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Functional Concerns and Treatment Priorities among Veterans Receiving VHA Primary Care Behavioral Health Services

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Abstract

Introduction: The Primary Care-Mental Health Integration program is a component of the Veterans Health Administration's patient-centered medical home, which emphasizes comprehensive, patient-centered care. One model of primary care-mental health integration, known as Primary Care Behavioral Health (PCBH), positions trained behavioral health providers as members of the primary care team. While patient perspectives are essential to effective patient-centered care, little empirical information exists regarding patients' goals and priorities for addressing their biopsychosocial concerns in PCBH.

Method: Regional mail survey of Veterans Health Administration patients. We collected data from 281 veterans (27% response rate) who received PCBH services in a northeastern region.

Results: Respondents identified difficulty with sleep (80%), low energy/amotivation (78%), and managing stress (72%) as the most prevalent individual concerns, though the majority endorsed concerns in multiple domains of functioning. Overwhelmingly, patients who endorsed any biopsychosocial problem area reported that they did (53–93%) or would like to (56–81%) address that concern with a behavioral health provider. Respondents most frequently identified anger as a top priority for future care, followed by stress management, energy/motivation, and sleep disturbance. While sample means signaled neutral or better quality of life in most individual domains, total Quality of Life Inventory scores suggested "very low" (32%) to "average" (30%) overall quality of life ratings for most participants.

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Discussion: In addition to symptom-focused PCBH assessments, providers should gather biopsychosocial data to identify and monitor functional and quality of life concerns, and evaluate patient preferences in addressing these concerns over the course of clinical care.

Keywords

biopsychosocial functioning; mental health; patient preferences; integrated primary care; veterans

The Veterans Health Administration (VHA) has implemented a national Primary Care-Mental Health Integration program to support primary care personnel in addressing behavioral aspects of care through a population health approach (Kearney, Post, Pomerantz, & Zeiss, 2014). This program consists of two models of behavioral health integration: care management (i.e., algorithmic, disease-specific care, often offered via telephone) and Primary Care Behavioral Health (PCBH; Robinson & Reiter, 2017) (known as co-located, collaborative care [CCC] in the VHA). In the PCBH model, behavioral health providers (BHPs) such as psychologists or clinical social workers work as part of expanded primary care teams to improve access to behavioral care and deliver brief interventions. Patient care episodes are typically brief (i.e., 30 minutes), time-limited (i.e., 1–4 appointments), and initiated via warm-handoff or referral by primary care personnel (Beehler et al., 2017). A core component of PCBH is a biopsychosocial assessment to evaluate the impact of presenting concerns on functional domains. In turn, BHPs employ interventions to improve patient functioning, psychological health and well-being, and/or discrete health behaviors.

Previous research on biopsychosocial evaluation in PCBH (King et al., 2017) has focused on BHP documentation as opposed to patient perspectives. The scarcity of data on patient opinions is problematic because eliciting patient perspectives, honoring their treatment goals, and adapting treatment to respond to their individual life contexts and values are essential features of patient-centered care (Epstein & Street, 2011). Understanding common clinical goals and desired intervention points is critical to tailoring PCBH to best meet population needs and further realize the aim of comprehensive, patient-centered care. This study addresses the gap in patient-level data by exploring common areas of biopsychosocial functioning in a veteran sample. Our aims were to describe veterans' self-reported functional concerns, quality of life influences, and priorities for future care in PCBH.

Method

Sample

We collected data via a mail-based survey of veterans who received PCBH services in a northeastern VHA region from October to December 2015. Veterans age 18 who attended one or more PCBH sessions (individual or group) were eligible to participate. Because the primary end-point included analysis of survey data, we based our sample size determination on a preferred margin of error of <5% for survey responses. Utilizing an approximate 30% item-response distribution and 95% confidence interval, we estimated that a representative sample of approximately 314 veterans would meet these criteria. Assuming an *a priori* response rate of approximately 30% (comparable to other ongoing studies), we selected a stratified random sample of 1,045 veterans that aligned with the regional patient

demographic (i.e., approximately 91% male, 83% White/Caucasian, 7% Black/African American).

Materials & Measures

Study Survey.—We developed a survey to gather data on participant demographics and opinions on 24 biopsychosocial domains, emphasizing aspects of physical, occupational, and interpersonal functioning described in prior PCBH research (e.g., King et al., 2017). Participants provided three dichotomous ratings (yes/no) for each domain: 1) whether they experienced the concern within the past year; and 2) whether they did ever or 3) would ever want to speak with a VHA BHP about the concern. Finally, we asked participants to consider each of the issues they experienced within the past year, and subsequently rank their top three priorities for future treatment.

Quality of Life Inventory (QOLI).—The QOLI (Frisch, 1994) is a 32-item measure of life satisfaction organized into 16 functional domains (e.g., relationships with relatives, community engagement). Questions elicit *how important* each domain is to an individual, as well as *how satisfied* the respondent is with current experiences in that domain. Scores on each domain are weighted by multiplying the relative importance by overall satisfaction score (range: –6 to +6). T-scores are then grouped into four overall quality of life ranges (“very low” to “high”). Psychometric studies support the measure’s reliability (Cronbach’s $\alpha = .79$; two-week test-retest $r = .73$) and validity (i.e., moderate to strong correlations [$r = .56-.75$] with comparable measures; Frisch, 1994); α in this study was .90.

Procedure & Analysis

Mailed study packets contained a study description, surveys, postage-paid return envelopes and details on how to opt-in/out or gather more information. Staff placed recruitment phone calls approximately one week later to ensure receipt of materials and to address questions, and mailed reminder letters to non-respondents after approximately 10 business days. Participants who returned a completed survey received a \$25 stipend. The VA Western New York Healthcare System’s Institutional Review Board approved all study procedures. Descriptive statistics were calculated using SPSS v.22.0 (IBM).

Results

A total of 281 veterans returned study surveys (27% response rate; 1.5% opted-out). Participants were primarily Caucasian (76%) males (87%) with an average age of 58.9 years ($SD=13.1$; see Table 1). Most self-identified at least one mental health concern, predominantly depression or PTSD; co-morbidity was common. As shown in Table 2, respondents commonly endorsed difficulty with sleep (80%), low energy/amotivation (78%), and managing stress (72%) as past-year functional concerns, though most endorsed multiple complaints: whereas 53% endorsed 10 or more concerns, 2.5% identified none. Participants who endorsed any biopsychosocial problem typically reported that they did or would like to address that concern with a BHP. In descending order, participants ranked anger, stress management, low energy/motivation, sleep, difficulty concentrating, and pain as top priorities for future PCBH. On average, the sample yielded neutral or better quality of life in

most QOLI domains (see Figure 1), though wide individual variability existed across domains (SD range: 2.7–3.9). However, a nearly bimodal distribution of overall quality of life emerged with peaks accounting for more than 60% of responses at “very low” (32%) and “average” (30%) QOLI ratings. Substantially smaller proportions yielded “low” (10%) or “high” ratings (9%; 20% missing).

Discussion

Participants in this study identified a wide array of functional concerns, including problems with sleep, energy/motivation, concentration, pain, anger, and stress management. Participants commonly reported addressing these concerns in PCBH, and identified them as top priorities for future services. Overwhelmingly, individuals who reported specific past year concerns reported that they either did (53%–93%) or would like to address them (56%–81%) with their BHPs in the future. These findings support that PCBH services are acceptable to patients for a host of concerns and complement existing evidence of PCBH as an accessible and well-received platform of care (e.g., Possemato et al., 2018). Whereas the evidence-base supporting PCBH is growing, brief, protocol-driven interventions for many of the concerns that participants identified (e.g., relationship difficulties) are either lacking or not widely disseminated. Further, most participants identified multiple concurrent concerns, and at present, few existing evidence-based behavioral treatment protocols can accommodate multiple clinical foci. Thus, clinicians may face the challenge of selecting *ad hoc* from the best available options to their practice.

While some concerns identified (e.g., amotivation) may be characteristic of a diagnosable mental health condition, our findings on the prevalence of varied biopsychosocial concerns also demonstrate the importance of appraising and addressing other aspects of functioning within PCBH. In addition to symptom-focused PCBH assessments, BHPs should gather biopsychosocial data to identify problems in physical (e.g., pain, sleep, mobility) and psychosocial functioning (e.g., interpersonal conflict, general stress management), as well as to monitor specific functional and quality of life outcomes associated with care. In the absence of a standardized measure of functioning (global or domain-specific), it is imperative that BHPs tailor functional assessments to individual patients' life contexts.

In summary, our data highlight the complexity of patients' presenting concerns in PCBH, demonstrate the need to address “life problems” as well as clinical syndromes, and reinforce the importance of BHPs in providing referral assistance and linkage with community resources (e.g., to address unemployment/financial stressors). In some instances, problem-solving around basic needs (e.g., housing, financial resources) may itself serve to ameliorate symptom reports and improve functional status more so than psychotherapy. Our results may also provide preliminary justification for the exploration of other modes of assessment and intervention. The field would benefit from research to: a) develop and evaluate interventions that may cross-cut diagnostic categories to improve personal functioning in addition to reducing symptoms; and b) develop cross-cutting measures that are both capable of capturing a range of functional outcomes and feasible for use in PCBH. Further development of the knowledgebase in these arenas may enhance the patient-centeredness of PCBH.

services, and promote use of standardized measurement data to support adaptive treatment decision-making.

Limitations

While our sample composition was slightly more diverse than anticipated, limitations to generalizability of these descriptive results include geographical and contextual factors associated with a clinical sample from a single VHA region (e.g., high proportion of older males, prevalence of depression and PTSD). As is often the case with large survey datasets, we observed a high volume of missing data, with results subject to potential self-report, self-selection, and recall biases. Although the lower than expected response rate yielded a slightly higher margin of error (6% vs. <5%) than desired, the practical impact on interpretation of our results may be minimal.

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Figure 1. Average Weighted Satisfaction on Quality of Life Domains as Measured by the Quality of Life Inventory (QOLI)

Note: Bars represent sample mean plus 95% confidence interval (CI). Raw scores range from -6 to +6; individual domain weights are calculated by multiplying relative importance scores of each domain (range: 0–2) by the overall satisfaction score (range: -3 to +3). Positive or negative scores signify a greater or lesser degree of domain satisfaction, respectively.

Table 1

Self-Reported Participant Demographics

Variable	<i>n</i> (%)
Age ^a	58.9 (13.1), 23- >89 ^b
Sleep (Hours/Night) ^a	5.1 (2.6), 0–10
Sex	
Female	34 (12.1)
Male	245 (87.2)
Transgender	1 (0.4)
Prefer Not to Answer	1 (0.4)
Race	
American Indian/ Alaskan Native	2 (0.7)
Black/African American	51 (18.1)
Multicultural/ Multiracial	12 (4.3)
White/ Caucasian	213 (75.8)
Other	3 (1.1)
Ethnicity	
Hispanic or Latino	3 (1.1)
Not Hispanic or Latino	259 (92.2)
Missing	19 (6.8)
Relationship Status	
Divorced	46 (16.4)
In Relationship, Unmarried	24 (8.6)
Married	126 (44.8)
Single	31 (11.0)
Separated	7 (2.5)
Widowed	11 (3.9)
Missing	36 (12.8)
Vocational Status	
Attending School (Full or Part-Time)	9 (3.2)
Unemployed, Could Work	13 (4.6)
Unemployed, Disabled	129 (45.9)
Employed, Full or Part-Time	48 (17.1)
Attending School and Working Full-Time	1 (0.4)
Volunteer	15 (5.3)
Missing	66 (23.5)
Income Range	
< \$24,999/ year	80 (28.5)
\$25,000-\$49,999/ year	90 (32.0)
\$50,000-\$99,999/year	64 (22.8)
> \$100,000/year	5 (1.8)

Variable	n(%)
Missing	42 (14.9)
Mental Health History	
Alcohol Use Disorder	44 (15.7)
Depression	214 (76.2)
General Anxiety	103 (36.7)
PTSD	168 (59.8)
Substance Use Disorder	26 (9.3)
Other	43 (15.3)

Note:

^a $M(SD)$, range;

^b Ages 89 or older were collapsed into a single category.

Table 2

Self-Reported Prevalence of Functional Concerns and Priorities for Future Care

Domain/V variable	% Endorsed [% Missing]		
	Past Year Problem ^a	Ever Addressed with BHP ^b	Want to Address with BHP ^c
Pregnancy/Birth/Adoption	5.3 [18.1]	73.3 [0.0]	66.7 [13.3]
New Relationship	13.9 [17.8]	64.1 [0.0]	61.5 [10.3]
Break-up/Divorce	18.5 [17.8]	76.9 [1.9]	67.3 [9.6]
Military Separation/Adjustment	20.6 [19.4]	82.8 [1.7]	77.6 [10.3]
Job Search/Loss	21.7 [17.4]	52.5 [1.6]	55.7 [9.8]
Spirituality/Faith Concerns	24.9 [5.3]	80.0 [1.4]	67.1 [11.4]
Job Stress	25.6 [18.5]	75.0 [0.0]	73.6 [9.7]
Parenting Stress	28.1 [17.1]	83.5 [0.0]	72.2 [6.3]
Complications from New Illness	28.5 [15.7]	82.5 [0.0]	81.3 [3.8]
Not Enough Family/Friend Support	35.2 [16.7]	75.8 [4.0]	65.7 [13.1]
Social Difficulty/Conflict	38.1 [17.4]	85.0 [1.9]	67.3 [11.2]
Relationship Stress	43.4 [17.4]	91.0 [0.8]	72.1 [11.5]
Financial Stress	44.5 [16.4]	76.0 [0.0]	65.6 [8.0]
Change in Appetite	46.3 [4.6]	75.4 [2.3]	64.6 [14.6]
Unintentional Weight Loss/Gain	47.3 [5.0]	71.4 [1.5]	66.2 [11.3]
Pre-existing/Chronic Illness	49.1 [16.4]	92.8 [1.4]	80.4 [8.7]
Family Stress	49.5 [16.7]	90.6 [2.2]	72.7 [13.7]
Feeling Like You Don't Matter/ Nobody Cares	53.4 [5.7]	86.0 [0.0]	75.3 [10.7]
Problem Controlling Anger	59.1 [3.6]	89.8 [1.8]	78.9 [12.7]
Significant Pain	60.5 [14.9]	85.3 [1.2]	71.8 [11.2]
Problem Concentrating	64.8 [3.6]	89.6 [0.0]	74.2 [12.1]
Difficulty Managing Stress	71.9 [4.3]	88.6 [2.5]	74.8 [12.9]
Low Energy/Motivation	77.6 [3.6]	83.5 [1.8]	72.0 [11.9]
Sleep Problem	79.7 [3.6]	90.2 [1.8]	72.8 [13.8]

Note: BHP = behavioral health provider.

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Percentage of respondents who endorsed past-year functional concerns.
_{*e*}
Percentage of individuals who endorsed past-year functional concerns and having addressed the concern with their BHP.
_{*q*}
Percentage of individuals who endorsed past-year functional concerns and would like to address these concerns with a BHP in the future.
_{*j*}