THEN & NOW

A reminder of the pace of change, and of timeless truths, from the 1972 Annual Review of Mary Hitchcock Memorial Hospital:

Dr. Jarrett Folley, MHMH's chief of staff, was quoted as saying: "I would foresee an extension of things done in the outpatient area . . . with [a] closer relationship with health agencies in other communities to provide continuing care. We will be trying to determine the role of our physicians in the broadening health-care system, particularly how they may better complement other physicians and hospitals throughout northern New England."

99

Number of employees today in the DHMC Office of Care Management, which coordinates patients' care not only during but after their hospital stays

Waitless environment is good for mental health

Just imagine: A mental-health clinic with no appointments and no waiting lists. Patients could stop in any time to see a counselor or a psychiatrist. The concept isn't imaginary, however. It's real and it works, says Dr. Andrew Pomerantz, chief of mental health at the DMS-affiliated VA Medical Center in White River Junction, Vt.

Model: His team developed a new model of delivering mental-health care within the White River VA's primary-care clinic. Known as the Primary Mental Health-Care (PMHC) Clinic, it has been well received by the nearly 13,000 veterans and their families who visit the primary-care clinic each year; 99% of patients who used the PMHC during its first year (2004-05) rated overall care there as good to excellent. Patient ratings have stayed high ever since.

Average waiting time was reduced from 33 days to just 19 minutes.

In the quarter before the PMHC opened, patients waited an average of 33 days to see a mental-health specialist and were often reluctant to continue treatment due to the stigma associated with seeking mental-health care. In the first quarter after the clinic opened, waiting time had ben reduced to an average of just 19 minutes, and lost productivity due to no-shows was eliminated.

The model has won two national awards: the American Psychiatric Association 2005 Psychiatric Services Achievement Award and the Veterans Health Administration 2006 Advanced Clinic Access Award.

Patients who come to the PMHC see both a psychologist (or a licensed counselor) and a psychiatrist on their first visit. "The full spectrum [of care] is there," says Pomerantz. "You're seeing people skilled in both the psychological treatments and the psychiatric treatments."

And having the new clinic in a primary-care setting helps avoid stigma. "You come in the primary-care clinic without being branded as a mental-health patient or a psychiatric patient," points out counselor Brady Cole, a cofounder of the PMHC. Its presence within primary care also fosters regular consultations between primary-care doctors and mental-health staff.

And since it's an open-access clinic, patients can visit any time, regardless of the severity of their illness. "What's different with this is that everybody gets in," says Pomerantz.

A patient new to the clinic first fills out self-report tests on a touchpad; the tests assess depression, anxiety, PTSD, and overall physical and mental functioning, as well as a suicide risk. Next the patient meets a psychologist or counselor who takes a psychosocial history, then a psychiatrist who does a mental-status exam and diagnostic assessment.

Finally, the patient, psychologist, and psychiatrist, plus possibly the patient's primary-care physician, meet together to discuss a treatment plan. About 75% of patients stay within the PMHC for care or return to their primary-caregiver, while 25% are referred for specialized mental-health care. The PMHC starts with an assumption that "the patient is okay," says Pomerantz, but something in his or her life needs to be addressed. "Our job is to focus on the [patient's] chief complaint," he adds.

Access: Running the clinic on an open-access basis can be a chore, notes Pomerantz, though 90% of the time the patient flow is fairly even. If five people show up at once, "we manage it," he says. "If one of them has that suicide question highlighted, we'll take care of that first. We'll adapt. Maybe I'll do everything. Maybe they'll only see me and not the therapist and I'll touch on the things that the therapist would normally do. In some situations, maybe we'll both see the person together."

The main thing, says Pomerantz, is "you need to learn to let the patient set the agenda."

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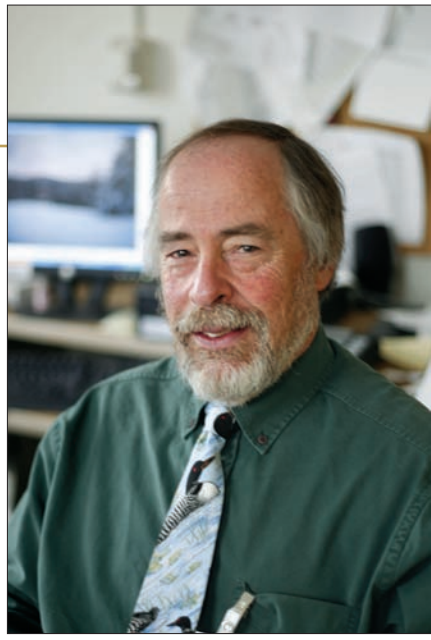

LAURA DECAPUA

Pomerantz's model has won two awards.