Re-Engineering Healthcare Integration Programs (REHIP)

Planning for Primary Care & Psychological Health Care Integration

A DCoE-Funded Tri-Service Demonstration Project

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	2. REPORT TYPE	3. DATES COVERED
2011		**00-00-2011 to 00-00-2011**

4. TITLE AND SUBTITLE	5a. CONTRACT NUMBER
Re-Engineering Healthcare Integration Programs (REHIP)	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) **DoD Deployment Health Clinical Center,Walter Reed Army Medical Center,Washington,DC,20307**	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
Approved for public release; distribution unlimited

13. SUPPLEMENTARY NOTES
Presented Mar 21 at the 1st Annual Armed Forces Public Health Conference 2011

14. ABSTRACT

15. SUBJECT TERMS

16. SECURITY CLASSIFICATION OF:			17. LIMITATION OF ABSTRACT	18. NUMBER OF PAGES	19a. NAME OF RESPONSIBLE PERSON
a. REPORT	b. ABSTRACT	c. THIS PAGE			
unclassified	**unclassified**	**unclassified**	**Same as Report (SAR)**	**24**	

Overview

- Purpose
- Background
- Approach
- Way Forward

Purpose

- Optimize Psychological Health* services in military Primary Care
- Implement emerging DoD policy and intent across the MHS

Prevalence

- 80% with a behavioral health (BH) disorder visit primary care (PC) at least once a year[1]
- 50% of all BH disorders are treated in PC[2]
- 48% of the appointments for all psychotropic agents are with a non-psychiatric PC provider[3]

1. Narrow et al., Arch Gen Psychiatry. 1993;50:5-107.
2. Kessler et al., NEJM. 2005;352:2515-23.
3. Pincus et al., JAMA. 1998;279:526-531.

Unmet Need

- 67% with a BH disorder do not get BH treatment[1]
- 30-50% of referrals from PC to outpatient BH clinic don't make 1st appt[2,3]
- 50% of primary care managers (PCMs), can only sometimes, rarely or never get high-quality behavioral health referrals for patients[4]

1. Kessler et al., NEJM. 2005;352:515-23.
2. Fisher & Ransom, Arch Intern Med. 1997;6:324-333.
3. Hoge et al., JAMA. 2006;95:1023-1032.
4. Trude & Stoddard, J Gen Intern Med. 2003;18:442-449.

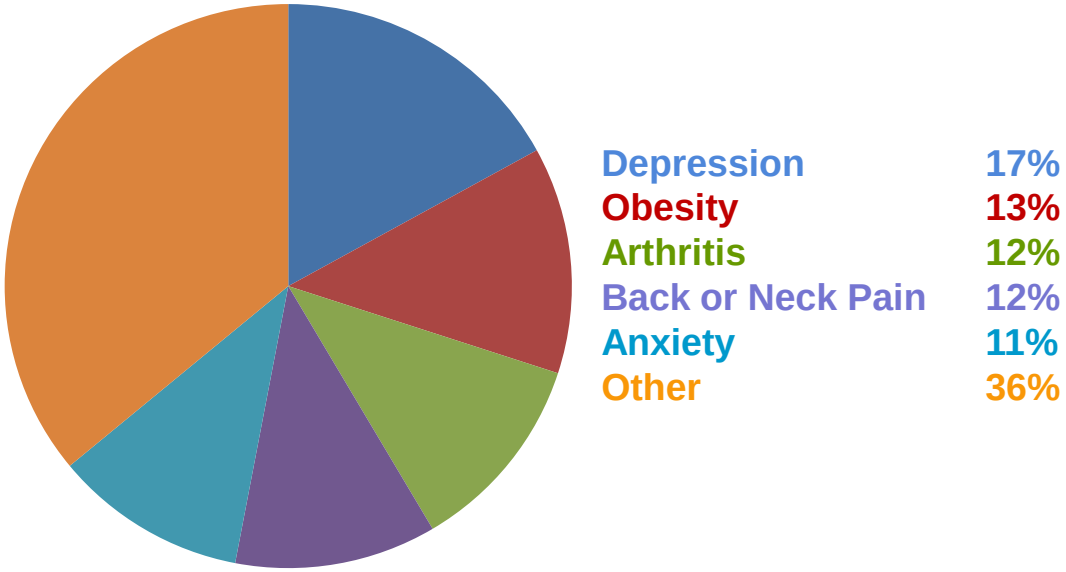
Unmet Need

- Health Care Survey of DoD Beneficiaries (2008):
  - *~35% of military health system beneficiaries report difficulties accessing BH care*
  - *~70% of family members report challenges accessing urgent BH care*

MHS Beneficiaries' Access to Behavioral Health Care Issue Brief Health Care Survey of DoD Beneficiaries (HCSDB) July 2008

Cost of Unmet Need

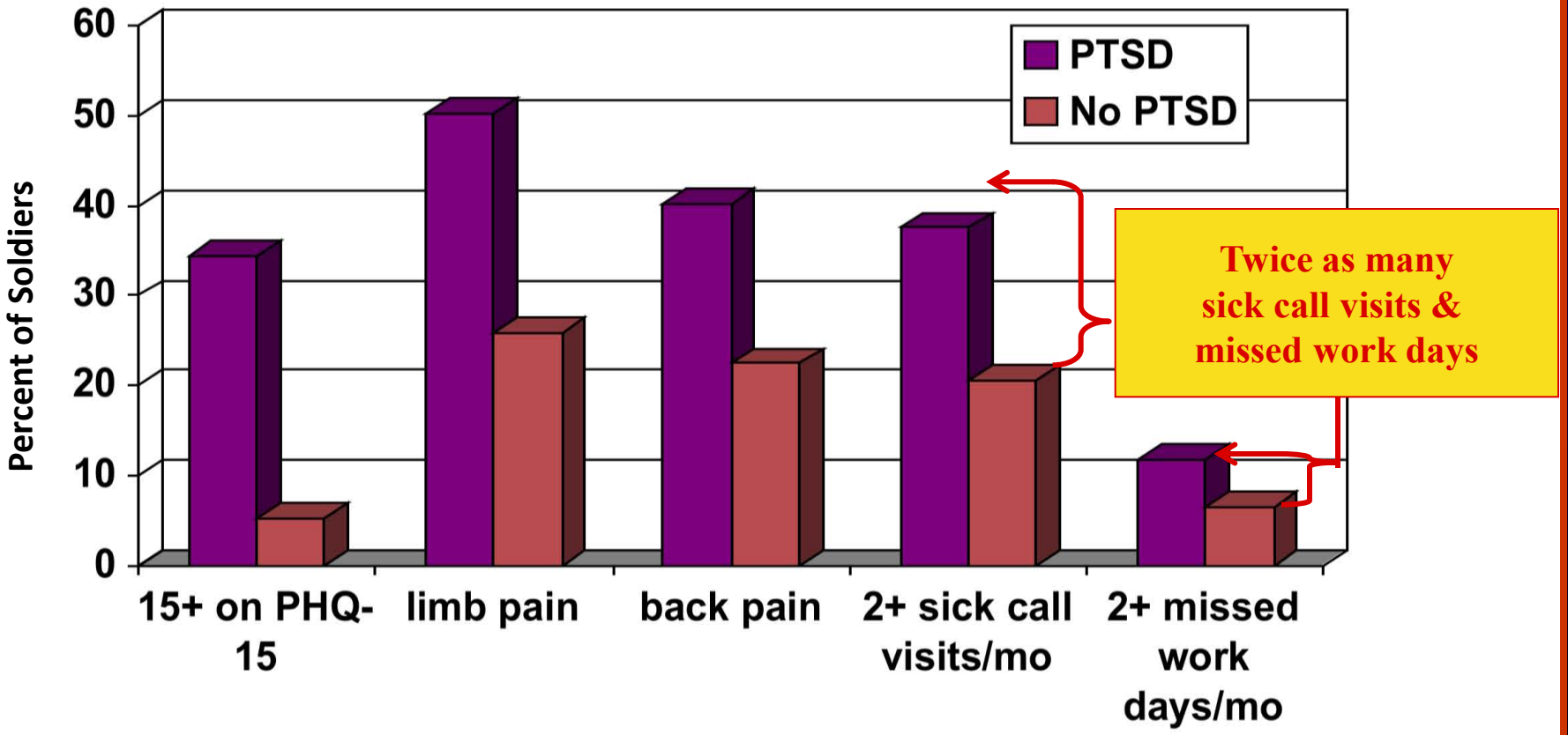
- BH conditions account for ½ as many disability days as “all” physical conditions[1]
- Annual medical expense for chronic medical + BH care is 46% greater than for chronic medical care alone[2]
- Top 5 conditions driving overall health costs (cost = reduced work productivity + medical costs + pharmacy costs)[3]



1. Merikangas et al., Arch Gen Psychiatry. 2007;64:1180-1188
2. Original source data is the U.S. Dept of HHS the 2002 and 2003 MEPS
3. Loeppke et al., J Occup Environ Med. 2009;51:411-428.

Potential for Offset: Service Use & Missed Work

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



Hoge et al, Am J Psychiatr, 2007

Lower Cost When Treated

- Medical cost ↓17% for those receiving BH tx[1]
  - *Controls who did not get BH tx cost ↑12.3%*
- Depression tx in PC for those with diabetes[2]
  - *$896 lower total health care cost over 24 months*
- Depression treatment in PC[3]
  - *$3,300 lower total health care cost over 48 months*

1. Chiles et al., Clinical Psychology. 1999;6:204–220.
2. Katon et al., Diabetes Care. 2006;29:265-270.
3. Unützer et al., American Journal of Managed Care 2008;14:95-100.

Lower Cost When Treated

Buncombe County Health Center

Decrease in Health Care Costs

- All health care-overall reduction---$66 PMPM
- Mental health care reduction---$295 PMPM
- In-patient cost reduction---$1455 PMPM
- High users of health care decreased---$435 PMPM

Lower Cost When Treated

Cherokee Health System

After At Least 1 Primary Care Behavioral Health Visit

- *28% ↓ in medical use for Medicaid patients*
- *20% ↓ in medical use for commercially-insured patients*
- *27% ↓ in outpatient psychiatry visits*
- *34% ↓ in out patient psychotherapy sessions*

Cherokee Data vs. Other Regional Providers

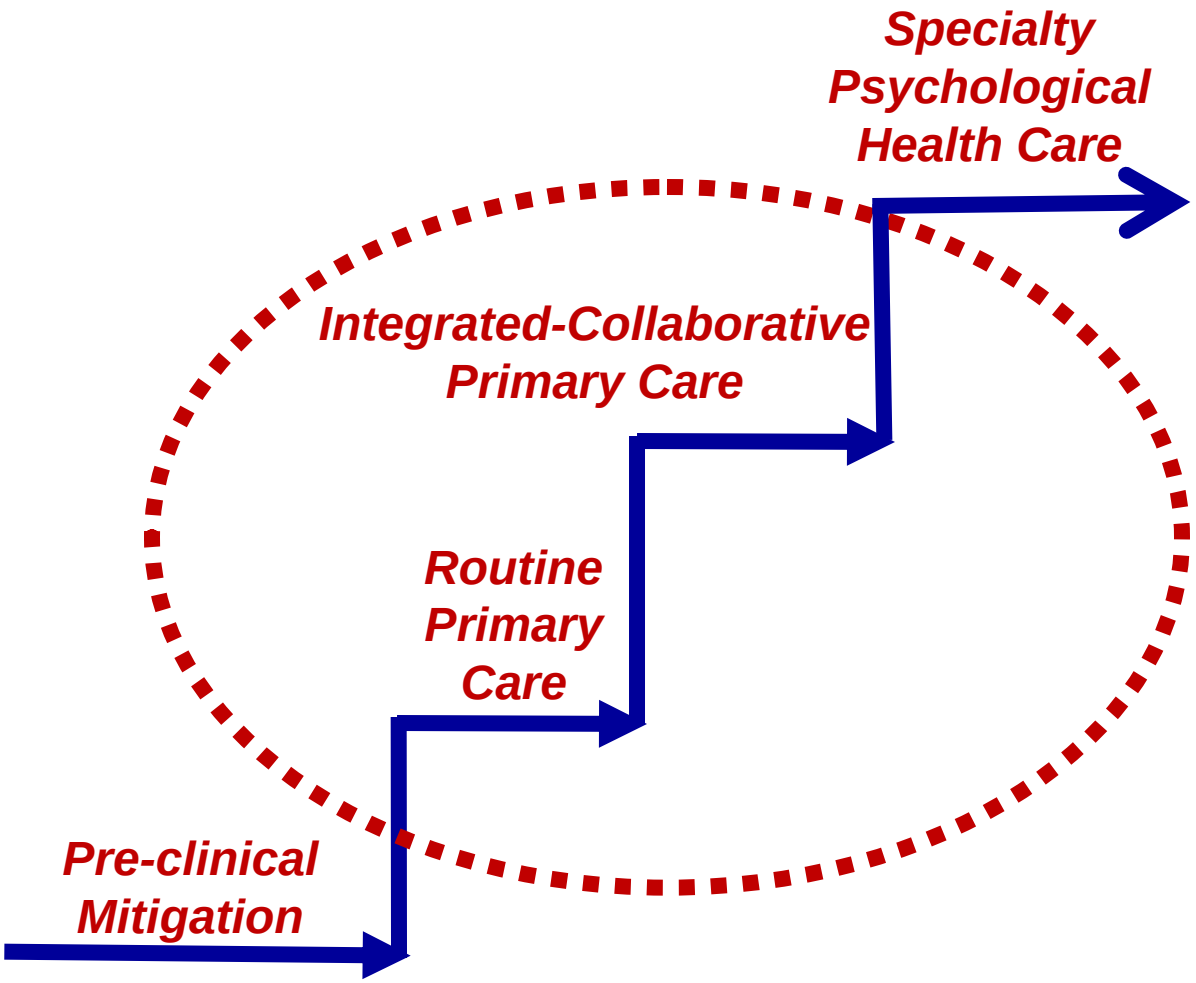
- *All Lower specialist utilization*
- *Lower ER utilization*
- *Lower hospital admissions*
- *Lower overall costs per enrollee*

Better Outcomes

- Quantitative & qualitative reviews[1-4]
  - *Depression*[1-4]
  - *Panic Disorder*[1,2]
- Other Studies[5]
  - *Tobacco*
  - *Alcohol Misuse*
  - *Diabetes, IBS, Primary Insomnia*
  - *Chronic Pain, Somatic Complaints*

1. Butler et al., AHRQ Publication No. 09- E003. Rockville, MD. AHRQ. 2008.
2. Craven et al., Canadian Journal of Psychiatry. 2006;51:1S-72S.
3. Gilbody et al., British Journal of Psychiatry, 2006;189:484-493.
4. Williams et al., General Hospital Psychiatry, 2007; 29:91-116.
5. Hunter et al., Integrated Behavioral Health in Primary Care: APA, 2009.

Stepped Care for Population Health Services



Adapted from Engel et al 2004. Can we prevent a Second Gulf War Syndrome? Advances in Psychosomatic Medicine

Models of Care

- **Care Management Model**
  - *Typically focused on a discrete clinical problem*
  - *Specific pathways to systematically address how BH problems are managed in PC*
  - *PC providers & care managers share information*
  - *Systematic interface with the outpatient mental health clinic*

Models of Care

- **Primary Care Behavioral Health Model**
  - *Focused on all enrolled patients*
  - *Embedded Behavioral Health Consultant (BHC)with PC team*
  - *BHCs & PCMs share patient information*
  - *Brings a team-based management approach*
  - *Helps team improve BH assessment & intervention*
  - *Sees patients in 15-30 minute appointments*
  - *Same day as well as scheduled appointment availability*
  - *Focuses on full range of BH & health behavior change*

REHIP: Blending Models

RESPECT-Mil Systems Continuity Method

- Reduces drop out
- Maximizes clinical efficiency
- Tracks to remission or referral to another level of care

GOALS TO IMPROVE

- Continuity of Care
- Access to Specialty Care
- Strong Empirical Support
- Clinical Feasibility & Efficiency
- Behavioral Medicine Approaches
- Implements DoD/VA Guidelines

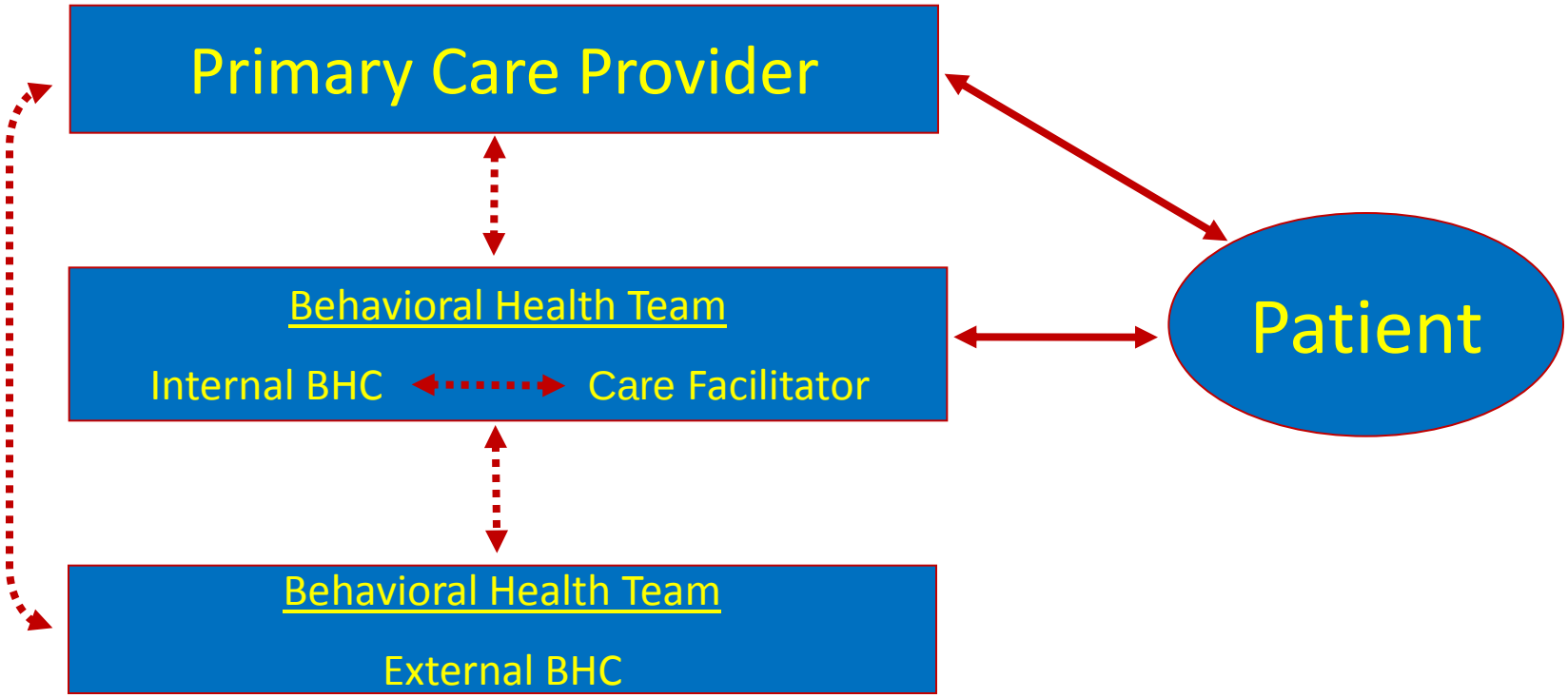
BHOP

Embedded Specialist Method

- PCM has expert consultants on team
- Improves PC access to psychosocial treatment
- Addresses broad range of PH problems

Re-Engineering Health Care Integration Programs

Primary Care Medical Home ~ A Prepared Interdisciplinary Practice



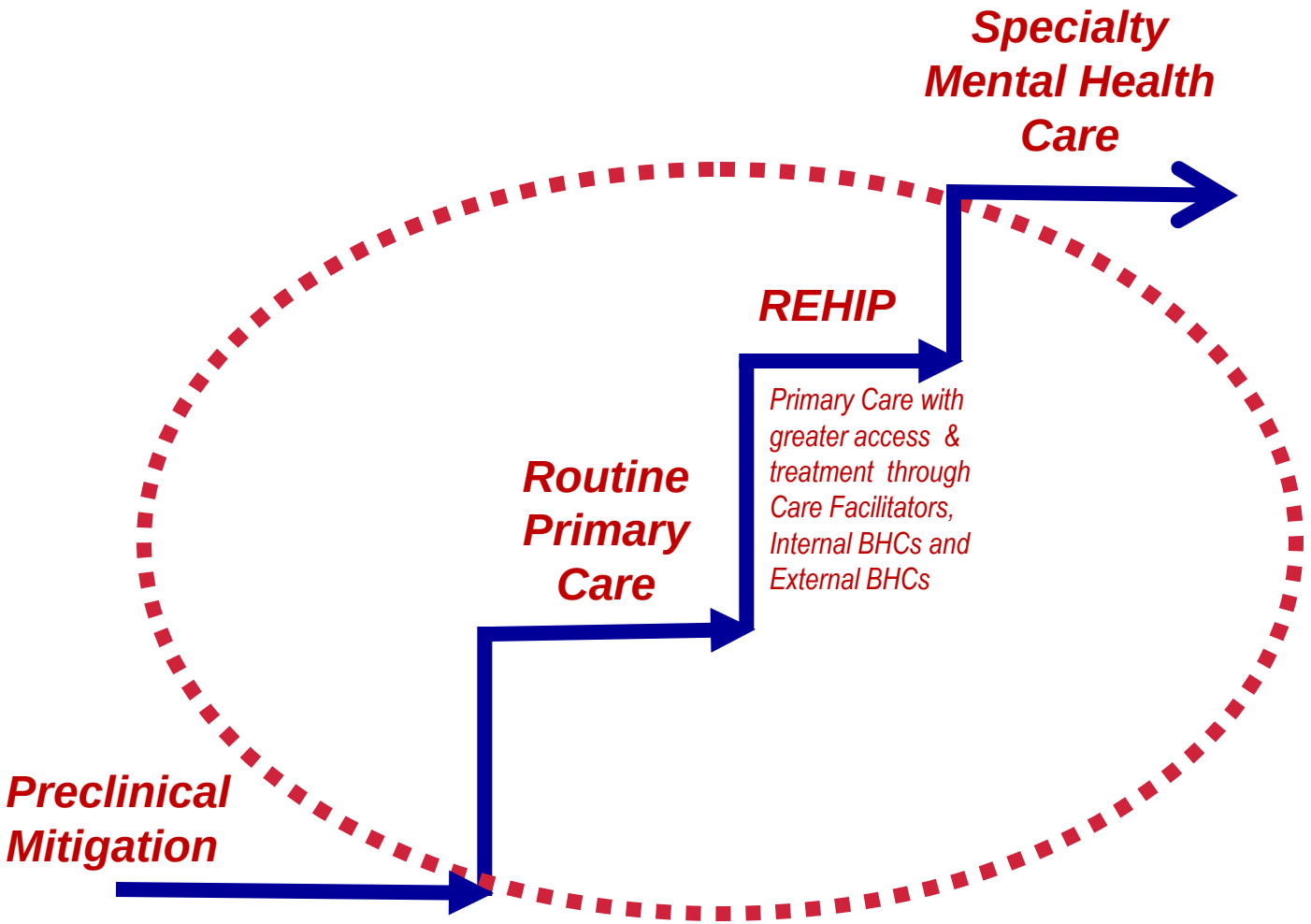
REHIP Proposal

- **A Tri-Service demonstration project and evaluation**
  - Operationalizes guidance from Mental Health Integration Working Group & Office of the Chief Medical Officer (TMA)
- **Marries components from existing programs into one consistent "best practice"**
  - Implements collaborative "team-medicine" approach
  - Enhances access to intensive, focused therapeutic intervention and collaborative treatment planning for a range of issues
  - Improves recognition, management, and continuity of care for depression and PTSD
- **Six sites (site=base/post), two per Service**

REHIP Components

- Approach is codified into manuals for Primary Care Provider, Care Facilitator, and Behavioral Health Consultants.
- Screening, assessment & treatment for all adult beneficiaries
- Universal screening for depression & PTSD for improved recognition & early intervention.
- Centralized training, evaluation with program development and management.
- Action Officers in each Service that will coordinate and communicate with site Champions and the REHIP Implementation Cell (RIC)

Why REHIP?



Adapted from Engel et al 2004. Can we prevent a Second Gulf War Syndrome? Advances in Pyschosomatic Medicine

REHIP Clinic Staffing

- One Primary Care Champion per site (Team Leader)
- One Behavioral Health Champion
- Internal Behavioral Health Consultants
- External Behavioral Health Consultants
- Nurse Care Facilitators - One or more FTE per for clinic
- Administrators

REHIP Implementation Cell (RIC)

Distinctively…

- Multidisciplinary
- Tri-Service
- Experienced
- Fully Funded

Providing…

- Training and Support
- Manuals and Tools
- A Data Repository
- Evaluation

REHIP Summary

- A Tri-Service Demonstration
- Evidence-based
- Improves population access
- Expands available care options
- Maximizes continuity of care
- Consistent with Patient-Centered Medical Home

REHIP Development Team

Sheila Barry, BS
DoD Deployment Health Clinical Center

CDR Richard Bergthold, MC USN
US Navy Bureau of Medicine

David Dobson, MD
DoD Deployment Health Clinical Center

LTC (P) Jay Earles, MS USA
Department of Behavioral Health, Fort Bragg

COL Charles Engel, MC USA
DoD Deployment Health Clinical Center &
Uniformed Services University

LCDR Chris Hunter, USPHS
Office of the Chief Medical Officer,
OASD(HA)/TMA

Timothy McCarthy, MA
DoD Deployment Health Clinical Center

Nicholas Polizzi PhD
US Navy Bureau of Medicine

Catherine Stuart APRN-NP
PH Clinical Standards of Care Directorate
Defense Centers of Excellence for PH & TBI

Mark Weis, MD
DoD Deployment Health Clinical Center

Maj Robert Vanecek, USAF BSC
USAF Behavioral Health Optimization Program

Consultants

Allen Dietrich MD

Thomas Oxman MD

Patricia Robinson PhD

Kirk Strosahl, PhD

John Williams, MD