Department of Veterans Affairs (VA)/Community Mental Health (CMH) Partnership Pilots

Section 3(a) of Executive Order #13625

Summary Report
February 2015

Department of Veterans Affairs

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EXECUTIVE SUMMARY

On August 31, 2012, President Barack Obama signed the *Executive Order (EO) 13625: Improving Access to Mental Health Services for Veterans, Service Members, and Military Families*. The goal of this Executive Order was "to build an integrated network of support capable of providing effective mental health services for Veterans, service members, and their families."

Section 3(a) of this EO focuses on the creation of "Enhanced Partnerships between the Department of Veterans Affairs (VA) and Community Providers" designed specifically to decrease wait times and increase the geographic reach of VA mental health services. In response to this call to action, VA established 24 pilot projects with community-based mental health and substance abuse treatment providers in seven Veterans Integrated Service Networks (VISNs) across the country. Twelve VA Medical Centers (VAMCs) partnered with 24 Community Mental Health Clinics (CMHCs) allowing for VA to gain broad regional experience from the pilot program.

This report summarizes the findings from these pilots and provides recommendations and key considerations for future community partnerships. Evaluation of the pilots included gathering data from Veterans about their experiences and from key staff at each of the participating VISNs and VA Central Office (VACO) as well as a review of key documents associated with the pilots. Pilot sites were able to select a model of care to best meet the needs of local Veterans. All sites used one of two broad approaches: Non-VA care or VA telemental health (TMH), with most sites choosing to provide Non-VA care to Veterans.

Non-VA care utilizes community providers for care that is paid for by VA, but delivered by a Non-VA health care provider on an individual Veteran basis or via local contracts with a community clinic that provides mental health care as a component of their medical services. Such services are purchased when eligible Veterans require health care that is either not available or not "feasibly available" (e.g. lack of available specialists, long wait times, or extraordinary distances from the Veteran's home) within a VA treatment facility.

TMH Care utilizes technology to deliver mental health services via modalities such as video conferencing and allows for real-time (or "synchronous") encounters between health care providers and patients who are not in the same location. During the VA/CMHC Pilot partnerships, TMH services allowed Veterans to receive care at designated community clinics that were closer to their homes than the nearest VA medical facilities or clinics.

VA and CMHC staff worked together in determining roles and responsibilities within each pilot partnership. Partnerships using tele-mental health required space, equipment, a technician, and a protocol for handling emergencies (e.g., a Veteran entering distress during a TMH session). For Non-VA care partnerships, there were other responsibilities that needed to be addressed: coordination of care (between VA and CMHCs), billing, and payment. While some VAMCs, such as in VISN 7, developed

strong systems for coordinating care, monitoring patients, and billing, staff working in other, smaller partnerships experienced continued challenges in these areas.

Results from follow up surveys indicate that Veterans were very satisfied with the services they received via these pilots. Success of implementation varied across sites, with key personnel citing slow VA contracting practices, incompatibility between information technology systems, changes in leadership within the VISN/VA and at partner sites, and lack of interest by potential patients (Veterans) as reasons for slow implementation. Conversely, having experienced leads within the VISN/VA who could champion the program, willing community mental health partners, and steady demand for additional access all lead to quicker and smoother implementation.

Since the implementation of this pilot program began, VA has moved to a centralized contract, Patient Centered Community Care (PC3) with the intent to manage the vast majority of care received through community providers. Promulgation of the PC3 contract has already reduced the need for local contracting as was undertaken at most of the pilot sites. Implementation of the Veterans' Choice Act will further reduce the need to utilize local contracting mechanisms for Veterans to obtain Non-VA care. However, even though centralized contracting for medical care has many benefits, local facility creation of relationships with community providers to address infrequently used services, or to fill a local gap for a specific test or treatment will remain. Regardless of the mechanism utilized to provide such care, the growing Veteran need for mental health services will increase the need to efficiently leverage Non-VA community providers when access to care is not available within the VA system of care. Whether mental health care is delivered directly by Non-VA mental health care providers, through TMH care at Non-VA sites, or any other variant, it will be critical for VA to continue to focus on providing Veterans with access to high quality mental health care in coordination with other VA services.

Key considerations in the development of these arrangements include the identification of appropriate partners, building partnerships, contracting, delivery of TMH services, coordination of care, documentation of care, sharing of Information, and ensuring the quality of care.

I. Background

The Department of Veterans Affairs (VA) addressed the health care needs of approximately six million Veterans in Fiscal Year (FY) 2013; of these Veterans approximately 2.45 million had a mental health (MH) condition.

In general, VA delivers health care to independently living Veterans through more than 150 hospitals, more than 800 community-based outpatient clinics, and 300 Readjustment Counseling Centers (or "Vet Centers"). Additionally, social services and health care are delivered to Veterans through 134 nursing homes (now called "community living centers"). Mental health care is provided to Veterans through a flexible system of care, which includes face-to-face in-clinic services, telehealth delivery (using clinical video technology), referral to other VA sites, or through referral to Non-VA care providers.

Since September 11, 2001, more than two million Service members have deployed for unprecedented durations and frequencies. Accordingly, Veteran need for mental health services is projected to continue to grow in the coming years as the impact of more than a decade of conflict takes its toll. VA is working to ensure that all Veterans and their families have access to the mental health services they need, both now and in the future.

In recognition of this growing demand for Veteran mental health services, President Barack Obama signed the ***Executive Order (EO) #13625: Improving Access to Mental Health Services for Veterans, Service Members, and Military Families*** on August 31, 2012, calling for improved coordination of services between VA, Department of Defense (DoD), and Health and Human Services (HHS).The goal of issuing this EO was "to build an integrated network of support capable of providing effective mental health services for Veterans, Service members, and their families." This EO included steps for strengthening suicide prevention efforts across the Armed Forces and in the Veteran community; enhancing access to mental health care by building partnerships between VA and community providers; increasing the number of VA mental health providers serving our Veterans; and promoting mental health research and development of more effective treatment methodologies. See Appendix for full text of the EO.

This report will address one particular aspect of the EO, which called for pilot testing VA/Community Mental Health (CMH) partnerships between VA and HHS. Across the country, there are geographical areas with high numbers of Veterans and insufficient local VA services to meet the Veteran need for mental health care. To address this gap, Section 3(a) of the EO focuses on the creation of "Enhanced Partnerships between the Department of Veterans Affairs and Community Providers." Specifically, the VA and HHS were directed to do the following:

"(a) Within 180 days of the date of this order, in those service areas where the Department of Veterans Affairs has faced challenges in hiring and placing mental health service providers and continues to have unfilled vacancies or long wait times, the Departments of Veterans Affairs and Health and Human Services shall establish pilot projects whereby the Department of Veterans Affairs contracts or develops formal arrangements with community based providers, such as community mental health

clinics, community health centers, substance abuse treatment facilities, and rural health clinics, to test the effectiveness of community partnerships in helping to meet the mental health needs of Veterans in a timely way. Pilot sites shall ensure that consumers of community-based services continue to be integrated into the health care systems of the Department of Veterans Affairs. No fewer than 15 pilot projects shall be established."

In response to this call to action, VA established 24 Community Mental Health Pilot projects with community-based mental health and substance abuse providers in seven Veterans Integrated Service Networks (VISNs) across the United States[1]. Within these seven VISNs, 12 VA Medical Centers (VAMC)s partnered with 24 CMH Clinics (CMHC) allowing for VA to gain broad regional experience from the pilot program. VA worked closely with HHS to identify CMHCs in areas of need. The pilot project sites were established based upon community provider available capacity and wait times, the community treatment types that were available to meet Veteran need, Veteran acceptance of external care, and location of care with respect to the Veteran population.

The VA/CMH Pilot Partnerships were funded by VA Central Office (VACO) using unobligated, end of FY 2012 funds. Mental Health Services (MHS) and the Office of Mental Health Operations (OMHO) managed the site selection process, maintained oversight, and managed the pilot implementation. Although VACO funding for the CMH pilots has ended, some facilities have maintained, or plan to increase the number of VA/CMH partnerships due to their success in improving access to mental health care. Table 1 lists the participating VAMCs, partner CMHCs, the partnership model used, and current status.

In order to fully benefit from the pilot partnerships, VA undertook an evaluation of these partnerships with the goals of improving access to mental health services, assessing methods for increasing mental health staffing and improving collaboration with community mental health providers. This report describes the pilots, summarizes findings from the evaluation and provides recommendations for future community partnerships. This report not only details the key knowledge and experience gained during the Community Mental Health Pilot partnerships but also provides a practical "lessons learned" assessment of the effort. This report and supporting materials will be posted on a resource web page so it is readily available to VA leaders and mental health service providers as they consider using VA/CMH partnerships as one method to address future Veteran need. As detailed in the table below, pilot sites used one of two broad approaches to meet pilot goals: Non-VA care and telemental health (TMH) both of which will be described in more detail later in this report.

[1] The official pilot and subsequent evaluation effort included 24 pilot sites across 7 VISNs. VISN 17 elected to participate but missed the deadlines established by VACO for establishing the pilot program. Nonetheless, VISN 17 received funding and technical support from VACO to partner with a CMHC to provide tele-mental health services remotely to Veterans. VISN 17 data are therefore included in the data analyses presented in this report.

Table 1: Pilot Sites

	Geographic Location	VISN	VAMC	Community Provider	Non VA Care or TMH	Status
1	Griffin, GA	7	Atlanta VAMC	McIntosh Trail Community Service Board (CSB)	Non-VA care	Ongoing
2	Flowery Branch, GA			Avita Community Partners	Non-VA care	Ongoing
3	Atlanta, GA			Peachford Behavioral Health System (4 locations)	Non-VA care	Ongoing
4	Atlanta, GA			DeKalb CSB	Non-VA care	Ongoing
5	Canton, GA			Highland Rivers CSB	Non-VA care	Ongoing
6	Lawrenceville, GA			View Point Health	Non-VA care	Ongoing
7	Newport, TN	9	James H. Quillen VAMC, Mountain Home, TN	Cherokee Health Systems	Non-VA Care	Ended
8	Mountain City, TN			Frontier Health	TMH	Ongoing
9	Bedford, IN	11	Richard L. Roudebush VAMC, Indianapolis, IN	Affiliated Service Providers of Indiana, Inc.	TMH	Ongoing
10	Columbus, IN				TMH	Ongoing
11	Kokomo, IN				TMH	Ongoing
12	Cashton, WI	12	Tomah VAMC	Scenic Bluffs Health Center	Non-VA Care	Ongoing
13	Bolivar County, MS	16	G. V. (Sonny) Montgomery VAMC, Jackson, MS	Delta Community Mental Health Services	Non-VA Care	Ended
14	Gulfport/Coastal MS		VA Gulf Coast Veterans Health Care System, Biloxi, MS	Gulf Coast Community Mental Health Clinic	Non-VA Care	Ended
15	Wrangall, AL	20	Alaska VA Healthcare System	Alaska Island Community Services	Non-VA Care	Ongoing
16	Southeastern AL		Alaska VA Healthcare System	South East Alaska Regional Health Consortium Behavioral Health Department	Non-VA Care	Ongoing
17	Huron, SD	23	Sioux Falls VA Health Care System	Community Counseling Services	Non-VA Care	Ongoing
18	Sioux Falls, SD	23		Southeastern Behavioral Health Care	Non-VA Care	Ongoing
19	Mitchell, SD	23		Dakota Counseling Institute	Non-VA Care	Ongoing
20	Cedar Rapids, Iowa	23	Iowa City VA Health Care System	Abbe Center for Community Mental Health	Non-VA Care	Ongoing
21	Iowa City, IA	23		Community Mental Health Center for Mid-Eastern Iowa	Non-VA Care	Ongoing
22	Des Moines, IA	23	Central Iowa VA Health Care System	Eyerly Ball Community Mental Health Center	Non-VA Care	Ongoing
23	Omaha, NE	23	VA Nebraska-Western Iowa Health Care System	One World Community Health Center	Non-VA Care	Ended
24	Omaha, NE	23		Charles Drew Health Center	Non-VA Care	Ended

II. Models of Service Delivery

Pilot sites used one of two broad approaches to fulfill the mission of the EO: Non-VA care and VA telemental health (TMH), with most sites choosing to provide Non-VA care to Veterans (see Table 2). Each method of providing services is briefly described in this section.

Table 2: Pilot Program by Model

	NON-VA CARE		VA CARE
	Contract Care	**Fee for Service**	**Telemental Health**
New Program for VISN	Spokane VAMC Jackson VAMC	Tomah VAMC Biloxi HCS	Lexington VAMC Mountain Home VAMC Texas Valley Coastal Bend HCS Alaska HCS (Sitka)
Existing Program for VISN	Atlanta VAMC Alaska HCS (Wrangell)	Central Iowa HCS Iowa City HCS Nebraska-Western Iowa HCS Sioux Falls HCS	Indianapolis VAMC

Non-VA Care: Fee for Service

Some VAMCs did not create formal contracts with participating CMHCs for the pilots, instead relying on standard Non-VA care referrals to obtain needed Non-VA services for Veterans (formerly called fee-basis care). This method of using community providers for care is paid for by VA, but delivered by a Non-VA health care provider on an individual Veteran basis. Such services may be purchased when eligible Veterans require health care that is either not available or not "feasibly available" within a VA treatment facility. If a Veteran is eligible for care that is available at a VA hospital or clinic, this is the preferred method of caring. However, if the VA medical facility cannot provide the care due to a lack of available specialists, long wait times, or extraordinary distances from the Veteran's home, VA may use Non-VA health care providers in the Veteran's community. All VA medical centers can purchase Non-VA care as necessary to meet Veteran need. The use of the Non-VA Care program is governed by federal laws containing eligibility criteria and other VA policies specifying when and why it can be used. When using Non-VA care, a pre-authorization for treatment in the community is required, unless the medical event is an emergency. VA may purchase care outside of VA for any form of care a Veteran may need, including inpatient, outpatient, emergent medication prescriptions, and long-term care.

Non-VA Care: Contracted Care

For these CMH pilots, some VAMCs chose to create local contracts with a community clinic that provides mental health care as a component of their medical services. This type of contracted mental health care must meet the specifications for Non-VA care as

described above. Contracting for Non-VA mental health care may help a VAMC ensure that Veterans have access to timely and accessible community care by an already identified service provider in parts of the VAMC's catchment area that are geographically distant from VA points of care, or when a VAMC cannot provide timely access to care due to insufficient clinical capacity either in terms of available provider time or presence of specific specialty care providers. However, such decentralized contracting efforts can have drawbacks. One VISN attempted to establish an Indefinite Delivery / Indefinite Quantity (IDIQ) contract with four CMHC sites but was unable to do so within the timeframe of the pilot[2].

[NOTE: Patient Centered Community Care (PC3) is a specific example of a relatively new centralized IDIQ contracting vehicle that was not used in these CMH pilots but is expected to be utilized more broadly for ensuring Veteran access to already vetted VA authorized health care providers. More information about PC3 can be found at http://www.va.gov/purchasedcare/programs/veterans/nonvacare/pccc/]

VA Care: Telemental Health

Telemental health technology can deliver mental health services via telecommunications technologies such as video conferencing. This technology allows for real-time (or "synchronous") encounters between health care providers and patients. During the VA/CMHC Pilot partnerships, TMH services allowed Veterans to receive care at designated community clinics that were closer to their homes than the nearest VA medical facilities or clinics. In these clinics, Veterans receive mental health services via video conferencing from VA mental health providers located elsewhere. Both psychotherapy and medication management are available during TMH medical encounters.

There are different models of arranging for the use of TMH equipment. The two most common are leasing space and paying for the procedure using the Current Procedural Terminology (CPT) code for "patient-side telemental health provision." In the first model, where VA leases space in a CMHC, contracting can be more challenging and the community facility has more responsibility for ensuring that logistical and infrastructure support is provided to VA as part of that contract. The integration of VA and Non-VA information technology systems can also pose challenges for both the VA and the CMHC. In the second model, VA pays for the mental health care using the relevant CPT code and the CMHC then bills the VA using CPT codes. CPT codes are indicators for specific health care procedures or services and are a uniform way of communicating information about the complexity, time, and costs incurred in service delivery to providers, coders, patients, and payers. For telemental health services, a CPT code (e.g. Q3014) can be used as an indicator of service delivery to monitor Veteran healthcare utilization and guide reimbursement.

[2] IDIQ is a U.S. Federal Government contracting acronym meaning indefinite delivery/indefinite quantity. This is a type of contract that provides for an indefinite quantity of supplies or services during a fixed period of time.

Given the inherent difficulties already involved in scheduling TMH appointments (i.e. the need to align availability of space and providers at both the provider- and patient-side locations, potentially using different scheduling systems), it has been found to generally be simpler to use this procedure code to "block" the patient-side telehealth room, however this cost is paid whether or not the facility is used for that time or not. For VA facilities that elect to hire Tele-health Clinical Technicians (TCT) and install dedicated VA lines within the CMHC to connect it to VA, scheduling was accomplished through the VA system. The VA TCT took responsibility for the patient visit within the CMHC, including scheduling for Veteran patients and enacting standards that ensure the safety of patients and staff.

III. Pilot Evaluation Results

The VA's Program Evaluation and Resource Center (PERC) conducted evaluations of these CMH pilot efforts. A Veteran-focused evaluation included collecting quantitative data on Veteran functioning, mental health symptoms, and satisfaction with treatment during the pilots. A total of 808 Veterans were included in these analyses. In addition, a qualitative implementation evaluation was conducted through in-depth interviews with key staff at VACO and in each of the participating VISNs, analysis of the memoranda of agreement, contracts, and other documents created as part of the pilot program.

In follow up surveys, Veterans overall reported that they were very satisfied with the services they received. Implementation varied across sites, with key personnel citing slow VA contracting practices, incompatibility between information technology systems, changes in leadership within the VISN/VA and at partner sites, and lack of interest by potential patients (Veterans) as reasons for slow implementation. Conversely, having experienced leads within the VISN/VA who could champion the program, willing community mental health partners, and steady demand for additional access all lead to quicker and smoother implementation.

Veteran Data (Quantitative Analysis)

Results from Veteran data are presented below (see Tables 3 and 4). [NOTE: The pilot sites in the Atlanta area were distinct compared to other sites in several ways. For example, the Atlanta site had already established partnerships with CMHCs and used this opportunity to add to existing efforts whereas most other sites were beginning new partnerships. Atlanta also utilized a unique model for Non-VA care that included embedding case managers at the Non-VA sites to assist with tracking, monitoring and coordination of care].

Approximately 90 percent of Veterans receiving care through these pilots were located in the Atlanta area and the data collected reflects this distribution. Less than three percent of respondents had experience with a program using TMH. Since the majority of respondents received contracted Non-VA care, a comparison between the different models is not possible.

Table 3. Number of Veterans Surveyed and Participating across Pilot Programs

		Entire Sample		Surveyed	
FACILITY	**Care Model**	**N**	**Percent**	**N**	**Percent**
Atlanta	Non-VA Care	1873	93.6	754	93.3
Biloxi	Non-VA Care	9	0.4	6	0.7
Indianapolis	TMH	28	1.4	10	1.2
Iowa/Nebraska	Non-VA Care	73	3.6	28	3.5
Texas	TMH	8	0.4	4	0.5
Tomah	Non-VA Care	10	0.5	6	0.7
TOTAL		**2001**	100.0	**808**	100.0

Note: Dates of Referral: January 14, 2013 to May 27, Survey Dates: December 19, 2013 to June 4, 2014

Data from surveys of Veterans regarding satisfaction with the program services are presented in Table 4. Veterans were surveyed at "baseline," usually prior to receiving care through the pilot programs, and at "follow-up," after they had an appointment to receive care. The table reports the most common (modal) value for the survey questions. Veterans overwhelmingly reported being satisfied with the services they received. For a majority of Veterans, the CMHC was closer than the VA facility they would have otherwise gone to for services. A plurality of Veterans experienced relatively short wait times between requesting an appointment and seeing a provider. Most Veterans indicated that they would recommend using the CMHC to their peers.

Table 4: Most Common Responses to Survey Questions Related to Satisfaction, Baseline, and Follow-up Surveys

	Veterans Responding at Baseline* (N=457)	**Veterans Responding at Follow-up* (N=391)**	**Veterans Surveyed Retrospectively** (N=210)**
Time between referral and actual appointment?			
Same day to 14 days	50.4%	51.6%	32.8%
15 or more days	25.2%	38.9%	51.4%
How long (in minutes) to get to CMHC?			
Less than 30 min	46.2%	51.9%	47.6%
More than 30 min	34.6%	41.9%	45.7%
How long (in minutes) to get to VAMC if you had gone there?			

Less than 30 min	17.9%	13.0%	14.8%
More than 30 min	64.6%	81.8%	78.6%
Did the provider seem to know your medical history?			
Yes *or* Somewhat	44.2%	71.4%	57.1%
No	15.1%	19.2%	28.1%
Did the provider explain things in ways that you could understand?			
Yes *or* Somewhat	57.3%	89%	79.5%
No	2.6%	2.8%	7.1%
How satisfied were you with the care you received at the CMHC?			
Completely *or* somewhat satisfied	47.0%	74.4%	60.9%
Completely *or* somewhat dissatisfied	6.4%	9.5%	18.5%
Do you feel you received an adequate amount of care at the CMHC?			
Definitely yes	35.0%	65.2%	44.3%
Definitely no	7.2%	12.0%	20.0%
Do you feel you received the same quality of care at the CMHC as you would have at the VA?			
Definitely yes	36.1%	61.4%	47.6%
Definitely no	8.8%	10.7%	19.0%
Would you recommend the CMHC to other Veterans?			
Definitely yes	41.1%	73.4%	53.8%
Definitely no	6.3%	7.2%	16.2%

*Participants who were referred between December 2013 and May 2014, were contacted for Baseline survey within six weeks of referral and re-contacted for Follow-up survey three to five months after referral (regardless of Baseline survey status). Because different participants were sampled in each phase, these percentages should not be interpreted as a change in satisfaction. Please also note that a number of respondents were contacted for the Baseline survey prior to their CMHC appointment and were unable to answer the treatment satisfaction questions.
**Participants who were referred between January and December 2013 (prior to the start of the evaluation), were sampled once, retrospectively, between 1 and 12 months after their referral.

Implementation Data (Qualitative Analysis)

These findings draw on interviews with 22 local VA mental health leaders and analysis of memoranda of agreement, contracts and other documents created as part of the pilot program. The evaluation focused on investigating how roles and responsibilities were

determined between VA and partner sites, the barriers they faced in setting up programs, challenges in ensuring delivery of coordinated care, how high quality care was assured, and how, if at all, the manner of service delivery affected program formation and implementation.

In setting up partnerships, VA staff and community clinic staff generally were excited to undertake the new program to provide services to Veterans. VA staff reported that most CMHCs were accommodating of VA requests. However, respondents indicated that they faced hurdles and delays when other parts of VA, often contracting or information technology, worked slowly. Other key barriers that had a large impact on getting partnership programs up and running included:

- Lack of knowledge among VA providers and Veterans that receiving treatment at a CMHC was an option.
- Mismatch between eligible Veterans based on location and/or Veterans suitable for treatment at a CMHC (i.e., having Veterans with post-traumatic stress disorder living close to a CMHC but needing the evidence-based care provided by VA clinicians).
- Changes at VAMCs to increase access for Veterans, including hiring more clinicians.
- Changes at CMHCs, specifically turnover among points of contact, clinical staff, or administrative staff.

VA and CMHC staff worked together to determine roles and responsibilities within each partnership. Partnerships using TMH required space, equipment, a technician, and protocols for handling medical emergencies (e.g., a Veteran entering distress during a TMH session). For Non-VA care partnerships, there were other responsibilities that needed to be addressed: coordination of care (between VA and CMHCs), billing, and payment. While some VAMCs developed strong systems for coordinating care, monitoring patients, and billing, staff utilizing smaller partnerships reported some difficulties in these areas.

Once a partnership was developed, problems were encountered by some VA staff working in Non-VA care facilities with regard to finding ways to communicate with CMHC staff about protected health information (PHI) and other issues such as billing. VA staff worked diligently to develop solutions to these problems, ranging from providing on-site liaisons to investigating the use of state-level health data sharing services. For partnerships involving TMH, these issues tended not to come up as problems. Partnerships involving TMH, found a bigger challenge in coordinating the scheduling of appointments, which requires taking into account the VA provider-patient availability and ability of the CMHC location with the TMH equipment. Some Non-VA care partnerships also encountered this challenge when attempting to schedule initial CMHC appointments, but follow-up CMHC appointments were usually scheduled by the patient themselves.

The majority of VA staff interviewed believed that the partnership programs provided high quality care for Veterans and they attempted to monitor this in various ways. For

partner pilot programs using TMH VA service providers, standard VA quality assurance systems were applied. Respondents also indicated that the use of selection criteria for determining which Veterans were a good fit for participation in the pilot was helpful. The development of inclusion criteria for Veteran participation was also beneficial and helped to identify potential participants that were not appropriate for this model of care. For example, mental health care may not be appropriate within the context of the service delivery model for those individuals that have complicated PTSD, psychosis, or those with severe co-occurring physical or psychological conditions that complicate treatment. In addition, some VA staff expressed concern about the level of training and experience possessed by providers in rural areas. By limiting the group of Veterans being seen by Non-VA providers, staff felt they were matching Veterans' needs with the capabilities of the partnership sites. The large partnership program in VISN 7 initiated a system involving periodic chart reviews of Veterans who received treatment at community based clinics (VISN 23 has also worked on a similar protocol). Lastly, VA staff offered training to community based staff to help clinicians and others learn more about working with the Veteran population as well as more about the evidence-based practices employed by VA.

IV. Key Considerations for Future Partnerships

Since the implementation of this pilot program, the VA has moved to centralized contracting. Through the PC3 described earlier, the intent is to manage the vast majority of care received through community providers. Though centralized contracting for medical care has many benefits, the need for local relationships with community providers to address infrequently used services, or to fill a local gap for a specific test or treatment will continue.

These CMH pilots and the evaluation completed by the PERC shed light on several key issues that need to be considered by VA facilities when developing a service relationship with community mental health providers. Standardized processes for referral, documentation management, care coordination, and treatment planning are critical to success and effective patient care. They also have implications for patient safety, confidentiality, quality, and access to care, etc. As such, the issues and key activities outlined below are intended to serve as guiding principles if and when VA facilities wish to establish future CMH/VA partnerships.

Issue: Identification of Partners

- Capitalize on pre-existing relationships with community based clinics where they exist.
- Partner with strong and motivated community based clinics that will support marketing and outreach activities.
- Match geographical need with available community based clinics services, including use of Veteran-level geographical, health utilization, and health care needs data if available.

Issue: Building Partnerships

- Vigorous and ongoing outreach to Veterans, Veteran Service Organizations, and other stakeholders can help ensure Veterans are aware of the care options available to them.
- Encourage partners to participate in local VA Mental Health Summits, which are held by each VA facility on an annual basis.

Issue: Contracting

- Ensure that appropriate potential contracting options are explored (e.g. local contract, IDIQ, PC3, Veterans Access, Choice and Accountability Act) to determine best mechanisms for ensuring availability of care options and to streamline contracting process.
- Ensure appropriate *clinical* oversight which is essential to the success of any clinical contract. Clinical oversight should fall under the purview of clinicians of appropriate licensure and scope and not non-clinical administrators with limited or no experience in the conduct of clinical operations.

Issue: Delivery of TMH Services

- Establish scheduling procedures, especially because both the TMH space and clinician availability must be coordinated. The best approach may depend on who "owns" the equipment and the space.
- Develop emergency procedures to deal with the possibility of a patient becoming distressed.

Issue: Coordination of Care

- Embed a VA staff member in a Non-VA site, if possible, to facilitate coordination of care.
- Establish mechanisms for real-time tracking of appointments and monitoring of Veterans receiving Non-VA care.
- Coordination of care must be a joint effort outlined in contracts and standard operating procedures.

Issue: Documentation of Care / Sharing of Information

- Include incentives in contracts for providing timely documentation of care (e.g. PC3 contract establishes documentation standards).
- Resolve issues of electronic access and connectivity at CMHCs that are geographically distant from one another and from VA sites or establish alternate plans for documenting care and sharing information.
- If there are IT or medical record system incompatibilities, establish standards and plans for sharing information to mitigate/reduce impact on patient care and provider workload while ensuring patient confidentiality and coordination of care.

Issue: Ensuring Quality of Care

- Establish clear roles and responsibilities for VA leadership team to effectively manage CMHC contract delivery and compliance.
- Promote military cultural competence among Non-VA providers.

- Promote use of and training in evidence-based interventions for behavioral/mental health problems that are most common among Veterans (e.g. PTSD, depression, sleep problems).
- Build quality monitoring into the process from the outset.
- Establish ongoing communication between VA Business Offices and Mental Health Service Lines regarding Non-VA care, including opportunities for clinical input into policies used in Non-VA care.

V. Conclusion

The 24 VA/CMH pilots described in this report either built or added to a foundation of community partnerships and facilitated relationships between local VAMCs and community mental health providers across the VA medical system. With the exception of one VISN that already had a strong partnership with local CMHCs, each program served a relatively small number of Veterans during the timeframe of the pilot. Most sites undertook local contracting for Non-VA care, with a few sites choosing to utilize TMH with VA providers offering care at partner sites. Promulgation of the PC3 contract has already reduced the need for local contracting as was undertaken at most of the pilot sites. Implementation of the Veterans' Choice Act will further reduce the need to utilize local contracting mechanisms for Veterans to obtain Non-VA care. Regardless of the mechanism utilized to provide such care, the growing Veteran need for mental health services will increase the need to efficiently leverage Non-VA community providers when access to care is not available within the VA system of care. Whether mental health care is delivered directly by a Non-VA mental health care provider, through TMH care at Non-VA sites, or any other variant, it will be critical for VA to continue to focus on the quality and coordination of mental health care with other VA services, in order to provide a Veteran access to the full range of treatment and rehabilitative services they may need.

The point of contact for this effort is Dr. Wendy Tenhula, Acting Deputy Chief Consultant for Specialty Mental Health, Mental Health Services, Veterans Health Administration at Wendy.Tenhula@va.gov or 202-461-4167.

Appendix

2012vetsmentalhealth.eo.rel.pdf