

# **RESPECT-Mil: Early Intervention & Outcomes of PTSD & Depression in Primary Care**

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## Report Documentation Page

*Form Approved*  
*OMB No. 0704-0188*

Public reporting burden for the collection of information is estimated to average 1 hour per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to Washington Headquarters Services, Directorate for Information Operations and Reports, 1215 Jefferson Davis Highway, Suite 1204, Arlington VA 22202-4302. Respondents should be aware that notwithstanding any other provision of law, no person shall be subject to a penalty for failing to comply with a collection of information if it does not display a currently valid OMB control number.

1. REPORT DATE <b>2011</b>	2. REPORT TYPE	3. DATES COVERED <b>00-00-2011 to 00-00-2011</b>			
4. TITLE AND SUBTITLE <b>RESPECT-Mil: Early Intervention &amp; Outcomes Of PTSD &amp; Depression In Primary Care</b>		5a. CONTRACT NUMBER			
		5b. GRANT NUMBER			
		5c. PROGRAM ELEMENT NUMBER			
6. AUTHOR(S)		5d. PROJECT NUMBER			
		5e. TASK NUMBER			
		5f. WORK UNIT NUMBER			
7. PERFORMING ORGANIZATION NAME(S) AND ADDRESS(ES) <b>Uniformed Services University School of Medicine, Department of Psychiatry, 4301 Jones Bridge Rd, Bethesda, MD, 20814</b>		8. PERFORMING ORGANIZATION REPORT NUMBER			
9. SPONSORING/MONITORING AGENCY NAME(S) AND ADDRESS(ES)		10. SPONSOR/MONITOR'S ACRONYM(S)			
		11. SPONSOR/MONITOR'S REPORT NUMBER(S)			
12. DISTRIBUTION/AVAILABILITY STATEMENT <b>Approved for public release; distribution unlimited</b>					
13. SUPPLEMENTARY NOTES <b>Presented Mar 21 at the 1st Annual Armed Forces Public Health Conference 2011</b>					
14. ABSTRACT					
15. SUBJECT TERMS					
16. SECURITY CLASSIFICATION OF:			17. LIMITATION OF ABSTRACT <b>Same as Report (SAR)</b>	18. NUMBER OF PAGES <b>52</b>	19a. NAME OF RESPONSIBLE PERSON
a. REPORT <b>unclassified</b>	b. ABSTRACT <b>unclassified</b>	c. THIS PAGE <b>unclassified</b>			

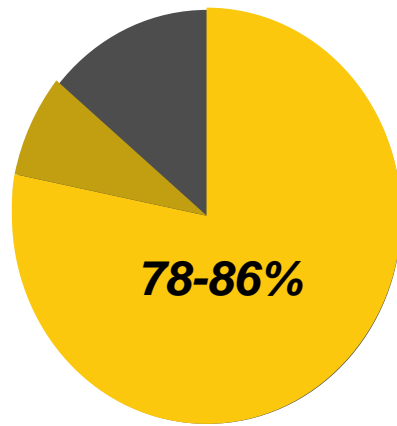
# *Why Primary Care?*

## **A Gap Between Needs & Services**

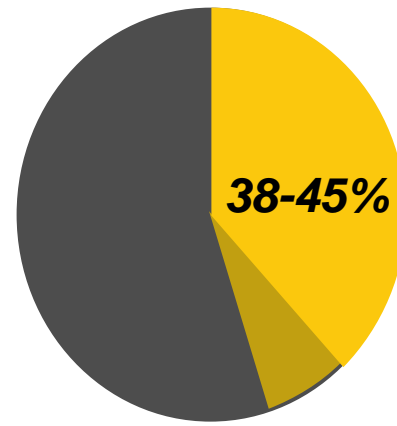
Among the 20% of Soldiers with moderate to severe disorder after OIF deployment...

Got help (past 12 months)

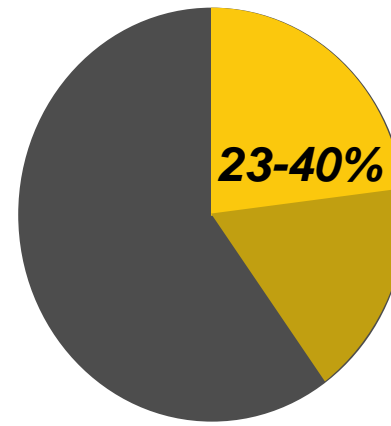
*Acknowledge  
a problem*



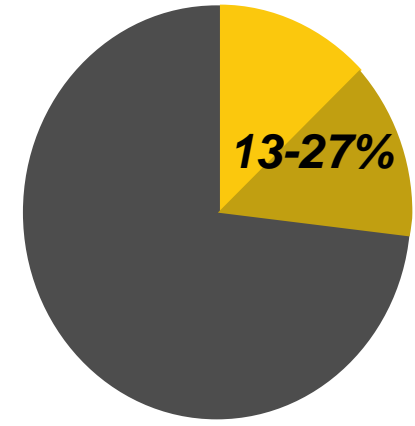
*Want help*



*Any  
professional*

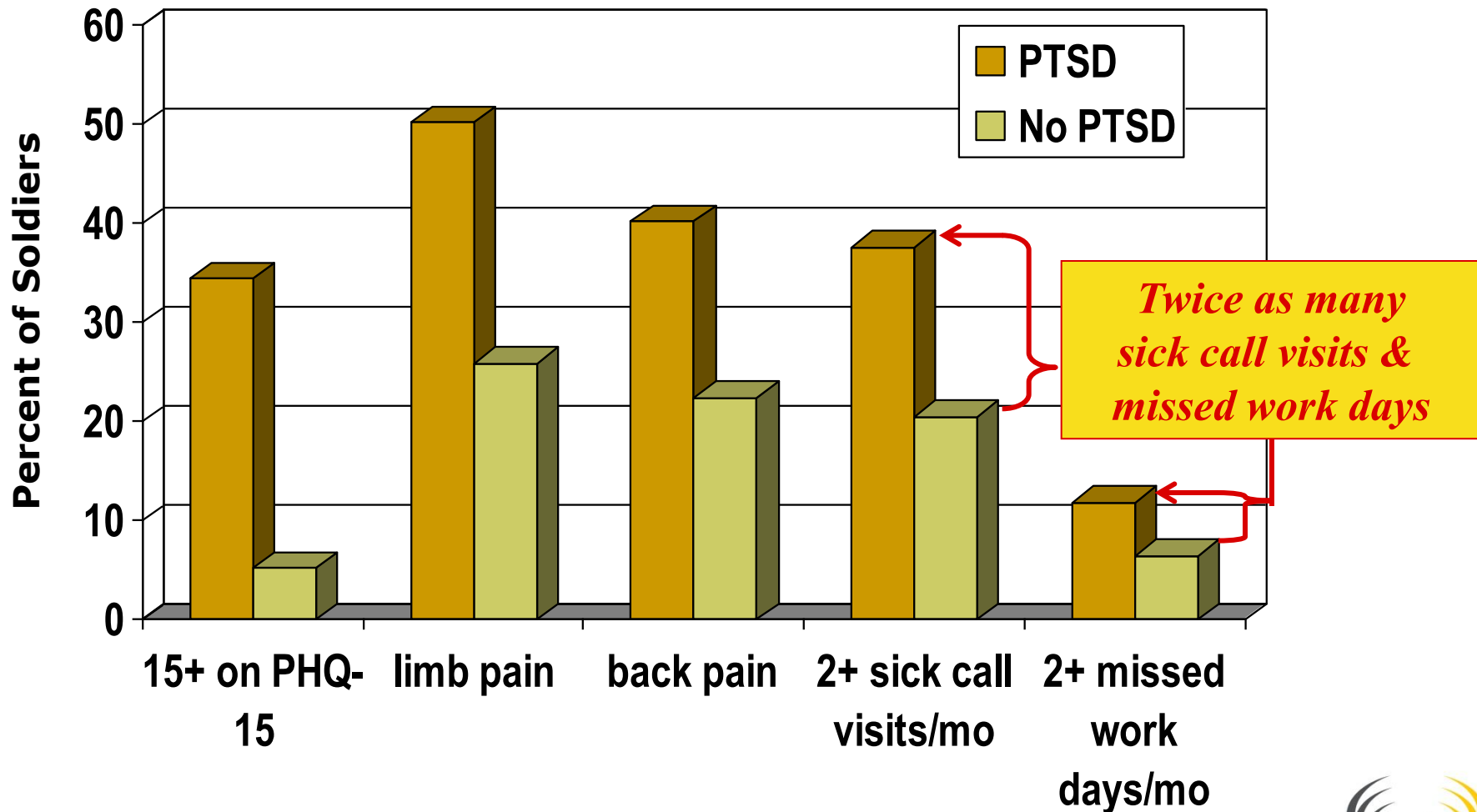


*Mental health  
professional*



# Potential for Offset: Service Use & Missed Work

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



# 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<sup>®</sup>

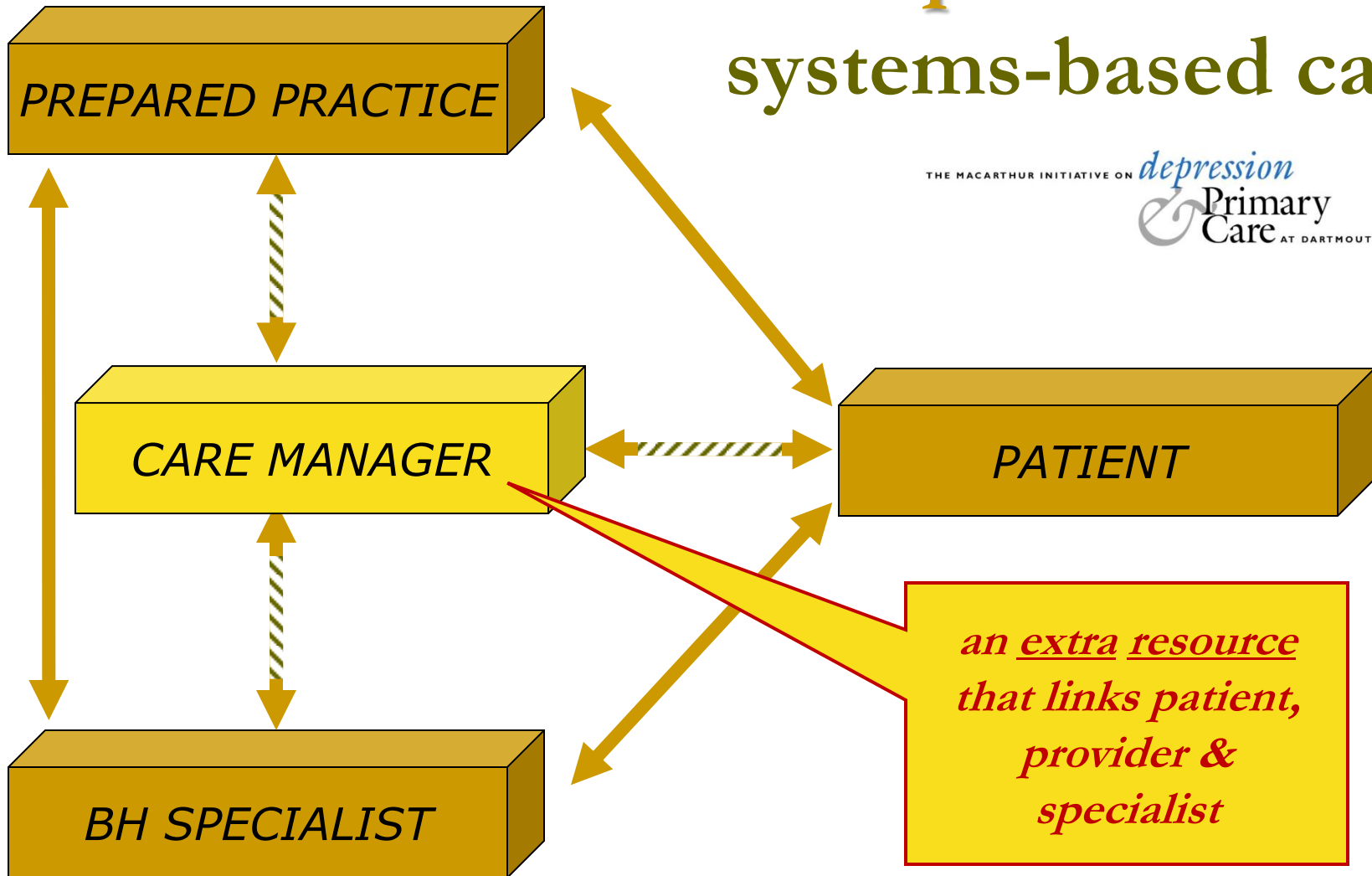
COLORADO SPRINGS, CO

5-7 OCTOBER 2010



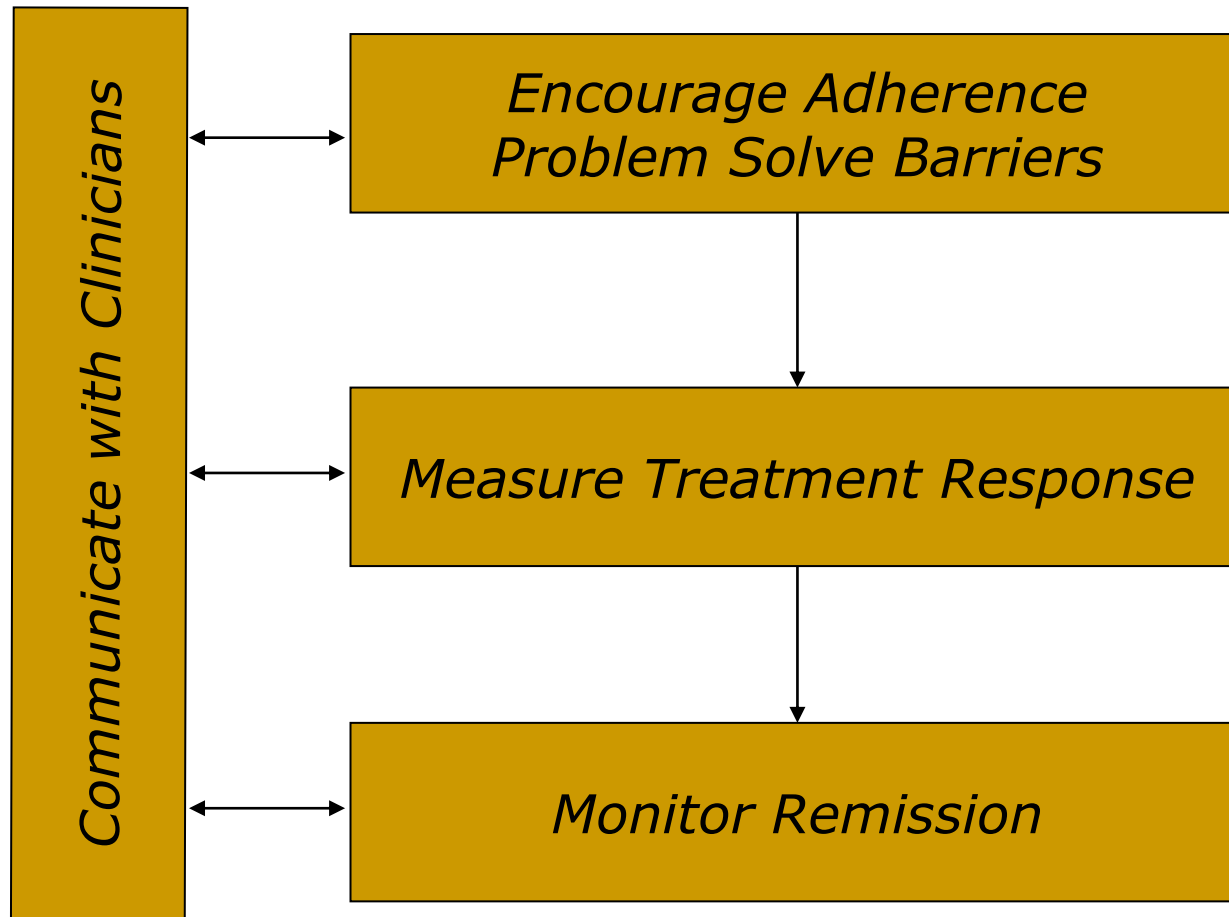
# 3 Component Model systems-based care

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

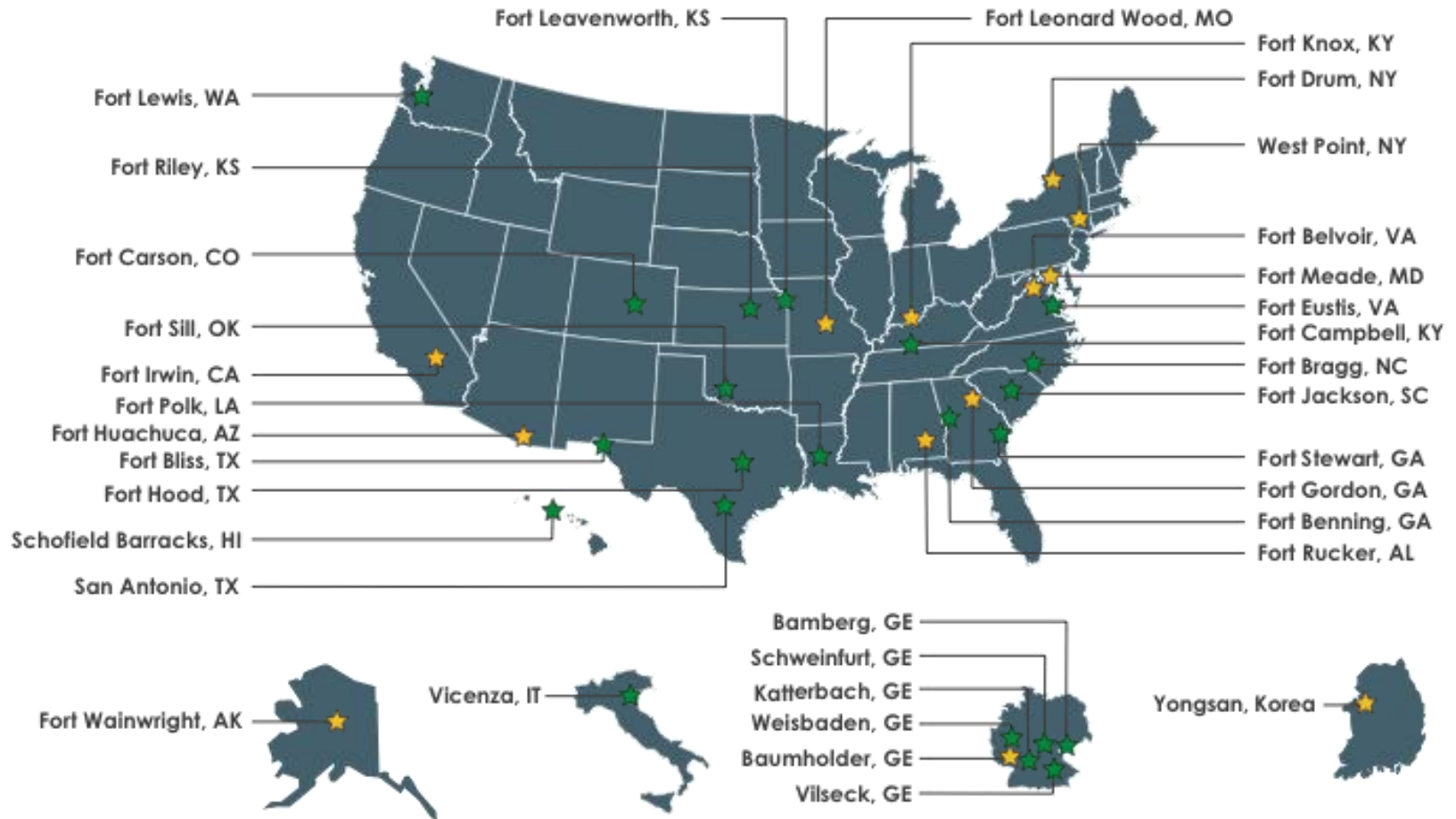


# RESPECT-Mil

## Care Facilitator Functions



# RESPECT-Mil Worldwide Sites



- ★ Fully Implemented Sites
- ★ Partially Implemented 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
- ★ Web-based care facilitation system
- ★ **“Just-in-time” treatment adjustment**
- ★ Weekly BH Champion review of facilitator caseload

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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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# 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 <i>in the last month</i> . 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

## Depression and Post-Traumatic Stress Disorder (PTSD)

### RESPECT-Mil (Re-Engineering Systems of Primary Care Treatment in the Military)



RESPECT-Mil

**RESPECT-Mil**  
A SOLDIER'S RESOURCE FOR RELIEF AND RECOVERY

NOT ALL WOUNDS ARE VISIBLE



**RESPECT-Mil**  
INFORMATION FOR SOLDIERS  
REGARDING DEPRESSION

### 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 checking 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.**  
Be sure to make a time to concentrate on your basic physical needs. One example is walking for a certain length of time each day.  
For \_\_\_\_\_ days next week, I'll spend at least \_\_\_\_\_ minutes doing \_\_\_\_\_.
- 2. Find time for pleasurable activities.**  
Even though you may not feel as excited or happy as you used to, commit to scheduling a fun activity, such as a favorite hobby, at least once a week.  
For \_\_\_\_\_ days next week, I'll spend at least \_\_\_\_\_ minutes doing \_\_\_\_\_ (Be sure to make your goal both easy and reasonable.)
- 3. Spend time with people who can support you.**  
It's easy to get in contact with people when you're feeling down. But, it's not like there that you need the support of friends and family. If you can, explain to them what you are going through. If you don't feel comfortable talking about it, reach out right. Just ask them to be with you, maybe during one activity, like a good first step. (Examples include: meeting a friend for coffee, going shopping with a friend, playing cards or taking a walk with a neighbor, working with a group in the garden – anything that is social and enjoyable.)  
During the next week, I'll make contact at least \_\_\_\_\_ times with \_\_\_\_\_ (name) doing/talking about \_\_\_\_\_.
- 4. Practice relaxing.**  
For many people, the changes that come with depression or PTSD can lead to anxiety. Slow physical activities can lead to mental relaxation, practice relaxing in a new way. Try deep breathing, taking a warm bath, or just finding a quiet, comfortable, peaceful place. Place comforting things to you in a safe place.  
For \_\_\_\_\_ days next week, I'll practice physical relaxation at least \_\_\_\_\_ times, for at least \_\_\_\_\_ minutes activities. (Remember to make your goal easy and reasonable.)
- 5. Set simple goals and small steps.**  
It's easy to feel overwhelmed when you're depressed. Some problems and decisions can be delayed, but others can't. It can be helpful to deal with them when you're feeling best. Take it by the reins and don't let things pile up as usual. Try breaking down large problems into smaller ones and then take one small step at a time. Give yourself credit for each step you accomplish.  
The problem is: \_\_\_\_\_  
My goal is: \_\_\_\_\_  
Step 1: \_\_\_\_\_  
Step 2: \_\_\_\_\_  
Step 3: \_\_\_\_\_
- 6. Eat nutritious, balanced meals.**  
You are what you eat. Many people find that when they eat more nutritious, balanced meals, the rest of their lives get a little better, especially when they're feeling down.  
During the next week, I will improve my diet by \_\_\_\_\_  
Example: "Drive to the store. Eat at least five fruits and vegetables a day."
- 7. Avoid or minimize alcohol use.**  
Alcohol is a depressant and can add to the feeling down and alone. It can also interfere with the help you may receive from antidepressant medication.  
I will restrict my alcohol intake to no more than two drinks on no more than two days per week.

# Goals & Self-Management Worksheet

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

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)				DEPRESSION PROVISIONAL DIAGNOSIS & TREATMENT RECOMMENDATIONS			
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	PHQ-9 Severity	Provisional Diagnosis	Treatment Recommendations
a. Little interest or pleasure in doing things	0	1	2	3	0-4	No Depression	N/A
b. Feeling down, depressed, or hopeless	0	1	2	3	5-9	Minimal Symptoms*	Support, educate to call if worse; return in one month.
c. Trouble falling or staying asleep or sleeping too much	0	1	2	3	10-14	Minor Depression + Dysphoria*	Support, watchful waiting; Antidepressant or counseling.
d. Feeling tired or having little energy	0	1	2	3	15-19	Major Depression, Mild	Antidepressant or counseling.
e. Poor appetite or overeating	0	1	2	3	20	Major Depression, Moderately Severe	Antidepressant and counseling.
f. Feeling bad about yourself or that you are a failure, or guilty	0	1	2	3			
g. Trouble concentrating on things, such as reading, watching TV, or listening to the radio	0	1	2	3			
h. Moving or speaking so slowly that other people could have noticed	0	1	2	3			
i. Thoughts that you would be better off dead, or of hurting yourself in some way	0	1	2	3			
Total Score: _____				Symptom Count: _____			
add columns: _____ + _____ = _____							
2. If you checked off any problems, how difficult have these problems made it for you to do your work...?				Functional impairment required for Dx:			
Not Difficult				Some what Difficult			
Very Difficult				Extremely Difficult			
PHQ-9 Severity				Functional impairment required for Dx			
Drop of 2-5 points from baseline				Adequate			
Drop of 3-4 points from baseline				Probably inadequate			
Drop of 1-2 points or no change or increase				Inadequate			
PHQ-9 Score				Treatment Response			
Drop of 2-5 points from baseline				Adequate			
Drop of 3-4 points from baseline				Probably inadequate			
Drop of 1-2 points or no change or increase				Inadequate			
PHQ-9 Score				Treatment Response			
Drop of 2-5 points from baseline				Adequate			
Drop of 3-4 points from baseline				Probably inadequate			
Drop of 1-2 points or no change or increase				Inadequate			

\*If symptoms present for 2 weeks, the probability of a major depression with or without antidepressant or counseling is high. If the patient has never been depressed and has no history of depression, even if you get a high score on the PHQ-9, it is not a diagnosis of major depression.

\*\*If symptoms present for 2 weeks or more and have functional impairment, consider active treatment. (Source: JANUARY 2008)

# Provider "Fast Facts"

RESPECT-Mil

# RESPECT-Mil Implementation

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# DESTRESS-PC - Web-based, nurse assisted, PTSD self-training

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

## 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).

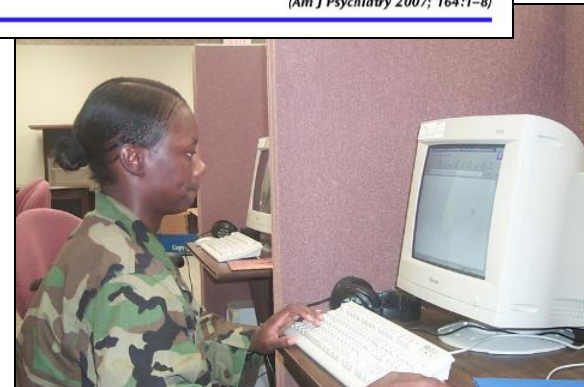
**Method:** Service members with PTSD from the attack on the Pentagon on September 11th or the Iraq War were randomly assigned to self-management cognitive behavior therapy (N=24) or supportive counseling (N=21).

**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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# FIRST-STEPS – Web-based Care-Manager Support & Reporting System

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

PRE Work Flow  
Collect Information

Medication Larry Gracen Summary Profile

Medication saved.

New Entry

Medication:  Save

Dose:  mg.

Prescribe Date:

Change Date:

Change Type:

Comments:

View Entries Current Archived Error

Archive?	Medication	Dose	Prescribe Date	Change Date	Change Type	Comments	Entered By	Error?
<input type="checkbox"/>	Ambien® (zolpidem)	50	10/15/2008	10/18/2008	Start Med	Todd Musig (30 Oct 08)		<input type="checkbox"/>

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

PRE Work Flow  
Collect Information

FINAL ESTIMATE FOR: Jane Smithe Summary Profile

The final estimate has NOT been made for this snapshot

You made the following estimates:

Category	First	Previous	Current
General Concern	Moderate	Low	Low
Medication Non-Adherence	High	High	Moderate
Counseling Non-Adherence	High	Moderate	Low
Self Management Concern	Low	Moderate	High
PCL	33-58	13-32	13-32
Suicide Staffing	A Week	A Week	NA
Case Status	Flagged	No Flag	No Flag

Based on the information obtained from the above Factor Groups, please rate the level of concern you have for this patient.

Low
  Moderate
  High

Home Resources Contact Help

Select Individual > Open/Recent PREs A B C D E F G H I J K L M N O P

PRE Work Flow  
Collect Information

SUMMARY FOR:

Episodes:

Episode is OPEN and waiting for input.

Episode/Product	Created	Closed	Estimate
First Steps Syste	30 Jun 08 - 11:58	Open (Musig)	

Snapshots:

Snapshots in Selected Episode:

Created	Estimate	PHQ-9 Severity Score	PCL Severity Score
30 Oct 08 - 11:14	Moderate	16	NA
30 Jun 08 - 11:58	High	20	NA

Historical Graph for: PHQ-9

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

# FIRST-STEPS – Improves Efficiency, Accountability & Effectiveness of 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	
<b>Acuity</b>				IMPORTANT MESSAGE		MESSAGE FROM PREVIDENCE	
				Welcome.		Welcome to the Previdence Risk <a href="#">more</a>	
Acuity	Case Closure	Call Schedule	Caseload	Closed Cases			
MY VIEW   UNIT VIEW						Print Preview	
Unit	Name	Suicide Staffing	Facilitator Concern	Deployers	Tx Non-Response	Last Staffing Date	Last Contact
Fort Hood	<a href="#">April, Test</a>	Unknown	Moderate	30-60 Days	No		25 Apr 08
Germany 1	<a href="#">Braxton, Bruce</a>	Emergency	High		No		12 Aug 08
Beta Fort Stewart	<a href="#">Frankie, Bill</a>	A Duty Day	High	60-90 Days	No	2 Oct 08	2 Oct 08
Beta Fort Bliss	<a href="#">Harry, Dirty</a>	A Duty Day	High	Not Deploying	No		20 Oct 08
Fort Drum	<a href="#">New, Tom</a>	A Duty Day	Unknown		No		24 Apr 07
Fort Carson	<a href="#">Turner, Bill</a>	A Duty Day	Unknown		No		20 Apr 07
Vicenza	<a href="#">Violet, Eric</a>	A Duty Day	Unknown		No		19 Apr 07
Fort Lewis	<a href="#">Wilking, Sarah</a>	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

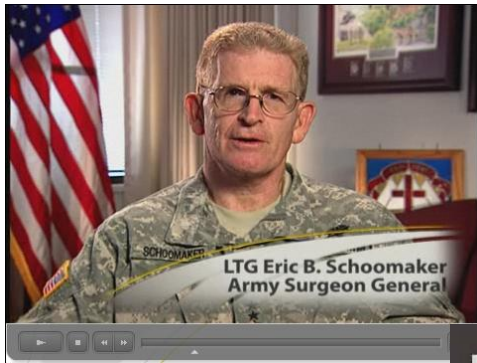
# RESPECT-Mil Implementation

## 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\*



Listen to a Soldier's story (Part 3)  
SFC Alex Turlington

Click the **Play** button to start the video.

Once you have completed SFC Turlington's story, click the **Next** button to continue.

Progress: 78%

Identify PTSD diagnostic concepts

For a PTSD diagnosis, the following elements must be present. The first two are specific to PTSD:

- Traumatic Experience
- Symptoms
- Impaired Functioning
- Persistence

Not only must a certain number of symptoms occur, but they must result in impaired functioning, consistently and persistently along with the symptoms, over a period of time.

Once you have viewed the video, click the **Next** button to continue.

**PTSD Diagnostic Concept**

- Traumatic experience**
  - Threat of death/serious injury
  - Intense fear, helplessness or horror
- Symptoms**
  - Reexperiencing the trauma
  - Numbing and avoidance
  - Physiologic arousal
- Impaired functioning**
- Persistence**

Progress: 33%

Recognize and diagnose PTSD

...we are better able to treat Soldiers like Alex who have PTSD.

...ing and CPT Ann Fuller of the symptoms have viewed the k the **Next** button e.

Progress: 31%

Evaluate suicidality

Whenever the first part of question 19 is checked "yes", you must follow this up with additional questioning. The suicide evaluation tool guides you as you talk with the Soldier and evaluate suicidality. The table provides recommendations based on the severity of risk. Even at intermediate levels of risk, depending on your comfort, you can refer the Soldier to the Behavioral Health Specialist.

**Evaluation of Suicide Risk**

- Have these symptoms/feelings we've been talking about led you to believe that you would be better off dead? YES  NO
- This past week, have you had any thoughts that life is not worth living or that you would be better off dead? YES  NO
- What about thoughts of hurting or even killing yourself? YES  NO
- What have you thought about? Do you have a plan or have you actually tried to hurt yourself? YES  NO

**5. RISK FACTORS:**

- History of Suicide attempt
- Substance abuse
- Significant comorbid anxiety
- Social Isolation
- Hopelessness

Progress: 41%

End-of-course assessment

The next ten pages contain questions to review your understanding of this course. You must answer each question and score at least 70% in order to obtain a completion for the course.

Once you have completed all questions, you will continue to the **Put it all together** page to view course highlights. To begin the assessment, click the **Next** button.

Question & Answer

Progress: 79%

View role play modeling inappropriate 3CM process (Part 2)

Discussion of:

- Treatment options
- Medications
- Care Facilitator
- Self-management

**Watch carefully!** This role play includes some less than optimal interactions. Once complete, you will be asked questions about what you have seen.

When you're ready to begin the role play, click the **Play** button.

Once you have viewed the

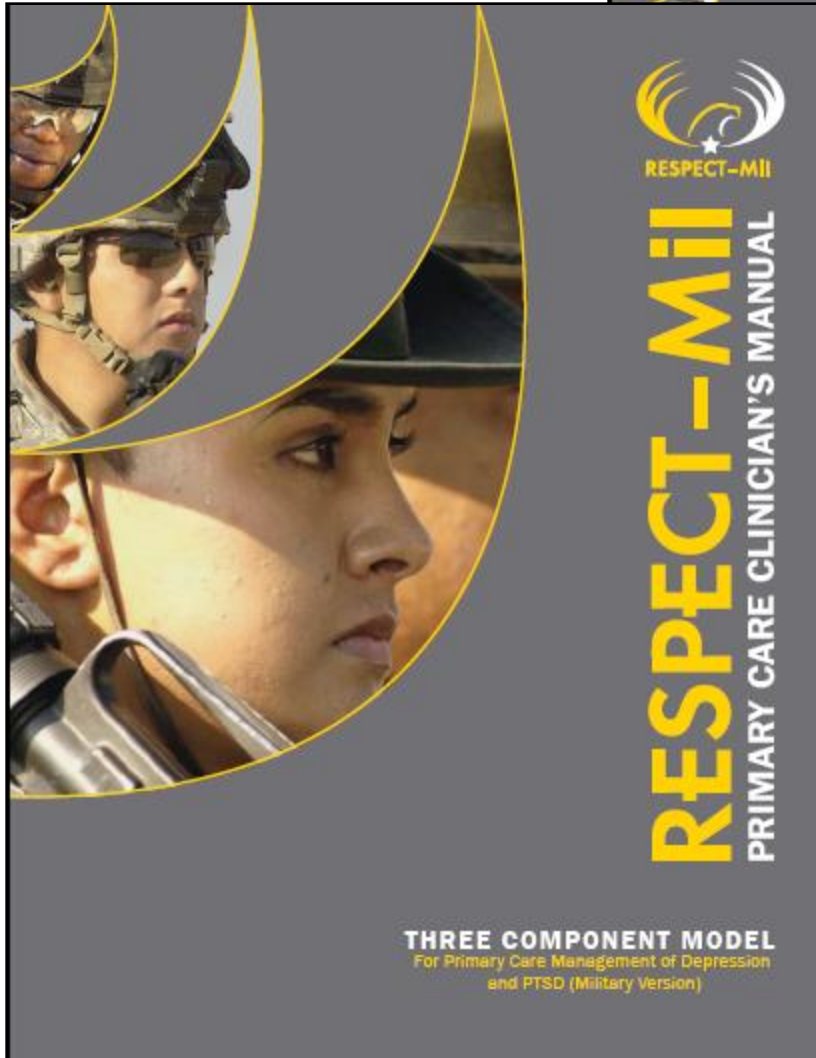
Progress: 62%

\* Includes suicide assessment training



# RESPECT-Mil

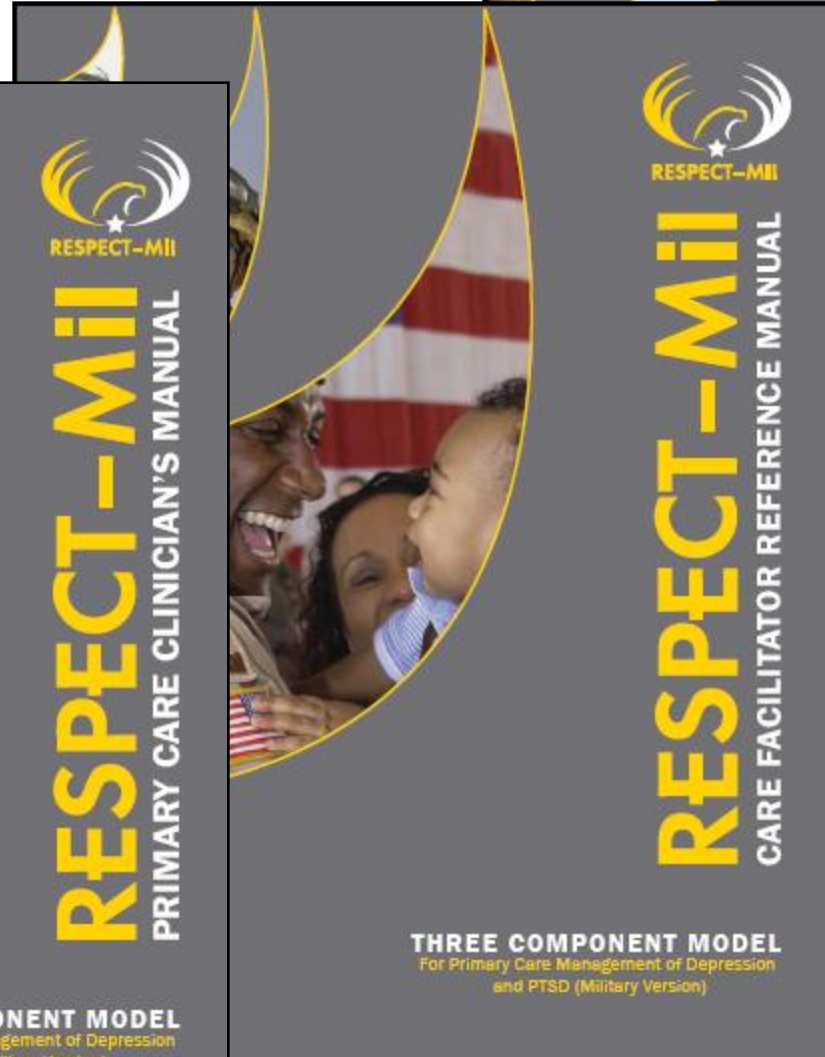
## Provider Manuals



**RESPECT-Mil**  
PRIMARY CARE CLINICIAN'S MANUAL

**RESPECT-Mil**  
PRIMARY CARE CLINICIAN'S MANUAL

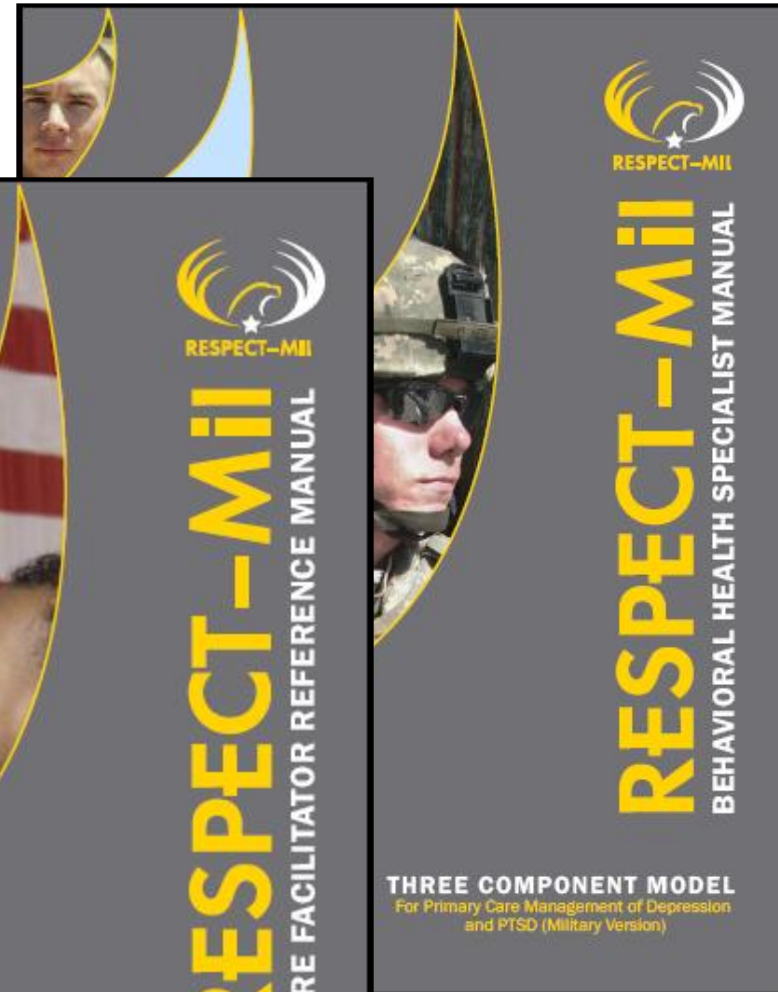
**THREE COMPONENT MODEL**  
For Primary Care Management of Depression  
and PTSD (Military Version)



**RESPECT-Mil**  
CARE FACILITATOR REFERENCE MANUAL

**RESPECT-Mil**  
CARE FACILITATOR REFERENCE MANUAL

**THREE COMPONENT MODEL**  
For Primary Care Management of Depression  
and PTSD (Military Version)



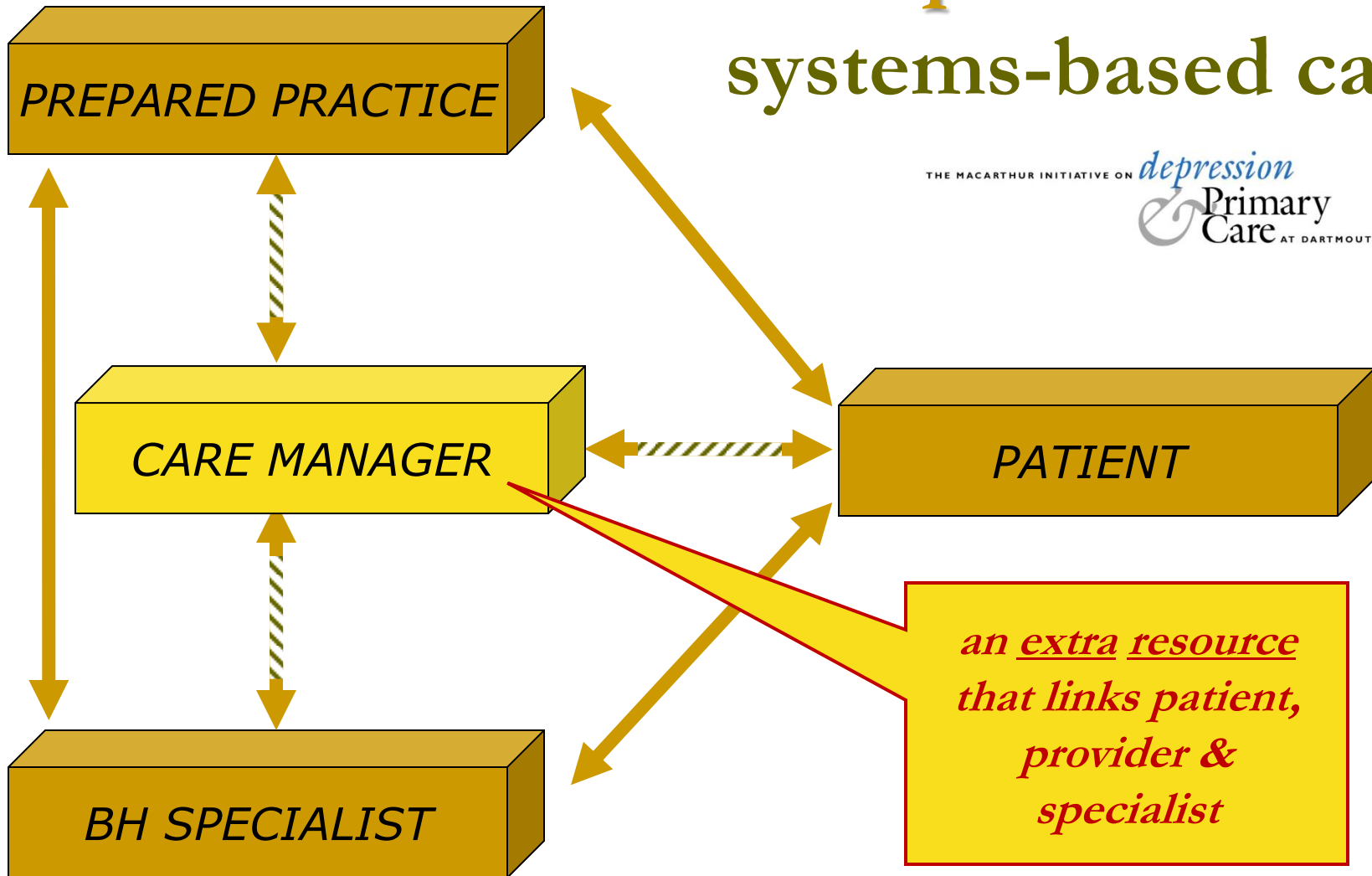
**RESPECT-Mil**  
BEHAVIORAL HEALTH SPECIALIST MANUAL

**RESPECT-Mil**  
BEHAVIORAL HEALTH SPECIALIST MANUAL

**THREE COMPONENT MODEL**  
For Primary Care Management of Depression  
and PTSD (Military Version)

# 3 Component Model systems-based care

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



# RESPECT-Mil

## Implementation Results

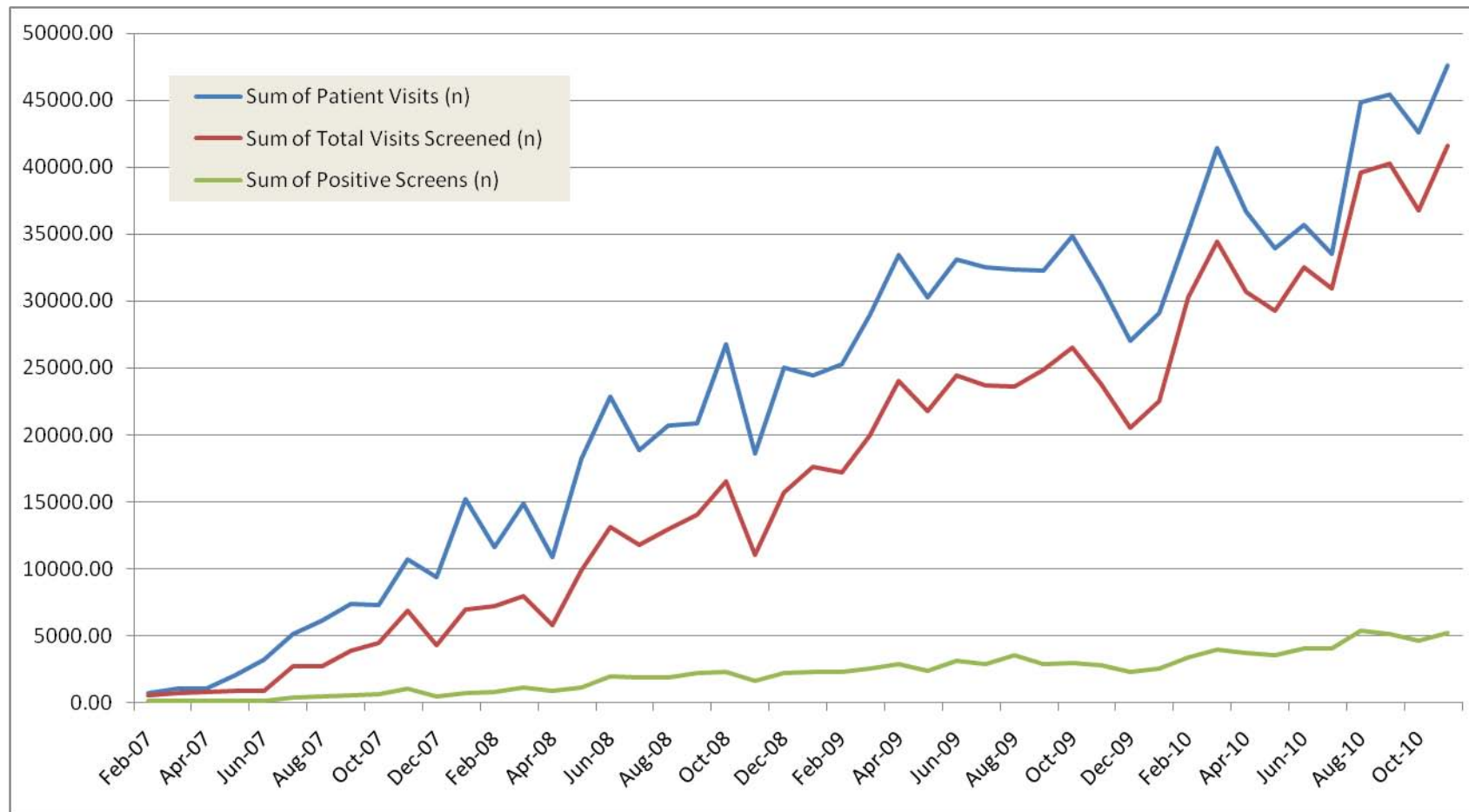
- ★ **61** of 95 primary care clinics at 34 sites are implementing, with the remainder expected on line by July 2011.
- ★ **86%** of visits at implementing clinics screened in last 12 months (75% since January 2007; 2-5% at non-RESPECT-Mil clinics)
- ★ **13%** of all screened visits are positive (PTS or depression)
- ★ **48%** of positive screens result in a primary care diagnosis of 'depression' or 'possible PTSD'
- ★ **26%** of positive screens receive other BH diagnoses (e.g., adjustment disorder)

\* *Data through November 2010*<sup>29</sup>



# RESPECT-Mil Screening Visits

**\*Steadily Rising Rate of Routine Screening\***

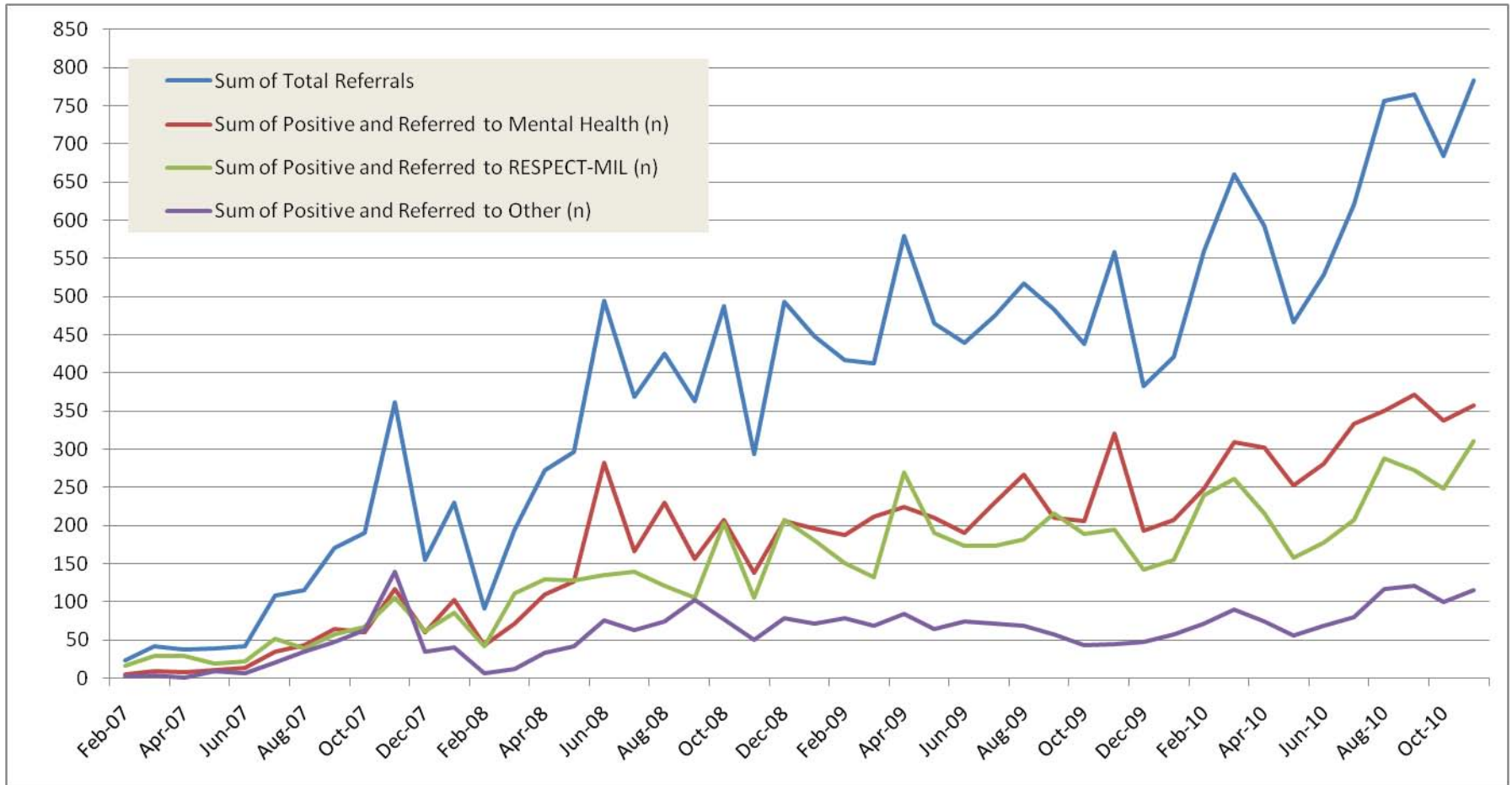


Data through November 2010 30



# Referrals for Enhanced BH Services

**\*Referrals for Facilitation Nearly as High as to Specialist\***

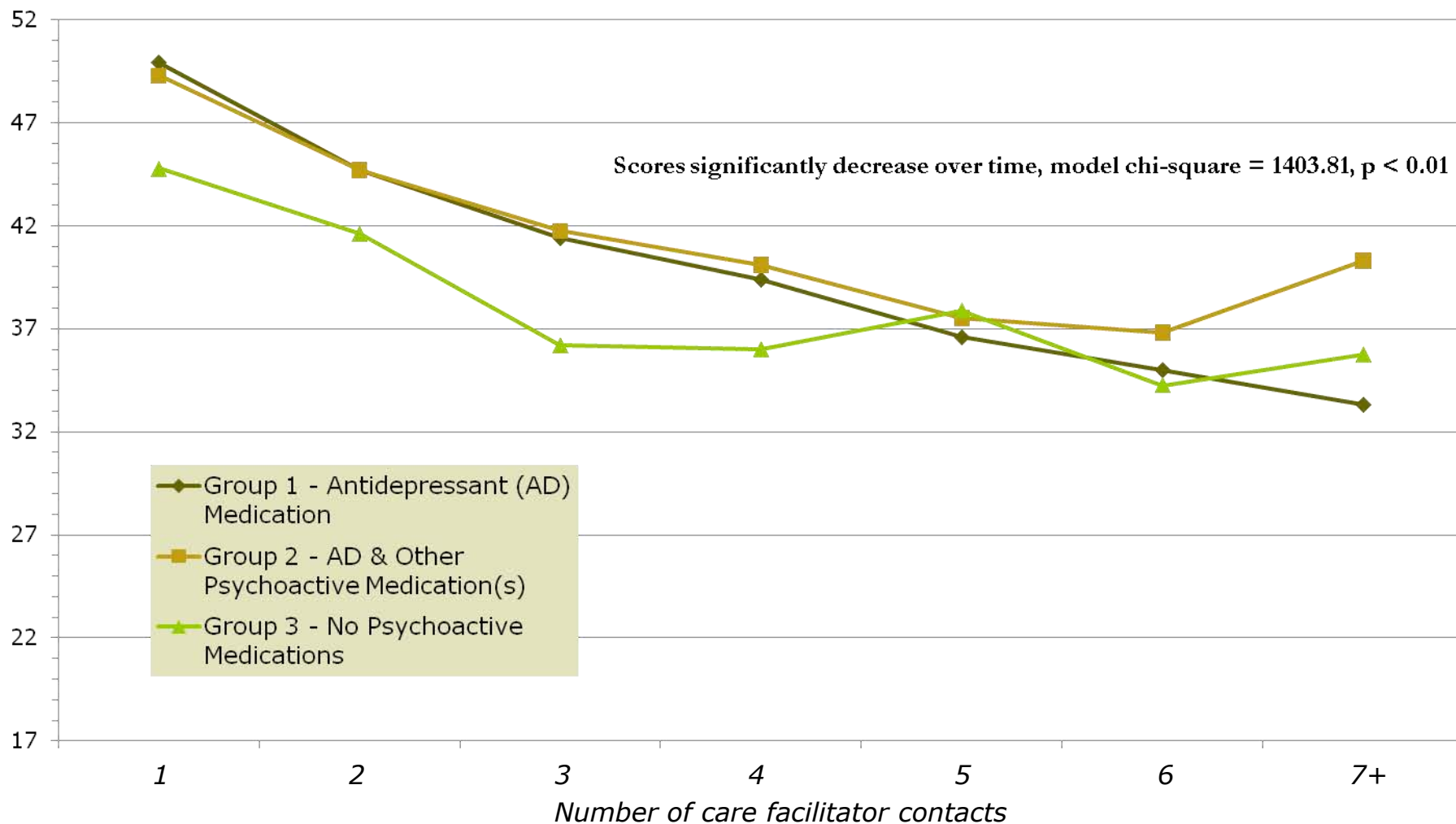


*\* Data through November 2010<sup>31</sup>*



# Care Facilitation & PTSD Severity (PCL-C)

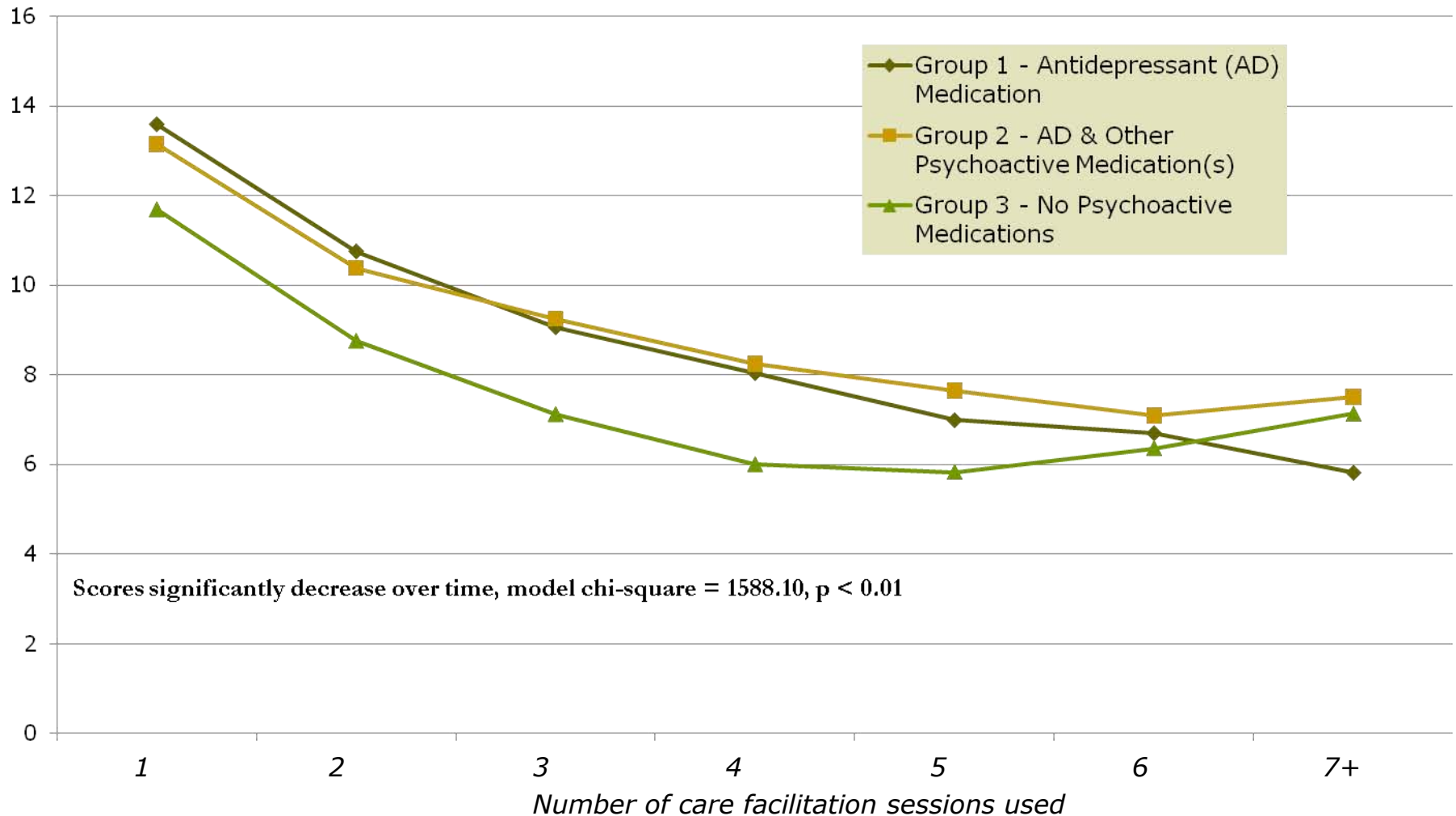
\*Number of facilitator visits associated with improvement\*



\* 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

## Safety & Risk Management

Visits associated with any suicidal ideation

- ★ **1%** of screened visits (**8.6%** of screen positive visits)
- ★ **25%** of visits involving suicidal ideation are rated by provider as intermediate or high risk (“non-low risk”)
- ★ **8,771** visits involved suicidal ideation
- ★ Frequent “save” anecdotes

*\* Data through November 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]

**4% of all visits**

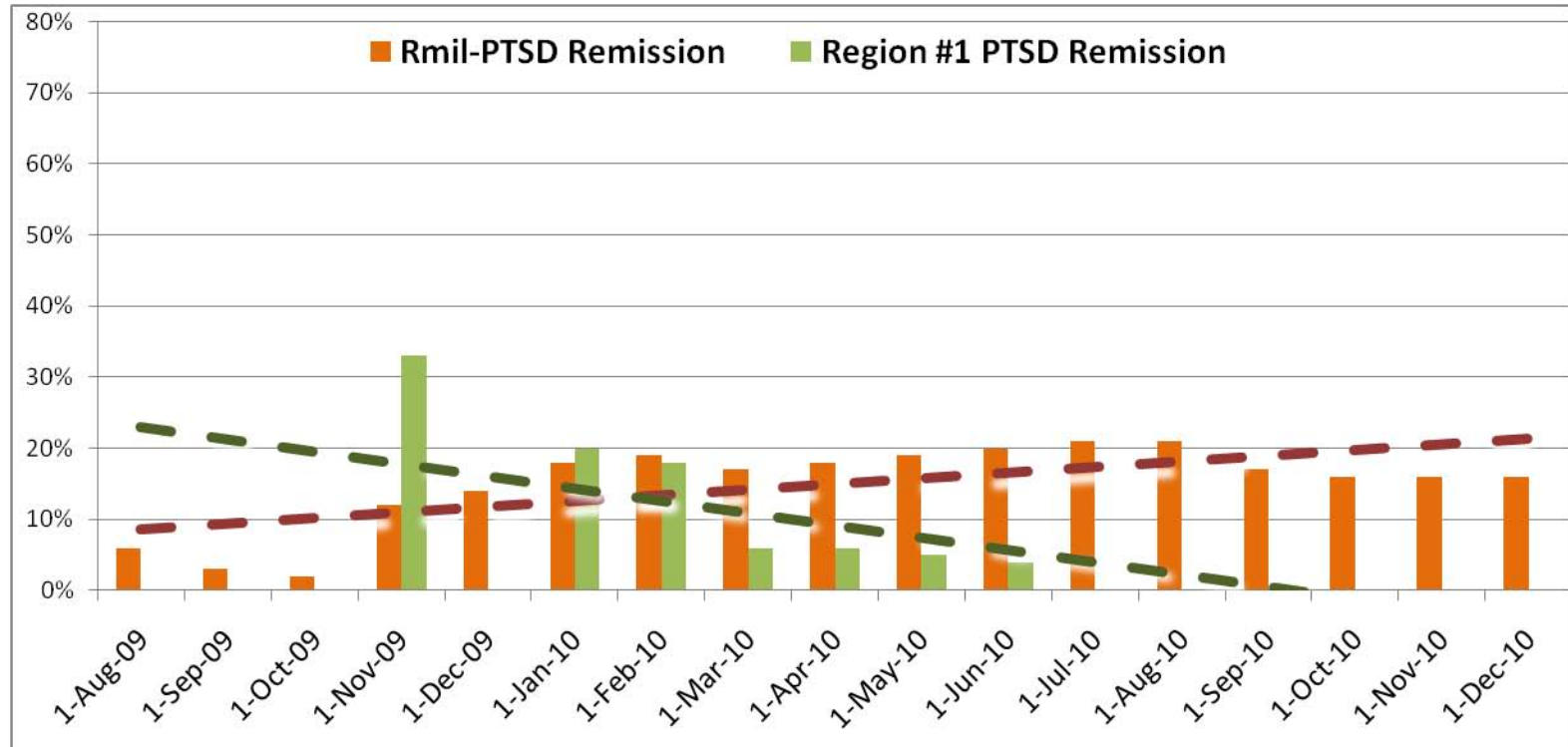
involve recognition & assistance for previously unrecognized mental health needs

\* *Data through November 2010*<sup>36</sup>



# Real-time Aggregate Data Reports

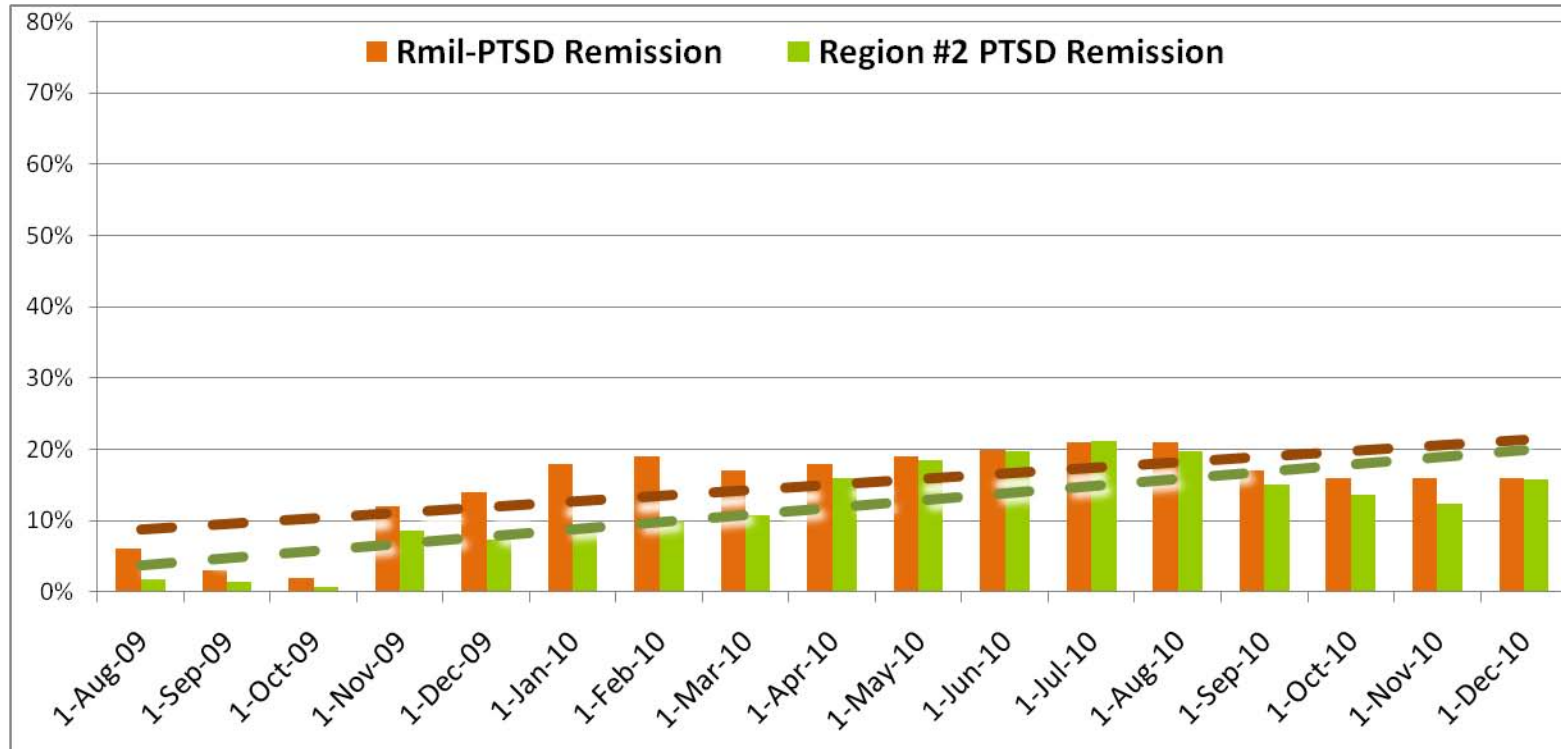
## PTSD Remission Trend – Region #1



\*\*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 27 or less.

# Real-time Aggregate Data Reports

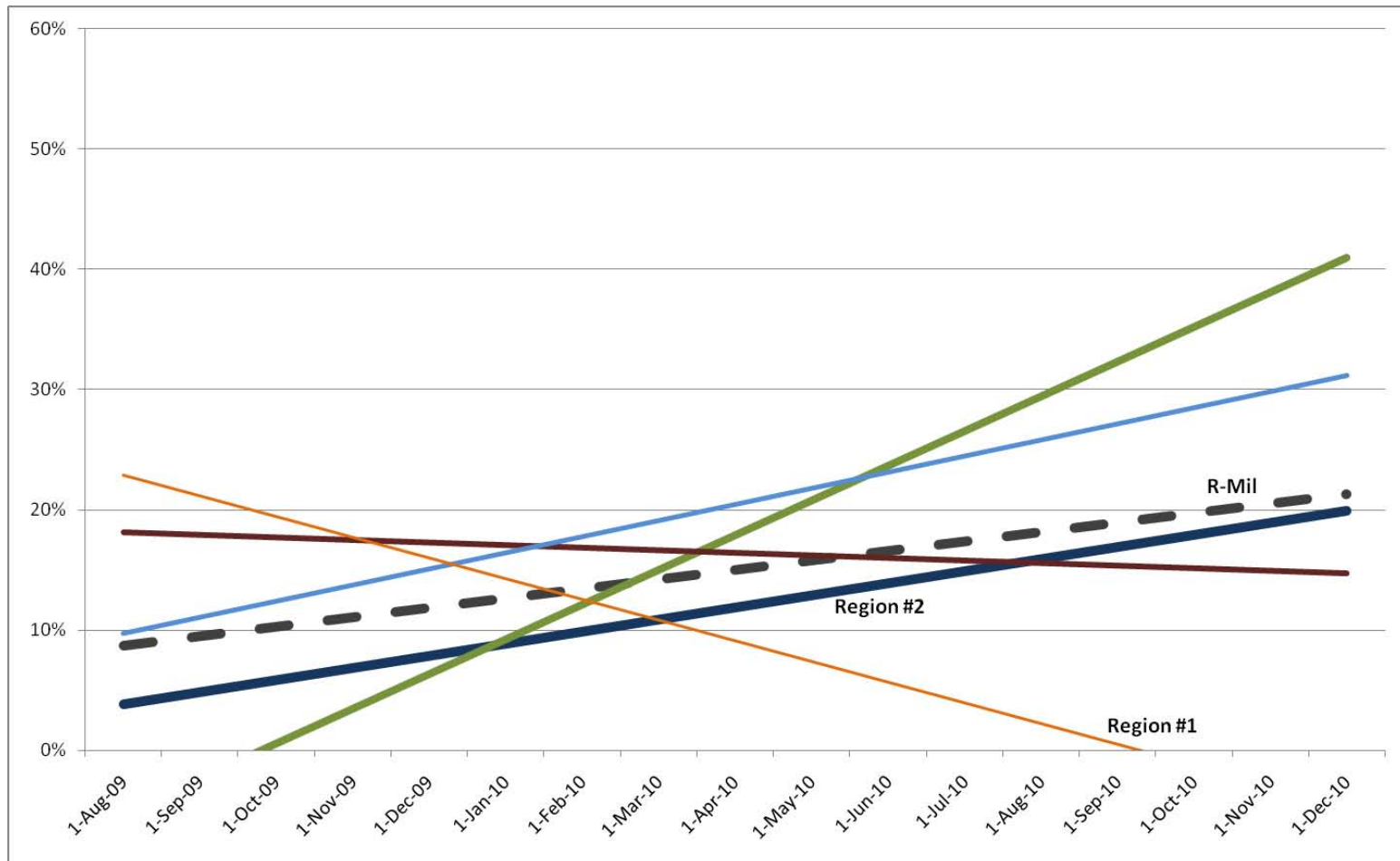
## PTSD Remission Trend – Region #2



\*\*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 27 or less.

# Real-time Aggregate Data Reports

## PTSD Remission Trends by Region



# Quarterly Progress Report: Fort Alpha

## Example of a High Performance Site



Installation Quarterly Performance Report  
1<sup>st</sup> Quarter, FY 2011

FT. ALPHA

February 28, 2011

Point of Contact: Justin Curry, PhD  
justin.curry@amedd.army.mil

**Objective:** This performance report provides summary findings of your RESPECT-Mil program from October 1, 2010 – December 31, 2010. These findings are designed both to inform and guide you and your staff regarding:

- The force health status at Ft. Alpha;
- Ft. Alpha's success in meeting RESPECT-Mil's objectives;
- Ft. Alpha's RESPECT-Mil workforce; and
- Potential strategies to improve or sustain Ft. Alpha's performance.

**Performance Ranking System:** Green arrows (➤) signify high performance, yellow arrows (➡) average performance, and red arrows (➡) low performance. Rankings are provided to help you identify strengths and weaknesses relative to other RESPECT-Mil sites.

**Summary:** In general, Ft. Alpha shows average rates for Service Members meeting criteria for a positive screening result (PTSD/Depression/both) and average rates for a presumptive primary care diagnosis of PTSD or depression. Approximately 45% of those Service Members with positive screens are already engaged in enhanced behavioral health care (EBHC)<sup>1</sup>. A greater number than expected of Service Members at Ft. Alpha report suicidal ideation (3.5%).

Procedurally, Ft. Alpha is performing well relative to other implementation sites in the RESPECT-Mil system. During this reporting period, RESPECT-Mil clinics at Ft. Alpha conducted 16,373 primary care visits (down 3.7% from last quarter). Performance against standards for implementing initial screening protocols is high (98%). However, rates for follow-up contacts should be improved. Roughly 26% of Service Members are declining referrals, indicating a need for improvement in this area. All Service Members with a positive PHQ9/PCL19 should have a further risk assessment conducted by a clinician. At Ft. Alpha, 100% of screens with a positive PHQ9/PCL19 received further assessment reflecting positive performance against this indicator.

During this reporting period, Ft. Alpha was implementing RESPECT-Mil at 2 clinics with 495 open cases in the RESPECT-Mil program. Staffing appears to be sufficient to handle this case load with 7 care facilitators (RCFs) managing approximately 71 cases each.

Table 1: FORCE HEALTH STATUS AT FT. ALPHA...

	Q04 FY2010 N (%)	Q01 FY2011 N (%)	Change (%)	Q01 FY2011 R-Mil Range
Screened visits positive for PTSD or Depression:	2,392 (14.5%) <sup>†</sup>	2,169 (13.5%) <sup>†</sup>	-1.1%	7.9% – 20.6%
Screened visits resulting in presumptive primary care diagnosis of PTSD or Depression:	1,102 (6.7%) <sup>†</sup>	953 (5.9%) <sup>†</sup>	-0.8%	1.6% – 10.6%
Screened visits positive for suicide risk:	360 (2.2%) <sup>†</sup>	557 (3.5%) <sup>†</sup>	+1.3%	0% – 5.5%
Positive screens already receiving enhanced behavioral health care:	1,059 (44.3%) <sup>††</sup>	984 (45.4%) <sup>††</sup>	+1.1%	18% – 59.8%

<sup>†</sup> Percentage expressed relative to total number of primary care visits screened ((N/Total Screens) × 100)

<sup>††</sup> Percentage expressed relative to number of positive screens only ((N/Positive Screens) × 100)

Table 2: R-Mil PROCEDURAL PERFORMANCE (SCREENING & FOLLOW-UP) AT FT. ALPHA...

Performance Parameter	Q04 FY2010 (%)	Q01 FY2011 (%)	Change (%)	Q01 FY2011 R-Mil Range	Q01 FY2011 R-Mil Rank
Percentage of primary care visits screened with MEDCOM 774:	96.8% <sup>†</sup>	98.4% <sup>†</sup>	+1.7%	17.9% – 100%	2 <sup>nd</sup> of 15
Percentage of patients referred to Respect-Mil contacted within 14 days:	79.6% <sup>††</sup>	82.3% <sup>††</sup>	+3%	37% – 100%	4 <sup>th</sup> of 15
Percentage of open R-Mil cases with at least one RCF contact during the reporting period:	85.8% <sup>†††</sup>	75% <sup>†††</sup>	-10.9%	36.6% – 100%	8 <sup>th</sup> of 15

<sup>†</sup> ((N/Total Screens) × 100)

<sup>††</sup> ((N/New R-Mil Referrals) × 100)

<sup>†††</sup> ((N/Open Cases) × 100)

Table 3: R-Mil PROCEDURAL PERFORMANCE (REFERRAL & RISK ASSESSMENT) AT FT. ALPHA...

Performance Parameter	Q04 FY2010 (%)	Q01 FY2011 (%)	Change (%)	Q01 FY2011 R-Mil Range	Q01 FY2011 R-Mil Rank
➤ Percentage of EBHC referrals offered that are accepted:	65.6% <sup>†</sup>	73.7% <sup>†</sup>	+8.2%	44% – 94.6%	6 <sup>th</sup> of 15
➤ Percentage of R-Mil referrals offered that are accepted:	71.9% <sup>†</sup>	77.6% <sup>†</sup>	+5.8%	0% – 91.3%	2 <sup>nd</sup> of 15
➡ Percentage of Behavioral Health referrals offered that are accepted:	47.5% <sup>†</sup>	47.7% <sup>†</sup>	+0.3%	28.6% – 100%	12 <sup>th</sup> of 15
➤ Among visits with documented suicidal ideation, the percentage of MEDCOM 774s evidencing provider risk assessment:	99.7% <sup>††</sup>	100% <sup>††</sup>	+0.3%	Program standard is 100%	

<sup>†</sup> ((N/Referrals Offered) × 100)

<sup>††</sup> ((N/Positive Suicide Risk) × 100)

**RESPECT-Mil Staffing at Ft. Alpha:** A RESPECT-Mil primary care champion was assigned for the entirety of the reporting period and that individual has received formal RESPECT-Mil training. A RESPECT-Mil behavioral health champion was assigned for the entirety of the reporting period and that individual has received formal RESPECT-Mil training.

Table 4: HUMAN RESOURCING DATA FOR FT. ALPHA...

Staff	# Assigned	# Authorized	Open Cases <sup>†</sup>	Active Cases <sup>††</sup>	Average Caseload	R-Mil Caseload Range
Total	9	10	–	–	–	–
Care Facilitators	7	7	495	371	71	12 – 188
Administrative Assistants	2	3	–	–	–	–

<sup>†</sup> Cases open in FIRST-STEPS Care Facilitation Management System during the reporting period

<sup>††</sup> Open cases with at least one contact<sup>†</sup> recorded in FIRST-STEPS during the reporting period

**Comments on Data:** Given the high proportion of open cases with no contact from RCFs, the reported caseload is likely to overestimate actual workload. Analysis of data from Ft. Alpha reveals very little between-clinic variation. Consequently, findings from overall site performance presented in this report can safely be interpreted at the clinic level. The only exception to this is in regards to suicidal ideation (SI). One clinic at Ft. Alpha did not report any positive screens for SI.

**Impressions:**

- 1) Generally excellent overall performance continues.
- 2) In the past 2 consecutive quarters Ft Alpha's only consistently poor performance has been in the area of Behavioral Health referral acceptance.
- 3) 25 % of open cases had no contact during the reporting period. This could be due to completed patient contacts not being entered into FIRST-STEPS or due to open cases not being closed on patients discharged from the program. These issues should be addressed as soon as possible so that it accurately reflects caseload and contact data.

**Recommended Actions:** The following bullet points reflect recommendations from the RESPECT-Mil Implementation Team to assist R-Mil staff and stakeholders at Ft. Alpha sustain or improve program performance:

- ✓ Fort Alpha successfully implemented previous recommendation to increase efforts in the area of suicide risk evaluation and documentation. Congratulate your providers on achieving the program standard of 100% on this performance indicator and encourage them to continue performing at this level.
- ✓ Encourage RCFs to review caseloads with BHC to appropriately disposition cases and to ensure that cases that are no longer in active care facilitation are closed in the FIRST-STEPS system.

<sup>2</sup> A contact is defined as a FIRST-STEPS "snapshot" created for an open case. PRN visits are not considered in determining number of active cases

<sup>1</sup> EBHC includes the RESPECT-Mil program or any behavioral health care service outside the scope of primary care practice.

# 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

- ★ Provider training and retraining
- ★ Expansion site training
- ★ 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
- ★ Intercalation with Patient Centered Medical Home
- ★ **STEPS-UP**: 5-year, 18-clinic controlled trial – intervention is blended + centralized care management + stepped psychosocial modalities

# RESPECT-Mil Central

## Implementation Team

### **COL Charles Engel, MC**

Director

### **Tim McCarthy**

Deputy Director

### **Sheila Barry, BA**

Associate Director,  
Program Development & Training

### **Mark Weis, MD**

Primary Care Health Proponent

### **David Dobson, MD**

Behavioral Health Proponent

### **Kelly Williams, RN**

Nurse Proponent & Educator

### **Lee Baliton**

Program Evaluation/IT Specialist

### **James Harris**

Program Manager

### **Justin Curry, PhD**

Associate Director, Program Evaluation

### **Barbara Charles**

Administrative Assistant

### **Phyllis Hardy**

Administrative Assistant

## Consultant Team

### **Allen Dietrich, MD**

Professor of Family Medicine, Dartmouth  
Medical School

### **Thomas Oxman, MD**

Emeritus Professor of Psychiatry, Dartmouth  
Medical School

### **John Williams, MD, MSPH**

Professor of Medicine, Duke University &  
Durham VA

### **Kurt Kroenke, MD**

Professor of Medicine, Indiana University &  
Regenstrief Institute





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*



PHILOSOPHICAL  
TRANSACTIONS  
OF  
THE ROYAL  
SOCIETY

*Philos. Trans. R. Soc. B* (2006) 361, 707–720  
doi:10.1098/rstb.2006.1829  
Published online 24 March 2006

**Maintaining future Gulf War Syndromes: international perspectives and new models of care**

*Charles C. Engel<sup>1,2,\*</sup>, Kenneth C. Hyams<sup>3</sup> and Ken Scott<sup>4</sup>*

**Can We Prevent a Second 'Gulf War Syndrome'? Population-Based Health Care for Chronic Idiopathic Pain and Fatigue after War<sup>1</sup>**

*Charles C. Engel<sup>a,b</sup>, Ambereen Jaffer<sup>b</sup>, Joyce Adkins<sup>b</sup>, James R. Riddle<sup>c</sup>, Roger Gibson<sup>d</sup>*

*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**

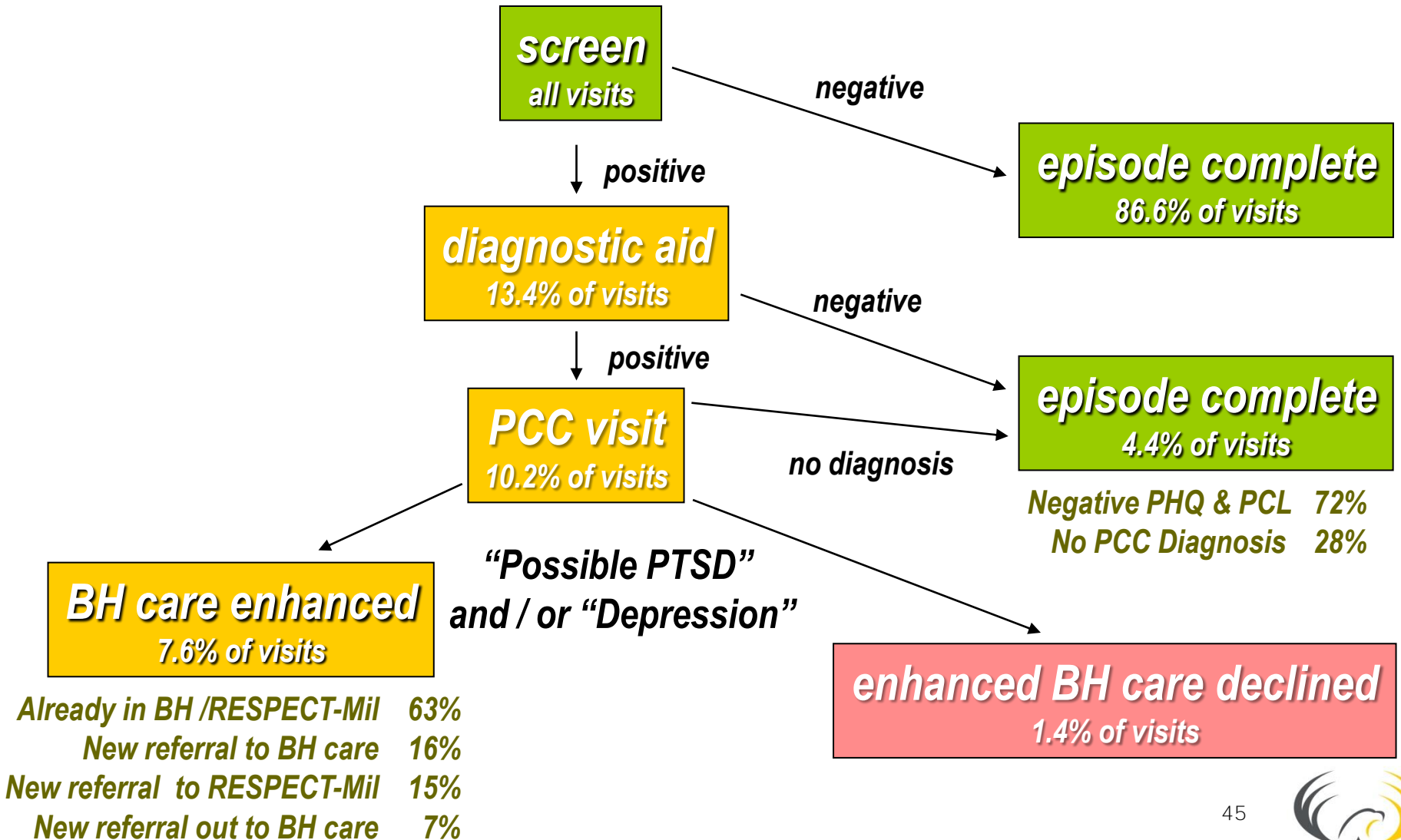
**Individual and Community Mental Health Interventions**

**Robert J. Ursano**  
**Carol S. Fullerton**  
**Ann E. Norwood**

**Questions?**

# RESPECT-Mil

## Patient Flow & Clinic Process



# RESPECT-Mil

## Time & Workload

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

### *Total Estimated Time Per Visit*

$$\text{Medic} = 2 + (0.134 \times 3) = 2.4 \text{ min}$$

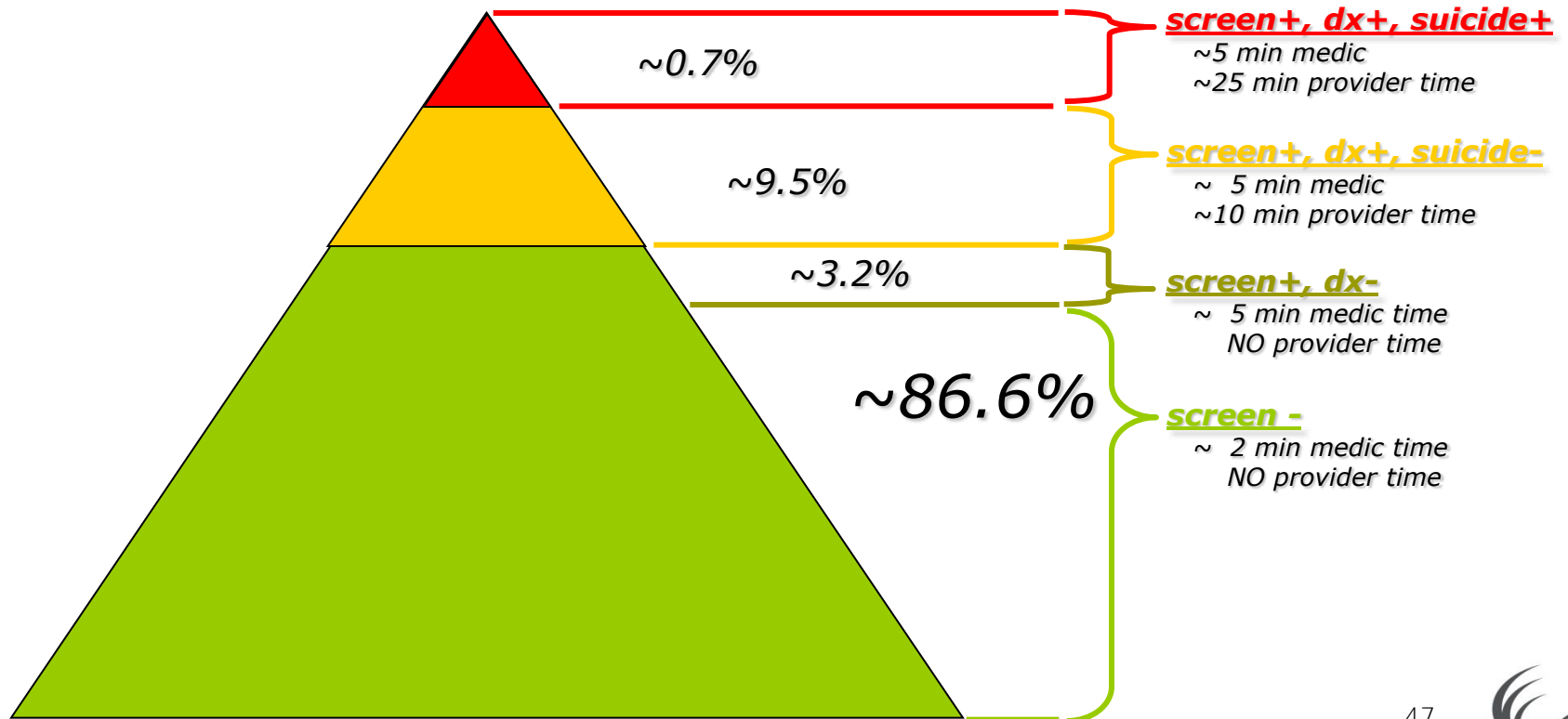
$$\text{Provider} = (0.102 \times 10) + (0.007 \times 25) = 1.2 \text{ min}$$

# RESPECT-Mil

## Creating Efficiencies

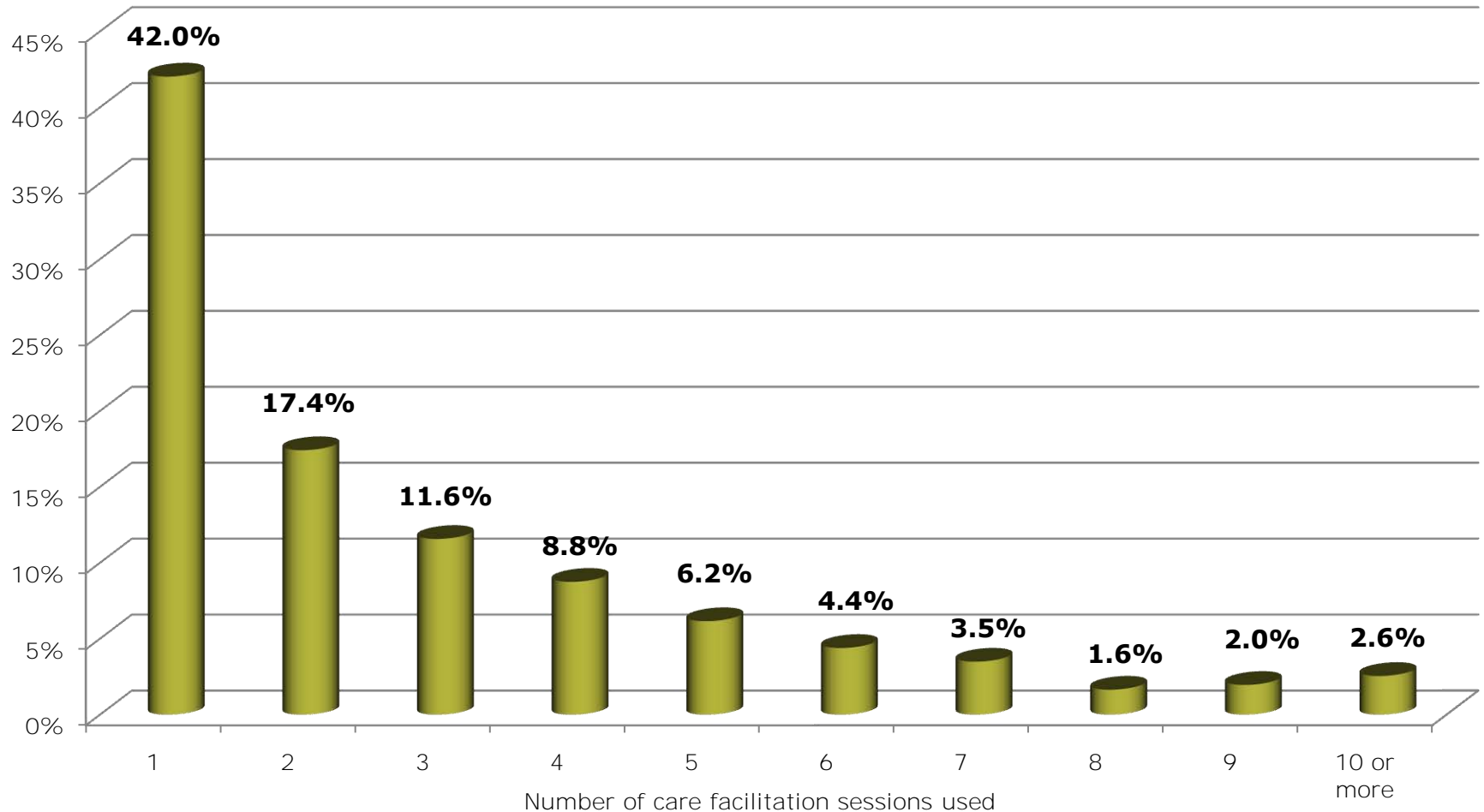
~ 90% of visits require **NO** added provider **time**

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



# 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)

# Quarterly Progress Report: Fort Bravo

## Example of an Average Performance Site



Installation Quarterly Performance Report  
1<sup>st</sup> Quarter, FY 2011

FT. BRAVO

February 28, 2011

Point of Contact: Justin Curry, PhD  
justin.curry@amedd.army.mil

**Objective:** This performance report provides summary findings of your RESPECT-Mil program from October 1, 2010 – December 31, 2010. These findings are designed both to inform and guide you and your staff regarding:

- The force health status at Ft. Bravo;
- Ft. Bravo's success in meeting RESPECT-Mil's objectives;
- Ft. Bravo's RESPECT-Mil workforce; and
- Potential strategies to improve or sustain Ft. Bravo's performance.

**Performance Ranking System:** Green arrows (▲) signify high performance, yellow arrows (▲) average performance, and red arrows (▼) low performance. Rankings are provided to help you identify strengths and weaknesses relative to other RESPECT-Mil sites.

**Summary:** In general, Ft. Bravo shows above average rates for Service Members meeting criteria for a positive screening result (PTSD/Depression/both) and average rates for a presumptive primary care diagnosis of PTSD or depression. Approximately 35% of those Service Members with positive screens are already engaged in enhanced behavioral health care (EBHC). Few Service Members at Ft. Bravo report suicidal ideation (0.5%).

Procedurally, Ft. Bravo is performing on par with other implementation sites in the RESPECT-Mil system. During this reporting period, RESPECT-Mil clinics at Ft. Bravo conducted 7,969 primary care visits (up 21.5% from last quarter). Performance against standards for implementing initial screening protocols is average (89%). However, rates for follow-up contacts should be improved. Roughly 34% of Service Members are declining referrals, indicating a need for improvement in this area. All Service Members with a positive PHQ9/PCL19 should have a further risk assessment conducted by a clinician. At Ft. Bravo, the reporting of suicide risk assessment data to the DHCC R-Mil Implementation Team was not carried out to standard. Consequently, it is not possible to report performance against this key program standard for Ft. Bravo at this time.

During this reporting period, Ft. Bravo was implementing RESPECT-Mil at 3 clinics with 497 open cases in the RESPECT-Mil program. Staffing appears to be insufficient to handle this case load with 4 care facilitators (RCFs) managing approximately 124 cases each.

Table 1: FORCE HEALTH STATUS AT FT. BRAVO...

	Q04 FY2010 N (%)	Q01 FY2011 N (%)	Change (%)	Q01 FY2011 R-Mil Range
Screened visits positive for PTSD or Depression:	1,140 (20.3%) <sup>1</sup>	1,136 (16.2%) <sup>1</sup>	-4.1%	7.9% – 20.6%
Screened visits resulting in presumptive primary care diagnosis of PTSD or Depression:	547 (9.7%) <sup>1</sup>	524 (7.5%) <sup>1</sup>	-2.2%	1.6% – 10.6%
Screened visits positive for suicide risk:	24 (0.43%) <sup>1</sup>	33 (0.47%) <sup>1</sup>	+0.04%	0% – 5.5%
Positive screens already receiving enhanced behavioral health care:	342 (30%) <sup>1</sup> **	400 (35.2%) <sup>1</sup> **	+5.2%	18% – 59.8%

<sup>1</sup> Percentage expressed relative to total number of primary care visits screened ((N/Total Screens) × 100)

\*\* Percentage expressed relative to number of positive screens only ((N/Positive Screens) × 100)

Table 2: R-Mil PROCEDURAL PERFORMANCE (SCREENING & FOLLOW-UP) AT FT. BRAVO...

Performance Parameter	Q04 FY2010 (%)	Q01 FY2011 (%)	Change (%)	Q01 FY2011 R-Mil Range	Q01 FY2011 R-Mil Rank
Percentage of primary care visits screened with MEDCOM 774:	85.7% <sup>1</sup>	87.8% <sup>1</sup>	+2.1%	17.9% – 100%	10 <sup>th</sup> of 15
Percentage of patients referred to Respect-Mil contacted within 14 days:	64.2% <sup>1</sup> **	75.9% <sup>1</sup> **	+11.7%	37% – 100%	6 <sup>th</sup> of 15
Percentage of open R-Mil cases with at least one RCF contact during the reporting period:	71% <sup>1</sup> ***	82.3% <sup>1</sup> ***	+11.3%	36.6% – 100%	4 <sup>th</sup> of 15

<sup>1</sup> ((N/Total Screens) × 100)

\*\* ((N/New R-Mil Referrals) × 100)

\*\*\* ((N/Open Cases) × 100)

Table 3: R-Mil PROCEDURAL PERFORMANCE (REFERRAL & RISK ASSESSMENT) AT FT. BRAVO...

Performance Parameter	Q04 FY2010 (%)	Q01 FY2011 (%)	Change (%)	Q01 FY2011 R-Mil Range	Q01 FY2011 R-Mil Rank
Percentage of EBHC referrals offered that are accepted:	57.2% <sup>1</sup>	66.1% <sup>1</sup>	+8.9%	44% – 94.6%	7 <sup>th</sup> of 15
Percentage of R-Mil referrals offered that are accepted:	46.9% <sup>1</sup>	52.8% <sup>1</sup>	+5.9%	0% – 91.3%	5 <sup>th</sup> of 15
Percentage of Behavioral Health referrals offered that are accepted:	53.5% <sup>1</sup>	65.4% <sup>1</sup>	+11.9%	28.6% – 100%	7 <sup>th</sup> of 15
Among visits with documented suicidal ideation, the percentage of MEDCOM 774s evidencing provider risk assessment:	Inadequate data reporting. No analysis performed.			Program standard is 100%	

<sup>1</sup> ((N/Referrals Offered) × 100)

<sup>11</sup> ((N/Positive Suicide Risk) × 100)

**RESPECT-Mil Staffing at Ft. Bravo:** A RESPECT-Mil primary care champion was assigned for the entirety of the reporting period and that individual has received formal RESPECT-Mil training. A RESPECT-Mil behavioral health champion was assigned for the entirety of the reporting period and that individual has received formal RESPECT-Mil training.

Table 4: HUMAN RESOURCING DATA FOR FT. BRAVO...

Staff	# Assigned	# Authorized	Open Cases <sup>1</sup>	Active Cases <sup>1</sup> **	Average Caseload	R-Mil Caseload Range
Total	6	9	–	–	–	–
Care Facilitators	4	6	497	409	124	12 – 188
Administrative Assistants	2	3	–	–	–	–

<sup>1</sup> Cases open in FIRST-STEPs Care Facilitation Management System during the reporting period

\*\* Open cases with at least one contact<sup>1</sup> recorded in FIRST-STEPs during the reporting period

**Comments on Data:** Given the high proportion of open cases with no contact from RCFs, the reported caseload is likely to overestimate actual workload. However, the average caseload at Ft. Bravo remains high even after correcting for inactive cases that remain open in the FIRST-STEPs system. Overall, there is little between-clinic variance evident in the data at Ft. Bravo suggesting that overall findings can be safely interpreted at the clinic-level. The only exception to this is in the referral rates where significant differences do exist between clinics and findings should, therefore, not be applied generally to clinic performance.

**Impressions:**

- 1) 18% of open cases had no contact during the reporting period. This could be due to completed patient contacts not being entered into FIRST-STEPs or due to open cases not being closed on patients discharged from the program. These issues should be addressed as soon as possible so that it accurately reflects caseload and contact data.
- 2) Irregular site-call attendance by one or more of the champions has been observed. Champions are reminded that their attendance at site calls is critically important in program implementation and for sustenance of success.
- 3) The RMIT acknowledges that high average RCF caseload has the potential to affect RCF performance. This should be kept in mind when considering the Recommended Actions below.

**Recommended Actions:** The following bullet points reflect recommendations from the RESPECT-Mil Implementation Team to assist R-Mil staff and stakeholders at Ft. Bravo sustain or improve program performance:

- ✓ Suicidal ideation evaluation and data reporting is not only an essential component of RESPECT-Mil but is paramount for patient safety. This issue should be addressed immediately.
- ✓ Continue efforts to remind providers that an important aspect of the RESPECT-Mil process is to encourage Service Members with positive screens to accept referral to RESPECT-Mil.
- ✓ Encourage RCFs to review caseloads with BHC to appropriately disposition cases and to ensure that cases that are no longer in active care facilitation are closed in the FIRST-STEPs system.
- ✓ Vacancies exist for both RCFs and Administrative Assistants. Position vacancies hinder program implementation and sustenance efforts and strain existing RESPECT-Mil staff. Ft. Bravo is encouraged to move forward on hiring actions for these positions.

<sup>2</sup> A contact is defined as a FIRST-STEPs "snapshot" created for an open case. PRN visits are not considered in determining number of active cases

<sup>1</sup> EBHC includes the RESPECT-Mil program or any behavioral health care service outside the scope of primary care practice.

# Quarterly Progress Report: Fort Charlie

## Example of a Low Performance Site



Installation Quarterly Performance Report  
1<sup>st</sup> Quarter, FY 2011

FT. CHARLIE

February 28, 2011

Point of Contact: Justin Curry, PhD  
justin.curry@amedd.army.mil

**Objective:** This performance report provides summary findings of your RESPECT-Mil program from October 1, 2010 – December 31, 2010. These findings are designed both to inform and guide you and your staff regarding:

- The force health status at Ft. Charlie;
- Ft. Charlie's success in meeting RESPECT-Mil's objectives;
- Ft. Charlie's RESPECT-Mil workforce; and
- Potential strategies to improve or sustain Ft. Charlie's performance.

**Performance Ranking System:** Green arrows (➤) signify high performance, yellow arrows (➡) average performance, and red arrows (➡) low performance. Rankings are provided to help you identify strengths and weaknesses relative to other RESPECT-Mil sites.

**Summary:** In general, Ft. Charlie shows average rates for Service Members meeting criteria for a positive screening result (PTSD/Depression/both) and below average rates for a presumptive primary care diagnosis of PTSD or depression. Approximately 38% of those Service Members with positive screens are already engaged in enhanced behavioral health care (EBHC)<sup>1</sup>. A greater number than expected of Service Members at Ft. Charlie report suicidal ideation (4%).

Procedurally, Ft. Charlie is performing on par with other implementation sites in the RESPECT-Mil system. During this reporting period, RESPECT-Mil clinics at Ft. Charlie conducted 456 primary care visits (down 33% from last quarter). Performance against standards for implementing initial screening protocols warrants greater attention and improvement (42%). Moreover, rates for follow-up contacts should be improved. Roughly 25% of Service Members are declining referrals, indicating positive performance against this indicator. All Service Members with a positive PHQ9/PCL19 should have a further risk assessment conducted by a clinician. At Ft. Charlie, the reporting of suicide risk assessment data to the DHCC R-Mil Implementation Team was not carried out to standard. Consequently, it is not possible to report performance against this key program standard for Ft. Charlie at this time.

During this reporting period, Ft. Charlie was implementing RESPECT-Mil at 1 clinic with 25 open cases in the RESPECT-Mil program. Staffing appears to be sufficient to handle this case load with 1 care facilitator (RCF) managing approximately 25 cases.

Table 1: FORCE HEALTH STATUS AT Ft. CHARLIE...

	Q04 FY2010 N (%)	Q01 FY2011 N (%)	Change (%)	Q01 FY2011 R-Mil Range
Screened visits positive for PTSD or Depression:	23 (21%) <sup>1</sup>	21 (10.8%) <sup>1</sup>	-10.3%	7.9% – 20.6%
Screened visits resulting in presumptive primary care diagnosis of PTSD or Depression:	1 (1%) <sup>1</sup>	3 (1.5%) <sup>1</sup>	+0.6%	1.6% – 10.6%
Screened visits positive for suicide risk:	0 (0%) <sup>1</sup>	7 (3.6%) <sup>1</sup>	+3.6%	0% – 5.5%
Positive screens already receiving enhanced behavioral health care:	4 (17.4%) <sup>2</sup>	8 (38.1%) <sup>2</sup>	20.7%	18% – 59.8%

<sup>1</sup> Percentage expressed relative to total number of primary care visits screened ((N/Total Screens) × 100)  
<sup>2</sup> Percentage expressed relative to number of positive screens only ((N/Positive Screens) × 100)

Table 2: R-MIL PROCEDURAL PERFORMANCE (SCREENING & FOLLOW-UP) AT Ft. CHARLIE...

Performance Parameter	Q04 FY2010 (%)	Q01 FY2011 (%)	Change (%)	Q01 FY2011 R-Mil Range	Q01 FY2011 R-Mil Rank
Percentage of primary care visits screened with MEDCOM 774:	16.1% <sup>1</sup>	42.5% <sup>1</sup>	+26.5%	17.9% – 100%	14 <sup>th</sup> of 15
Percentage of patients referred to Respect-Mil contacted within 14 days:	66.7% <sup>2</sup>	75% <sup>2</sup>	+8.3%	37% – 100%	7 <sup>th</sup> of 15
Percentage of open R-Mil cases with at least one RCF contact during the reporting period:	58.8% <sup>3</sup>	72% <sup>3</sup>	+13.2%	36.6% – 100%	10 <sup>th</sup> of 15

<sup>1</sup> ((N/Total Screens) × 100)      <sup>2</sup> ((N/New R-Mil Referrals) × 100)      <sup>3</sup> ((N/Open Cases) × 100)

<sup>1</sup> EBHC includes the RESPECT-Mil program or any behavioral health care service outside the scope of primary care practice.

Table 3: R-MIL PROCEDURAL PERFORMANCE (REFERRAL & RISK ASSESSMENT) AT Ft. CHARLIE...

Performance Parameter	Q04 FY2010 (%)	Q01 FY2011 (%)	Change (%)	Q01 FY2011 R-Mil Range	Q01 FY2011 R-Mil Rank
Percentage of EBHC referrals offered that are accepted:	50% <sup>1</sup>	75% <sup>1</sup>	+25%	44% – 94.6%	4 <sup>th</sup> of 15
➤ Percentage of R-Mil referrals offered that are accepted:	100% <sup>1</sup>	N/A <sup>1</sup>	N/A	0% – 91.3%	N/A
➤ Percentage of Behavioral Health referrals offered that are accepted:	33.3% <sup>1</sup>	75% <sup>1</sup>	+41.7%	28.6% – 100%	4 <sup>th</sup> of 15
➤ Among visits with documented suicidal ideation, the percentage of MEDCOM 774s evidencing provider risk assessment:	<i>Inadequate data reporting. No analysis performed.</i>			Program standard is 100%	

<sup>1</sup> ((N/Referrals Offered) × 100)      <sup>2</sup> ((N/Positive Suicide Risk) × 100)

**RESPECT-Mil Staffing at Ft. Charlie:** A RESPECT-Mil primary care champion was assigned for the entirety of the reporting period and that individual has received formal RESPECT-Mil training. A RESPECT-Mil behavioral health champion was assigned for the entirety of the reporting period and that individual has received formal RESPECT-Mil training.

Table 4: HUMAN RESOURCING DATA FOR Ft. CHARLIE...

Staff	# Assigned	# Authorized	Open Cases <sup>1</sup>	Active Cases <sup>2</sup>	Average Caseload	R-Mil Caseload Range
Total	2	2	–	–	–	–
Care Facilitators	1	1	25	18	25	12 – 188
Administrative Assistants	1	1	–	–	–	–

<sup>1</sup> Cases open in FIRST-STEPs Care Facilitation Management System during the reporting period  
<sup>2</sup> Open cases with at least one contact<sup>1</sup> recorded in FIRST-STEPs during the reporting period

**Comments on Data:** Ft. Charlie reports that no cases were referred to the RESPECT-Mil program during the reporting period. Consequently, the percentage of R-Mil referrals accepted is not reported. Reported performance against time to initial contact standards reflects referrals made in the last days of the previous reporting period.

### Impressions:

- 1) 28% of open cases had no contact during the reporting period. This could be due to completed patient contacts not being entered into FIRST-STEPs or due to open cases not being closed on patients discharged from the program. These issues should be addressed as soon as possible so that it accurately reflects caseload and contact data.
- 2) Ft. Charlie appears to be resolving some of its original implementation concerns but will require persistent effort to achieve overall performance consistent with program standards.
- 3) RESPECT-Mil screening rate at Ft. Charlie remains low at 42.5% but has increased by 26.5% since the previous reporting period.
- 4) Overall, Ft. Charlie evidences significant improvement over last quarter on several critical indicators of program performance.

**Recommended Actions:** The following bullet points reflect recommendations from the RESPECT-Mil Implementation Team to assist R-Mil staff and stakeholders at Ft. Charlie sustain or improve program performance:

- ✓ Suicide evaluation and reporting is not only an essential component of RESPECT-Mil but is paramount for patient safety. This issue should be addressed immediately.
- ✓ While screening performance did improve from last quarter, Ft. Charlie maintains a screening rate well below both program average and program standards. Thorough investigation of the screening process is necessary to rectify this significant deficiency.
- ✓ Encourage RCFs to review caseloads with BHC to appropriately disposition cases and to ensure that cases that are no longer in active care facilitation are closed in the FIRST-STEPs system.
- ✓ RCFs should review processes to identify and overcome barriers to timely contact of new RESPECT-Mil referrals.

<sup>2</sup> A contact is defined as a FIRST-STEPs "snapshot" created for an open case. PRN visits are not considered in determining number of active cases

# DoD STEPS-UP

**S**tepped  
**T**reatment  
**E**nhanced  
**P**TSD  
**S**ervices  
  
**U**sing  
**P**rimarily Care

A 6-site (18 clinic) RCT comparing 12-months of collaborative PTSD & depression care vs usual primary care.

*Intensified intervention...*

- aggressive case management  
(behavioral activation, motivation enhancement, centralized tracking)
- stepped psychosocial care

*Supported by a DoD grant (DR080409) from the Congressionally-Directed Medical Research Program (CDMRP)*



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