2011 Military Health System Conference

Behavioral Health in the Patient Centered Medical Home: Meeting the Quadruple Aim

Part 1

The Quadruple Aim: Working Together, Achieving Success

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Report Documentation Page

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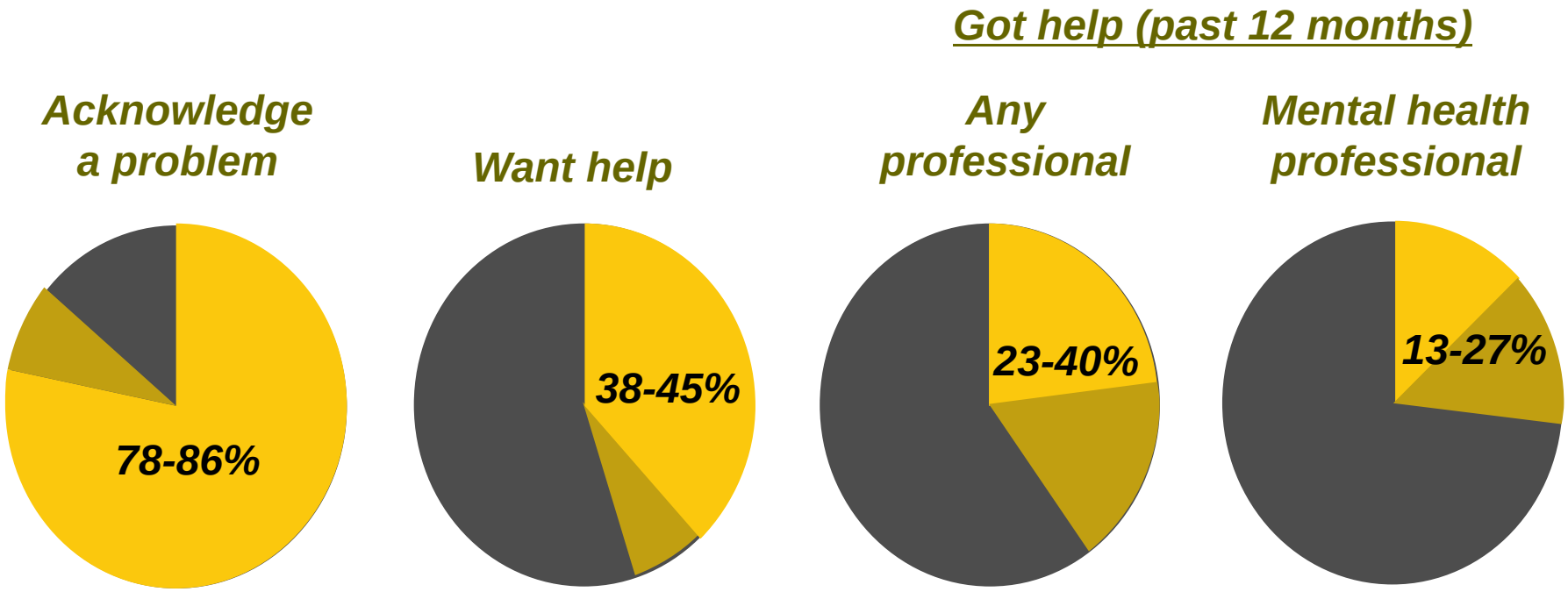
Why Primary Care?
A Gap Between Needs & Services

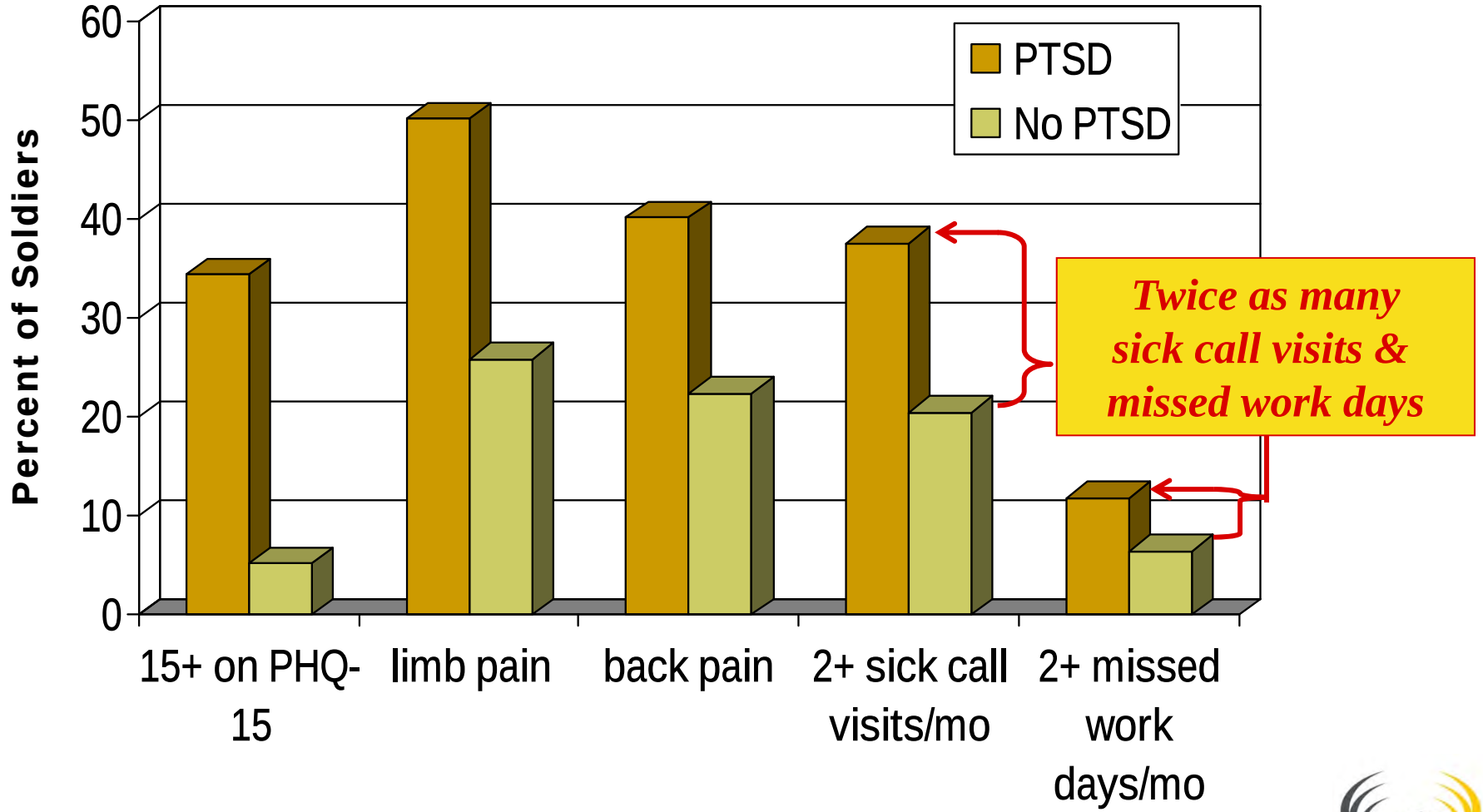
Among the 20% of Soldiers with moderate to severe disorder after OIF deployment…



Hoge CW, et al. N Engl J Med. 2004;351:13-22.

Potential for Offset: Service Use & Missed Work

2,863 Iraq War returnees one-year post-deployment



Hoge et al, Am J Psychiatr, 2007

RESPECT-Mil

Primary Care…
Where Soldiers Get Their Care

- Mean primary care use is 3.4 visits per year
- 88-94% have one or more visits per year
- Primary care approach to mental health is an opportunity to…
  - Reduce stigma & barriers
  - Intervene early
  - Reduce unmet needs
  - Reduce unnecessary service use

Primary Care Intervention is Evidence-Based

Randomized trials offer sound evidence that systems-level approaches benefit…

- Depression (e.g., IMPACT Trial BMJ 2006)
- Suicidal ideation & depression (Bruce et al, JAMA 2004)
- Depression and physical illness (e.g., Lin et al, JAMA, 2003)
- PTSD and physical injury (Zatzick, AGP, 2004)
- Panic disorder (e.g., Roy-Byrne et al, AGP 2005)
- Somatic symptoms (e.g., Smith et al, AGP 1995)
- Health anxiety (e.g., Barsky et al, JAMA 2004)
- Substance dependence (e.g., O'Connor et al. Am J Med. 1998)
- Dementia (e.g., Callahan et al, JAMA 2006)

RESPECT-Mil

Re-Engineering Systems of Primary Care Treatment in the Military

Defense Centers of Excellence for Psychological Health & TBI

Office of The Surgeon General, Army

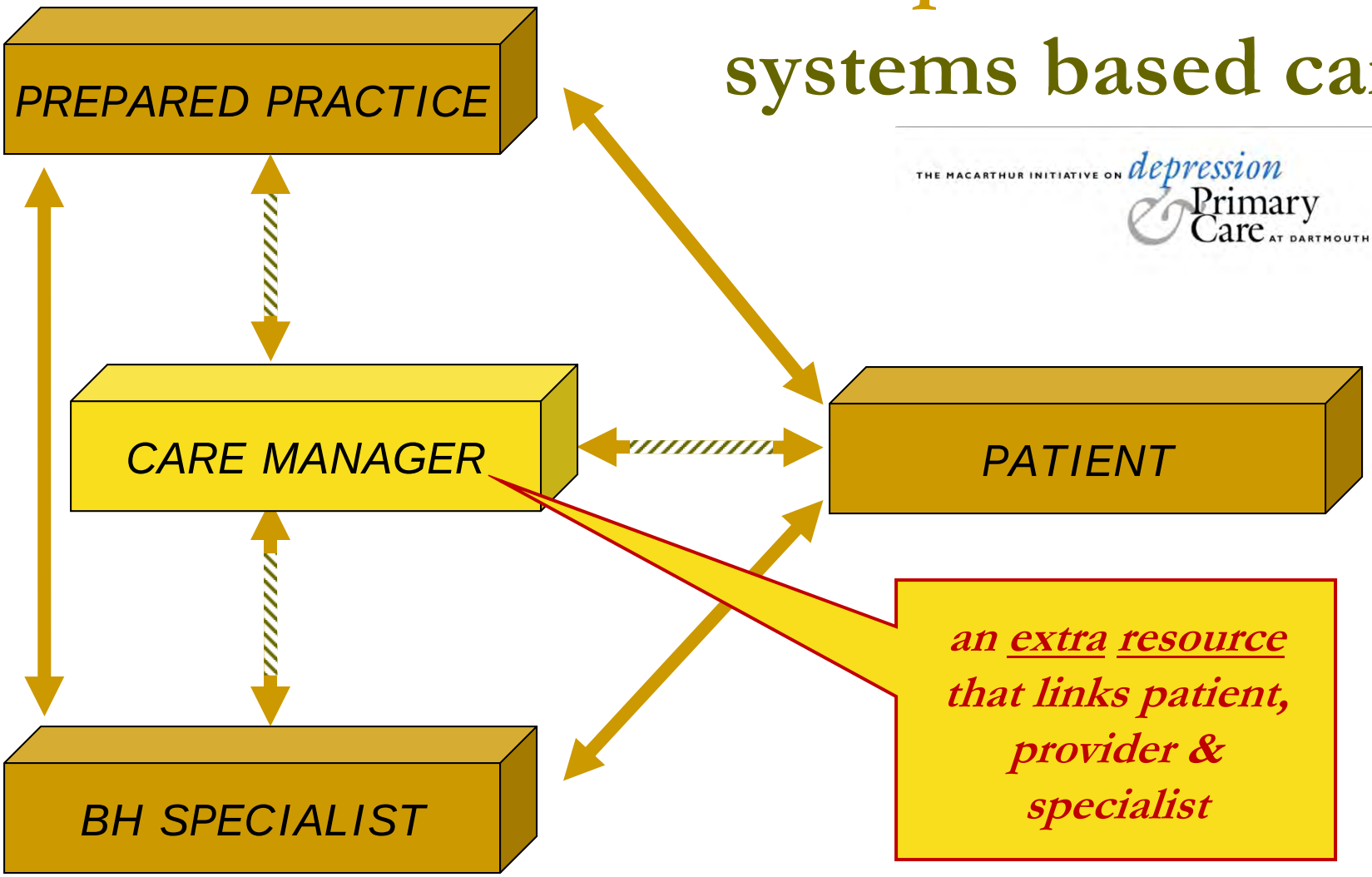
Deployment Health Clinical Center

Uniformed Services University

3CM®

COLORADO SPRINGS, CO 5-7 OCTOBER 2010

3 Component Model systems based care



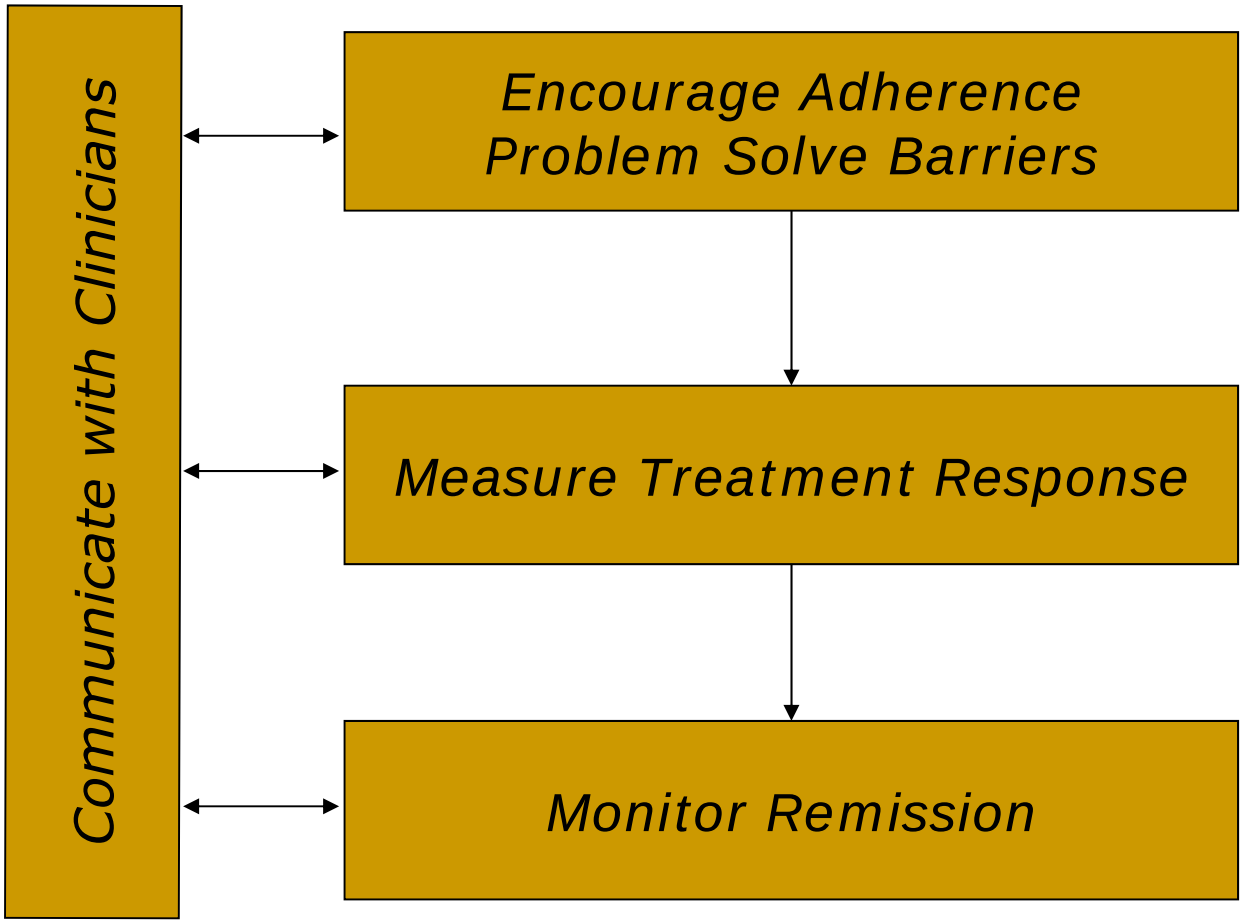
THE MACARTHUR INITIATIVE ON depression & Primary Care AT DARTMOUTH & DUKE

Oxman et al, Psychosomatics, 2002;43:441-450

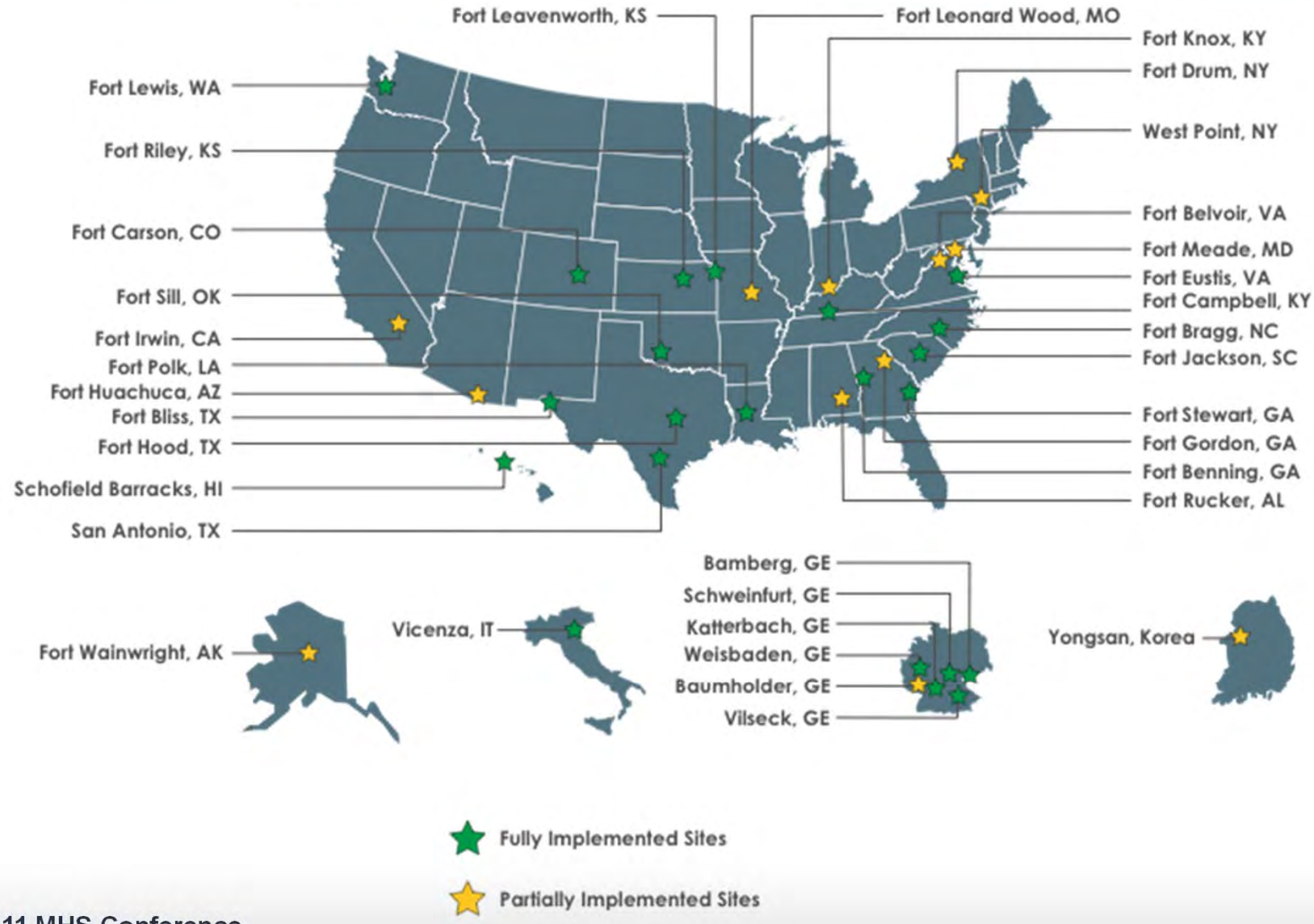
RESPECT-Mil

RESPECT-Mil

Care Facilitator Functions



RESPECT-Mil Worldwide Sites



Levels of Implementation

- Micro: Clinic level implementation
- Meso: Site level implementation (R-SIT)
- Macro: Program level implementation (R-MIT)

RESPECT-Mil Implementation
Micro- or Clinic-level

- Brief PTSD & depression screening (all visits)
- Pre-clinician diagnostic aid
- Patient education materials
- Psychosocial options
- Care Facilitator assisted follow-up option
- Aggressive facilitator outreach & monitoring
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- “Just-in-time” treatment adjustment
- Weekly BH Champion review of facilitator caseload

RESPECT-Mil Implementation
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MEDICAL RECORD - RESPECT-Mil PRIMARY CARE SCREENING

For use of this form, see MEDCOM Circular 40-20; The Surgeon General is the proponent.

TODAY'S DATE: _____

The Army Surgeon General mandates that all Soldiers routinely receive the following primary health care screen.

Please check the best answer to each of the questions on this page. Enter your personal information at the bottom and return this page to the medic or nurse.

PATIENT HEALTH QUESTIONNAIRE

SECTION I *(Check all that apply):*

Over the LAST 2 WEEKS, have you been bothered by any of the following problems?

1. Feeling down, depressed, or hopeless. ☐ Yes ☐ No
2. Little interest or pleasure in doing things. ☐ Yes ☐ No

SECTION II *(Check all that apply):*

Have you had any experience that was so frightening, horrible, or upsetting that IN THE PAST MONTH, you...

3. Had any nightmares about it or thought about it when you did not want to? ☐ Yes ☐ No
4. Tried hard not to think about it or went out of your way to avoid situations that remind you of it? ☐ Yes ☐ No
5. Were constantly on guard, watchful, or easily startled? ☐ Yes ☐ No
6. Felt numb or detached from others, activities, or your surroundings? ☐ Yes ☐ No

FOR OFFICIAL USE ONLY

PATIENT'S HEALTH QUESTIONNAIRE *(Additional Comments):*

Provider please reference section and question number when entering additional comments from patient. Please sign and date entry.

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1

PTSD Instrument (PCL-C)

PCL

Below is a list of problems and complaints that persons sometimes have in response to stressful life experiences. Please read each question carefully circle the number in the box which indicates how much you have been bothered by that problem *in the last month.* Please answer all 19 questions.

	No.	Response:	Not at all	A little bit	Moderately	Quite a bit	Extremely
ONE	1	Repeated, disturbing memories, thoughts, or images of a stressful experience from the past?	0	1	2	3	4
	2	Repeated, disturbing dreams of a stressful experience from the past?	0	1	2	3	4
	3	Suddenly acting or feeling as if a stressful experience were happening again (as if you were reliving it)?	0	1	2	3	4
	4	Feeling very upset when something reminded you of a stressful experience from the past?	0	1	2	3	4
	5	Having physical reactions (e.g., heart pounding, trouble breathing, or sweating) when something reminded you of a stressful experience from the past?	0	1	2	3	4
THREE	6	Avoid thinking about or talking about a stressful experience from the past or avoid having feelings related to it?	0	1	2	3	4
	7	Avoid activities or situations because they remind you of a stressful experience from the past?	0	1	2	3	4
	8	Trouble remembering important parts of a stressful experience from the past?	0	1	2	3	4
	9	Loss of interest in things that you used to enjoy?	0	1	2	3	4
	10	Feeling distant or cut off from other people?	0	1	2	3	4
	11	Feeling emotionally numb or being unable to have loving feelings for those close to you?	0	1	2	3	4
	12	Feeling as if your future will somehow be cut short?	0	1	2	3	4
TWO	13	Trouble falling or staying asleep?	0	1	2	3	4
	14	Feeling irritable or having angry outbursts?	0	1	2	3	4
	15	Having difficulty concentrating?	0	1	2	3	4
	16	Being "super alert" or watchful on guard?	0	1	2	3	4
	17	Feeling jumpy or easily startled?	0	1	2	3	4
		For Primary Care Provider - Subtotal	0 +	+	+	+	
			Total = _____				
	18	IF you checked off any of the above problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people? _____Not difficult _____Somewhat difficult _____Very difficult _____Extremely difficult					
	19	During the last 2 weeks have you had thoughts that you would be better off dead, or of hurting yourself in some way? _____Yes _____ No If 'Yes', how often? ____Several days ____More than half the days ____Almost everyday					

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Participant Education &Self-Management Materials

HOW CAN YOU IMPROVE YOUR SLEEP?

Sleep problems are common for those with PTSD. Changing your sleep pattern can take at least six to eight weeks.

Here are some areas where you may improve your sleep.

Avoid Caffeine: Caffeine is a stimulant found in items such as coffee, tea, soda, and chocolate, as well as in many over-the-counter medications. Those with insomnia are often sensitive to mild stimulants, and should avoid caffeine six to eight hours before bedtime. You may want to consider a trial period of avoiding caffeine altogether.

Avoid Nicotine: Some smokers claim smoking helps them to relax, but nicotine is actually a stimulant. Relaxing effects may occur when nicotine first enters the system, but as it builds up, it produces an effect similar to caffeine. Avoid smoking, dipping, or chewing tobacco before bedtime, and don't smoke to get yourself back to sleep.

Avoid Alcohol: Alcohol is a depressant. While it might help you fall asleep, as alcohol is metabolized, your sleep can become more disturbed and fragmented. Avoid alcohol after dinner, and limit its use to small or moderate quantities.

Cautiously Use Sleeping Pills: Sleep medications are effective only temporarily. If taken regularly, they lose effectiveness in about two to four weeks. Over time, sleeping pills may make sleep problems worse or lead to an insomnia "rebound." Many people, after long-term use of sleeping pills, mistakenly conclude that they need them to sleep

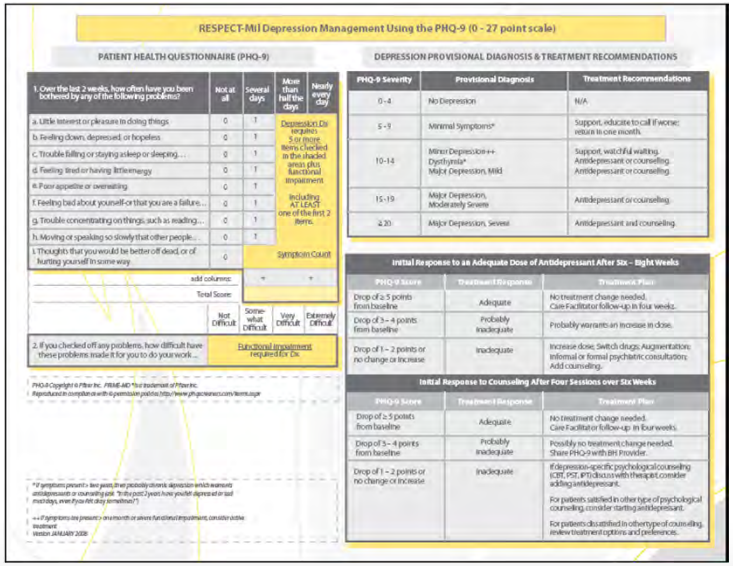
Participant Brochure

SELF-MANAGEMENT WORKSHEET

There are several things you can do to help you feel better, even when you're not at your best. Start by selecting one of the activities from this list. Remember to take it slowly at first and add new things as you begin to feel better.

1. Make time for pleasurable physical activities.
2. Find time for pleasurable activities.
3. Spend time with people who can support you.
4. Practice relaxing.
5. Simple goals and small steps.
6. Eat nutritious, balanced meals.
7. Avoid or minimize alcohol use.

Goals & Self-Management Worksheet



RESPECT-Mil Depression Management Using the PHQ-9 (0 - 27 point scale)

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

1. Over the last 2 weeks, how often have you been bothered by any of the following problems?	Not at all	Several days	More than half the days	Nearly every day
a. Little interest or pleasure in doing things	0	1		
b. Feeling down, depressed, or hopeless	0	1		
c. Trouble falling or staying asleep or sleeping…	0	1		
d. Feeling tired or having little energy	0	1		
e. Poor appetite or overeating	0	1		
f. Feeling bad about yourself–or that you are a failure…	0	1		
g. Trouble concentrating on things, such as reading…	0	1		
h. Moving or speaking so slowly that other people…	0	1		
i. Thoughts that you would be better off dead, or of hurting yourself in some way…	0	1		
add columns:			+	+
Total Score:				

Depression Dx requires: 5 or more items checked in the shaded areas, plus functional impairment. Including AT LEAST one of the first 2 items.

Symptom Count

2. If you checked off any problems, how difficult have these problems made it for you to do your work…	Not difficult	Somewhat difficult	Very difficult	Extremely difficult
Functional impairment required for Dx.				

DEPRESSION PROVISIONAL DIAGNOSIS & TREATMENT RECOMMENDATIONS

PHQ-9 Severity	Provisional Diagnosis	Treatment Recommendations
0 - 4	No Depression	N/A
5 - 9	Minimal Symptoms*	Support, educate to call if worse; return in one month.
10-14	Minor Depression++ Dysthymia* Major Depression, Mild	Support, watchful waiting. Antidepressant or counselling. Antidepressant or counselling.
15-19	Major Depression, Moderately Severe	Antidepressant or counselling.
≥ 20	Major Depression, Severe	Antidepressant and counselling.

Initial Response to an Adequate Dose of Antidepressant After Six – Eight Weeks

PHQ-9 Score	Treatment Response	Treatment Plan
Drop of ≥ 5 points from baseline	Adequate	No treatment change needed. Care Facilitator follow-up in four weeks.
Drop of 3 – 4 points from baseline	Probably inadequate	Probably warrants an increase in dose.
Drop of 1 – 2 points or no change or increase	Inadequate	Increase dose; Switch drugs; Augmentation; Informal or formal psychiatric consultation; Add counselling.

Initial Response to Counseling After Four Sessions over Six Weeks

PHQ-9 Score	Treatment Response	Treatment Plan
Drop of ≥ 5 points from baseline	Adequate	No treatment change needed. Care Facilitator follow-up in four weeks.
Drop of 3 – 4 points from baseline	Probably inadequate	Possibly no treatment change needed. Share PHQ-9 with BH Provider.
Drop of 1 – 2 points or no change or increase	Inadequate	If depression-specific psychological counseling (CBT, IPT, BPT) discuss with therapist; consider adding antidepressant. For patients satisfied in other type of psychological counseling, consider starting antidepressant. For patients dissatisfied in other type of counselling, review treatment options and preferences.

PHQ-9 Copyright © Pfizer Inc. PRIME-MD ® is a trademark of Pfizer Inc. Reproduction in compliance with fair use laws and/or Pfizer policy http://www.phqscreeners.com/terms.aspx

* If symptoms present > two years, then probably chronic depression which warrants antidepressant or counselling visit. "In the past 2 years have you felt depressed or sad most days, even if you felt okay sometimes?"

++ If symptoms are present > one month or severe functional impairment, consider active treatment.

Version JANUARY 2008

Provider "Fast Facts"

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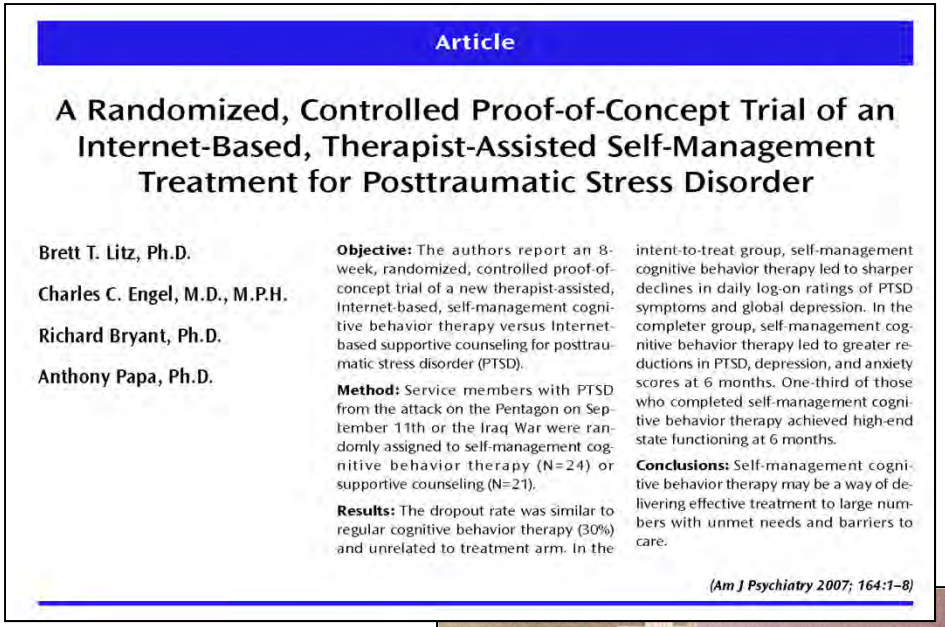
1

DESTRESS-PC

- **DE**livery of
- **S**elf-
- **TR**aining &
- **E**ducation for
- **S**tressful
- **S**ituations –
- **P**rimary **C**are version

Web-based, nurse assisted, CBT-based PTSD self-training



Article

A Randomized, Controlled Proof-of-Concept Trial of an Internet-Based, Therapist-Assisted Self-Management Treatment for Posttraumatic Stress Disorder

Brett T. Litz, Ph.D.
Charles C. Engel, M.D., M.P.H.
Richard Bryant, Ph.D.
Anthony Papa, Ph.D.

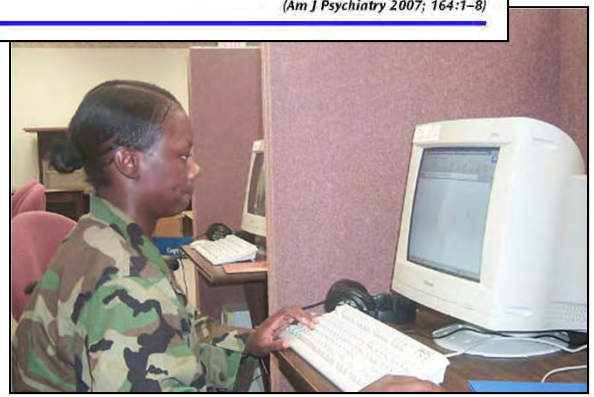
Objective: The authors report an 8-week, randomized, controlled proof-of-concept trial of a new therapist-assisted, Internet-based, self-management cognitive behavior therapy versus Internet-based supportive counseling for posttraumatic stress disorder (PTSD).

Method: Service members with PTSD from the attack on the Pentagon on September 11th or the Iraq War were randomly assigned to self-management cognitive behavior therapy (N=24) or supportive counseling (N=21).

Results: The dropout rate was similar to regular cognitive behavior therapy (30%) and unrelated to treatment arm. In the intent-to-treat group, self-management cognitive behavior therapy led to sharper declines in daily log-on ratings of PTSD symptoms and global depression. In the completer group, self-management cognitive behavior therapy led to greater reductions in PTSD, depression, and anxiety scores at 6 months. One-third of those who completed self-management cognitive behavior therapy achieved high-end state functioning at 6 months.

Conclusions: Self-management cognitive behavior therapy may be a way of delivering effective treatment to large numbers with unmet needs and barriers to care.

(Am J Psychiatry 2007; 164:1–8)



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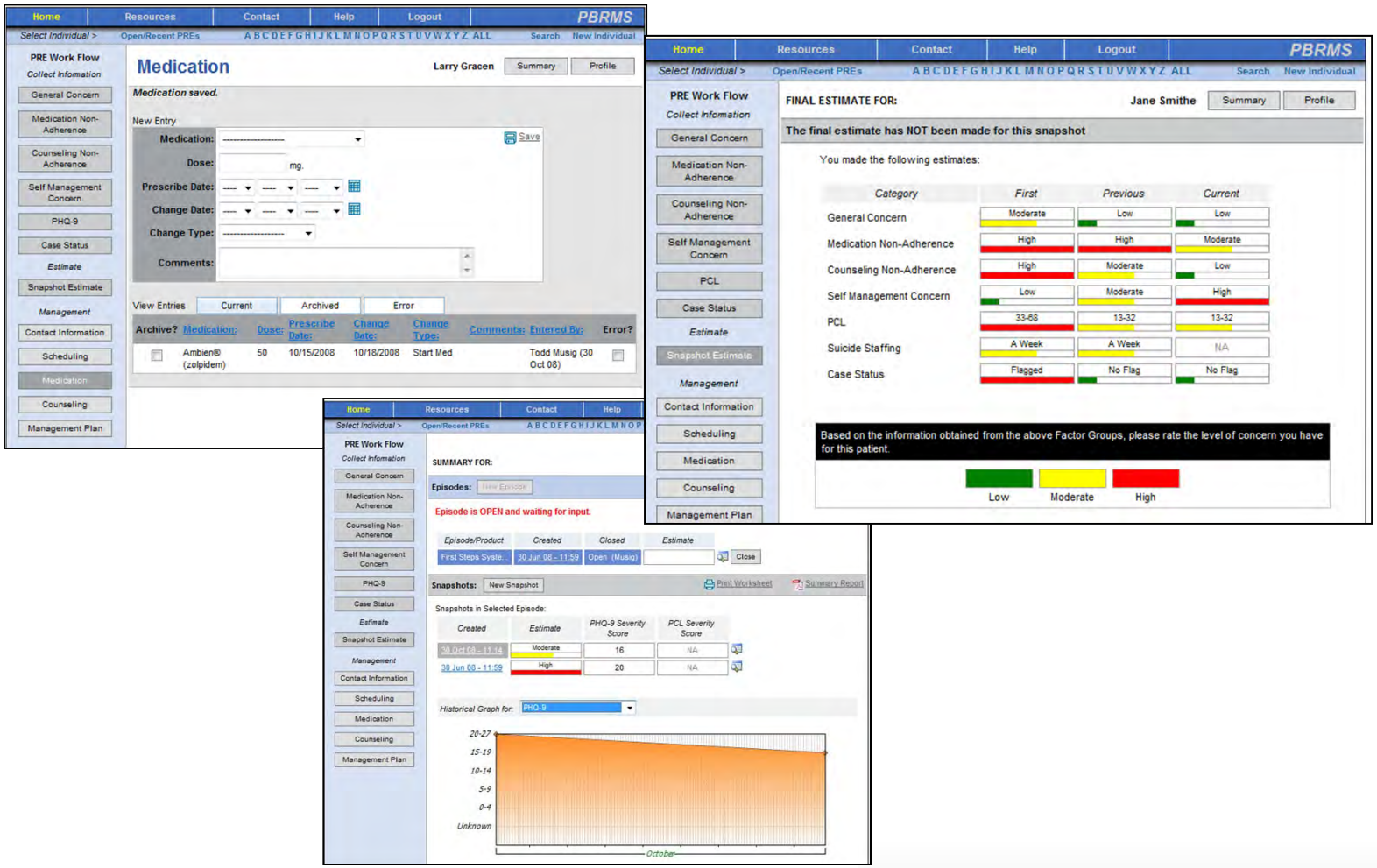
1

FIRST-STEPS

Web-based Care-Manager Support & Reporting System



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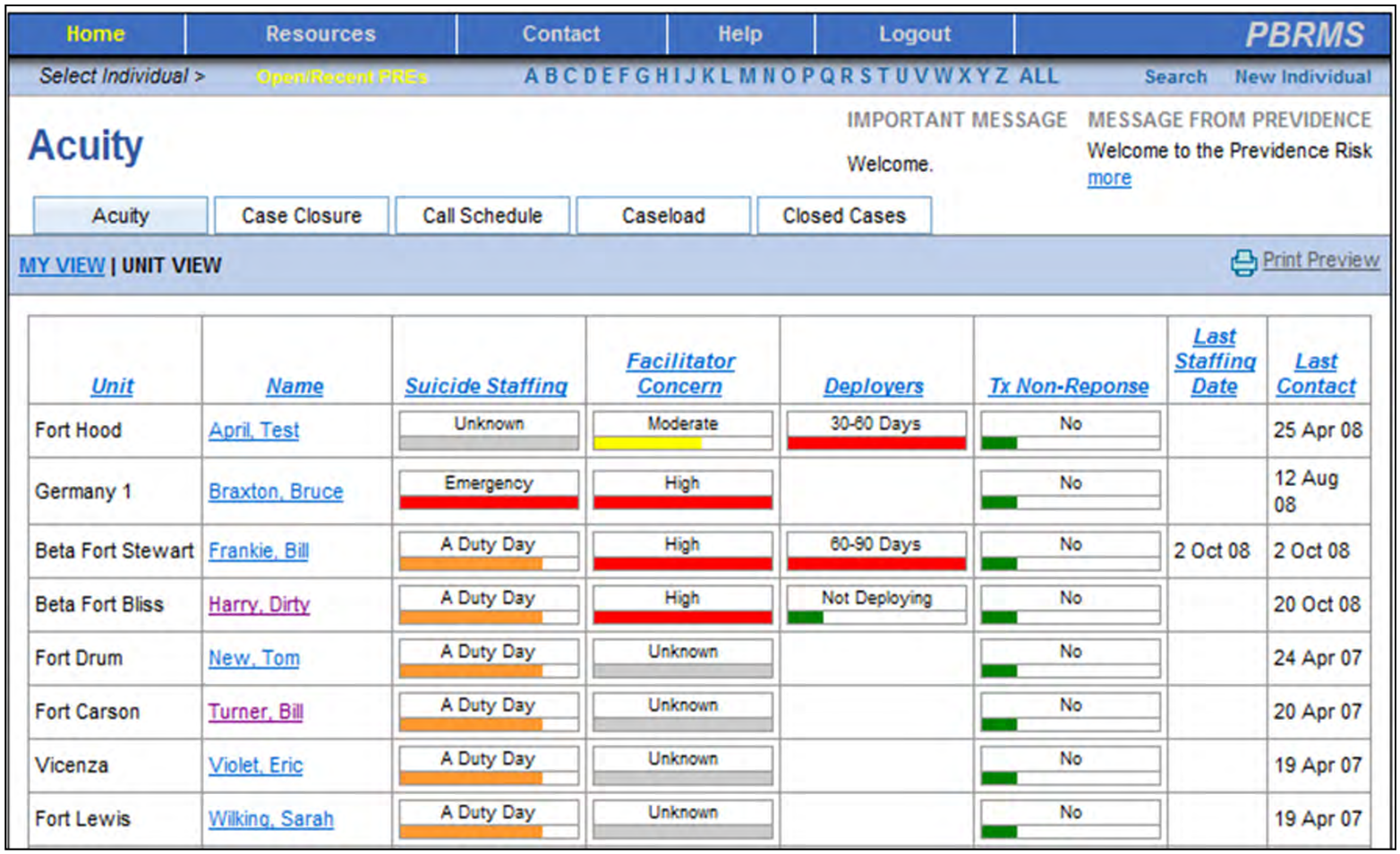
- **Weekly BH Champion review of facilitator caseload**

FIRST-STEPS

Improves Efficiency, Accountability & Effectiveness of Facilitator Staffing



Home | Resources | Contact | Help | Logout | PBRMS

Select Individual > Open/Recent PREs A B C D E F G H I J K L M N O P Q R S T U V W X Y Z ALL Search New Individual

Acuity

IMPORTANT MESSAGE
Welcome.

MESSAGE FROM PREVIDENCE
Welcome to the Previdence Risk
more

Acuity | Case Closure | Call Schedule | Caseload | Closed Cases

MY VIEW | UNIT VIEW — Print Preview

Unit	Name	Suicide Staffing	Facilitator Concern	Deployers	Tx Non-Reponse	Last Staffing Date	Last Contact
Fort Hood	April, Test	Unknown	Moderate	30-60 Days	No		25 Apr 08
Germany 1	Braxton, Bruce	Emergency	High		No		12 Aug 08
Beta Fort Stewart	Frankie, Bill	A Duty Day	High	60-90 Days	No	2 Oct 08	2 Oct 08
Beta Fort Bliss	Harry, Dirty	A Duty Day	High	Not Deploying	No		20 Oct 08
Fort Drum	New, Tom	A Duty Day	Unknown		No		24 Apr 07
Fort Carson	Turner, Bill	A Duty Day	Unknown		No		20 Apr 07
Vicenza	Violet, Eric	A Duty Day	Unknown		No		19 Apr 07
Fort Lewis	Wilking, Sarah	A Duty Day	Unknown		No		19 Apr 07

RESPECT-Mil Implementation
Macro- or Program-level

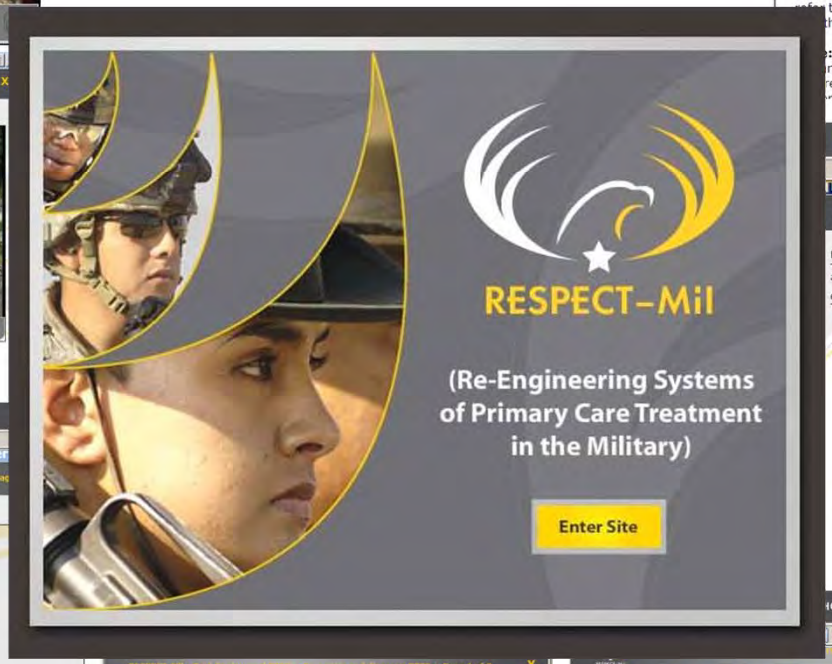
RESPECT-Mil Implementation Team (R-MIT):

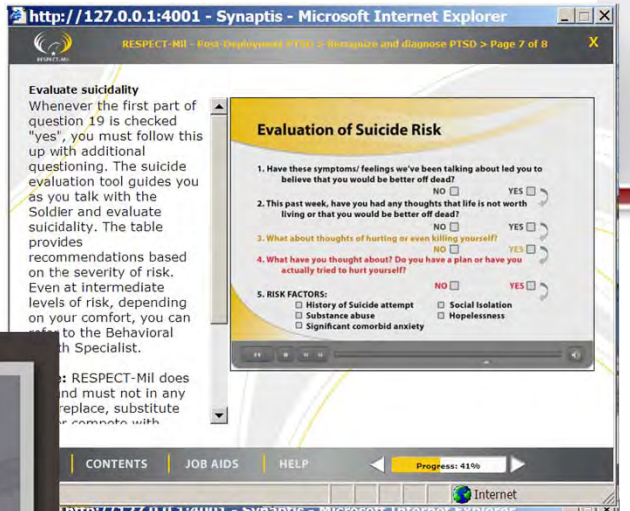
- Monitors program implementation, fidelity, outcomes
- Trains & consults with R-SiTs
- Develops & disseminates education modules and tools
- Pilots & evaluates new components
- Performs site visits & site calls

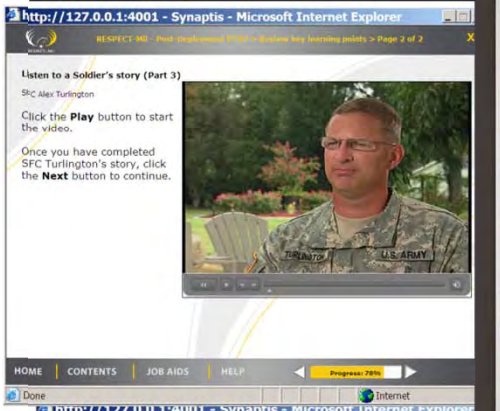
RESPECT-Mil Implementation
Meso- or Site-level

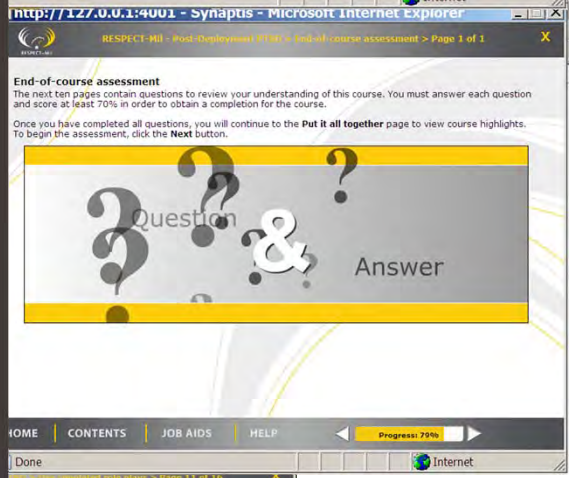
- RESPECT-Mil Site Team (R-SIT)
- Primary Care Champion
  - Monitors local program & process
- Behavioral Health Champion
  - Monitors facilitator caseloads
- Facilitator
  - RN, 1 per 6K in eligible population
- Administrative assistant
  - 1 per 10K in eligible population

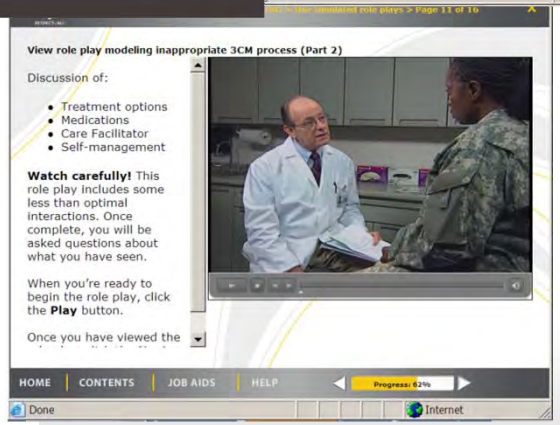
Web-Based PTSD & Depression Training for Primary Care Providers*





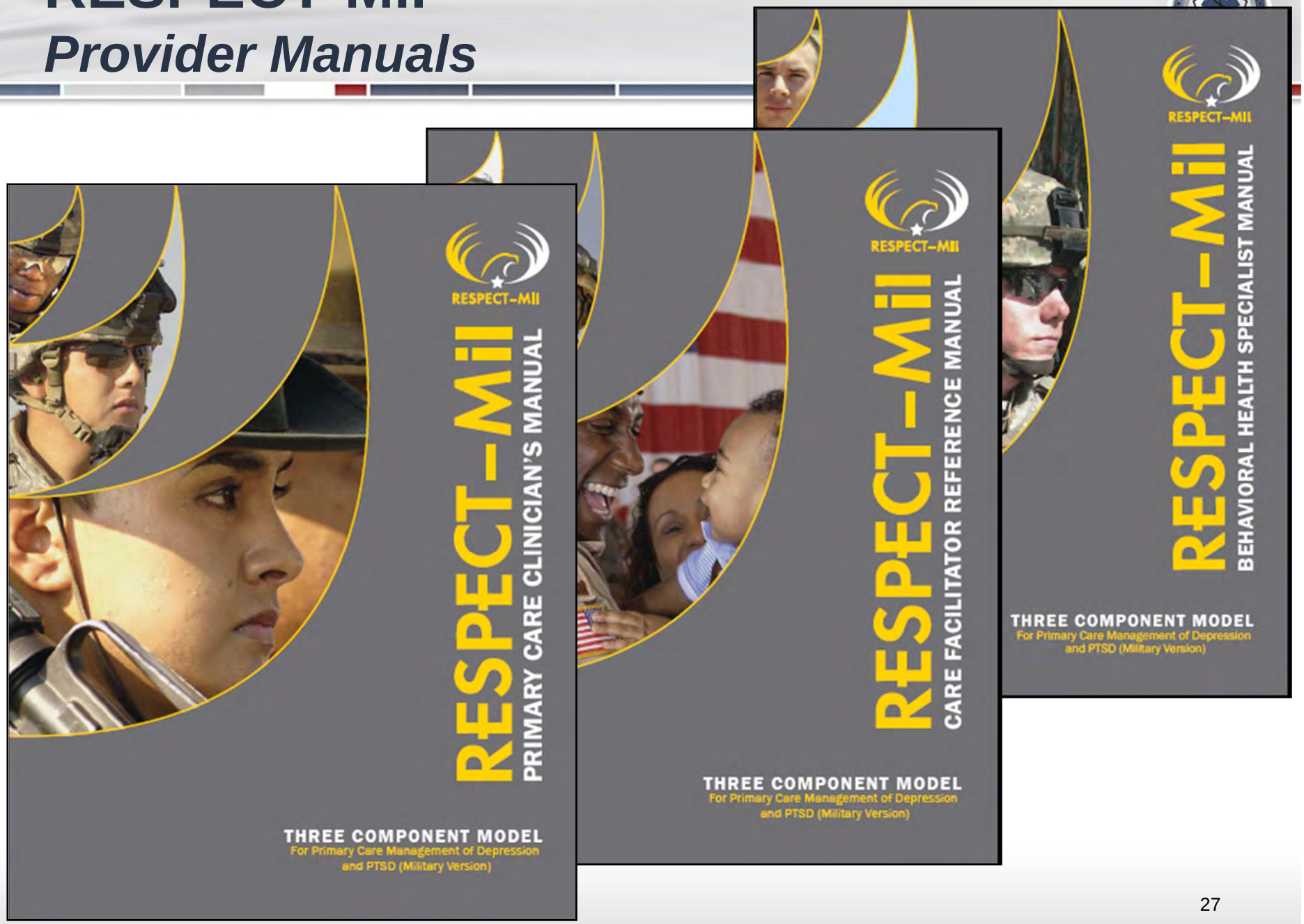




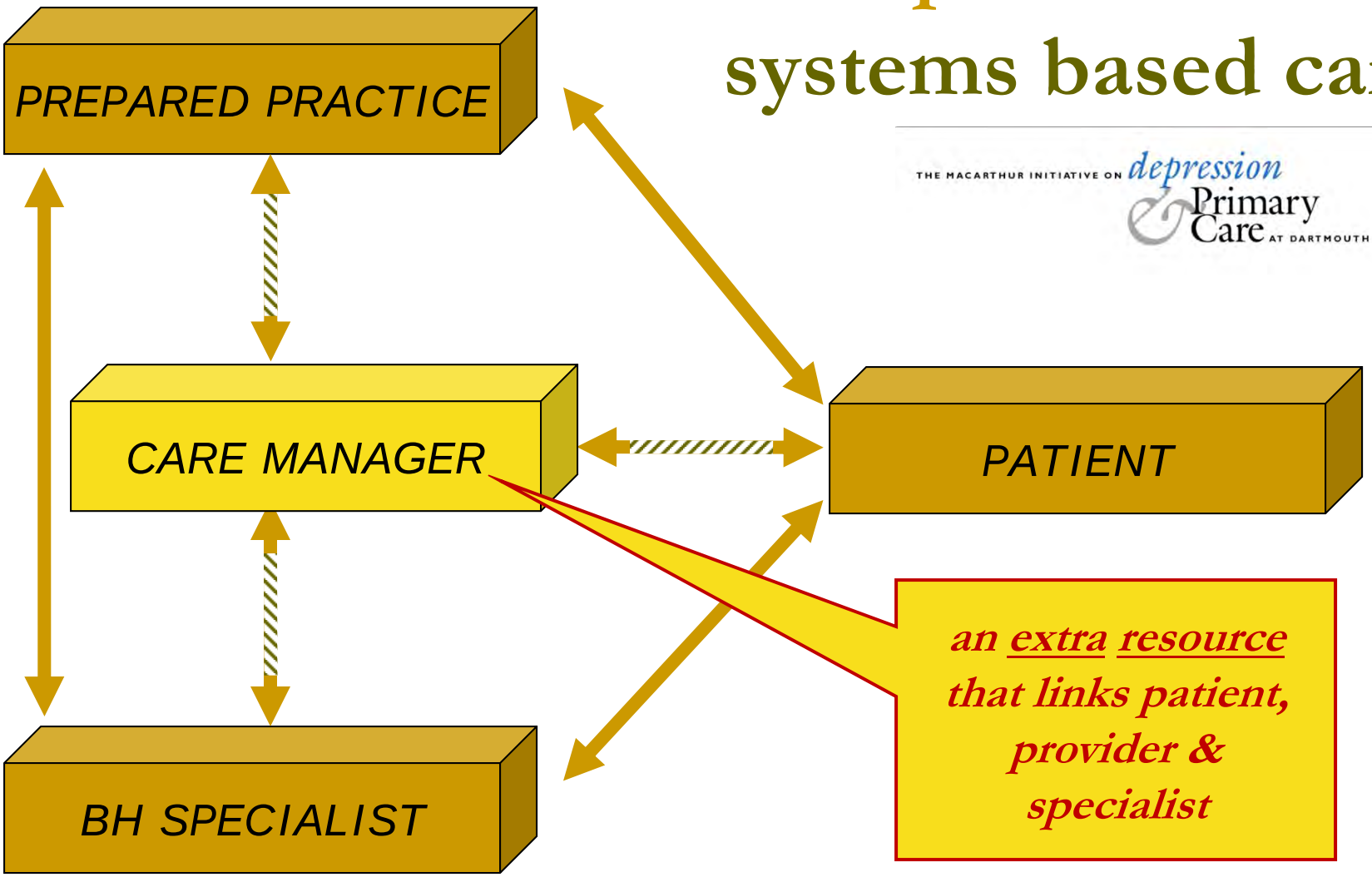


*** Includes suicide assessment training**

RESPECT-Mil
Provider Manuals



3 Component Model systems based care



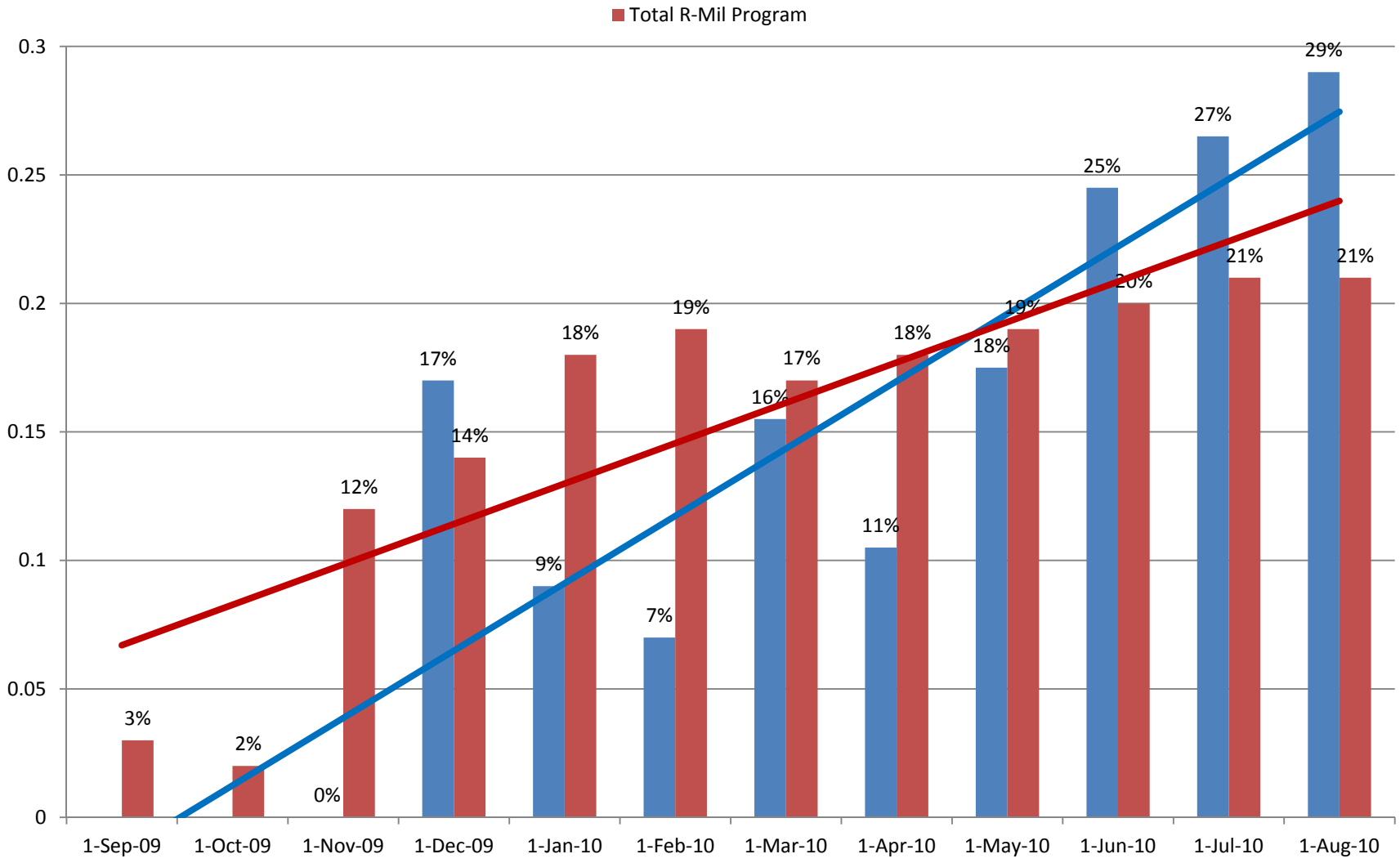
THE MACARTHUR INITIATIVE ON depression & Primary Care AT DARTMOUTH & DUKE

Oxman et al, Psychosomatics, 2002;43:441-450

RESPECT-Mil

Real-time Aggregate Data Reports

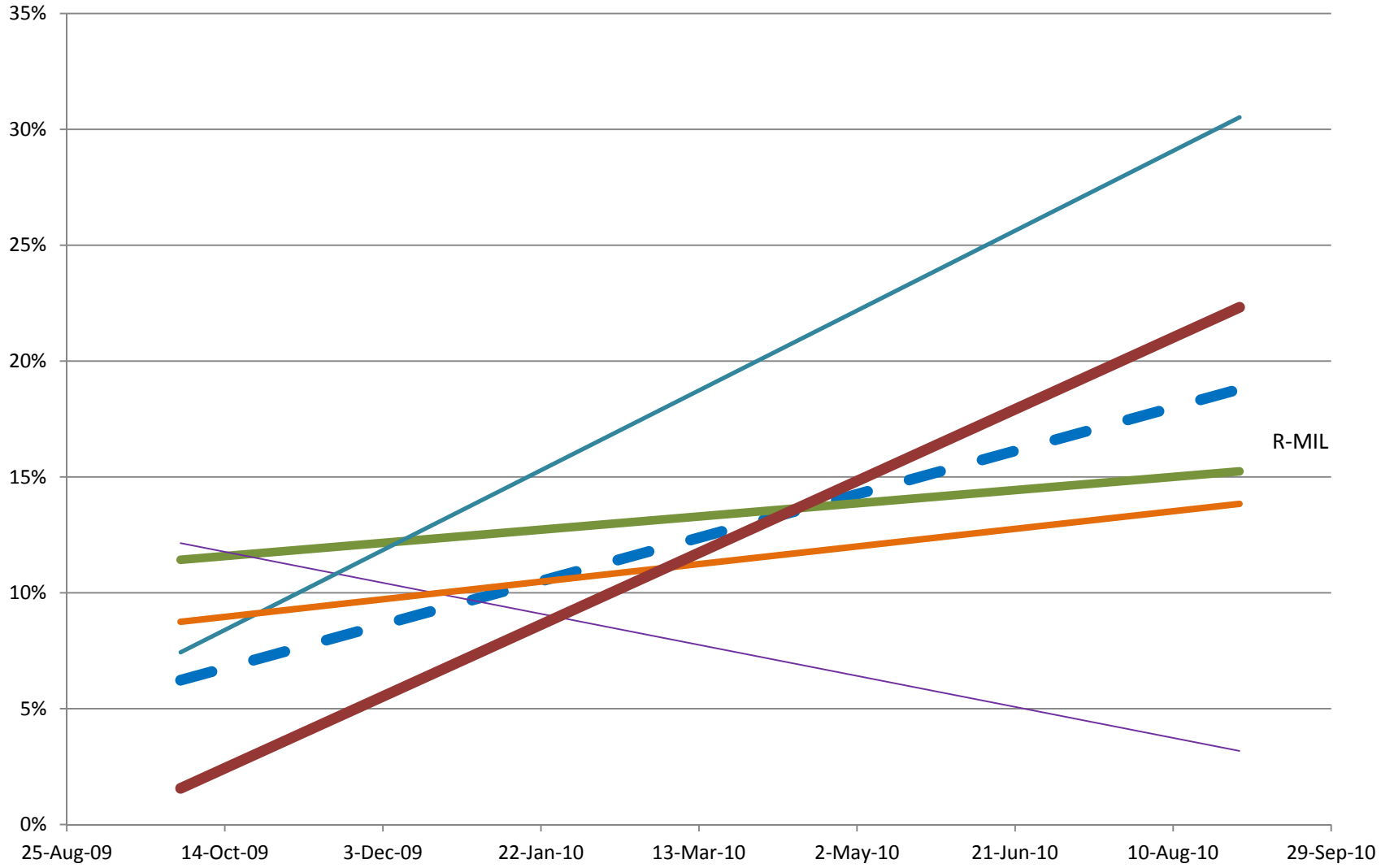
Region PTSD Remission Trend



**Remission is defined as the count of individuals who have an open episode in FIRST STEPS, have been in the system 8 weeks or more, and have a PCL score of 10 or less.

Real-time Aggregate Data Reports

PTSD Remission Trends by Region



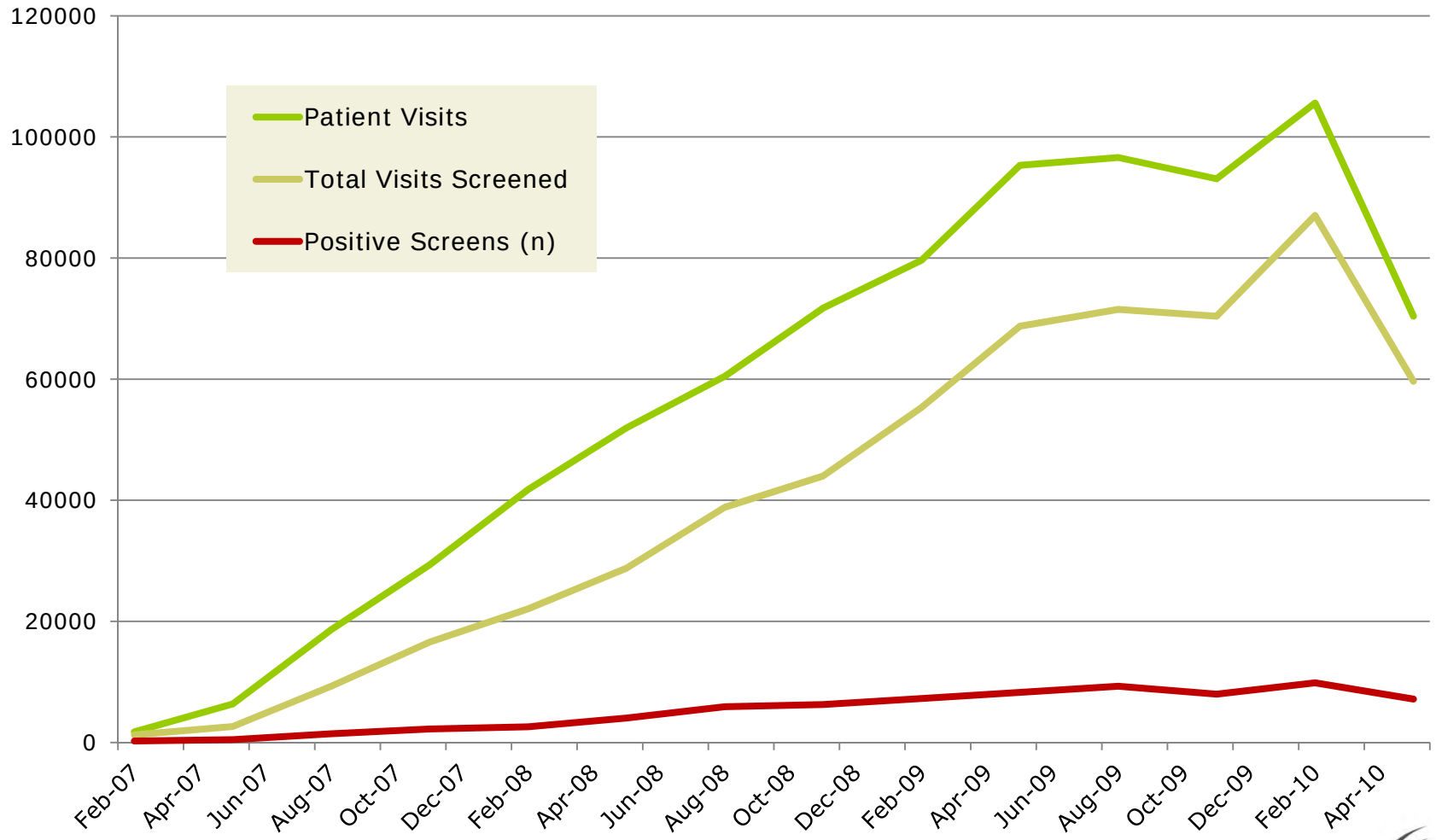
RESPECT-Mil
Implementation Results

- **55** clinics now implementing (95 projected)
- **84%** of visits screened (versus 2-5% in non-RESPECT-Mil teaching clinic)
- **13%** of all screened visits are positive
- **48%** of positive screens result in a diagnosis of ‘depression’ or ‘possible PTSD’

** Data through November 2010*

RESPECT-Mil Screening Visits

Consistently Rising Rate of Program Implementation

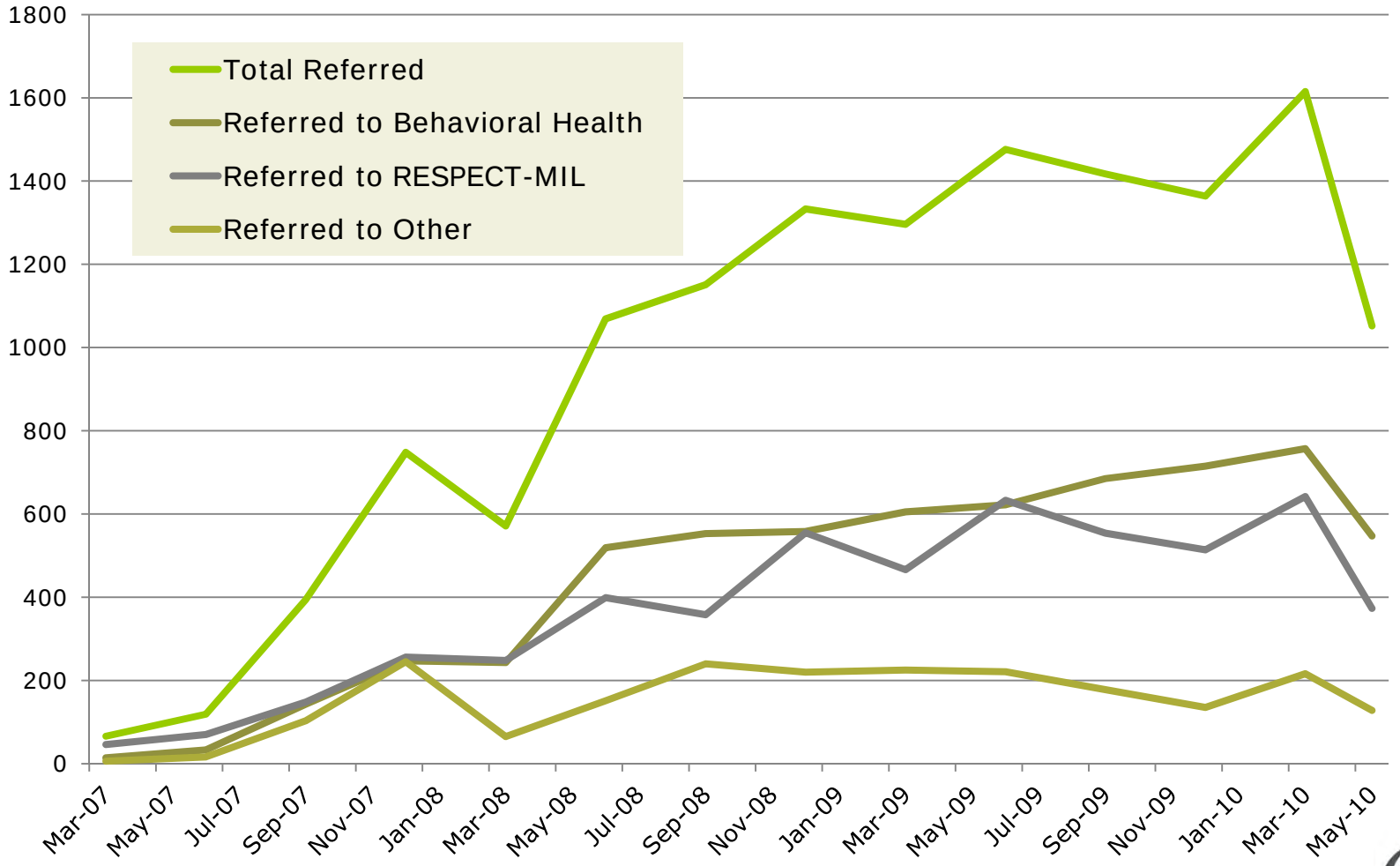


Data through May 2010

RESPECT-Mil

Referrals for Enhanced BH Services

Referrals for Facilitation Nearly as High as to Specialist

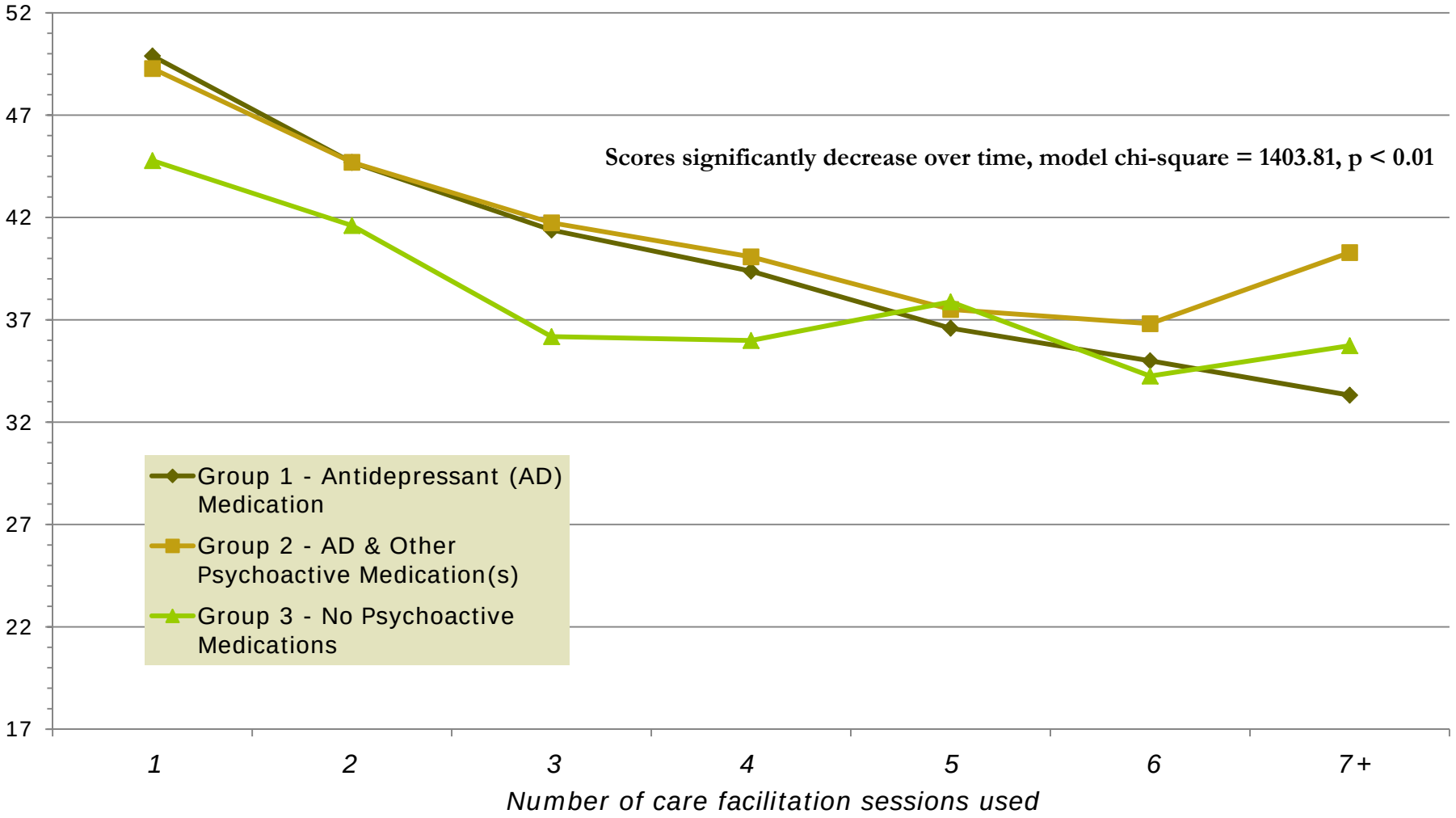


** Data through May 2010*

RESPECT-Mil

Care Facilitation & PTSD Severity (PCL-C)

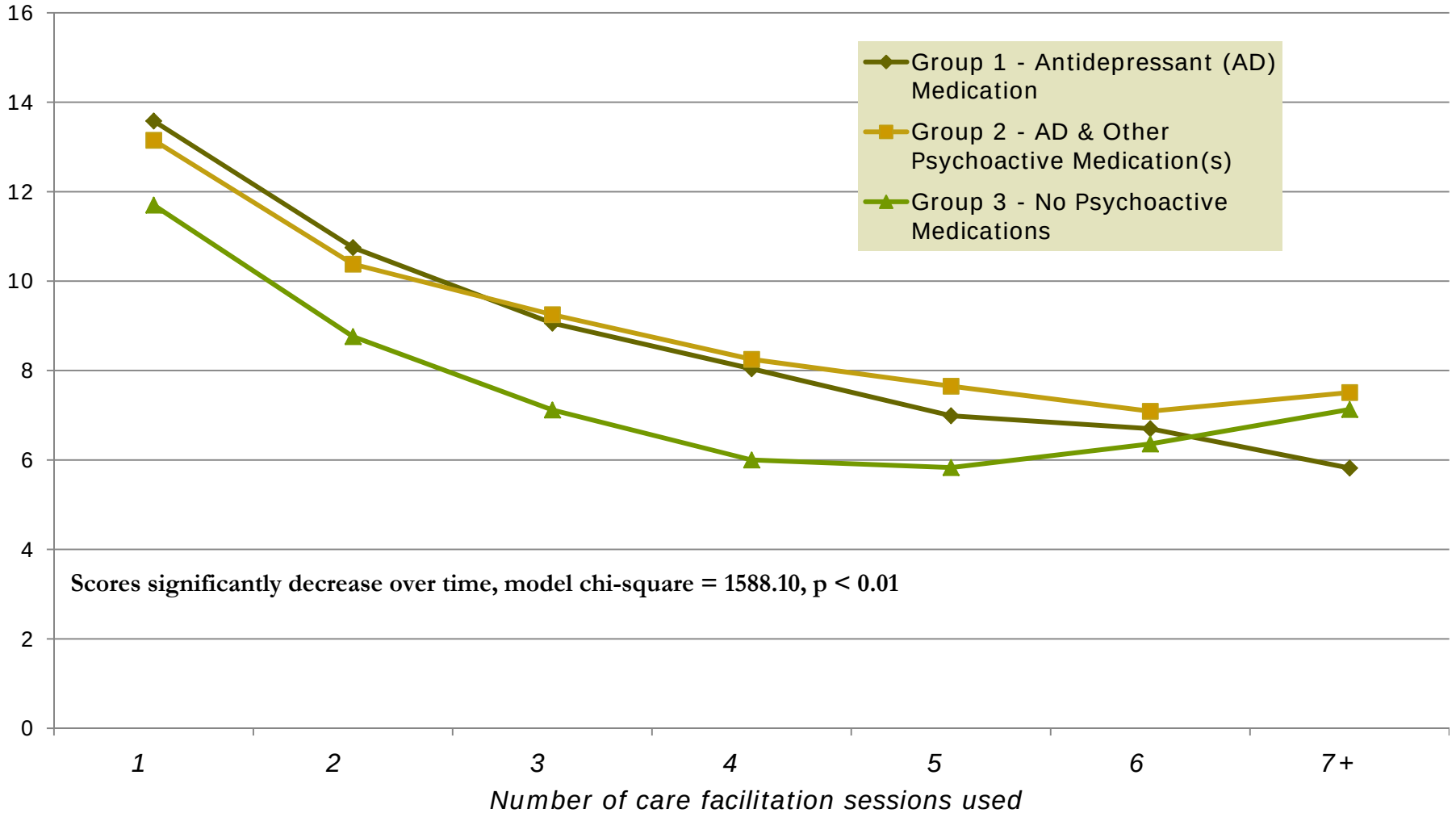
Number of facilitator visits associated with improvement



* Data from RESPECT-Mil enrolled cases from 01 Feb 2007 to 31 Aug 2009 (N = 2,548)

Care Facilitation & Depression Severity (PHQ-9)

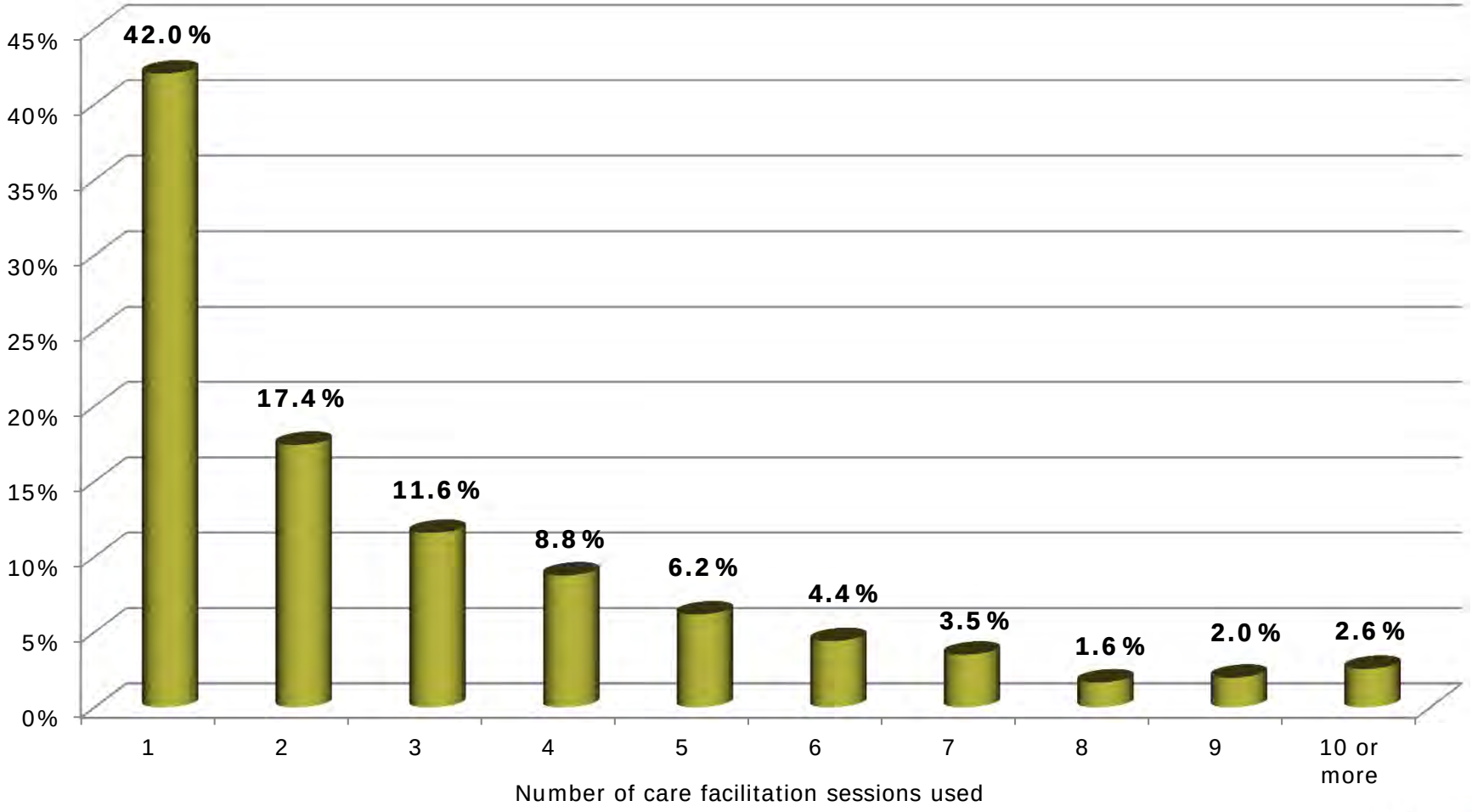
Number of facilitator visits associated with improvement



* Data from RESPECT-Mil enrolled cases from 01 Feb 2007 to 31 Aug 2009 (N = 2,548)

RESPECT-Mil Facilitator Use

Only 20.6% have four or more facilitator contacts



* Data from RESPECT-Mil enrolled cases from 01 Feb 2007 to 31 Aug 2009 (N = 2,548)

RESPECT-Mil

RESPECT-Mil
Safety & Risk Management

- Visits associated with any suicidal ideation
- 1% of screened visits (7.6% of screen positive visits)
- 27% of visits involving suicidal ideation are rated by provider as intermediate or high risk ("non-low risk")
- Frequent "save" anecdotes

** Data through Nov 2010*

RESPECT-Mil
Safety & Risk Management

- Visits associated with any suicidal ideation
- Appropriate risk assessment
  - 99.4% of screened positive visits
- Appropriate risk assessment
  - 99.9% of screened visits

** Data through May2010*

RESPECT-Mil
Dispositions

66% assistance rate
accept/[accept + decline]

3% of all visits
involve recognition & assistance for
previously unrecognized mental health needs

** Data through Nov 2010*

RESPECT-Mil
Findings to Date

- Often concerns about getting started
- Once started, approach is acceptable and feasible for both Soldiers and providers
- Enrolled soldiers show clinical improvement
- Identifying & referring Soldiers with previously unrecognized and unmet needs
- Enhanced safety and risk assessment capabilities

RESPECT-Mil
Challenges & Road Ahead

- Intercalation with **Patient Centered Medical Home**
- Web-based training ongoing
  http://www.pdhealth.mil/respect-mil.asp
- **FIRST-STEPS** performance reporting
- **Alcohol SBIRT** demonstration in preparation
- **REHIP** triservice demonstration of a “blended” model
- **STEPS-UP Trial** – a 5-year, 18-clinic controlled trial (n=1500) intervention is blended + centralized care management + stepped psychosocial modalities

RESPECT-Mil
Review of Findings to Date

- Often concerns about getting started; once started the approach is feasible and acceptable
- Identifying & referring patients with previously unrecognized and unmet needs
- Clinical improvement is related to use of care facilitation
- Only ~20% reach 4 facilitator visits (~5 months)
- Most sites lack accessible evidence-based psychosocial therapies

RESPECT-Mil Central

Implementation Team

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Deputy Director

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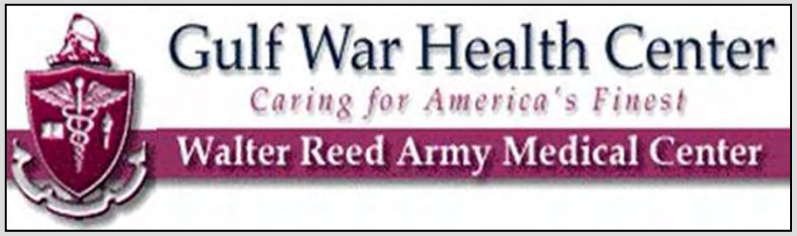
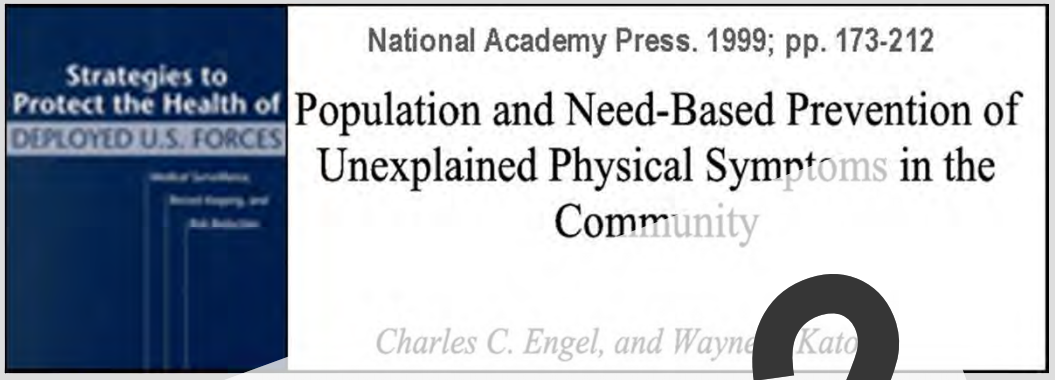
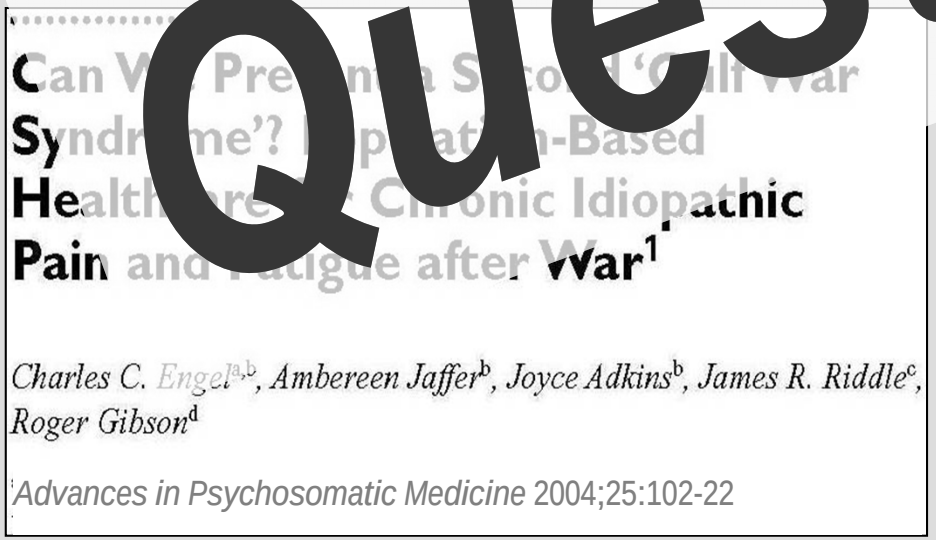
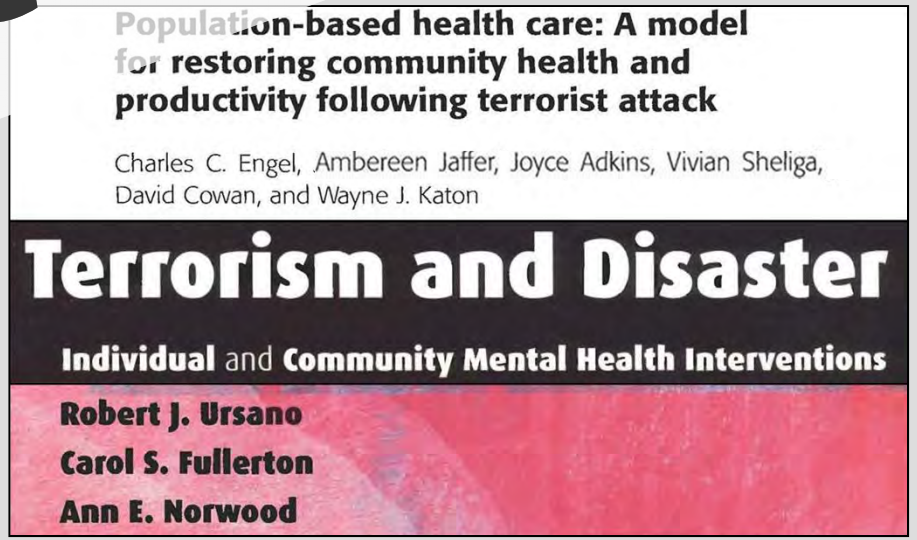

Gulf War Health Center
Caring for America's Finest
Walter Reed Army Medical Center


Strategies to Protect the Health of DEPLOYED U.S. FORCES
National Academy Press. 1999; pp. 173-212
Population and Need-Based Prevention of Unexplained Physical Symptoms in the Community
Charles C. Engel, and Wayne J. Katon


DHCC
DEPLOYMENT HEALTH CLINICAL CENTER


PHILOSOPHICAL TRANSACTIONS OF THE ROYAL SOCIETY B
Phil. Trans. R. Soc. B (2006) 361, 707–720
doi:10.1098/rstb.2006.1829
Published 24 March 2006
Management of future Gulf War Syndromes: international lessons and new models of care
Charles [illegible] Engel[1,2,*], Kenneth C. Hyams[3] and Ken Scott[4]

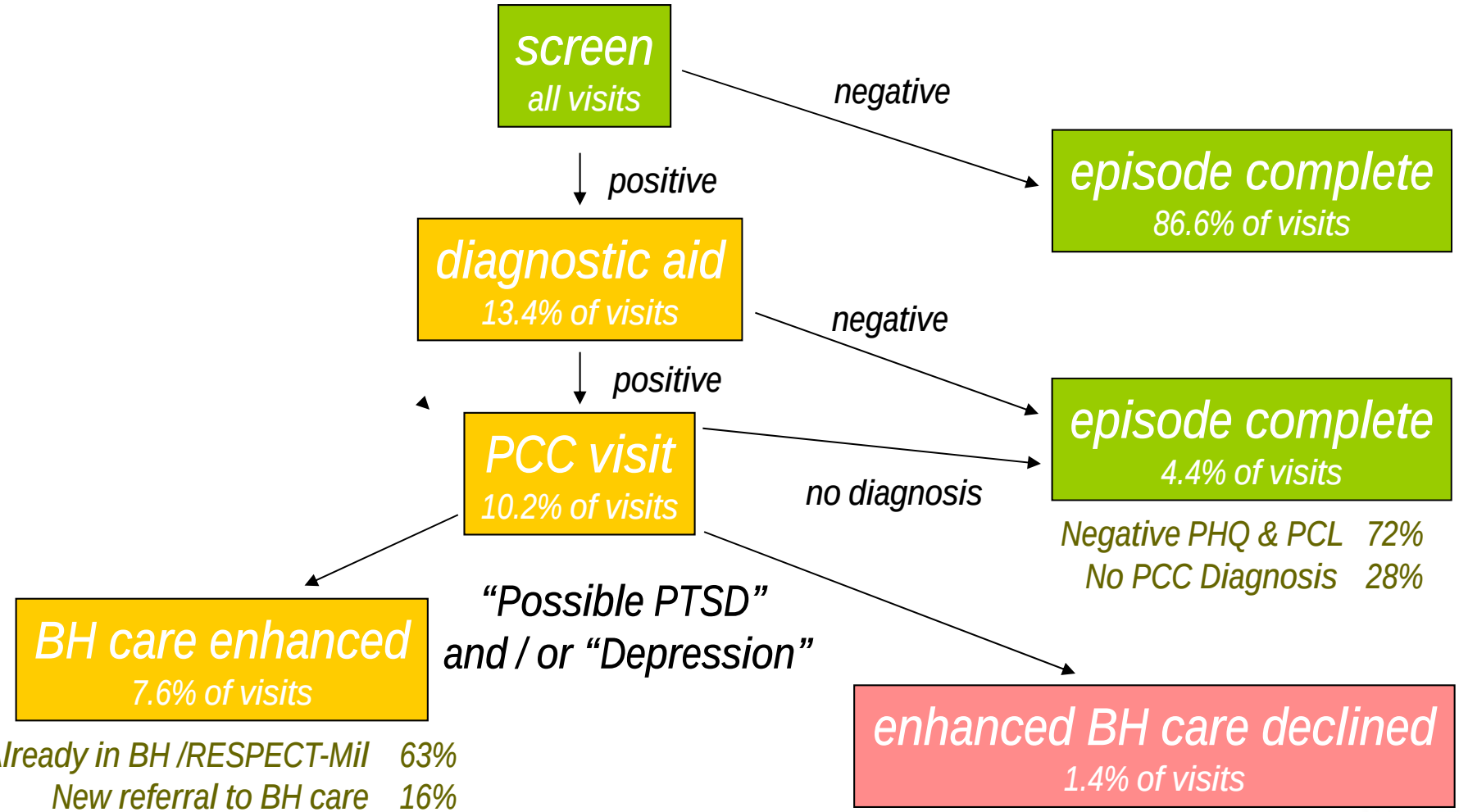

Can We Prevent a Second 'Gulf War Syndrome'? Population-Based Healthcare for Chronic Idiopathic Pain and Fatigue after War[1]
Charles C. Engel[a,b], Ambereen Jaffer[b], Joyce Adkins[b], James R. Riddle[c], Roger Gibson[d]
Advances in Psychosomatic Medicine 2004;25:102-22


Population-based health care: A model for restoring community health and productivity following terrorist attack
Charles C. Engel, Ambereen Jaffer, Joyce Adkins, Vivian Sheliga, David Cowan, and Wayne J. Katon
Terrorism and Disaster
Individual and Community Mental Health Interventions
Robert J. Ursano
Carol S. Fullerton
Ann E. Norwood

Questions?

RESPECT-Mil

Patient Flow & Clinic Process



RESPECT-Mil

Time & Workload

component	% visits	estimated time / visit
All clinic patients	100.0%	2 minutes medic time
Screen positive	13.4%	3 minutes medic time
Diagnosis	10.2%	10 minutes clinician time
Suicidality	0.7%	25 minutes clinician time

Total Estimated Time Per Visit

Medic = 2 + (0.134 x 3) = 2.4 min

Provider = (0.102 x 10) + (0.007 x 25) = 1.2 min

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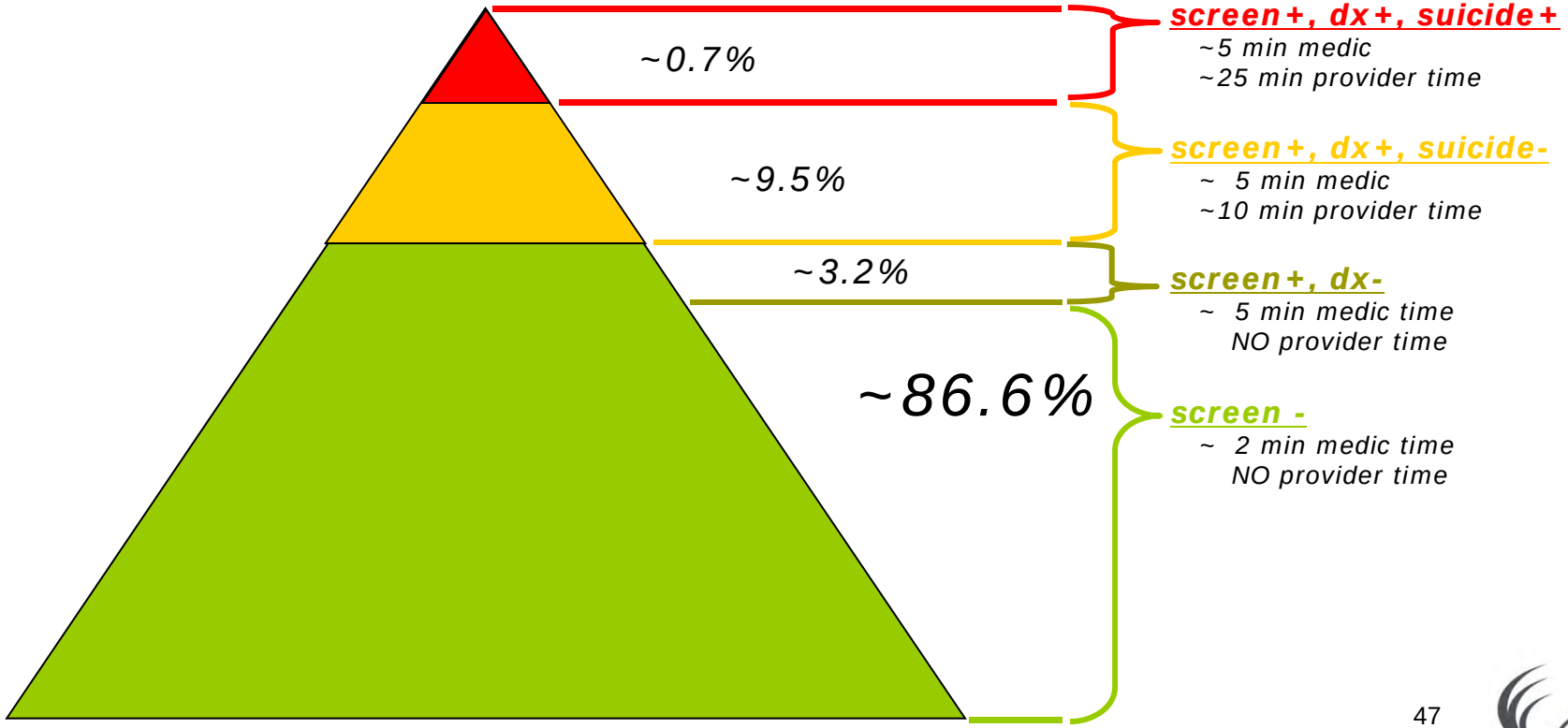
Creating Efficiencies

*~ **90%** of visits require **NO** added provider **time***

*~ **84%** of added clinician time is for the **0.7%** of visits at highest risk*



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