were tried, with disappointing results. In 1997 a new collaborative care clinic opened in the primary care clinic. This clinic was a half-time enterprise, staffed by a psychologist or master's-level therapist. Primary care providers were encouraged to bring patients who were being referred for mental health care to the clinic. Patients were briefly interviewed, and appointments were scheduled for new mental health evaluations. Some patients whose needs clearly called for focal therapy were treated entirely within this clinic.

In 1998, in collaboration with White River Junction's academic affiliate, the New Hampshire–Dartmouth Psychiatric Research Center, the clinic responded to a request for proposals from the Substance Abuse and Mental Health Services Administration (SAMHSA), which initiated the PRISM-E study. The PRISM-E study compared integrated care with an enhanced model of referral care. In 1999, the national VA joined the study, but the clinic remained a SAMHSA site, presenting the opportunity to increase staffing to full-time levels. At that time, services of a psychiatrist were a secondary feature of the clinic. Urgent and emergent cases required that a second-year psychiatry resident be paged. The resident would see the patient and then present the case to the attending psychiatrist. Routine psychiatric care would be provided through referral to the mental health service within four weeks. The study, which was confined to veterans over the age of 65 years,

demonstrated that when access to mental health care was located in a primary care clinic instead of in mental health services, engagement in treatment increased from 47 percent to 75 percent.

By 2002, after years of staff attrition and a steady increase in the number of referrals, the waiting time for a new appointment in mental health had begun a rapid increase to more than 40 days. Toward the end of fiscal year 2003, the average waiting time surpassed 50 days. In late 2002, the clinic began a performance service improvement process aimed at reducing the waiting time. With a no-show rate of 38 percent in the month studied, the service began telephoning patients in advance of appointments and discontinued its automatic rebooking policy. A day-long retreat in February 2004 resulted in a workgroup that over the next four months developed the concept of a primary mental health care clinic.

Current operations

The primary mental health care clinic is open five days a week, during the hours of operation of the primary care office. It uses three nonadjacent offices in one of the two primary care clinics, in a hallway that is also occupied by primary care providers, nurses, and social workers. The hallway connects directly to the hospital emergency department. Patients who attend the clinic are greeted by a clerk, who provides them with a wireless electronic touchpad. At that time, the patient completes four self-report tests: the Beck Depression Inventory (BDI), the Spielberger State-Trait Anxiety Inventory (STAI), the PTSD Checklist–Military (PCL-M), and the Medical Outcomes Study (MOS) 36-item Short Form (SF-36). Test results are wirelessly transmitted to a centralized, secure, Web-based database that is compliant with the Health Information Portability and Accountability Act (HIPAA).

The patient is then seen by a mental health clinician (Ph.D., M.A., or M.S.W.), who by then has received a one-page summary printout of the survey results. This clinician interviews the patient, obtaining psychosocial, historical, clinical, and problem-focused information. The clinician then reviews the case with a provider who has prescribing privileges (an M.D. or an advanced practice nurse), who does a medically oriented interview, performs a Mental Status Examination, and completes a *DSM-IV* diagnostic assessment. The psychiatrist, the psychologist, and the patient then agree on a treatment plan. Any medications or medication changes are instituted at that time.

The design of the model allows for the use of collaborative, integrated, consultative, or referral approaches to any patient, depending on the needs of the patient and on the primary care provider. If the patient is thought to need secondary care, initial treatment is begun, and an appointment in the specialized mental health clinic, which still exists for patients with greater needs, is made by the clerk, usually within a few days or a week. If care is going to be provided in the primary mental health care clinic, the patient is instructed to return within a specified period. Because many of these rural patients live far from the medical center and travel is often difficult, they are usually advised to come to the clinic when they are there for another appointment, unless the situation suggests that it is in the patient's best interest to come sooner. In some instances, the provider will telephone the patient in the interim period between appointments. Patients of the primary mental health care clinic may also be given lists of ongoing specialized open group therapies that may be relevant to their condition.

Staffing

The primary mental health care clinic is staffed by the equivalent of just one full-time psychiatrist and one full-time psychologist or social worker. Each psychiatrist and clinician usually works one half-day per week in the primary mental health clinic and the rest of the time provides care in the specialized psychiatric clinic. Ensuring that a psychiatrist is on-site at all times has proven to be essential to the model's success. Having the psychiatrist nearby means that primary care providers have immediate access to the knowledge and expertise that is critical to high-quality care for patients with mental illness. This feature of the model enhances providers' ability to deliver this care directly, when appropriate, and assures them of immediate availability of backup when needed. Having a psychiatrist "in the next office" also makes psychiatrists more likely to be viewed as important medical colleagues rather than as arcane specialists who work in closed systems. Patients also benefit from the clinic's ability to make *DSM-IV* diagnoses and begin treatment at the initial intake visit rather than at a separate visit that may be days, weeks, or months away.

The psychiatrist's proximity also enhances the proper prescribing of psychotropic medications by primary care providers in the primary care setting. In some instances, the psychiatrist will join a primary care provider in the provider's office, along with the patient, to gather more information or to conduct a mental status examination. This interaction helps to demystify the specialty of psychiatry for both providers and patients.

Impact and future directions

Because this new system uses structured clinical instruments and local templates, it has been possible to precisely track treatment effectiveness and outcomes. In addition, the process has enabled the development of an improved, reliable individual patient database as well as an informed and qualitative approach to local resource management. Multiple mechanisms are used to track patient outcomes, resources, and adherence to evidence-based practices, including follow-up psychometrics, patient satisfaction surveys, VA performance measures, and local management analysis of workload patterns.

A revised version of the model was implemented in July 2004 and was instrumental in raising the overall 30-day mental health access performance measure for the parent facility and community-based outpatient clinics from a low of 45 percent in January 2004 to 100 percent in January 2005.

No additional staff were added, and in the ensuing 12 months the primary

mental health care clinic provided assessment and whatever treatment was needed to 987 individual veterans, each of whom saw a psychologist or a social worker as well as a psychiatrist or an advanced-practice nurse. Thus the estimated panel size for individual clinicians in this model is twice the national standard for psychiatrists and four times the standard expectation for a mid-level provider. Of these 987 veterans, 181 were evaluated, had treatment initiated, and were deemed to need a more intensive level of care. Their care was continued in the specialized mental health care clinic, where they were seen for their next appointment within ten days.

The clinic completed 231 new evaluations in August and September 2004, compared with 27 during the same period of 2003, and the no-show rate dropped from 30 percent to zero. Waiting time dropped from 42 days in January 2004 and is currently just minutes.

These data attest to the VA's success in meeting its strategic goals of improving access and enhancing collaboration. The inexorably rising waiting time that had been haunting the service for several years has been eliminated altogether. The model not only has helped the service meet the access performance measure but also has created a system that favors the use of evidence-based practices and eliminates much of the variation in treatment between providers. High ratings on patient and practitioner satisfaction surveys (for both mental health and primary care) demonstrate that the clinic is well accepted by all. The primary care providers are exceedingly supportive of this program and have said that they cannot think of anything about it that could be improved. As the director of primary care said, "It can't get any better." The psychiatrist and the other mental health professionals in the clinic have expressed their sense of relief as a result of the reduced workload in the traditional mental health clinic, which is now in a better position to serve the more complex cases referred from the primary care clinic. Patient satisfaction questionnaires indicate that more than 98 percent of the patients have high levels of satisfaction with the services they receive.

The model's design has also enhanced recruitment for research projects, encouraged the use of standardized treatment protocols, and provided a fertile ground for training the next generation of health care providers. This model could enjoy wide applicability and success in a variety of clinical settings.

The White River model has been recognized by the VA nationally as a promising emerging best practice for 2005. Within the VA system, there have been consultations with centers that want to adopt the model in Pennsylvania, Delaware, and New Jersey. There has also been interest from the VA in New England. Outside the VA system, local community clinics as well as the Dartmouth–Hitchcock department of psychiatry are interested in modifying this model for their own use. The clinic is now working with its community-based outpatient clinics to adapt this model to settings with a much smaller mental health staff (.6 to 1.5 full-time equivalent [FTE]) and far fewer enrolled veterans (2,000 to 3,000).

Summary

Using the White River Model, the mental health service at the White River Junction VA Medical Center in Vermont has instituted an evidence-based approach to improve integration of mental health services and collaboration of providers. The primary mental health care clinic developed through the model has been very well received by patients and providers alike. Use of the model has dramatically increased the number of patients who can be effectively treated with a given level of staffing and has nearly doubled the number of identified patients who actually engage in treatment. In particular, it has allowed for the development of new recovery, self-help, supported employment, and PTSD programs. The model has decompressed clinical workload for providers and enabled the mental health service to increase the resources available to the most needy, seriously mentally ill veterans.

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