

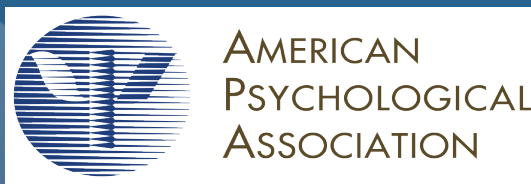
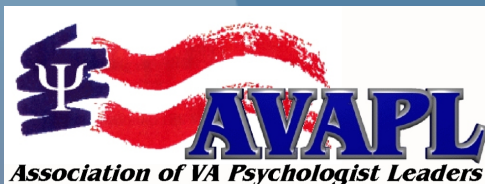
Provider Perspectives on VA Mental Health and Social Work Services

presentation to
Commission on Care

Association of VA Psychologist Leaders
Association of VA Social Workers
American Psychological Association

*Disclaimer: These organizations do not represent the VA

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OVERVIEW

- VA Mental Health Provider Expertise & Outcomes
- Mental Health Integration in Primary and Specialty Care
- How MH Care in VA Compares to Community Care
- Access to Care Problems
- Contrasting Two Models of VA Health Care
- Specific Recommendations for Improving Veterans Care

**VA MENTAL HEALTH (MH) PROVIDER
EXPERTISE & OUTCOMES**

State of the Art Mental Health Care in VA

- Provider expertise in delivering Evidence-Based Psychotherapies (EBP) for prevalent MH disorders
 - 10,500 unique providers trained to date
 - 15 EBPs
- Rigorous Clinical Practice Guidelines
- Primary Care-Mental Health Integration
 - Facilitates engagement
 - Key to coordinated care
- Extensive evaluation and research

VA PTSD Treatment

- 7100 VHA & Vet Center providers received extensive training and supervision in evidence-based psychotherapies (EBP) for PTSD
- Skill development via ongoing consultation
- Veterans who received EBP in the VA experienced clinically meaningful improvement in their PTSD and depression (Karlin et al 2010; Eftekhari et al 2013; Chard et al 2012)

VA Depression/Bipolar Treatment

- 1800 VHA providers trained to deliver three EBPs for depression
- Veterans receiving VA EBP have robust improvements in depression symptoms (Karlin et al 2013a, Karlin et al 2013b, Stewart et al 2014, Walser et al 2013)
- Randomized controlled trials of collaborative care model for bipolar showed positive outcomes (Bauer et al 2006a, 2006b)

VA Insomnia Treatment

- Chronic insomnia is common among Veterans, including half of patients over 65
- Extensive VA provider training of CBT for Insomnia (CBT-I)
- Veterans who have received this care shown large reductions in insomnia and improvements in depression and quality of life (Karlin et al 2015) and a reduction in suicidal ideation (Troczel et al 2015)

VA Geropsych Treatment

- Vets from WWII, Korea, and Viet Nam eras currently comprise over 50% of those receiving VA health care
http://www.va.gov/vetdata/quick_facts.asp
- In all the EBP training modules, VA incorporates effective means to serve older Veterans
- VA has more mental health services specific to older adults, including home-based mental health care, than most community agencies

**VA OUTPERFORMS COMMUNITY IN
HEAD-TO-HEAD STUDIES**

VA Outperforms Community on Psychiatric Medication Indicators

- Large scale RAND study of psychiatric medications used with VA and privately insured MH patients. (Watkins et al 2015)
- VA performance was demonstrably superior on all 7 quality indicators

VA Outperforms Community with Serious Mental Illness (SMI) Patients

- Veterans with SMI conditions who get VA health care (not just mental health care) live longer than persons with SMI in the general US population (Kilbourne et al 2009)
- Veterans with SMI who had dropped out of VA health care and returned had lower rates of mortality compared to Veterans with SMI who did not return
- Above finding led to the national implementation of the VA SMI Re-Engage program to reconnect Veterans with SMI who had been lost to follow up (Davis et al 2012)

VA Outperforms Community on Reducing Veterans' Suicide Rate

- Veterans who receive their health care from VHA have a significantly *lower* rate of suicide than Veterans who do not receive VHA care (Hoffmire et al 2015)
- Possible explanations for results:
 - Veterans Crisis Line can more easily coordinate care with local VA mental health providers than with providers in the community
 - Assignment of a dedicated VA Suicide Prevention team at every VA, and a medical record “flagging” system
 - Required frequency of follow-up contact and monitoring

INTEGRATING MENTAL HEALTH INTO PRIMARY AND SPECIALTY CARE

Primary Care-Mental Health Integration (PC-MHI) Model

- The VA has systematically integrated mental health services into primary care settings since 2008
- Psychological screening and integrated care interventions for MH conditions and behavioral aspects of chronic medical conditions in medical settings is frequently not the norm in the US (Fisher & Dickinson 2014)
- Community service delivery typically focuses upon episodic, acute care (rather than collaborative coordinated care)

PC-MHI Model (cont.)

- Minimizes barriers and reduces stigma that can discourage Veterans from seeking care (Zeiss & Karlin 2008)
- PCMHI contact on day of PC visit expedites MH access
- Increases identification, treatment and referral of MH disorders (Pomerantz et al 2014)
- Helps identify behavioral components of medical disorders in the PC population

PC-MHI In the VA: Research

- 25% of Veterans seen in primary care have MH diagnoses (often dual MH dx) (Trivedi et al 2015)
- Integration of MH in VA primary care increases recognition of MH conditions (Zivin 2010)
- Veterans who screen positive for MH symptoms when evaluated in PC setting have greater tx initiation if they also see a MH professional in PC on the same day (Bohnert et al 2015)

PC-MHI In the VA: Research (cont.)

- Veterans who received integrated care services and were referred for further MH care were much more likely to attend their first specialty MH appointment (Bohnert et al 2013; Zanjani 2008)
- Major Depression collaborative care (TIDES, BHL) leads to improved outcomes and contained costs in VA (Painter et al 2015) in vulnerable populations

Interdisciplinary Pain Management

- Interdisciplinary pain management is prime example of integrated mental and physical health care.
- Since 2009, VA has utilized the evidence-based Stepped Care Model for Pain Management in primary care and specialty care settings, where multiple disciplines (including MH) provide evaluation and collaborative treatment

Interdisciplinary Pain Management (cont.)

- Interdisciplinary pain program has strong evidence for efficacy and reduced cost
- Approach, though growing internationally, has greatly diminished in the US, *except* in VA. VA accounts for 40% of the US interdisciplinary pain programs even though serves 8% of adult population (Schatman 2012)
- VA use of evidence based psychotherapy CBT for Chronic Pain has resulted in increased functioning.
- Importance of effective pain management, including behavioral interventions, further underscored by the fact that pain is the most commonly identified risk factor when examining Veterans' suicides (VA Behavioral Health Autopsy Program Report, 2012 - 2015)

**COMMUNITY MH TREATMENT LACKS
VA READINESS & EXPERTISE**

Community Provider Readiness

- The 2014 RAND “Ready to Serve” *national study of psychotherapists who treat PTSD and major depression* reported that compared to providers affiliated with the VA or DoD, “a psychotherapist selected from the community is unlikely to have the skills necessary to deliver high-quality mental health care to service members or veterans with these conditions.” (Tanielian et al 2014)(p.21)

Ready to Serve, Table 12 (section): Relationship Between Provider Characteristics and “Readiness”

	Military culture competency & Trained in 1+ EBP & Reported often/always use EBP for PTSD and/or MDD (in %)
Affiliation of provider	
Works in military or VA setting	45.9
TRICARE affiliated	17.8
Not TRICARE affiliated	5.5

Community Provider Expertise

- A recent study of Vermont and Texas community-based psychotherapists found that only about half of those who reported providing psychotherapy for clients with PTSD *ever* used evidence based approaches PE or CPT (Carey et al 2015)
- In a separate survey of community-based psychotherapy providers in Texas, only 12% reported *ever* using PE and 23% CPT with their clients with PTSD (Finley et al 2015)

VA: PROBLEM OF ACCESS TO CARE

Problem with VA Access

- The number of Veterans using VA MH services continues to grow (by 71% between FY05 and FY14)
- Movement to provide psychotherapy via evidence-based individual psychotherapy requires greater staff time
- Research demonstrates the size of a provider's caseload restricts ability to spend more weekly time delivering EBPs for PTSD (Chard et al 2012)
- Timely access to initial appointment and starting EBP care is the problem, not quality of care when provided

Summary of VA MH Care

- Current high skill level, with good outcomes
- In head to head comparisons, VA MH expertise and quality outperforms community
- Care is integrated with primary and specialty care
- Problem with accessing care

**CONTRASTING TWO CARE MODELS:
Perspectives from Mental Health
Providers**

Problems with Dispersing Core Services to Community Partners

We understand from the Commission On Care's December 4, 2015 Interim Report (p17) that the Commission is tasked to consider two competing business models for the VA healthcare for eligible Veterans:

- (a) as a comprehensive provider of all health care services
- (b) as a provider of service-related health care services with remaining health care services rendered by community providers

There are a number of reasons we believe option (b) would result in less effective care.

Problems with Dispersing Core Services to Community Partners

1. Undermines the part of the system that is not broken

- All health care systems -- VA and non-VA -- have flaws
- For VHA, recent critiques have particularly focused on wait-times and failures to accurately disclose delays
- While increasing access to community care may reduce some wait-times, if it is done at the cost of reducing VA services, the overall effect is not likely to improve overall access
- In addition, if primary care and other services that are not unique to veterans are provided in the community rather than VA, care coordination is much more challenging and overall quality is likely to be reduced
- No compelling reason to undo this national network of care that offers quality treatment

Problems with Dispersing Core Services to Community Partners

2. Having a fragmented assortment of providers in the community eliminates the treatment (and cost) advantages of an interprofessional, integrated VA model

- Good care means integrated care
- The use of outsourced fee-basis care for several decades has been difficult to coordinate and integrate
- Huge barriers with electronic medical record access

Problems with Dispersing Core Services to Community Partners

3. Quality of care provided by outside providers can't be tracked like it can within VA

- The VA system sets and monitors standards
- For example, the 2011 RAND *Program Evaluation of VHA Mental Health Services: Capstone Report*: “Because the VHA is a single health care system, in contrast to the large number of other health systems represented in the MarketScan data, it has the advantage of a unified organizational structure, a single set of clinical practice guidelines, and policies and procedures that likely contribute to reducing variation across VISNs.” (p. 145)

Problems with Dispersing Core Services to Community Partners

4. New layers of bureaucracy would be created with outsourced care

- New care management and business systems would be needed to track and oversee purchased care
- These additional bureaucratic systems would require more resources

Bolstering current system is more effective

- Given the high level of expertise, training and research, and that the problem is access, not quality of care
- We recommend the current system be maintained and bolstered with a focus on the VA as the comprehensive provider of integrated Veterans health care services.
- Allocate resources for purchased care in the community when VA unable to provide timely or geographically convenient care.
- Community partnering should emphasize VA as expert consultant, and partners providing services currently outside the VA's mandate

**RECOMMENDATIONS FOR IMPROVING
CARE FOR VETERANS WITHIN
CURRENT VA MODEL**

Improve Access by Collecting Community Wait Time Data

- No current data on length of time between when Veterans are referred for community care and when they begin treatment
- Having this “wait time” data is essential to evaluate whether community referrals result in more or less timely care than is delivered in the VA.

Improve Access by Augmenting Staff

- Improving access is the highest priority
- Increase funding to VA medical centers and community based outpatient clinics where staff/patient ratios are inadequate to provide timely access
- Hire more on-station and tele-health professionals, assure close monitoring of vacancy rates and provide for additional space, as needed

Improve Access by Adding MH EBP Providers

- The number of Veterans using MH services continues to grow
- VA providers have MH EBP expertise that many community providers do not, yet not enough MH average weekly time is available to deliver EBP treatment for the growing number of Veterans needing MH services
- Higher MH staffing ratios correlate with shorter new patient wait times and appointment access
- Therefore: Increase VA MH and tele-MH FTE and support policies that assure providers can use their EBP expertise to meet clinical needs

Improve Delivery of MH Treatment by Promoting Measurement-Based Case

- Collecting data to assess on-going response to MH treatment during the course of treatment enables adjustments based on change in symptoms and functioning
- Collecting data fosters shared decision-making between patients and providers
- Gathering such data may also allow for comparisons between treatment rendered by the VA and by community providers (where monitoring on-going treatment response is lacking as well)
- Implementing measurement-based care was identified in VACO MH leaders' Commission on Care briefing as a top strategic priority

Strengthen Community Partnering

- Expand VA consultation with community providers and MyVA Strategic Partners
 - VA world class expertise now available to community providers who treat Veterans with PTSD. This expertise could also be offered to MyVAs Strategic Partners. More VA consultant FTE would be needed
- Integrate community partner with VA medical record
- Establish accountability by partners for VA performance measures

Strengthen Community Partnering

- Capitalize on current academic affiliate partnerships
 - Often the other leading healthcare system in the area
 - Shared staff, which facilitates coordination and collaboration
 - Affiliates provide support for evaluation and training
- Reimbursement rates must be competitive

Thank you for this opportunity.

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