Integrating Mental Health and Primary Care

A Model of Coordinated Services

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When primary care and mental health care providers work in close proximity and in constant communication with one another, it's believed that patients benefit. This article explains how one VA facility translated this idea into a reality.

In recent years, there has been an increased awareness of the benefits of integrating mental health care and medical treatment.[1–5] For example, in a randomized study by Druss and colleagues involving 120 VA patients with serious mental disorders, those who received both primary care and mental health care from an integrated clinic had better outcomes than those who received these services from two separate clinics.[6] Specifically, patients who received integrated care were significantly more likely to visit their primary care provider, were more likely to receive preventive measures specified in clinical practice guidelines, and had significantly greater improvements in health scores.[6]

The VA is exploring several models for integrating mental health and primary care services. One of these trains psychiatric residents to treat both mental health and medical symptoms.[7] In another model, community-based outpatient clinics expand their staff to include mental health care professionals.[8,9]

When, in 1997, the VA Sierra Nevada Health Care System (VASNHCS) in Reno, NV instituted primary care teams, we had the opportunity to create one team that would be integrated with the facility's Mental Health Clinic and Addictive Disorders Treatment Program. Doubts were voiced: Would veterans with mental disorders feel stigmatized by having their primary care delivered by a special, integrated team instead of by one of the hospital's other primary care teams? Would they receive the same level of care as veterans who were served by these other teams? How would the proximity of mental health programs affect the delivery of primary care services?

In the intervening years, experience dissolved our doubts and produced unforeseen benefits. In this article, we describe how our model for integrating primary care and

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mental health care works, what benefits we've seen thus far, and what implications we believe its success has for a more general and pervasive coordination of health care services.

OUR MODEL FOR INTEGRATION

Originally, the Mental Health Primary Care Team (MHPCT) consisted of a nurse practitioner and supportive nursing, pharmacy, and clerical staff. Over the years, however, the nurse practitioner position has been replaced with first one and then two internal medicine physicians (Table 1).

Table 1. Profile of the Mental Health Primary Care Team at the VA Sierra Nevada Health Care System, Reno, NV

Mental health population served per year	2,400
Panel size per clinician	845
Number of patients seen per clinician per half-day	6.5
Staffing	Internal medicine physicians (2.0 FTE*), registered nurse (1.0 FTE), licensed practical nurse (1.0 FTE), pharmacist (0.6 FTE), program assistant (1.0 FTE)
Appointment policy	Scheduled appointments with the provision for four urgent care appointments per day
Waiting times	New and return visits: < 30 days; urgent care visits: < 24 hours
Appointment length	30 minutes, with the provision to expand to 40 minutes for new patients

*FTE = full-time equivalent.

At current staffing levels, the team functions as follows: A registered nurse and a licensed practical nurse, both with mental health backgrounds, provide front-line nursing assessments, including vital signs, prevention screening, and triaging of symptom acuity. The physicians examine the patients and treat any physical conditions, with a sensitivity to their particular psychiatric diagnoses and symptoms. The pharmacist helps with the formulation of medication regimens, medication adjustments, and refills. Treatment of mental health conditions, including prescribing of all psychotropic medications, is provided by the psychiatrists and other mental health staff members of the Mental Health Clinic and the Addiction Disorders Treatment Program.

Although the MHPCT is held to the same standards of care and uses the same practice guidelines and preventive indexes as the other VASNHCS primary care teams, its location and focus make it unique. The team is physically adjacent to the Mental Health Clinic and Addictive Disorders Treatment Program, sharing a common waiting room and support staff. This facilitates provider consultation and appointment coordination, thus improving convenience and reducing costs for veterans. Veterans traveling long distances for mental health visits, for instance, can arrange medical follow-up appointments on the same day.

A hallmark of the MHPCT is coordination of care. Physicians and nurses from the MHPCT attend patient transfer, treatment planning, and program staff meetings held by the mental health service line (MHSL). Clinicians from the MHPCT and mental health programs work together—often with the patient and family members present—to develop treatment plans; discuss such issues as treatment goals, patient adherence or resistance to treatment, and medication interactions; and plan the ways in which the various teams will support one another. Liberal use of electronic patient records facilitates collaboration and offers a convenient way for the entire treatment team to sign off on care plans.

The proximity of the MHPCT and outpatient mental health programs also allows for informal consultation and discussion. For example, if a veteran comes to a primary care appointment intoxicated or has missed recent appointments due to problems with drugs or alcohol, the Addictive Disorders

Treatment Program staff is accessible to meet with the veteran and address the problem. Conversely, veterans entering this treatment program are introduced to the primary care nurse on their first visit in order to arrange an initial primary care health screening. When needed, mental health and primary care providers are available at the same appointment to facilitate difficult treatment issues, such as abuse of pain medications.

An additional example of coordinated care occurs once a week, when representatives from each program meet to discuss assignments of new intakes and transfers between programs. Using a master list of patients, the representatives review items relevant to each patient, including dates for yearly physical examinations, "due now" items such as Abnormal Involuntary Movement Scale (AIMS) testing, the level of mental health monitoring needed, referral to an appropriate mental health case manager, and assignment to a primary care provider.

BEYOND OUTPATIENT PRIMARY CARE

In addition to examining and treating clinic patients, the MHPCT physicians perform admitting history and physical examinations on our inpatient psychiatry unit. This cross-program service enhances the continuity of care between inpatient and outpatient services. The MHPCT physicians are familiar with the patients' medical conditions in both settings and can serve as consultants to the mental health programs on physical health issues. These providers are also members of the hospital's pharmacy and therapeutics committees and the pain panel.

Other liaison functions offered by the MHSL include the Behavioral Medicine Program, in which two psychologists provide consultation to geriatricians and extended care clinicians and to the two nonintegrated primary care teams. These consultants have extensive involvement in oncology, complex pain management, rehabilitation, and palliative care programs. Psychiatrists and social workers also provide mental health services at the two community-based outpatient clinics that are affiliated with the VASNHCS.

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SIGNS OF SUCCESS

Thus far, the MHPCT has produced outstanding results in quality of care. Regular tabulation of such preventive indexes as diabetes monitoring, tobacco use screening, presence of major depressive disorder, and AIMS and Addiction Severity Index testing has indicated that the integrated primary care team consistently exceeds the hospital's overall scores. This was illustrated when the team's pharmacist compared six-month progress toward blood pressure and low-density lipoprotein goals in a sample of diabetic patients treated by the MHPCT with that of the complete group of diabetic patients treated throughout the hospital (Table 2).

The patients praise the integrated team. Feelings of stigmatization are rare. Far more frequent are requests to transfer from other primary care teams to the MHPCT for the more personal provider-patient relationship, less stressful environment, and coordination of care reported by veteran peers. Patient satisfaction surveys—which are administered routinely to rate staff's performance in terms of courteousness, understanding, listening skills, time spent listening, avoidance of difficult words, and the patients' confidence in the staff—consistently have yielded high scores (fours and fives on a five-point scale, in which five is the highest level of performance).

Table 2. Progress toward blood pressure (BP) and low-density lipoprotein (LDL) goals in diabetic patients treated by the Mental Health Primary Care Team (MHPCT) compared with a facility-wide group of diabetic patients

Patient group	Met BP goal	Met LDL goal
MHPCT patients	74.5%	78.0%
Facility patients	50.4%	51.8%

Staff satisfaction with the program also is high. Providers have commented on the improvements in communication between staff members in this coordinated team approach to patient care. One staff psychiatrist, for example, said that the integration of the MHPCT "increases efficiency and quality of care," expressing appreciation for "the accessibility of the primary care team to discuss a patient's medical issues and schedule appropriate follow-ups 'on the spot,' if needed." This provider also stressed the importance of coordinating the care of veteran patients because of age and comorbidity issues. An alcohol counselor communicated a sense of appreciation for the proximity of primary care providers, praising the ease of scheduling medical appointments and consultations. And one of the team's internal medicine physicians has said that the integrated system facilitates the management of chronic pain and addictive disorders and increases patient adherence.

In 2000, the VA named our MHPCT as one of 12 Innovative Programs of Integrated Primary Care, Mental Health and Geriatrics. We are now networked with all the VA health care systems to act as mentors, and we've been tapped as a resource by the VA Employee Education Service's Primary Care Multidisciplinary Education Committee.

A BROADER VISION

The integration of medical and mental health care has the potential to lead to more appropriate interventions for all veterans—not just those in mental health programs. In our view, the value of broad application of traditional psychotherapeutic interventions has been grossly underestimated. Some research has suggested that one to three psychotherapy sessions can reduce utilization of all health services (such as physician visits, hospital bed days, X-rays, and laboratory tests) by 65% during the second year following the initial visit, and that brief therapy (over 6.2 sessions) can reduce utilization by 75%.[10] In this study, both reductions took into account the added therapy visits.[10]

The incorporation of primary care into standing mental health programs is a good idea, but hopefully, integration won't end here. For instance, we envision mental health staff presence on all primary care teams at the VASNHCS to integrate care from all directions. As we plan to meet the primary care needs of burgeoning veteran demand, we need to consider the very real possibility that a more general model of integration will offset medical costs in a more significant way.

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