DEFENSE CENTERS OF EXCELLENCE
For Psychological Health & Traumatic Brain Injury

A Population Approach to Treatment Engagement in Behavioral Health Care

Aug 28, 2014, 1-2:30 p.m. (EDT)

Moderator

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Webinar Details

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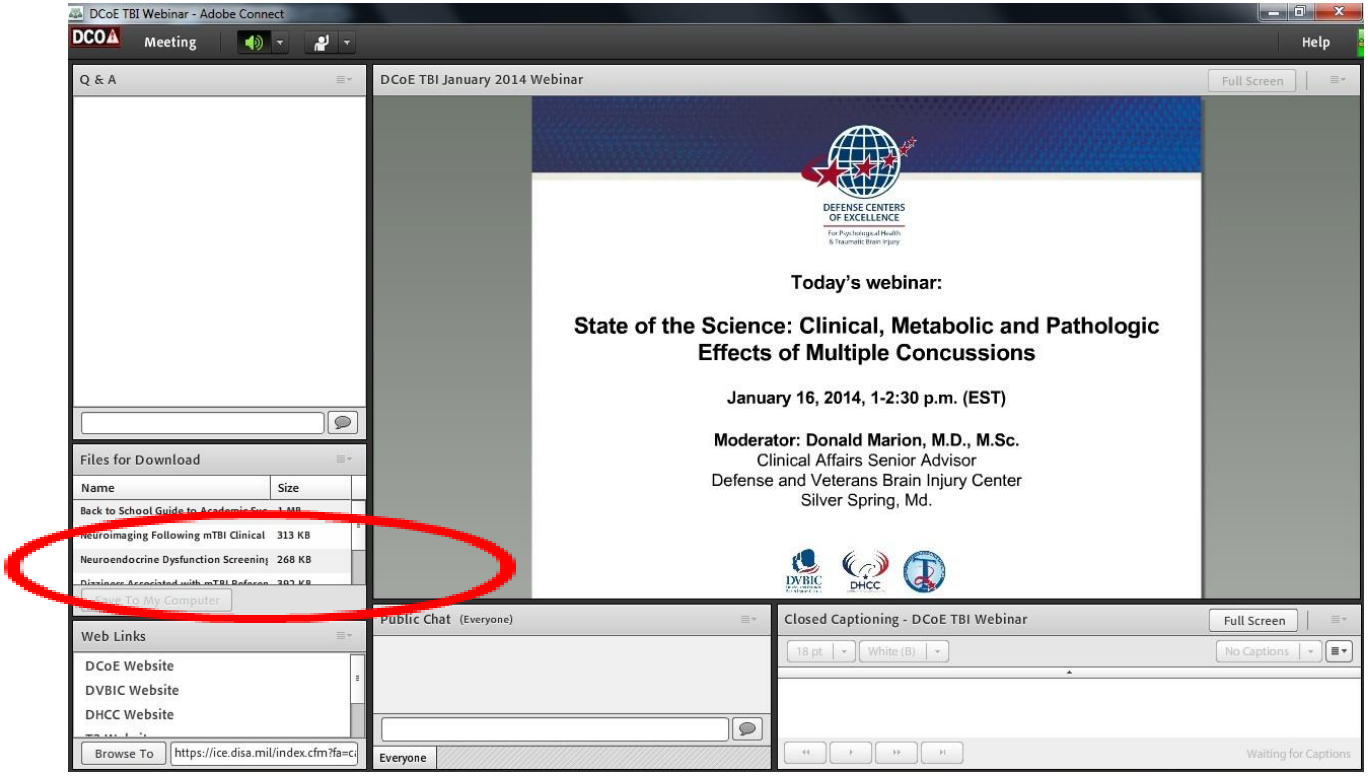

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- The authority for training of contractors is at the discretion of the chief contracting official.
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Questions and Chat

Throughout the webinar, you are welcome to submit technical or content-related questions via the Q&A pod located on the screen. Please do not submit technical or content-related questions via the chat pod.

The Q&A pod is monitored during the webinar, and questions will be forwarded to our presenter for response during the question-and-answer session of the webinar.

Participants may also chat amongst each other during the webinar using the chat pod.

We will keep the chat function open 10 minutes after the conclusion of the webinar.

Webinar Overview

The webinar will address two major challenges relating to psychological treatment engagement in the military. First, many with psychological health conditions do not access timely services. Second, most who access services drop out of treatment before it is completed. Frontloading services in primary care can improve the first challenge. A recent Institute of Medicine report noted the growing burden of posttraumatic stress disorder among service members and veterans and recommended an integrated, coordinated treatment strategy and measurement based care with feedback to clinicians to improve treatment engagement once patients access care.

Webinar participants will review systems-level interventions that improve access and continuity of behavioral health care. Delivering high quality services in primary care can improve treatment access. Once in treatment, strategies such as motivational interviewing, behavioral activation and problem solving can increase continuity, help patients manage symptoms and improve functioning, adherence, outcomes and risk management. The addition of a care facilitator into staffing plans and workflows further strengthens continuity through improved engagement.

During this webinar, participants will learn to:

- Define a population approach to behavioral health care in the Military Health System
- Differentiate patient level engagement strategies from system level strategies
- Foster total care team involvement in engaging patients in care
- Discuss examples and ways to improve treatment engagement

Michael C. Freed, Ph.D., EMT-B

- The Associate Director of Research (by contract) in the DoD Deployment Health Clinical Center, a component center of the Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury. Leads a multidisciplinary team of researchers, clinicians, and administrators who work to improve the healthcare system for service members and their family with psychological health needs through research and knowledge translation activities. A licensed psychologist who holds appointments as a Research Assistant Professor, in the Department of Psychiatry, and Scientist, in the Center for the Study of Traumatic Stress, both at the Uniformed Services University of the Health Sciences.
- Health services researcher, serving as principal or co-investigator on several research studies, all designed to improve screening of and care for service members with PTSD and depression. Most notably, the initiating PI and director of Stepped Enhancement of PTSD and Depression Services Using Primary Care (STEPS UP), a nearly complete 5-year, $14.7 million MRMC-funded randomized effectiveness trial being conducted at 6 US Army posts. Author of numerous peer-reviewed publications, book chapters, and scholarly presentations.

Charles C. Engel, M.D., M.P.H.

- Senior Health Scientist with the RAND Corporation in Washington DC.
- Research focuses on health system strategy for mitigation of chronic mental and physical health effects of war, terrorist attacks, and natural or man-made disasters. Work interests include mental health in primary care, persistent medically unexplained symptoms, post-war syndromes, Gulf War syndrome, posttraumatic stress disorder, clinical trial research methods, clinical practice guideline development, clinical program implementation and evaluation, and environmental risk communication
- Prior to joining RAND in last October, retired as a Colonel after 31 years in the U.S. Army Medical Corps and served as associate chair for research for the Department of Psychiatry at the Uniformed Services University; founded and directed Deployment Health Clinical Center for 17 years; founded and directed an Army Behavioral Health primary care program for 7 years, overseeing implementation in 37 installations worldwide including nearly 90 Military Health System primary care clinics.
- Served on the board of directors of the International Society for Traumatic Stress Studies. Authored or coauthored more than 100 scholarly articles, including in the New England Journal of Medicine, JAMA, and the American Journal of Psychiatry. Published more than 200 scholarly abstracts and delivered more than 200 invited presentations in 11 countries.

Koby Ritter, R.N.

- Supports the Defense Health Clinical Center as the Central Care Facilitator in the STEPS UP study providing telephonic and/or face to face centralized case management for active duty soldiers diagnosed with depression and/or PTSD
- Previously the Nursing Care Facilitator for Tuttle Army Health Clinic. Participated in local, national and international conferences and calls relative to program operations
- Contributed to STEPS UP and FIRST STEPS adaptations projects and was awarded a Certificate of Appreciation for her contributions to the RESPECT-Mil program by the DHCC director
- Has performed in the role of Behavioral Health Care Facilitator (BHCF) since 1997
- Assistant trainer for the Tri-Service BHCF course

Disclosure

The views expressed are those of the authors and do not represent the views of the Deployment Health Clinical Center, Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury, Department of Defense, RAND Corporation or any other agency either public or private.

The presenters have no relevant financial relationships and do not intend to discuss the off-label / investigative (unapproved) use of commercial products/devices.

Polling Question 1

When I think of patient engagement, I think of which patient group the most:

a) **Patients currently seeing a behavioral health specialist who might drop out of care early.**

b) **Patients who previously saw a behavioral health specialist but who dropped out of care early.**

c) **Patients who never saw a behavioral health specialist but who have related needs for which they could benefit from services.**

d) **All of the above.**

Objectives

- ★ Define “engagement” and why it is important to effective behavioral health (BH) care
- ★ Describe patient and population engagement objectives and strategies
- ★ Discuss role of the interdisciplinary team & engagement
- ★ Illustrate engagement through some examples

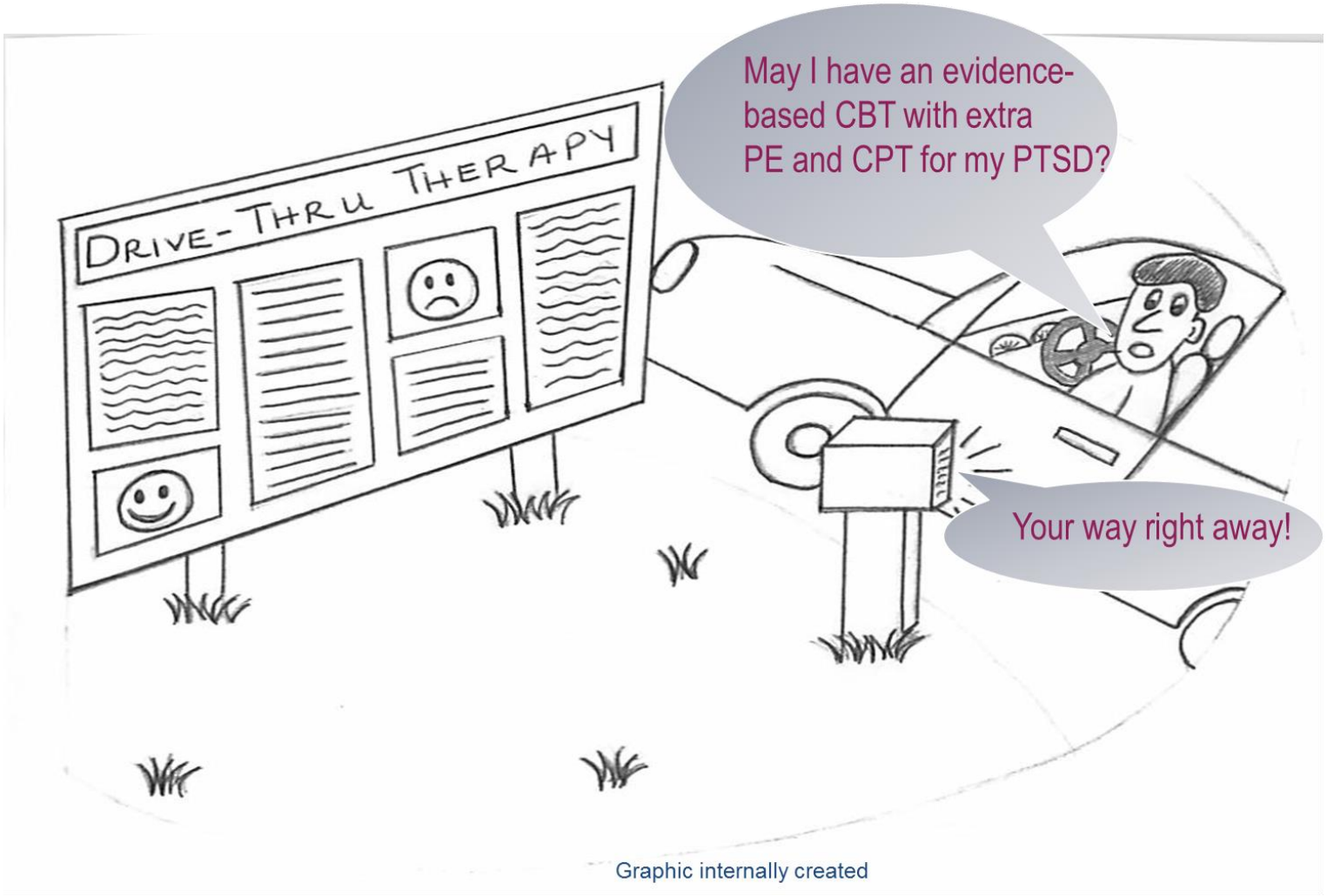
Engagement is a High Priority

- ★ Institute of Medicine (IOM) is concerned about those service members with needs but who are not in care (IOM 2014)
- ★ IOM recommends DoD and VA develop an integrated and coordinated management strategy for PTSD (IOM, 2014)
- ★ Presidential executive order to improve access to mental health services (2012)
- ★ Measurement based care that provides feedback to clinicians can improve patient engagement (IOM 2014, National Research Action Plan 2013)
- ★ PTSD and depression may make engagement more difficult
  - Social isolation, avoidance, irritability, lack of motivation, lethargy…

Engagement
Population & Provider-Patient Perspectives

- ★ Population engagement: recognizing those with needs and attracting them to a form of assistance. This starts at the population level.
- ★ Provider engagement: once recognized and involved in care, keeping them involved long enough to obtain lasting benefit. This is largely a care delivery issue.
- ★ Patient engagement: the degree of attachment and reciprocity in the patient-provider relationship as measured by proactive, patient-initiated behaviors like adhering to treatment, completing homework, regular on-time attendance at appointments, and ease of contact (e.g., returning phone calls or emails). This is a treatment planning issue.

If Only…



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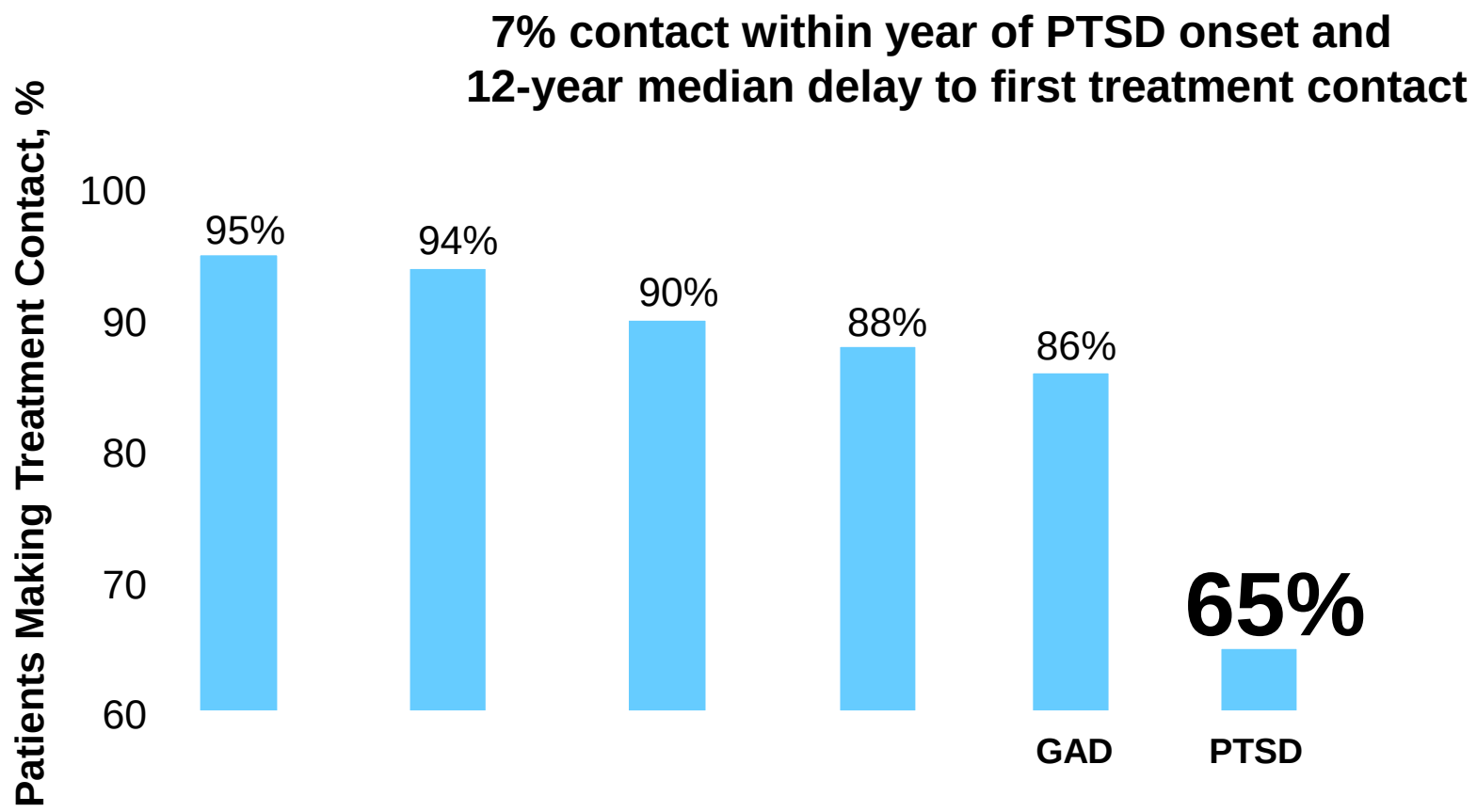
Systems & Stigma
Lifetime Probability of Treatment Contact

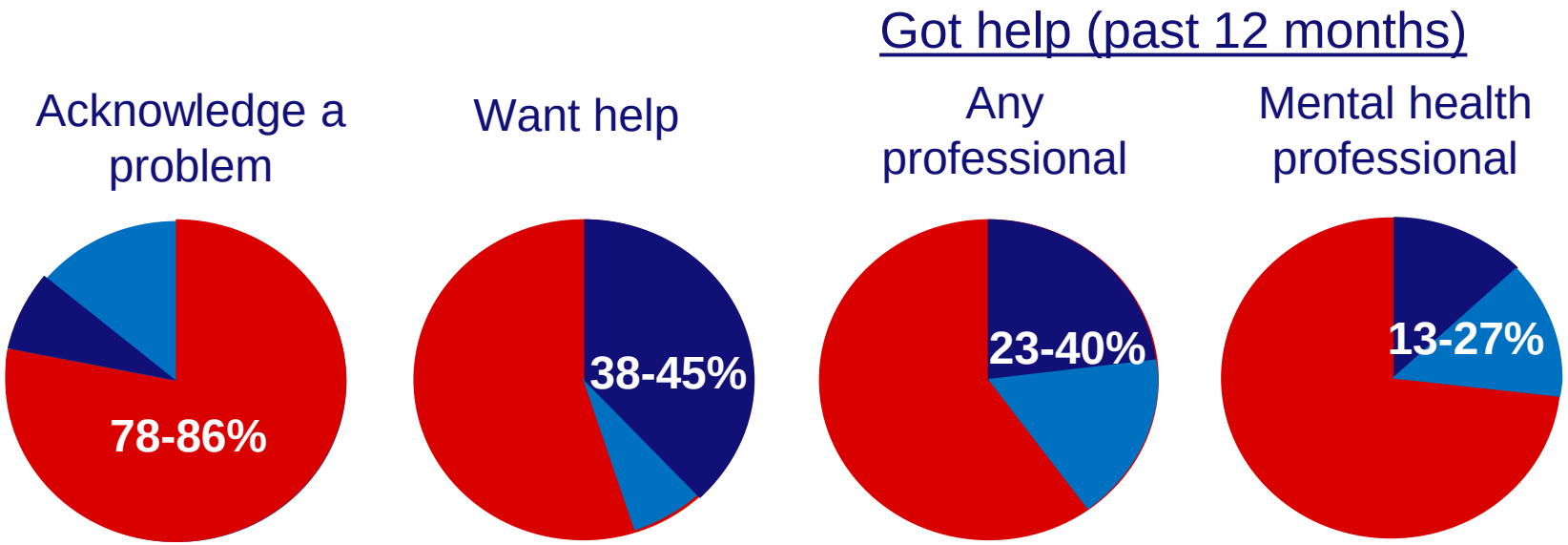


GAD = generalized anxiety disorder

(Wang, Berglund, Olfson, Pincus, Wells, & Kessler, 2005)

Engaging a Population

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



Hoge, Castro, Messer, McGurk, Cotting, & Koffman, 2004; Hoge, Tanielian & Jaycox, 2008; Hoge, Auchterlonie, & Milliken, 2006; Kessler, Berglund, Demler, Jin, Koretz, & Merikangas, 2003

Graphics created from findings in aforementioned literature

Barriers to Care

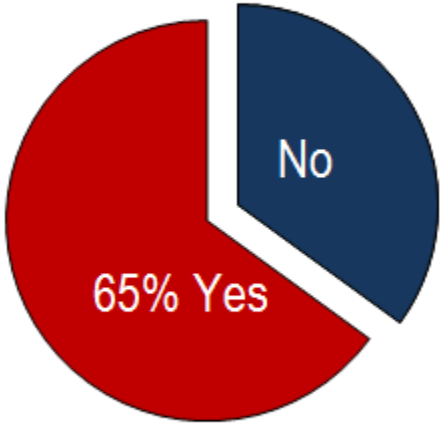
- ★ In a sample of SMs who screened positive for a mental health problem….
  - Those interested in receiving help
    - Acknowledged a problem
    - Receiving prior mental health services in the past year
  - Those not interested in receiving help reported
    - Negative views about treatment
    - Stigma
  - Interest in and willingness to go may be different constructs
  - Improving attitudes toward mental health services may increase likelihood SMs will seek out care

Brown, Creel, Engel, Herrell, & Hoge, 2011

Engaging a Population

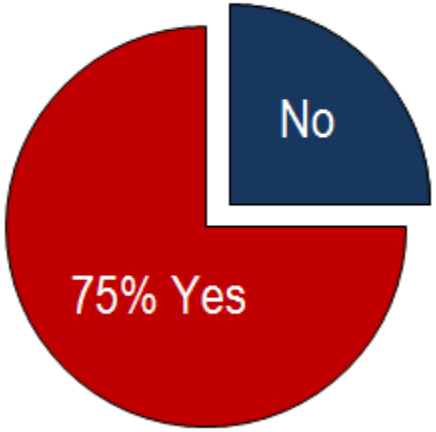
★ **More recently, improvements with initial access…**

Need Help and Got Help
(at least 1 visit within 180 days)



(DeFraites & Vythilingam 2011; IOM 2013)

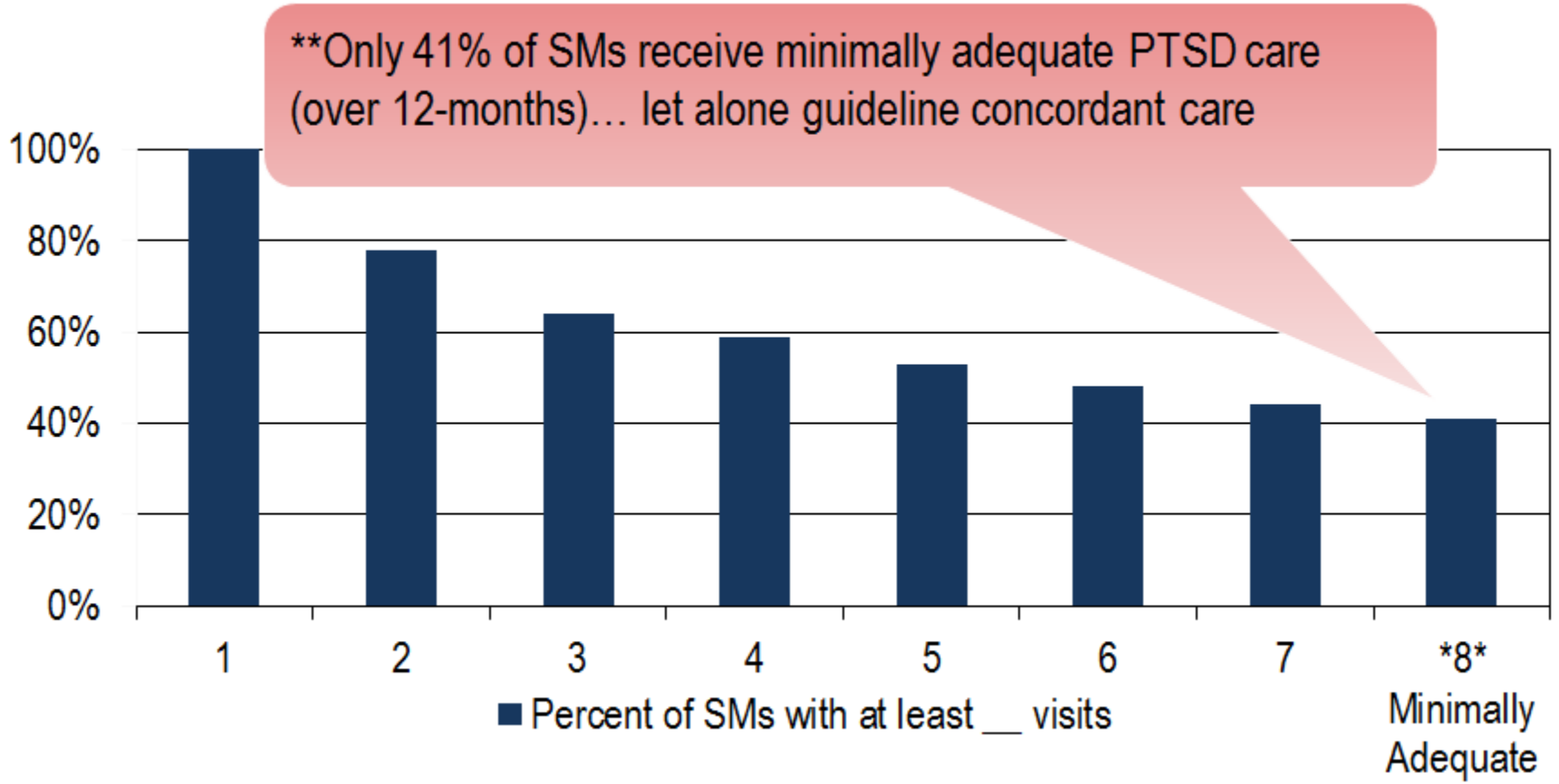
Need Help & Got Help
(at least 1 visit for PTSD within 90 days)



Hoge, Grossman, Auchterlonie, Riviere, Milliken, & Wilk, 2014

Adequacy of Care Remains Problematic

★ **More recently, but adequacy is still a problem** (Hoge et al., 2014)



Engagement is Key to Improving Care

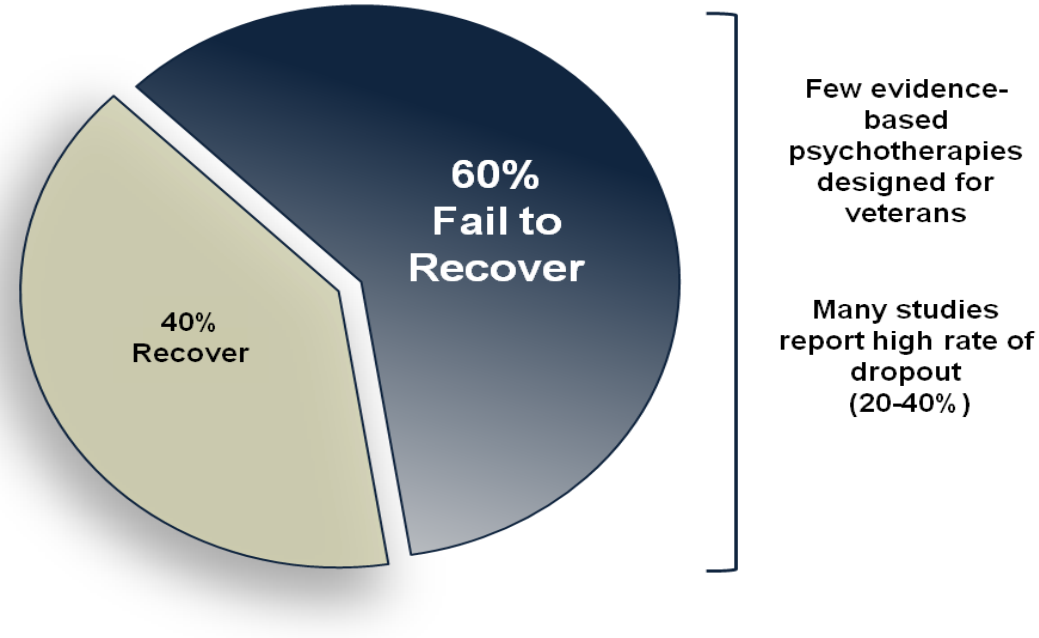
- **40% of patients prematurely discontinue depression medication** (**Reported in** Cantrell, Eaddy, Shah, Regan, & Sokol, 2006)
- **~25% of patients referred to psychotherapy do not attend the first session** (**reported in** Simon, Ding, Hubbard, Fishman, Ludman, & Morales, 2011)
- **~25-50% of patients prematurely discontinue psychotherapy** (**Reported in Simon, et al., 2011**)
- **Compliance (e.g., homework completion) improves outcomes** (**Burns & Spangler, 2000**)

Reasons for Dropout

- **More recently, why SMs drop out of care** (Hoge, Grossman, Auchterlonie, Riviere, Milliken, & Wilk, 2014)
- **More frequent reasons**
  - Too busy with work
  - Appointments not available or too far apart
  - Stigma (unit member or leaders might treat differently)
  - Felt like take care of problems on own
  - Treatment didn't seem to be working
  - Didn't feel comfortable with the MH professional
  - Didn't have sufficient time with the MH professional
  - Worried about confidentiality
- **Less frequent reasons**
  - Got better and didn't need further care
  - Transportation not available
  - MH provider moved or SM moved away

Improving Engagement Takes Focus!

★ Even in well-resourced clinical trials for PTSD, high dropouts reduce overall effectiveness.



Peterson, Luethcke, Borah, E., Borah, A., & Young-McCaughan, 2011; Steenkamp & Litz 2013; Hoge , 2011
Graphics internally created from findings in aforementioned literature

Tailor Engagement Strategies & Treatment Choices Using Patients' Readiness for Treatment

- ★ Readiness factors to consider before a patient enters treatment (Trusz, Wagner, Russo, Love, & Zatzick, 2011)
  - Level of engagement
  - Barriers & Logistical Problems (e.g., transportation, competing demands)
  - Crisis, other significant clinical issues, or conversely, remission
  - Provider and setting challenges (e.g., poor training, limited resources)
  - Patient preference (e.g., confidence in or like for tx modality)
  - Stigma (e.g. confidentiality concerns, labeling, feeling embarrassed)
- ★ Engagement strategies
  - Cognitive behavioral (Gorman, Blow, Ames, & Reed, 2011) and
  - Motivational interviewing (e.g., Van Voorhees, Fogel, Pomper, Marko, Watson, …& Domanico, 2009; Zuckoff, Swartz, & Grote, 2008)

Polling Question 2

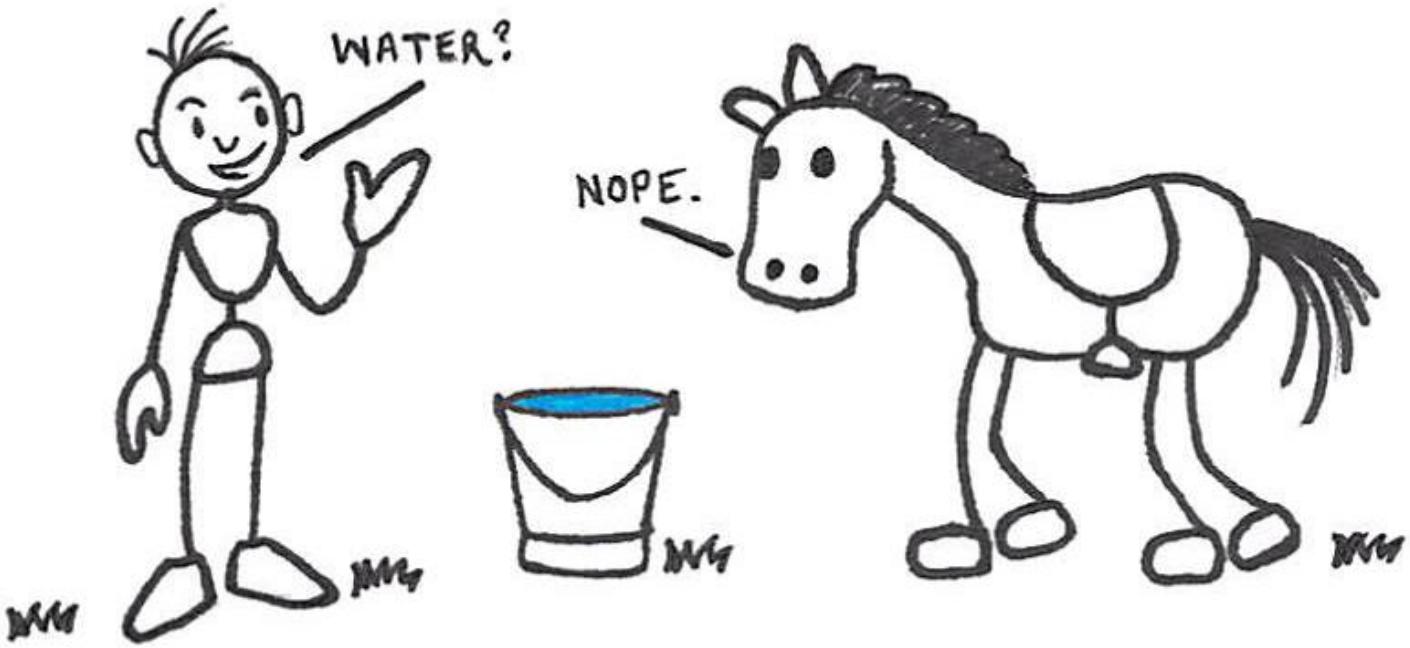
If you and your patient disagree on a treatment plan, what single factor most influences how hard you work to persuade your patient of your view?

a) Patient's symptom severity (assume here that even highly symptomatic patients do not need involuntary hospitalization).

b) Level of evidence favoring your plan.

c) Likelihood your patient will remain in care.

Everyone Likes Freedom of Choice



You can bring a horse to water…

Graphic internally created

A Population-Based Perspective

- **Maximal efficiency comes from a combination of low and high intensity interventions** (Engel, Hyams, & Scott, 2006; Engel, Jaffer, Adkins, Riddle, & Gibson, 2006)
  - Low intensity, low risk, but low resources needed and high reach
  - High intensity, higher risk, higher resources needed, and lower reach
- **Goal is to engage those in need and demonstrate improvements over the population.**

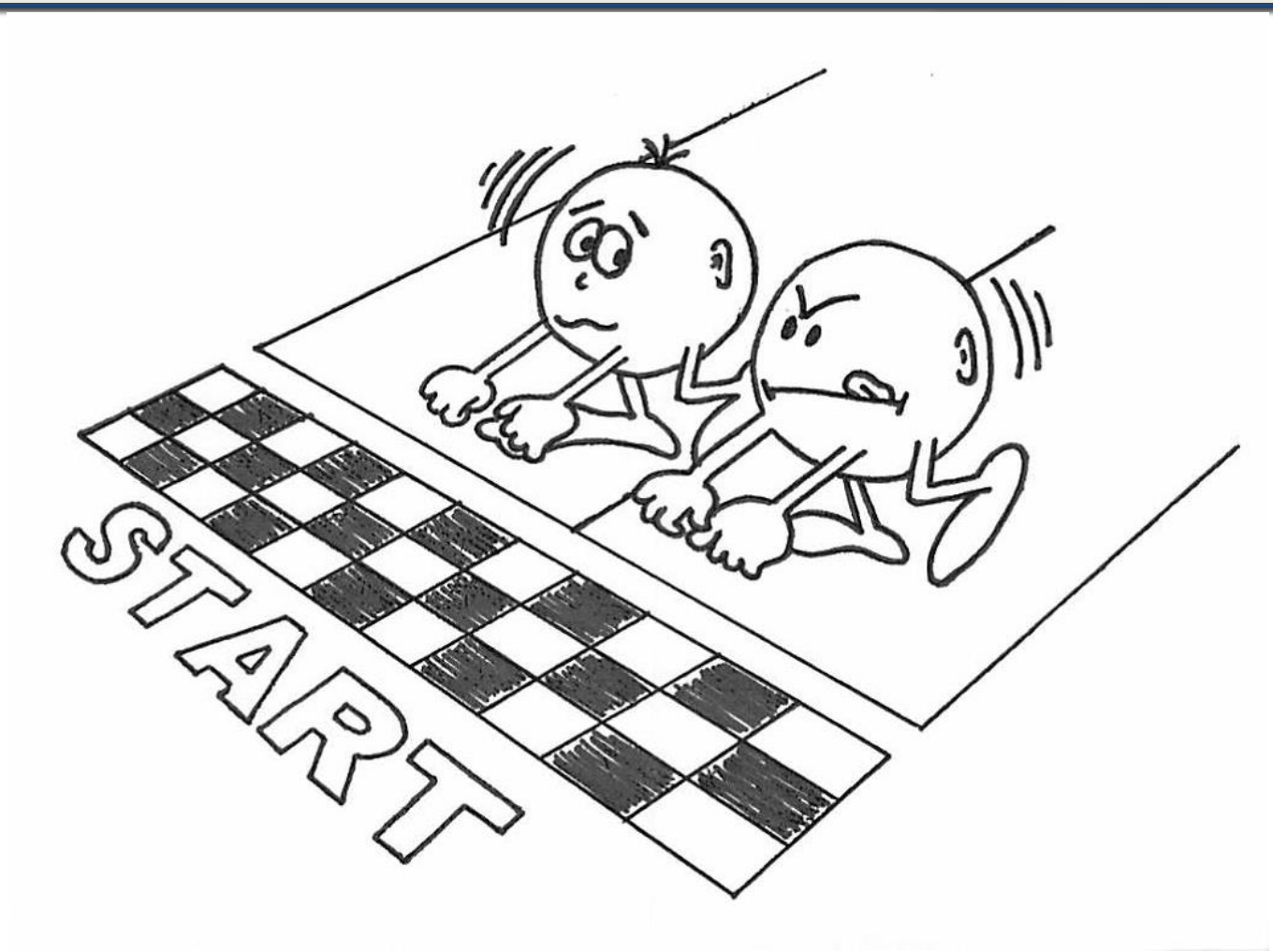
Offer Treatment Choices for the Full Range of Population Needs

Risk, Resources and Intensity

- ★ We need a healthcare system that can engage all beneficiaries in need.
- ★ Examples
  - Referral to specialist in behavioral health for intensive CBT and/or more intensive medication
  - Co-located behavioral health provider and/or second-line medication
  - Telephone therapy (Simon, Ludman, Tutty, Operskalski, & Von Korff, 2004 et al., 2004) and/or first line medications
  - MI with a nurse or other provider to assist with preference setting and patient-centered treatment planning
  - BA or PST in person or over phone with a nurse
  - Self-administered or nurse-assisted computerized cognitive behavioral therapy, like Beating the Blues (NICE, 2006)
  - Battlemind (Adler, Bliese, McGurk, Hoge,& Castro, 2011)
  - Real Men. Real Depression ((National Institute of Mental Health, 2003); Realwarriors.net

Population Reach

Goal: Offer Places Where Different Patients Can See Themselves Starting (& Continuing!)



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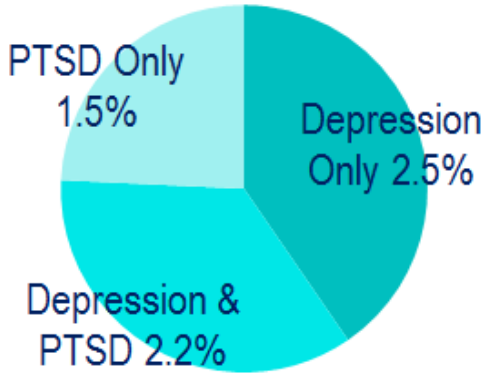
Primary Care: One Place to Start For Many

- ★ The de facto mental health service system (Regier, Narrow, Rae, Manderscheid, Locke, & Goodwin, 1993)
- ★ Service members go to primary care 3.5 times per year (Engel, 2005)
- ★ And service members with PTSD and depression go to primary care (Engel, et al., AFPHC, 2011)

Of ~834k visits
between 2007-2010…



- ★ SMs are not getting evidenced-based specialty care (Hoge, Castro, Messer, McGurk, Cotting, & Koffman, 2004; Tanielian & Jaycox, 2008; Hoge, Auchterlonie, & Milliken, 2006; IOM 2012, 2013; 2014)

Collaborative Care: Evidence-Based Place for Extending the Reach of Engagement Efforts

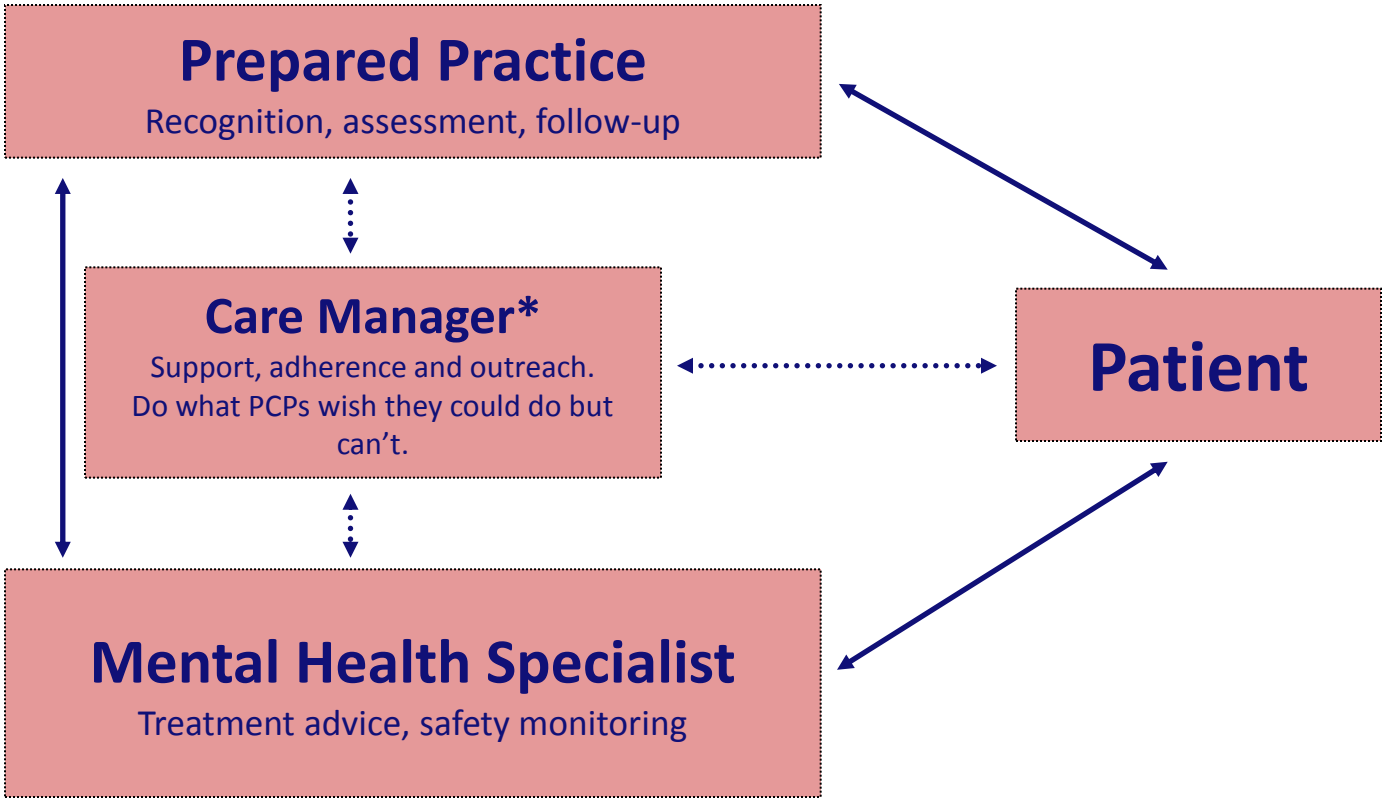
- ★ Over 69 randomized trials offer sound evidence that systems-level interventions improve care (Engel, Oxman, Yamamoto, Gould, Barry, Stewart, ... & Dietrich, 2008; Gilbody, Bower, Fletcher, Richards, & Sutton, 2006; Katon, & Guico-Pabia, 2011; Katon, Unutzer, Wells, & Jones, 2010)
  - Mostly depression
  - Other anxiety and mental health problems
  - Co-morbid medical conditions
  - No clinical benefit in VA trial (Schnurr, Friedman, Oxman, Dietrich, Smith, Shiner, ... & Thurston, 2013)but…
    - Veterans received more guideline concordant care
    - And follow up care
- ★ Recommended platform for testing new interventions (IOM, 2013)

Key Ingredients of Collaborative Care

- ★ Regular proactive follow-up (in person or telephone) with adherence and response to treatment monitoring
- ★ Disease registries to track care
- ★ Self management training with patients and family
  - Disease management
  - Active partner with the care team
- ★ Decision support to PCPs
  - Structured algorithms
  - Facile access to expert consultation & guidelines

Katon, Unutzer, Wells, & Jones, 2010; Wagner, Austin, & Von Korff,1996

The Collaborative Care Model



Oxman, Dietrich, Williams, & Kroenke, 2002

Contrasting Collaborative Care to Usual Approach to Engagement

Care as Usual

- ★ Crisis driven model
- ★ Wait for patients to come for their care
- ★ No one on the team responsible for keeping patients in care
- ★ Measurement is “another duty as assigned”
- ★ Patients that stop coming are “lost to follow-up”
- ★ Providers engage the team when they can

Collaborative Care

- ★ Outreach & engagement model
- ★ Use registries/automation to identify those with needs
- ★ Care facilitator job is engagement
- ★ Care facilitator measures while engaging
- ★ Reengagement intensifies when patient seems falls out of care
- ★ Care facilitator keeps team together

Polling Question 3

Do you work in an interdisciplinary care team (including administrative staff) that directly supports the care of your patients?

a) Yes
b) No

IF YES…

How coordinated is your team in the pursuit of collaborative care engagement approach?

a) Not at all – "treat 'em and street 'em". Staff come and go. Team?…HA!
b) A little bit – we're talking about it
c) Moderately – we're starting to implement something like this
d) Quite a bit – got a team, refining a plan and we know our roles better all the time
e) Extremely – "collabo-nirvana", written process, measuring, engaging, clear team roles

Collaborative Care, Gen 2
Expanding the Engagement Team & Tools

- Centralized phone-based components to maximize model fidelity and scalability and to extend hours and resources for clinics
  - centralized care management option for mobile patients
  - centralized, weekly psychiatrist case reviews with all nurse care managers
- Care Manager training in engagement to maximize duration and continuity of follow-up
  - motivational interviewing
  - behavioral activation

Collaborative Care Gen 2 (Continued)
Expanding the Engagement Team & Tools

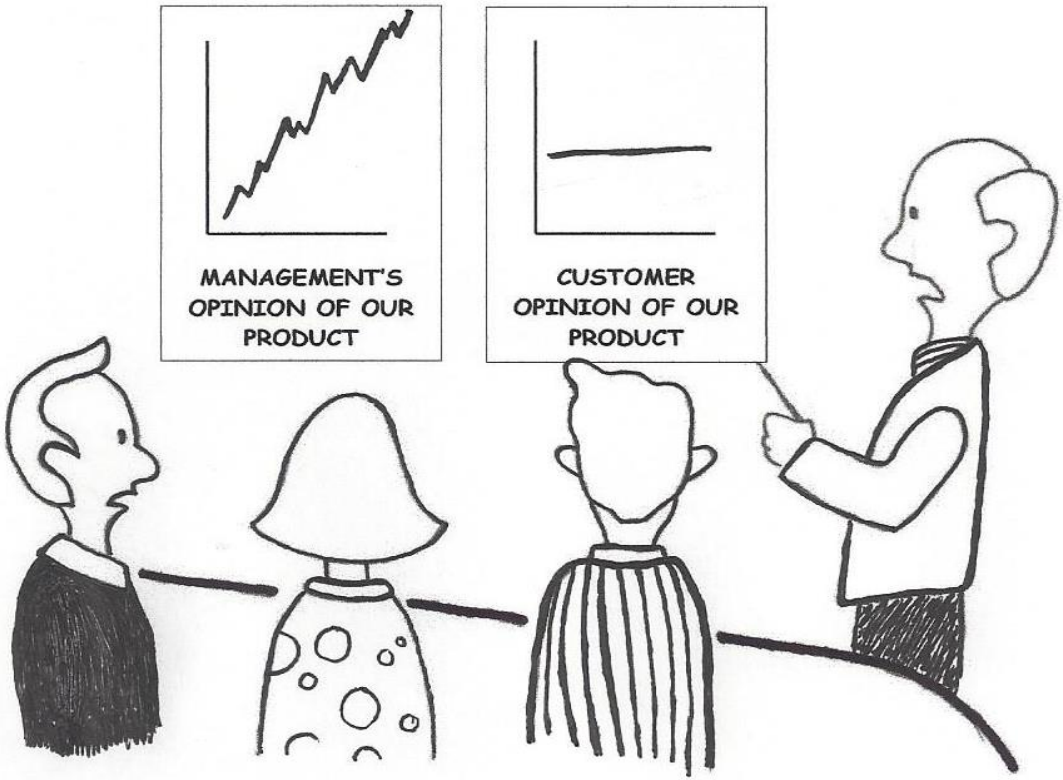
- Stepped psychosocial treatment options for primary care
  - web-based, nurse assisted self-administered CBT
  - phone-based CBT with flexible, modularized delivery sequence
  - face-to-face brief therapy with a mental health specialist working in primary care
- Population emphasis bolstered with web-based decision support
  - develops registries that stratify risk and monitor outcomes
  - supports timely stepping of care for non-response
  - reduces time from recognition to first treatment
  - reinforces treatment continuity and duration

Measuring & Targeting Engagement

Level of Engagement	Definition
0: Not Engaged	Unable to contact, does not return calls, no contact for 1 month.
1: Somewhat Engaged	Sporadically returns call, inconsistently able to contact, inconsistently attends appointments.
2: Moderately Engaged	Returns calls, consistently able to contact, may call proactively.
3: Extremely Engaged	Spontaneously contacts care team/therapist, proactively schedules future appointments, rarely misses sessions.

Trusz, Wagner, Russo, Love, & Zatzick, 2011

Measurement Based Care



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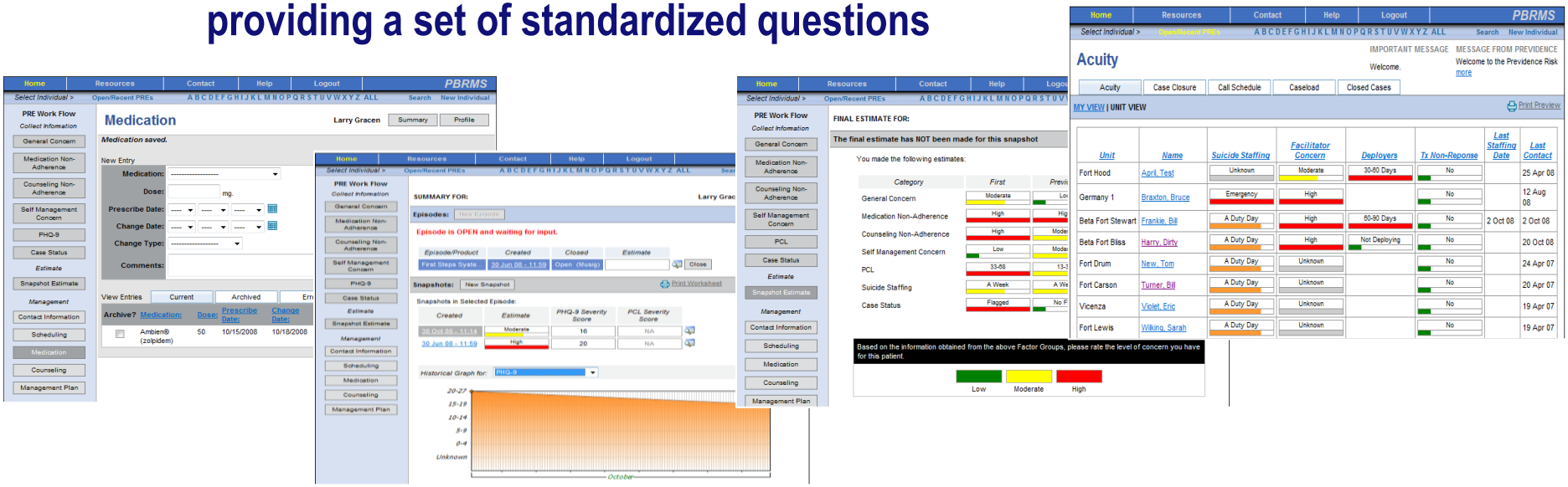
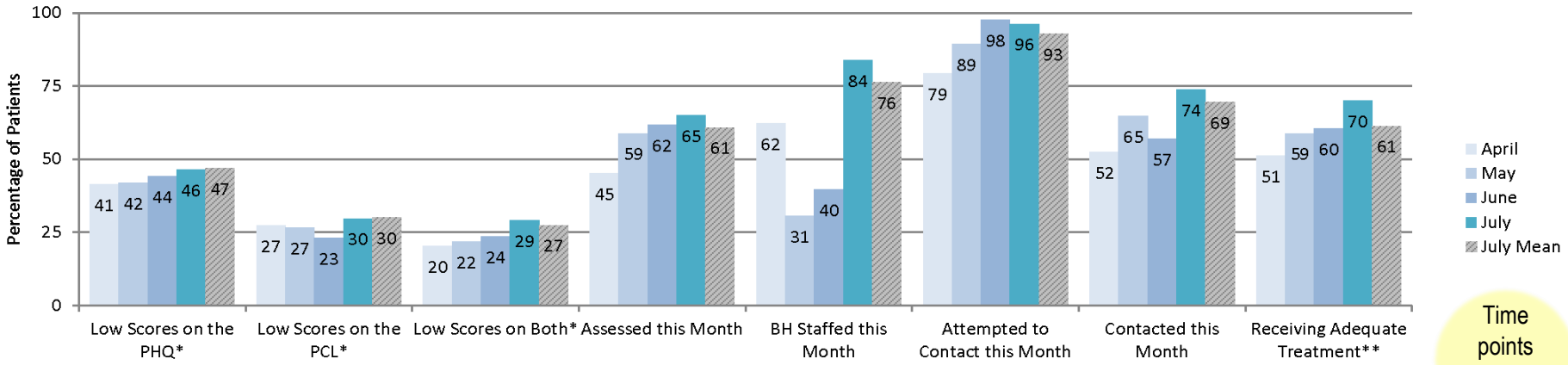
Measurement & Registries Allows Centralized, Real-Time Engagement Assistance

★ FIRST-STEPS

- DoD-approved software designed to manage symptoms, treatment response and assess risk
- Currently used in RESPECT-Mil/PCMH-BH sites and facilitates for the monitoring of patient symptoms and supervision sessions
- Provides clinicians with the ability to document and monitor suicide risk, providing a set of standardized questions



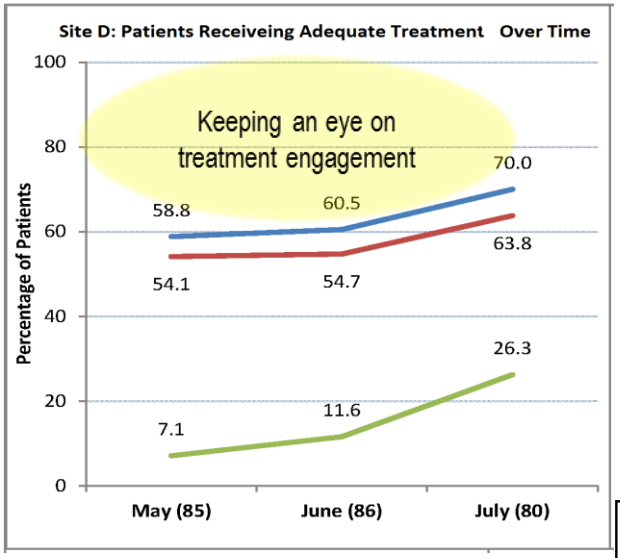
Use of Real-Time Reports to Maximize Engagement and Outcomes



Patient Outcome Metrics

Care Facilitator Process Metrics

Time points included in figure



*Percentage of patients with 2+ assessments in the last three months:	
PCL:	88%
PHQ:	80%
Both:	78%

Number of patients involved in a Medical Evaluation Board:
24 (30%)

Monitoring timeliness of PHQ/PCL administrations

Keeping track of patients in special circumstances

DEFENSE CENTERS OF EXCELLENCE
For Psychological Health & Traumatic Brain Injury

Graphic created from internal program data

The Behavioral Health Care Facilitator (BHCF) An Essential Key to Patient Engagement

- ★ Acts as a guide & facilitator to the patient's adherence to the PCM's prescribed treatment plan for depression and/or anxiety disorders.
- ★ Contacts patient on a routine basis in order to assess patient's progress, ultimately promoting improved patient engagement in the treatment plan.
- ★ Utilizes behavioral health specialist as an added resource for treatment plan recommendations.
- ★ Acts as a coordinator of communication & information to the primary care provider regarding the patient's adherence to treatment and progress toward remission.

Connecting the Patient

- **PCM**
  - Determines diagnosis and treatment plan for patients with depression and/or anxiety
  - Refers patient to BHCF for continued follow up

- **BHCF**
  - Contacts patients on a routine basis
  - PRN contacts completed as needed
  - Intended to be mostly telephonic, however may be face-to-face occasionally to improve rapport

Staffing – An Added Resource

- ★ The BHCF will staff the patient with the Internal Behavioral Health Consultant (IBHC) / External Behavioral Health Consultant (EBHC)
  - Review of clinical information on specific patients based on factors that may impede clinical improvement
  - To provide "Team" input to the PCM in order to assist with treatment planning/adjustments

Routine Call Schedules

- The BHCF routine schedule of calls is:
  - Week 1 (Range is 7 to 10 days*)
  - Week 4 (Range of 4 to 6 weeks*)
  - Week 8
  - Week 12
  - Week 16…

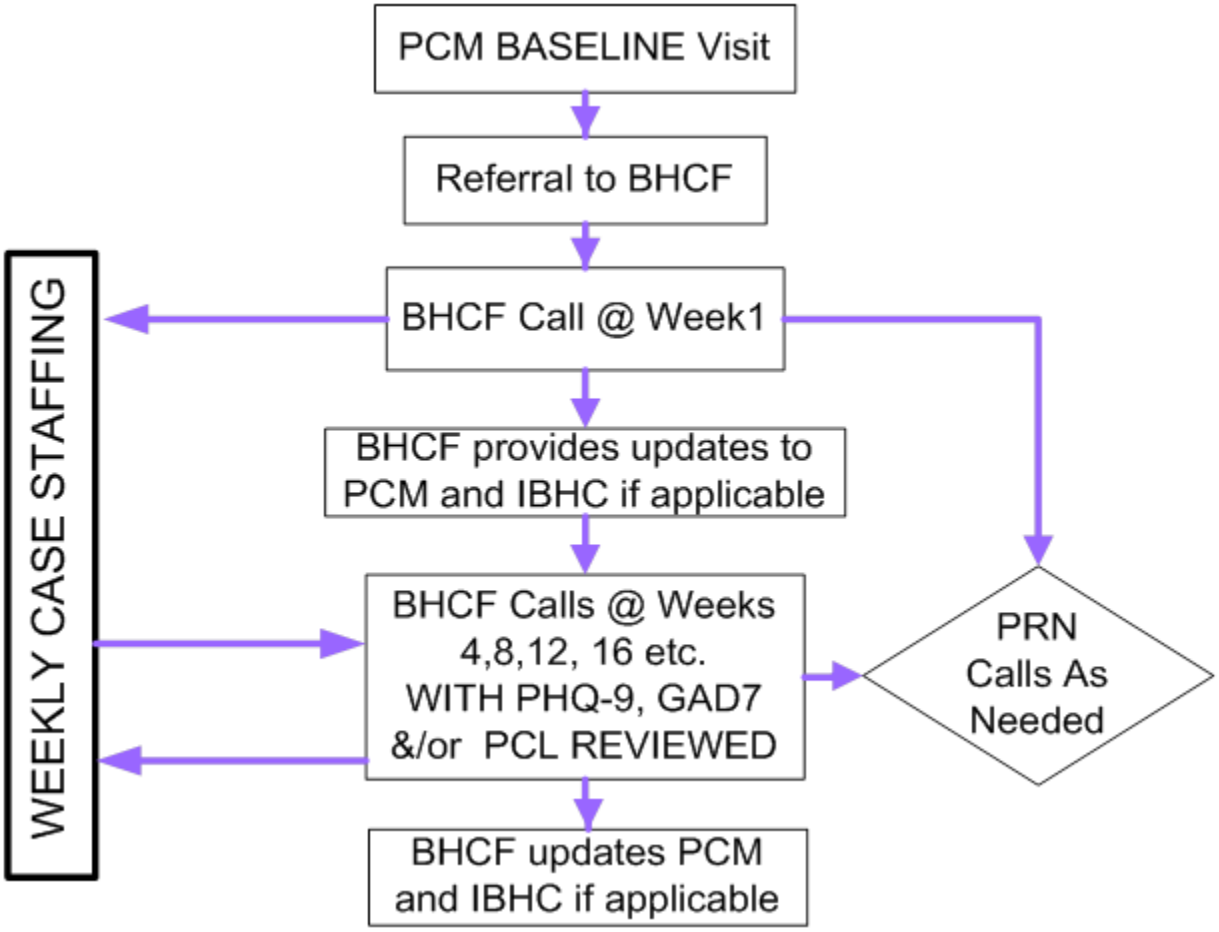
(Continue 4 week interval contacts until remission or case closure)

** Fidelity/Outcome Measures*

Routine Call Content

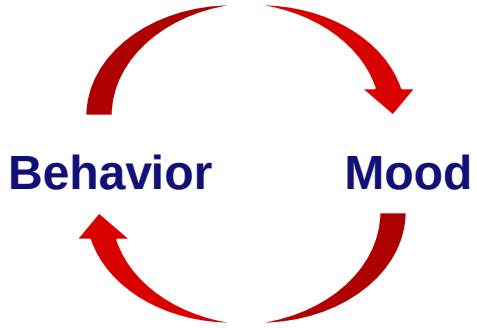
- ★ Assess patient's adherence to treatment plan
  - Medication therapy
  - Mental Health treatment
  - Self-Management Goals
  - Ongoing support and education to include available resources, medication side effects, sleep hygiene, etc.
- ★ Assist with barriers using:
  - Motivational Interviewing
  - Problem Solving
  - Behavioral Activation

PCMH-BH: The Team Approach



Intervention Options

- **Behavioral Activation** (Hopko, Lejuez, Ruggiero, & Eifert, 2003; Jacobson, Martell, & Dimidjian, 2001)
  - **Smile and you will be happy**
  - **Do the behavior and the feeling will follow**
  - **Think enjoyable, social, active, and feasible to do**
  - **Measure mood before, during, and after**
  - **Effective in primary care for depression and PTSD** (Zatzick, Rivara, Jurkovich, Russo, Trusz, Wang, J., ... & Katon, 2011; Jakupcak, Tull, McDermott, Kaysen, Hunt, & Simpson, 2010)



Intervention Options

- ★ **Motivational Interviewing Addresses ambivalence and treatment preferences** (Arkowitz, Westra, Miller, & Rollnick, 2008;. Arkowitz, Rollnick, Mason, & Butler, 1999)
- ★ **Assess motivation vs. motivate through lecturing**
- ★ **1 session can enhance readiness to change and action toward health behavior change goals**(VanBuskirk & Wetherell, 2014)

Graphic internally created

Intervention Options

★ Problem Solving Therapy

- **Empirically supported for depression in primary care** (Mackin, & Areán, 2007; Malouff, Thorsteinsson, & Schutte, 2006)
- **1-hour session followed by 8 additional sessions, ~30 min each**
- **In person or via telephone**
- **Action oriented**
  - ☆ 1. Clarify and Define the Problem
  - ☆ 2. Set Realistic / Achievable Goal
  - ☆ 3. Generate Multiple Solutions
  - ☆ 4. Evaluate and Compare Solutions
  - ☆ 5. Select a Feasible Solution
  - ☆ 6. Implement the Solution
  - ☆ 7. Evaluate the Outcome

A Case Example

★ Anthony: 31 year old recently divorced male

- Chief complaints: loss of interest, avoidance, isolation, feeling distant from others, being super alert and easily startled
- Moderate to Severe PTSD symptoms from PCL
- Multiple deployments serving in mortuary affairs to include the Pentagon after 9/11
- Prescribed Zoloft 50mg and referred to BHCF and IBHC

★ Daily Stresses

- Feels worthless since Med Boarding out of Army for PTSD and back pain
- Just wants to stay in the house for fear of going out in public
- Lives with mom due to financial problems since he can't leave house to look for a job
- Hasn't followed up with the VA for continued treatment but doesn't know why

A Case Example – The Plan

- ★ **Close follow up and sustained engagement will be important**

- ★ **BHCF supports treatment plan(s) provided by PCP/IBHC**
  - Provided initial and ongoing education on medication and treatment options
  - Routinely determined what areas the patient preferred to work on and how to move forward (Problem Solving)
  - Routinely assessed patient's motivation to make the changes (MI)
  - Set goals determined by the patient with the assistance of the BHCF
  - Provided continued follow up and encouragement through routine contacts which were communicated to both the IBHC/EBHC and the PCP

A Case Example – The Outcome

- ★ Patient remained engaged in care through Care Facilitation for a period of 6 months
- ★ Continued on medication which was tapered for effect based on patient feedback and team participation
- ★ Connected with VA for continued care
- ★ Accomplished several goals such as taking walks on the waterfront and enrolling in school
- ★ Referred a friend with PTSD to the nurse in order to get connected with Care Facilitation

Summary

- Patients in care starts before the patient is at a provider's door.
- Who is not in care and should be?
- We need a *system* that can support *access* to and *continuity* of mental health care
- All members of the care team are integral to engaging patients in care and ensuring patients stay in care
- Randomized trials offer sound evidence that systems-level interventions improve care
- The use of IT software can assist in the management of symptoms, treatment response, assessment of risk, and workflow of an entire care team
- Providers can use strategies like as Motivational Interviewing, Behavioral Activation and Problem Solving
- The BHCF can play an integral role in keeping the patient engaged with the entire team, thus improving treatment outcomes.

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References

Adler, A. B., Bliese, P. D., McGurk, D., Hoge, C. W., & Castro, C. A. (2011). Battlemind debriefing and Battlemind training as early interventions with soldiers returning from Iraq. Sport, Exercise, and Performance Psychology, 1, 66-83.

Arkowitz, H., Westra, H.A., Miller, W.R., & Rollnick, S. (Eds.) (2008). Motivational Interviewing in the Treatment of Psychological Problems . New York: Guilford Press.

Brown, M.C., Creel, A.H., Engel, C.C., Herrell, R.K., & Hoge, C.W. (2011). Factors associated with interest in receiving help for mental health problems in combat veterans returning from deployment to Iraq. J Nerv Ment Dis. 199(10):797-801.

Burns, D.D. & Spangler, D.L. (2000). Does Psychotherapy Homework Lead to Improvements in Depression in Cognitive-Behavioral Therapy or Does Improvement Lead to Increased Homework Compliance? J Consult Clin Psychol, 68(1), 46-56.

Cantrell, C.R., Eaddy, M.T., Shah, M.B., Regan, T.S., & Sokol, M.C. (2006). Methods for Evaluating Patient Adherence to Antidepressant Therapy: A Real-World Comparison of Adherence and Economic Outcomes. Med Care, 44(4), 300-303.

DeFraites, R. & Vythilingam, M. (2011). DoD Deployment Mental Health Assessments: A Review and Update [PowerPoint slides]. Retrieved from http://www.pdhealth.mil/education/2011_Presentations/AFPCH%2011%20Department%20of%20Defense%20Deployment%20Mental%20Health%20Assessments.pdf.

Department of Defense, Department of Veterans Affairs, Department of Health and Human Services, & Department of Education. (2013). National Research Action Plan: Responding to the Executive Order: Improving Access to Mental Health Services for Veterans, Service Members, and Military Families (August 31, 2012). Retrieved from http://www.whitehouse.gov/sites/default/files/uploads/nrap_for_eo_on_mental_health_august_2013.pdf.

Engel, C.C. (2005). Improving Primary Care for Military Personnel and Veterans with Posttraumatic Stress Disorder- The Road Ahead. Gen Hosp Psychiatry, 27(3), 158-160.

Engel, C.C., Freed, M.C., Lane, M.E., Jaycox, L.H., Bray, R.M., Zatzick, D., et al. (2013, November). DoD STEPS-UP: Design, Roll-Out, and Early Lessons from a Randomized Effectiveness Trial of Collaborative PTSD Care in Army Primary Care. Poster session presented at the 29th annual meeting of the International Society for Traumatic Stress Studies, Philadelphia, PA.

References

Engel, C.C., Hyams, K.C., & Scott, K. (2006). Managing Future Gulf War Syndromes: International Lessons and New Models of Care. Philosophical Transactions of the Royal Society B: Biological Sciences, 361(1468), 707-720.

Engel, C., Jaffer, A., Adkins, J., Riddle, J., & Gibson, R. (2006). Can we prevent a second 'Gulf War Syndrome'? Population-based healthcare for chronic idiopathic pain and fatigue after war. Adv Psychosom Med, 25, 102-122.

Engel, C. C., Oxman, T., Yamamoto, C., Gould, D., Barry, S., Stewart, P., ... & Dietrich, A. J. (2008). RESPECT-Mil: feasibility of a systems-level collaborative care approach to depression and post-traumatic stress disorder in military primary care. Military medicine, 173(10), 935.

Exec. Order No. 13,625, 3 C.F.R. 77 FR 54783 (2012).

Gilbody, S., Bower, P., Fletcher, J., Richards, D., & Sutton, A. J. (2006). Collaborative care for depression: a cumulative meta-analysis and review of longer-term outcomes. Archives of Internal Medicine, 166(21), 2314-2321.

Gorman, L.A., Blow, A.J., Ames, B.D., & Reed, P.L. (2011). National Guard Families After Combat: Mental Health, Use of Mental Health Services, and Perceived Treatment Barriers. Psychiatr Serv, 62(1), 28-34.

Hoge, C.W. (2011). Interventions for War-Related Posttraumatic Stress Disorder: Meeting Veterans Where They Are. JAMA, 306(5), 549-551.

Hoge, C.W., Auchterlonie, J.L., & Milliken, C.S. (2006). Mental Health Problems, Use of Mental Health Services, and Attrition from Military Service After Returning from Deployment to Iraq or Afghanistan. JAMA, 295(9), 1023-1032.

Hoge, C.W., Castro, C.A., Messer, S.C., McGurk, D., Cotting, D.I., & Koffman, R.L. (2004). Combat Duty in Iraq and Afghanistan, Mental Health Problems, and Barriers to Care. N Engl J Med, 351(1), 13-22.

Hoge, C.W., Grossman, S.H., Auchterlonie, J.L., Riviere, L.A., Milliken, C.S., & Wilk, J.E. (2014). PTSD Treatment for Soldiers After Combat Deployment: Low Utilization of Mental Health Care and Reasons for Dropout. Psychiatr Serv, 65(8), 997-1004.

Hopko, D. R., Lejuez, C. W., Ruggiero, K. J., & Eifert, G. H. (2003). Contemporary behavioral activation treatments for depression: Procedures, principles, and progress. Clinical psychology review, 23(5), 699-717.

Institute of Medicine. (2012). Treatment for Posttraumatic Stress Disorder in Military and Veteran Populations: Initial Assessment. Washington, DC: The National Academies Press.

Institute of Medicine. (2013). Returning Home from Iraq and Afghanistan: Assessment of Readjustment Needs of Veterans, Service Members, and Their Families . Washington, DC: The National Academies Press.

References

Institute of Medicine. (2014). Treatment for Posttraumatic Stress Disorder in Military and Veteran Populations: Final Assessment. Washington, DC: The National Academies Press.

Jacobson, N. S., Martell, C. R., & Dimidjian, S. (2001). Behavioral activation treatment for depression: Returning to contextual roots. Clinical Psychology: science and practice, 8(3), 255-270.

Jakupcak, M., Tull, M. T., McDermott, M. J., Kaysen, D., Hunt, S., & Simpson, T. (2010). PTSD symptom clusters in relationship to alcohol misuse among Iraq and Afghanistan war veterans seeking post-deployment VA health care. Addictive Behaviors, 35(9), 840-843.

Johnson, S.J., Sherman, M.D, Hoffman, J.S., James, L.C., Johnson, P.L., Lochman, J.E., et al. (2007). The Psychological Needs of U.S. Military Service Members and Their Families: A Preliminary Report. Retrieved from http://www.apa.org/about/policy/military-deployment-services.pdf.

Katon, W. (2012). Collaborative depression care models: from development to dissemination. American journal of preventive medicine, 42(5), 550-552.

Katon, W., & Guico-Pabia, C. J. (2011). Improving quality of depression care using organized systems of care: a review of the literature. The primary care companion to CNS disorders, 13(1).

Katon, W., Unutzer, J., Wells, K., & Jones, L. (2010). Collaborative Depression Care: History, Evolution and Ways to Enhance Dissemination and Sustainability. Gen Hosp Psychiatry, 32(5), 456-464.

Kessler, R.C., Berglund, P., Demler, O., Jin, R., Koretz, D., Merikangas, K.R. (2003). The Epidemiology of Major Depressive Disorder: Results from the National Comorbidity Survey Replication (NCS-R). JAMA, 289(23), 3095-3105.

Mackin, R. S., & Areán, P. A. (2007). Cognitive and psychiatric predictors of medical treatment adherence among older adults in primary care clinics. International journal of geriatric psychiatry, 22(1), 55-60.

Malouff, J. M., Thorsteinsson, E. B., & Schutte, N. S. (2006). The efficacy of problem solving therapy in reducing mental and physical health problems: A meta-analysis. Clinical psychology review, 27(1), 46-57.

References

National Institute for Health and Clinical Excellence. Computerised cognitive behaviour therapy for depression and anxiety: Review of Technology Appraisal 51. (Issue date: February 2006).[Internet]. London: The Institute). http://www.nice.org.uk/guidance/TA97/chapter/1-guidance. Retrieved August 15, 2014.

National Institute of Mental Health. (2003). Real men. Real depression. Washington, DC: Author.

National Research Action Plan. (2013). Responding to the Executive Order Improving Mental Health Services for Veterans, Service Members and Military Families (August 31, 2012) http://www.whitehouse.gov/sites/default/files/uploads/nrap_for_eo_on_mental_health_august_2013.pdf Retrieved August 25, 2014.

National Institute for Health and Clinical Excellence (2006). Beating the Blues, Ultrasis PLC, London: Author.

Oxman, T. E., Dietrich, A. J., Williams, J. W., & Kroenke, K. (2002). A three-component model for reengineering systems for the treatment of depression in primary care. Psychosomatics, 43(6), 441-450.

Peterson, A.L., Luethcke, C.A., Borah, E.V., Borah, A.M., & Young-McCaughan, S. (2011). Assessment and Treatment of Combat-Related PTSD in Returning War Veterans. J Clin Psychol Med Settings, 18(2), 164-175.

Regier, D.A., Narrow, W.E., Rae, D.S., Manderscheid, R.W., Locke, B.Z., & Goodwin, F.K. (1993). The De Facto US Mental and Addictive Disorders Service System. Epidemiologic Catchment Area Prospective 1-Year Prevalence Rates of Disorders and Services. Arch Gen Psychiatry, 50(2), 85-94.

Rollnick, S., Mason, P., & Butler, C. (1999). Health behavior change: a guide for practitioners. Elsevier Health Sciences.

Schnurr, P. P., Friedman, M. J., Oxman, T. E., Dietrich, A. J., Smith, M. W., Shiner, B., ... & Thurston, V. (2013). RESPECT-PTSD: Re-engineering systems for the primary care treatment of PTSD, a randomized controlled trial. Journal of general internal medicine, 28(1), 32-40.

Simon, G.E., Ding, V., Hubbard, R., Fishman, P., Ludman, E., & Morales, L., (2011). Early Dropout from Psychotherapy for Depression with Group- and Network-Model Therapists. Adm Policy Ment Health, 39(6), 440-447.

Simon, G. E., Ludman, E. J., Tutty, S., Operskalski, B., & Von Korff, M. (2004). Telephone psychotherapy and telephone care management for primary care patients starting antidepressant treatment: a randomized controlled trial. Jama, 292(8), 935-942.

Steenkamp, M.M. & Litz, B.T. (2013). Prolonged Exposure Therapy in Veterans Affairs: The Full Picture. JAMA Psychiatry, 71(2).

Tanielian, T. L., & Jaycox, L. (Eds.). (2008). Invisible wounds of war: Psychological and cognitive injuries, their consequences, and services to assist recovery (Vol. 1). Rand Corporation.

Trusz, S.G., Wagner, A.W., Russo, J., Love, J., Zatzick, D.F. (2011). Assessing barriers to care and readiness for cognitive behavioral therapy in early acute care PTSD interventions. Psychiatry, 74(3), 207-23.

References

VanBuskirk, K., & Wetherell, J., (2014). Motivational interviewing with primary care populations: a systematic review and meta-analysis. Journal of Behavioral Medicine, 37(4), pp. 768-780.

Van Voorhees, B.W., Fogel, J., Pomper, B.E., Marko, M., Reid, N., Watson, N.,…& Domanico, R., (2009). Adolescent Dose and Ratings of an Internet-Based Depression Prevention Program: A Randomized Trial of Primary Care Physician Brief Advice versus a Motivational Interview. J Cogn Behav Psychother, 9(1),1-19.

Wagner, E.H., Austin, E.T., Davis, C., Hindmarsh, M., Schaefer, J., & Bonomi, A. (2001). Improving Chronic Illness Care: Translating Evidence into Action. Health Aff, 20(6), 64-78.

Wagner, E.H., Austin, E.T., & Von Korff, M. (1996). Organizing Care for Patients with Chronic Illness. Milbank Q, 74(4), 511-544.

Wang, P.S., Berglund, P., Olfson, M., Pincus, H.A., Wells, K.B., & Kessler, R.C. (2005). Failure and Delay in Initial Treatment Contact After First Onset of Mental Disorders in the National Comorbidity Survey Replication. Arch Gen Psychiatry, 62, 603-613.

Zatzick, D., Rivara, F., Jurkovich, G., Russo, J., Trusz, S. G., Wang, J., ... & Katon, W. (2011). Enhancing the population impact of collaborative care interventions: mixed method development and implementation of stepped care targeting posttraumatic stress disorder and related comorbidities after acute trauma. General hospital psychiatry, 33(2), 123-134.

Zuckoff, A., Swartz, H. A., & Grote, N. K. (2008). Motivational interviewing as a prelude to psychotherapy of depression. Motivational interviewing in the treatment of psychological problems, 109-144.

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