



Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury (DCoE) Webinar Series

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

“A Population Approach to Treatment Engagement in Behavioral Health Care”

Good afternoon, and thank you for joining us today for the DCoE Psychological Health August 2014 webinar. My name is Dr. Lolita O'Donnell. And I would like to introduce Captain Richard Stoltz. He will be our moderator for today's webinar. Captain Stoltz is the Director of the Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury. He is responsible for the work of DCoE Headquarters and its Centers; namely, the Defense and Veterans Brain Injury Center, the Deployment Health Clinical Center, and the National Center For Telehealth and Technology, in a combined mission to improve the lives of our nation's service members, the families and veterans, while advancing excellence in psychological health and Traumatic Brain Injury prevention and care.

Thank you, and welcome, Captain Stoltz.

Good afternoon and welcome. Before we begin, I'd just like to briefly review some webinar details. Live closed captioning is available through the Federal Relay Conference Captioning. Please see the pod beneath the presentation slides. Defense Connect Online and Adobe Connect are the technical platforms hosting today's webinar. Should you experience any technical difficulties, please visit www.dcoe.mil/webinars and click on the troubleshooting link underneath the Monthly Webinars heading.

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Throughout the webinar you're 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.

I'll now move on to today's webinar. The title is: A Population Approach to Treatment Engagement in Behavioral Health Care. Patient engagement is an extremely important issue related to psychological health. And in our webinar today, we'll address two major challenges related to psychological treatment engagement in the military.

First, many with psychological health conditions do not access services in a timely fashion. Second, many who access services drop out of treatment before it's completed. And while frontloading services in primary care can improve the first challenge, a recent Institute of Medicine report noted the growing burden of Post-Traumatic 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 today will review system's level interventions that improve access and continuity of behavioral health care; delivering high-quality services in primary care can improve treatment access; and 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 plan and workflows also further strengthens continuity through improved engagements. 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 a system-level perspective; foster total care team involvement in engaging patients in care; and discuss examples and ways to improve treatment engagement.

I would now like to introduce our three presenters today. The first is Dr. Michael C. Freed, who is the Associate Director of Research in the DoD Deployment Health Clinical Center, which is a component of the Defense Centers of Excellence for Psychological Health and TBI. Dr. Freed leads a multidisciplinary team of researchers, clinicians and administrators who work to improve the health care system for service members and their families with psychological health needs through research and knowledge translation activities.

He is a health services researcher, serving as a principal or co-investigator on several research studies, all designed to improve screening of and care for services members with PTSD and depression. Most notably, he is the PI and Director of Stepped Enhancement of PTSD and Depression Services Using Primary Care (STEPS UP), which is a five-year, nearly complete \$15 million study being conducted at six US Army posts. He has authored numerous peer-reviewed publications, book chapters, and scholarly presentations.

Our second presenter will be Dr. Charles C. Engel. He is a Senior Health Scientist with the RAND Corporation in Washington DC. His research focuses have been on health system strategy for mitigation of chronic mental and physical health effects of war, terrorist attacks, and natural or man-made disasters. His work interests include mental health in primary care, persistent medically unexplained symptoms, post-war syndrome, 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 this past October, Dr. Engel retired as a Colonel after 31 years in the U.S. Army Medical Corps and served as Associate Chair for the research for the Department of Psychiatry at the Uniformed Services University. He also founded and directed the 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.

Dr. Engel served on the Board of Directors of the International Society for Traumatic Stress Studies. He has authored or co-authored more than 100 scholarly articles, including the New England Journal of Medicine, JAMA, and the American Journal of Psychiatry. He has published more than 200 scholarly abstracts and delivered more than 200 presentations in 11 different countries.

Our third and final presenter today is Ms. Koby Ritter. She supports the Defense Health Clinical Center as a Central Care Facilitator in the STEPS UP study that I previously referred to, providing telephonic and/or

face-to-face centralized case management for active duty soldiers diagnosed with depression and/or PTSD.

She was previously the Nursing Care Facilitator for Tuttle Army Health Clinic. She participated in local, national and international conferences and calls relative to program operations. She has continuously supported the STEPS UP projects and was awarded a Certificate of Appreciation for her contributions for her involvement in the RESPECT-Mil program.

She has performed in the role of a Behavioral Health Care Facilitator since 1997 and also trains others in how to conduct themselves as a Behavioral Health Care Facilitator.

Thanks again for joining us. I will now turn this over to Dr. Freed.

Thank you.

Before we get started, none of the authors here have any disclosures, no financial obligations or relevant financial relationships.

Before we get started, I just wanted to ask the audience – start this off with a polling question: When I think of patient engagement, I think of which patient group the most: Patients currently seeing a behavioral health specialist who might drop out of care early; patients who previously saw a behavioral health specialist but who dropped out of care early; patients who never saw a behavioral health specialist but who have related needs for which they could benefit from services; or all of the above.

[Pause for poll response]

This is great. We see the majority of audience members saying, "All of the above." And so I think this will be a really great talk because what we're hoping to do today is really talk about patient engagement from these different levels.

And so our objectives: define "engagement" and why it's important to effective behavioral health care; describe patient and population engagement objectives and strategies; discuss the role of the interdisciplinary care team in engagement; and then give some examples of how this might work.

You may have noticed that the three presenters today are interdisciplinary, and so we see this as an interdisciplinary problem.

But backing up a bit, engagement really is the high priority. The Institute of Medicine, which did the report which Captain Stoltz previously mentioned, sees care for service members not as just those patients that have walked through your door as a provider, but those who are not in care that may need care. They've recommended the VA DoD to develop an integrated and coordinated management strategy for PTSD. So this isn't just a treatment; this is management thinking that patients may fall out of care, may not come in for help. This is a very overall, broad perspective.

The President's Executive Order of 2012 spoke to improving access to mental health services; and more recently, made 19 executive actions, many of which speak to improved access -- the idea that measurement-based care can provide feedback to clinicians to improve patient engagement. And when you think about PTSD and depression, the hallmark symptoms of these two disorders really may make engagement more difficult. When you think of social isolation, avoidance, irritability, lack of motivation, and lethargy, these are things that might prevent patients coming in for care.

So how do we define patient engagement? We see this as an active process, and we see three levels here. The first is population. And that is the things the health system can do to recognize those with needs and attract them to some form of assistance. So this starts at the broad population level.

The second would be the provider engagement level. Now, once we recognize that patients have needs, how do we keep them in care long enough so that they can benefit from those services that we want to offer?

And the third then really is at the patient level. And how do we take a look at how patients are engaged in care? Are they calling me back to make a phone call to? Are they engaged in the homework that you might be offering? Are they taking the medication? So this really is a treatment planning issue.

So we look to see this. Are patients coming in saying they want evidence-based care, speaking exactly to what evidence-based care they want? So here we have cognitive behavioral therapies with the extra prolonged exposure in cognitive processing therapy for PTSD. Now, these are pretty intensive treatments. They're going to do the homework, they're going to get better, and you're going to see massive symptom improvement for all patients that come in.

But we know that this isn't the case. So this graph, which is a little bit of a translation error here with some things on the bottom missing. But really the point of this is that there are many mental health disorders, and we see that a lot of times patients will be willing to come in on their own and ask for help. With PTSD, a traditionally lower percentage of patients are going to be coming in and saying – Hey, I need some help.

And not only that, when you think about this isn't a community sample. But only 7% of patients come in with the first year of onset asking for help. And really the average time to raising your hand and saying, "I need some help for my PTSD symptoms," is 12 years. That's a long time.

For mood disorders, it's shorter; and a higher percentage of patients come in. But for PTSD, this is an important point. Nearly a decade ago, Charles Hoge and colleagues looked at this further in the military. And looking at the screening data, determined that a large percentage of service members acknowledged that they had a problem, about half wanted help. But when you look at who actually got help, it was a much smaller percentage of folks, really speaking to this disconnect of needs and service. And wanting to really engage a population in this study about engagement of a population, what can (inaudible) do?

So the next logical question is, Why? Why aren't patients getting help? And this might be a function of barriers of care. So when you look at this a little bit further and you say, "Okay, so who are those patients who are interested in receiving help," those patients acknowledge that they have a problem and they've received help before. So those are the folks that are actually interested in receiving help.

Those patients not interested in help said that they had really some negative views about treatment and reported stigmas that made the barrier. Some other things to consider in terms of engagement is interest in getting help and actual willingness to go may be different. And in this article, Brown et al, they were arguing that perhaps trying to intervene in ways that would improve attitude toward mental health might increase the likelihood service members would seek help.

Now, the graphs previously reported were about a decade ago. And more recently, we see some improvement with initial access to care. So that is, of patients that are screening positive, how many are actually getting seen for at least one visit? This isn't great, but it certainly is an improvement. So see 55% in one report and 75% in Dr. Hoge's recent article in 2014.

But the quality of care really is problematic here. Because when you take a closer look at the sample, you have a problem and you've got one visit, how many visits are really needed for patients to receive better help? And in Dr. Hoge's article, he argues that eight – and this is the standard that was used – eight visits within the 12-month period. And we see that, at least in his sample, only 41% of service members received at least eight visits. And that's just looking at diagnosis; that's not even assessing for whether they got guideline concordant care.

But we know that engagement isn't just an issue with the military. If we take a look at other samples as well, we know that patients prematurely discontinue from medication; patients don't always continue psychotherapy; a lot of patients don't actually come after they've been referred. But we also know that

something like compliance can really help improve outcomes. And so, for example, homework compliance with psychotherapy does improve outcomes.

So why are patients dropping out of care? In Hoge's article, he surveyed a smaller sample. And some reasons include service members are too busy with work, appointments just aren't available; stigma, feeling like they can take care of the problems on their own, thinking that treatment isn't working, not feeling comfortable with the mental health provider. And these are the most frequent reasons that this sample reported. But there are some other reasons as well.

But notice that this is not a very frequent reason why patients drop out of care, suggesting that they really do need care and that they're not getting the care that they need. Engagement really does take a lot of focus. So you may think that, well, this is taken care. These data were from the health care system. What about clinical trials where you have the best and the brightest researchers, the best and the brightest clinicians, and are highly resourced to be able to get patients into care? And we see that a high percentage fall out of care, and that really affects the overall truth in assessing them because when patients aren't coming in to care and they're not sticking with treatments, they're not getting better.

And so why might that be? One factor might be readiness; that is, are patients really ready to receive intensive treatment? Because it doesn't matter how good your treatment is; if they're not able to come in and complete what you're asking them to do, then your treatment is not going to be effective. And so looking at level of engagement is really important. And being able to assess that at the front end, before they're even coming in to treatment, can better equip you with your treatment plan.

And those things like barriers – patients can't get to their appointments, they have competing demands on their life – can we address these things first before they sign up for pretty intensive treatment? And there are strategies that exist for this – the problem behavioral strategies, the motivational interviewing strategies both designed at the front end to help with treatment readiness.

The second polling question: 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? Is that symptom severity, the level of evidence favoring your plan; or likelihood that your patient will remain in care?

[Pause for poll response]

That was a great response. Most folks are saying likelihood. I hope this is not like the anecdote. My wife is a dentist, and she asks if people floss and brush; and everything says, "Yes." So I'm hoping that this is really what you're thinking. This is great. The likelihood that patients remain in care, engagement and your assessment of engagement is exceptionally important in how you determine (inaudible) with your patients.

So then let's think. Choice really is important. And choice of the treatment can really influence how you engage your patients. Again, it doesn't matter how good your treatment is; they're not going to be engaging in your treatment if they just don't want to do it. So find ways to offer patients options that are palatable to them and that we think are going to give them some benefit.

One way to think about this is a population-based approach to engagement. And here we want to think about the entire population. Can we have tools and interventions in our arsenal that are going to be high-intensity, like we talked about cognitive behavioral therapy or prolonged exposure to PTSD, or maybe some things that are lower intensity but that also require lower resources to deliver and can really reach the population that will give some patients some benefit.

And so when we think about these things, we have a lot of different options available that DoD is already doing and other health systems are doing but we can do more of. And here is just a way to think about some of these different interventions. If you look at the arrow on the left, that demonstrates that the interventions up high relate to those are either risky or resource-intensive. But also the arrow on the left says, how much are we reaching the population? So you can't necessarily offer really intensive treatment

to everybody. And so what are things we can offer to people that maybe don't want this really intensive treatment so you have a much broader reach.

Things like public health campaigns, web-based interventions for PTSD or depression, first-line intervention strategies. So where do patients first encounter the health care system? Do they meet with primary care provider or do they meet with the nurse? And can those providers do some things that would be acceptable to those patients? And are there some quick wins – so behavioral activation or some problem-solving approaches? And this builds up as we go back up the list. So those patients that are ready for care, really able to engage in care, can get the high-intensity CBT or medication for their problems.

Now we have to ask, Where do we start? This is a broad or conceptual idea of patient engagement. But where do we start and what can things look like? And for that I'll turn the camera over to Dr. Engel.

Thanks, Mike.

What we've been hearing about so far really is that there are two levels of engagement, two broad levels. One is there are people who aren't receiving care that need care, so we have to find gateways into care for them. And on the flip side, once people are in care, we have to find ways to keep them in care. And the bottom line is that if we can't keep them in care, we certainly have no chance of making them better with the care that we deliver. And this is one of the identified problems.

So how do we deal with that? Well, one way of thinking about the first – how to bring people into care – is to intervene where patients go for their care. We know that a relatively small proportion of them are coming in for specialty care; but a much larger proportion are receiving medical care, some primary care services. So if we can set up medical care through primary care in ways that allow people to raise their hand and suggest to us when they have needs, we can step forward and hopefully offer the kinds of things that will, if not completely meet those needs, begin to meet those needs and help them take baby steps towards getting better.

One of the things that we've learned so far is that choice is an engagement strategy. Any mom who has kids knows that when you tell them to do something, you give them two things to do, both of which you'll be satisfied if they do either one. You don't tell them exactly what to do mainly because they'll object if they're told exactly what to do. It may have been one of the choices that you would offer in a multiple choice opportunity, and they would have accepted it just fine.

So in a similar way in health care, we have to think about tailoring the services that we offer to the places and the services that we think the patients that we serve will see themselves in. And we know that a large proportion of people are going to primary care. A relatively high proportion of them will be presenting to primary care with problems like depression or anxiety problems that we know that we can treat. And so if we can set things up there so that they can be successful, then this is one way of solving the front end of the engagement problem, the reach problem -- how do we reach out where they are and bring them into some sort of care.

The other nice thing about this primary care opportunity is that we have quite a bit of evidence that it works. And it's important to understand that just putting a specialist into the primary care clinic, while a good thing in and of itself, there needs to be more that goes on than simply putting that specialist in the primary care clinic. You can actually put a specialist in the clinic, and nothing will ever really change in the way that care is delivered. You have to do certain things. And when you look at the clinical trial literature on what works in primary care, what you find is there are some specific things that you have to put into effect.

The conditions for which these things work are those common things that we were just talking about – depression, anxiety. There is even one study that looks at a problem that's not an overwhelming problem

necessarily in military facilities – dementia – and looks at and finds improvements in dementia outcomes, both for patients and for caregivers. So just organizing the care in the right way can be a powerful benefit.

So what are those ingredients in collaborative care that go beyond just putting a specialist in the primary care clinic? One is that you have to work very hard to follow up with patients. Again, you have to offer them choices in the way that they follow up. Many patients will want to come in and be seen, many would prefer not to or would have a hard time making it in. And you have to be working very hard over the phone to bring them in to care and to keep them adhering to the treatment plan that has been put in place – whether that be medicine or that be therapy sessions. You have to design the therapy in a place where they will go, and you have to work hard to contact them to ensure that they're coming in for that and that they're responding to that treatment.

You need to be using automated systems to understand the status of your patients. You can use disease registries both to track patients who are in care for problems like depression, posttraumatic stress disorder, and so on, alcohol problems. But you can also use sophisticated automated systems to track health outcomes. If data is collected in the right way, it's possible to know and to generate reports that will tell you which of the patients are not getting better; when was the last time that their treatment was charged; and help you to know that you have to do something to redesign the care for those patients in an active way.

The way care is often delivered is that we put them on a medicine or we start them in therapy; and as long as they keep coming back to talk to us, we keep talking to them. But if we don't know whether that's really working or we're just eyeballing whether it's working, then we may be doing the patient a disservice. We may have set them on a journey with a treatment plan that really is only getting part of the way there. So you have to use registries also to understand which groups of patients are not responding to treatment so you can advance the treatment plan.

And then along with this idea of choice, you have to have a range of self-management approaches. There are studies; one which comes to mind is looking at PTSD care in the National Comorbidity Study where they looked at the different reasons why many people were reluctant to go in to see the specialist. And a lot of them reported – a high percentage of those not going in reported that they wanted some sort of do-it-yourself approach to try first. So there are many people who prefer that. We can't afford to go about it with the idea of if they won't take the Cadillac, then we're not going to engage them and deliver anything for them. We have to offer them self-management strategies. And that self-management strategy, whether they succeed or not, may ultimately help you in keeping the person in treatment longer.

And we also need decision support for primary care providers, for care managers, for specialists, frankly. And a big part of those decision supports relate to what I was saying earlier. You would like to have some kind of a report that will tell you which of your patients are getting better and which are not, what proportion of your overall caseload is getting better versus the larger population of patients who meet the same illness criteria. So that if you're not getting patients as well as you might, you can actually look within and try and figure out what it is that you might do to improve the care that you deliver. And at the individual patient level, that you can identify those patients in a timely fashion without having to use a lot of office time.

So those elements that I just described have to be organized in some fashion. First, it's not enough just to put a specialist in the clinic and walk away. It's not enough to know these ingredients and even to do these ingredients. But you really have to have some sort of a way that you're going to put it altogether and implement it.

The model that you see in the slide in front of you was designed by a group funded by the MacArthur Foundation. They called it the three-component model. And essentially, the three components that they saw were prepared primary care practice, the use of a care manager, and enhancing the interface with mental health specialty care. That may or may not mean putting a specialist in the clinic. The good news is more and more in the military health system, we see relatively universal placement of mental health providers in the primary care clinic.

But within this collaborative care model, the important thing to understand is that whether you're the primary care doc or whether you're the specialist, that you're busy delivering services for patients. There needs to be some specific attention brought to the process of engagement. And that really is what the care manager does. The care manager is working very hard to stay in touch with patients first and foremost. And in the process of staying in touch with patients, they're using validated metrics to understand whether patients are getting better or not and to record that into the health information system so that these sorts of reports can be generated that I described earlier.

So that care manager is like a guardian of engagement in the clinic. And this is the back end engagement. We've talked about using the primary care practice to extend reach on the front end engagement piece, the many people who are out there with needs that aren't receiving care. On the back end side, once they're in care, they really need somebody who's working hard to keep them involved in their care.

And the other thing that the care manager does is foster the team approach, where the entire health care team is working hard to help that patient get better and that they're sharing information with each other. Any of us who practice know, if we're honest with ourselves, how very difficult it is to talk with other providers on the health care team. We're working very hard to see lots of patients, many of them very sick. Emergencies happen; we head in different directions. There's just really not a lot of time, unless we bump into another member of the team, to speak about specific patients.

That care manager is an important conduit of information, making sure that recommendations from the mental health specialist get conveyed to the primary care provider; that symptom assessments go to the mental health specialist as well as the primary care provider, and everybody knows the status of the patient over time. So you have to have that specialty piece, you have to have elements of the plan, and then you have to have this team concept that holds it altogether to make this model work.

So this is contrasting the way that care usually works versus the way it might work in a collaborative care model if it's done completely. In care as usual, it's standard in medical care for years is that it tends to be a fairly crisis-driven approach. Patients wait until they have a problem and then they come in for care, and the provider is faced with that problem and has to do some things in a fairly taxing situation a lot of the time. In collaborative care, the approach is to screen in primary care; identify people with needs; and then work very hard, once they've been referred into the collaborative care model and they're being followed by the care manager and by the specialist, work very hard to keep them involved.

In care as usual, you wait for patients to come in for care. In collaborative care, you use registries and automation to identify those with needs and then track whether they're responding to treatment.

In care as usual, typically there is no one on the team responsible for keeping patients in care. Everybody is delivering services. The primary care provider is assessing patients and treating patients. The specialist is assessing patients and treating patients. And again, if we're honest with ourselves, we know that when a patient drops out of care, we're so busy it's very hard to lean on them in whatever way that we have at our disposal to bring them back in. In collaborative care, there's a care facilitator, whose job it is to be actively working to contact these patients and keep them in care.

In care as usual, measurement is another duty as assigned for the clinician. In collaborative care, the care facilitator helps with that and uses it as part of the engagement process.

In regular care, patients that stop coming are lost to follow-up. In collaborative care, re-engagement intensifies when a patient seems to fall out of care. That's in many ways the beginning of when the more intensive strategies begin.

And then in care as usual, providers engage the team when they can, as I've mentioned. The care facilitator helps the team to stay together within this collaborative care model.

So Polling Question #3: Do you work in your setting in an interdisciplinary care team? And we're talking here also about administrative staff that directly supports the care of your patients. Yes or No? And if the answer is, yes – and I suspect that most of you would say yes to that, but you never know – how coordinated is your team in the pursuit of a collaborative care engagement approach, from not at all to extremely here. And we've tried to give you some anchoring statements to help you to decide where in that spectrum that you are.

[Pause for poll response]

Okay, so what we see is that about 15% of providers actually say, no, they don't work in an interdisciplinary team. That may be skewed by I suppose there may be some non-clinicians who are listening in.

And then among those who say, yes, we see a distribution – which is what I would expect – from not at all collaborative to very collaborative.

So this is a process in trying to make care better over time. So we'll talk a little bit in the closing parts of my presentation about that.

So what's Collaborative Care, Generation 2? Some things that we're doing right now in a large study that we're just finishing up called the STEPS UP trial, we're centralizing the way that the model is implemented and using a central office to support what happens in the primary care clinic. There are centralized phone-based elements, which is care management, and even therapy that's delivered by phone. And then we have a care manager that is also operating remotely, which Koby is doing; and she can tell us a little bit about that. And we do some unique training with them – motivational interviewing, training and behavioral activation, which Koby will talk more about.

In addition to STEP medication care, which is common in primary care, with the availability of more and more clinicians, specialists in primary care clinics, we're able to do a step psychosocial version of care that involves web-based elements, phone-based elements, as I've mentioned, and face-to-face elements with the primary care-based mental health specialists. There's also a population effort to develop registries using a web-based decision support approach.

So we measure and target engagement so that we get implement in our efforts centrally to guide specialists and teams at the various centers. We measure the degree of engagement that's going on so that when we see patients becoming engaged, we can intensify our efforts to keep them in. And we're using this measurement approach, as I mentioned, using automated systems that the care manager feeds.

I believe that is the end of my part.

We talked a little bit – we've heard a lot about actually the behavioral health care facilitator. So we're just going to talk a little bit about the role of the behavior health care facilitator, otherwise known as the BHCF, for a little bit. The BHCF is the part of the team that is oftentimes known as the glue to keep everybody connected. The BHCF will act as a guide and a facilitator to the patient's adherence to the treatment plan that the PCM has prescribed for the patient. When they have been diagnosed with depression, CPFD, anxiety, the BHCF will contact the patient on a routine basis in order to assess their progress and how they're coming along with the treatment plan.

The BHCF will also have the ability to staff their patients with a behavior health specialist, and we'll talk a little more about that in detail in a minute. And then, of course, just the coordinator of communications back to the primary care provider regarding how that patient is doing. The primary care provider is the person that the patient belongs to. So the communication between the BHCF and the PCM concerning the patient is going to be very important.

We talked a team approach a lot in order to improve engagement. So who is this team, and how does the patient get connected to them? First, of course, is the primary care manager. This is usually the first person that the patient sees, comes into contact with. So the primary care manager, once they determine a diagnosis of depression or anxiety, they have the option to refer their patient to the BHCF for continued follow-up. The BHCF, again, will contact that patient on a routine basis with PRN calls, as needed. Most of these calls are intended to be telephonic; however, at least with the initial contact with the patient, it is recommended to have a face-to-face if at all possible just to further increase the rapport between that patient and that care facilitator.

The other member of the team is the IBHC, or the Internal Behavior Health Consultant, or at some sites is the External Behavior Health Consultant or EBHC. A unique and valuable component of this model is the ability to staff or review the patient that the care facilitator has on her caseload with a behavioral health specialist, whether that's the IBHC or the EBHC. They review clinical information on specific patients based on factors that may be impeding their clinical improvement – some form of treatment non-response or any reason that that patient may be a red flag. They can staff that patient or review that patient with the IBHC.

And then, most importantly again, the communication comes into play. The BHCF will take that information gathered from the patient, as well as the recommendations from the behavioral health specialist, and communicate that back to the primary care provider or manager for their input on the next step to take with that patient.

So we mentioned earlier that the BHCF will help to keep the patient engaged for scheduled, routine calls. This slide just demonstrates the timeline of those scheduled calls. The initial call will be approximately 7 to 10 days from the date of referral from the primary care manager. At that point, it's just a get-to-know-you conversation; to review the treatment program that the provider has established with the patient; and to let them know what your role is going to be for them as the BHCF.

And then at that point, the BHCF will call the patient about every four weeks. And then, of course, with PRN calls, as needed, whenever the BHCF feels it's necessary. The patient, of course, has the option to contact the BHCF themselves. Should they come into problems or barriers or have questions, they have that resource that they can call the BHCF as well. Also, the IBHC or the primary care manager themselves can ask the BHCF to make a PRN call concerning something specifically that they would like addressed.

What does the BHCF talk about on these routine calls? Basically, you're assessing the patient's adherence to the treatment plan. You're talking about their medication. How are they doing on it? Are they having any barriers? Are they taking it? Do they have enough refills? Just really trying to head off any barriers that could come up in the future. Mental health treatment – are they involved in any mental health treatment? How is it going? Are there any barriers, homework assignments that they might be having questions about?

Self-management goals is a big thing that the behavioral health care facilitator works with the patient very closely on, and we'll talk about that a little bit more in depth in a few minutes when we get into some of the behavioral activation. And then, of course, just being a resource for the patient and providing them with local resources, educating them, ongoing education as far as medication, sleep hygiene. Again, helping them get connected to the available resources in the clinic, on post and off post.

And then, of course, assisting. We've spoken a lot about the barriers that patients come into, and then we just continue to help them with those barriers with things like motivational interviewing, problem solving and behavioral activation.

This is sort of a busy slide, but we just wanted you to see it because there is, in fact, an easy-to-follow, mapped out flow of this model that we're speaking of; and everybody has a very important role in this model. Basically from the top, as we have already discussed, the primary care manager sees the patient; makes the referral to the BHCF if they so choose. The BHCF will call the patient for that initial call in 7 to

10 days, and then every four weeks after that. And then, of course, most importantly, the communication part between the IBHC and the primary care manager continues.

Typically the staffing with the IBHC and the BHCF will occur on a weekly basis at a designated time. And then the information from that staffing, of course, is then communicated back to the primary care manager who is responsible for that patient.

We had mentioned some of the intervention options. I'm going to speak briefly on the behavioral activations. One of the methods that behavioral health care facilitators use quite often, especially in dealing with their self-management goals, the BHCF assists the patient in setting goals towards getting active – of course keeping in mind that the patient is not always going to feel like doing anything at first. And therefore part of what we do as the BHCF is we help them to set those goals and then encourage them to do the behavior. And most likely, once they start doing it, then the feeling will follow.

I have oftentimes given examples to my patients from my personal life, and they seem to really relate to that. For example, when I wake up in the morning, I know I need to run and exercise; but I don't always feel like doing that. And so I'll set a baby-step goal for myself, very similar to what we do with the patients. And I'll just set a baby-step goal of running around the block. So I get out, and I set out to do the baby-step; and the most of the time, as I'm out – once I'm actually engaged in the activity, I feel better about it. I'm feeling accomplished that I've set my goal. And usually I can even then continue on with that goal.

So it's been extremely helpful for the patients in getting them activated, especially the ones that have the loss of interest from depression. And so I use it for every one of the patients that I have. Self-management goals via behavioral activation is something that I use for all of them.

Another method is the motivational interviewing. And Dr. Freed is going to talk a little bit about that for us.

Thanks, Koby.

Most patients are going to come in and not ask for specific treatments. And patients may be unsure about coming for any treatment. They may need a little bit of encouragement, but still they may be unsure of treatment. And then once they're in treatment, they may not be compliant; they may have side effects from medications; exposure therapy; the anxiety might be pretty tough for them. And so we want to be able to assess that hesitancy or ambivalence and doing so in a very non-judgmental way and essentially ask them to weigh the pros and cons of their decision. Obviously, they're there in your room – or even not. But how do you think about where patients are coming from, and how do you allow them to weigh the pros and cons of their decisions? And that's really to engage in any care or (inaudible).

And you can do that by asking them questions of how motivated they are on a scale of 1 to 10. How much they believe that the treatment is going to work on a scale of 1 to 10. And then you can take the approach, if someone gives a 2 – they're really not motivated – or a 1. Or if they say, "I still don't believe the treatment is going to work, and I kind of believe that maybe about a 4," say, "Okay, well you didn't say a 3 or a 2." And you really try to pull out from them what it is that's making them ambivalent and figuring out then what treatments might work for them. So again, it's sort of a pros and cons option.

And in the same way that we had some earlier polling questions, a lot of folks gave the answers that were related to engagement; but some folks didn't. And so to ask them -- What made you not say that? What made you say, "Well, my treatment decisions are made on symptoms or evidence or something like that." But MI is a really useful tool. It can be used in one session. We've trained nurses; we've trained providers to use it. This can be done really at the front end of treatment, but also sort of ongoing in the treatment to really help with patient engagement.

And with that, I'm going to turn it back over to Dr. Engel to talk about problem solving.

Problem solving, although it's a therapy, it's important to realize that what we're talking about here is pretty simple stuff. It's an effort to create a formula for the patient to break down their problem in matter-

of-fact terms and to develop a series of steps that will help them to solve that problem. So there's a clarification and defining of the problems; there's a goal setting piece; generating of solutions; helping the patient to look at how to get it done; and selecting the option that is most attractive to them; and then implementing that solution.

And in a broad way, I almost, again, see it a little bit like what most parents do with their kids. When they present problems to us, we help them to break it down and to think through what the options are and to solve those problems. So even though we call it problem-solving therapy, and this slide describes a lot of sessions and so on, I think that the way we do this within a care facilitation approach is much more of a very basic approach, a simple-minded approach to helping patients in the course of identifying what it is that they want to do to identify what some of the things are that are keeping them from doing those therapeutic challenges and using this problem-solving approach to take some steps forward.

We know that in depression and PTSD, passivity is a big issue. So this is a way of, like behavioral activation, getting them off the mark. And like motivational interviewing in some fashion, which is not kicking people and telling them to take the hill; it's helping them to identify what it is that their needs are and which of their needs they want to go after and what is their point of view on the thing that they think they can be most committed in trying to solve.

Thank you, Dr. Engel.

So in closing, I just wanted to give an example. What does this model look like in real life? This is actually an example of an actual patient of mine, with a few changes of course to protect identity. Anthony was 31-year-old recently-divorced male that came to his primary care manager with loss of interest, avoidance, isolation, feeling distant, being super alert, easily startled. He had symptoms of PTSD, certainly PCL. Multiple deployments – he was actually in mortuary affairs to include the Pentagon after 9/11.

He was initially prescribed Zoloft, 50mg, and referred to the BHCF and IBHC. He was definitely dealing with some feelings of worthlessness. He had been recently med boarded out of the Army for PTSD and back pain. His main complaint was just not being able to get out of the house. He just wanted to stay in the house for fear of going out in public. He lived with his mom because of financial problems; that was related to not being able to leave the house to look for a job. And he had also been recommended to follow up with the VA for continued treatment but, like many others, had not been able to do that yet when he came to me.

So again, he saw his primary care manager. His primary care manager started him on the medication and offered him over to me for continued care management. Just as in this case and any other case example with the patient with these service members, close follow up is going to be very important to keep the patient engaged.

And so that's where the BHCF can kind of fill the gap, so to speak. Just fulfilling the roles that I have spoken of earlier as far as continued routine contacts with Anthony; provided initial, of course, ongoing education on his medication and treatment options; routinely worked on some problem-solving to figure out where he was and what he direction he wanted to move forward in; routinely assessed his motivation to make these changes. Because like many of these patients, he would teeter back and forth; or he would say one thing and do another; or not do anything at all.

Goals were set, some self-management goals were set. The BHCF, again, assists the patient in setting their own goals. As nurses, it's almost natural for us to tell the patients what to do: take this pill, go for a walk, check your blood sugar. But this is where we are encouraged to use the motivational interviewing, use the behavioral activation, to help the patient try to come up with their own plan, their own baby steps in the direction that they want to go and not where we necessarily think they want to go.

And so that's what I did for Anthony. I just helped him find his own place throughout several months. It was not overnight certainly. But I stuck with him. And that was one of the things that I remember most

about Anthony, as well as many of my patients in the past, was they were actually shocked whenever I called them. I heard many times, "I can't believe you actually called me back." So that's a welcome change for a lot of the patients, is to have somebody that actually follows up with them on those things that they're going through.

And so what was Anthony's outcome? He remained in care facilitation for the entire time that we wanted him to, which was for six months. That, of course, will vary for every patient depending on what their needs are. He did continue on his medication. We were able to get it titrated up to a dose that was very effective for him through the staffing and communication with the primary care manager. We were able to get him connected with the VA so that he did have connections with resources when care facilitation ended as well.

He did accomplish several goals. His first goal that he wanted to do was just to get out of the house. He actually lived on a waterfront. Our first goal that he set for himself was to go to the waterfront during the day when it was the least crowded and try to read a book. When I followed up with him about that, he actually had not even made it to the car for fear of the outcome of getting to the waterfront.

So we had to step back and reassess and find something that would meet Anthony where he was at that time. And that started off just getting in the car period. But over the next few months, we were able to actually get him to where he met that goal. And when we closed him out of care facilitation, he was actually sitting on the waterfront several times a week and had actually enrolled in school and was going to start going to college. So that was a big step for him.

And then finally, I think the thing that stood out to me probably the most was that he had a friend was also suffering from PTSD symptoms similar to his. And she actually called me to find out how to get him connected to a nurse care facilitator of course via his PCM. To me that just spoke volumes to the value of this model of care.

And with that, that ends my portion of the presentation. So just briefly in summary, we talk about patient care starts before the patient is even at the provider's door; who is not in care and who should be; that we need a system that can support access to and continuity of mental health care; all members of the team are integral to engaging the patients in the care and ensuring that they stay in the care; randomized trials offer sound evidence that systems-level intervention can improve care; the use of some IT software can assist in the management of symptoms and treatment response, assessment of risk, as well as the workflow of an entire care team.

And providers can use strategies like motivational interviewing, behavioral activation and problem solving. And, of course, the BHCF can play an integral role in keep the patient engaged with the entire team, thus improving treatment outcomes.

Okay, I'd like to thank our panelists for their excellent presentations. And I just have a few comments, and then we'll start responding to some of the questions that have come in.

First of all, I hope everybody that is with us today realizes how huge this issue is because on the one hand, we have a number of very well-trained providers out there. We have a number of treatments that we know work for a lot of the highest-volume conditions that people come to seek mental health care for. But on the other hand, we have so many that don't connect with them. And then when we have that connection take place, too often the person that seeks that help drops out quickly; and treatment is not allowed to continue to the point of really being effective.

Patient engagement is an incredibly important issue. And I think our primary focus today was looking at how the primary care clinic, augmented with other professionals, can really help a great deal to solve this problem. And I think it's great that we had a clinical psychological, a psychiatrist, and a nurse giving their perspectives on how to improve engagement by all of these various things that they've talked about. Whether it was motivational interviewing or whether it was problem solving or whether it was making

telephone calls at certain intervals, other kinds of efforts to keep people engaged, to monitor them, is more likely to lead to better outcomes.

So there are all kinds of questions that have emerged. But the first one I'll ask since this came in on a couple of the questions is: What's the evidence that this approach works? Is there any data to show that what we've discussed today is effective? And this is to all three of the panelists.

I can speak to that. This is Chuck Engel. I think that we're still learning a lot about what engagement strategies actually work best. But I think that I would speak to it from the broad level; and that is, as I presented early in my talk, there is quite a bit of evidence that when you gear the system so that there are specifically players on the team – the care facilitator, who is working hard to keep people engaged – and you're using automated systems to identify people at various levels of symptom severity and levels of engagement in their care, there is good evidence, particularly for depression, that this improves outcomes.

Now, does it cure? No. This is a systems kind of approach in many ways that is limited by the basic treatment strategies that we have on the ground -- you know, whether that be medicine or evidence-based psychotherapies. What we're really trying to do though is squeeze the most out of those treatments using these kinds of strategies. Do I extend the reach by identifying people who need care and extend the number of sessions that they stay in using this sort of engagement player, if you will, that Koby has so well described.

And while depression is the best supported by evidence, there are a range of studies that look at posttraumatic stress disorder, that literature is emerging; panic disorder; unexplained physical symptoms, such as our musculoskeletal and other injuries, which are very high on the list of health care problems that patients present with; as well as substance use problems. There's more and more evidence that hazardous drinking, which is very common in our military population, is responsive to these kinds of strategies. We make incremental improvements in the outcomes using these strategies and that the cost that is required to actually implement these strategies is quite acceptable by normative standards that look at what people are willing to pay in order to make gains through health system strategies.

So there's the big-picture evidence; but when we get down to the details about the engagement strategies themselves, that's an evolving literature.

Mike? Koby?

Sure, and just to add on, the nice thing about this population-based approach and integrated health care system is that the better the integration the better the outcome. And an integrated approach also allows for new and emerging treatments just to kind of plug into this existing system of care, which then allows for instead of having a disconnect between you might see in (inaudible) military, like a university setting or somewhere else, and wondering how generalizable that is to the military setting, with this integration you can plug that right in and you already have a nice structure in place that allows for – okay, so if someone doesn't want evidence-based CBT because it's too intensive, they have other competing demands in their lives, we can offer them something else and can keep them in care. So they can be in care management and know that every couple of weeks, every month, they'll be getting a call just to check in. And when they're ready, they can then come in for care. So the system has both eyes on these people and also has ways for them to very easily just raise their hand and say, "Okay, I think I'm ready now. I think things are bad enough."

My wife is a dentist and she said, "Nobody really wants a root canal. But at some point, if the bad is bad enough, they'll come in." And what we want to do is have things even before that so that we know that patients might get medication, that they know where to go; they know how to come. And there might be other strategies that might work for them. So if coming in to a face-to-face office with a provider is not really accessible, maybe there are some other things, like talking to somebody on the telephone. What you give up is that face-to-face contact if they think that's important; but what you gain is that flexibility in terms of time and location in something that's acceptable to them.

Okay, Koby, so a question for you is if this model works so well in the primary care clinic, are there circumstances, and if so when are they, when somebody that's being treated for a psychological health issue in primary care ought to be referred to a specialty mental health clinic?

Good question. Absolutely those circumstances come up, which is another valuable reason for our added resource of being able to staff with the behavioral health specialist that is there, available, for the BHCF. On a weekly basis, and as needed, we have the ability to staff with that behavioral health specialist patients that may be falling into that based on our criteria that we have or just what their professional opinion is. If the behavioral care specialist or the primary care manager feels that it's best that this patient be elevated up to specialty behavioral health, then certainly we do that.

I just wanted to comment on that. It's important to recognize the way that the care facilitator works with the rest of the team, that they are meeting with the clinic-based specialist or in some sites where they don't have a clinic-based specialist, they're interfacing with a specialist that's not based in that clinic. So they do get weekly advice from a specialist on the patients that they're managing. So if there are problems emerging, they have the opportunity for real-time assistance there. Their job is not necessarily to be the active interveners when those situations come up but the player on the team that raises their hand and says, "Patient X is having some difficulties. I need somebody to help us with that."

The other thing I'll say about this is that the approach really only starts in primary care. We talk a lot about what happens in primary care, but we see ourselves linked very carefully with specialty care. That's really the goal. And it's not about treating people only in primary care. It's about identifying those patients who would prefer to be treated there. And when patients tell us that they'd rather been seen in a specialty clinic, their preference – that choice that they make – is huge to us. So it may boil down to their severity of illness. It may boil down to issues of where they want to get care and what kind of care they want to get as to how and when we move them to a specialty care opportunity.

Okay, the next question is for all three of you: Have you considered peer-to-peer specialists working with the care management team?

I have. I will say that we haven't put that into action, but I think that it's a very logical approach. Those that have been listening pretty carefully would think it would be a very logical thing too because we've mentioned sort of the first aspect of the problem is how many people are out there that don't have assistance. So certainly in a military setting in particular, there's the opportunity to equip folks in the community to assist in peer-to-peer ways. And then once people are in care, there is the opportunity to use peer support as a strategy to help them stay in care.

And I think that's a very promising area. It's been thought about, I know, among people who are thinking about collaborative care. To my knowledge, I haven't seen a study that's actively integrated it into a collaborative care model. But to my own mind, this is probably one of the most promising additional ways forward that hasn't really been, so far, extensively tapped into.

The same with community resources. So that model has been used outside of the military with the mental health population where peer-to-peer is very, very important and even in terms of the different models of alcohol treatment. Alcoholics Anonymous, Narcotics Anonymous, you have very much a peer support culture, which is important. And the military is just a natural place for this. You have battle buddies in other places. And in terms of unit support, in terms of community cohesion, these things are really, really important factors that, if nudged the right way, can help get patients in care, can help support the care that's being provided.

The IOM recommended family members, for example, be included in the treatment of PTSD. So these are things that service members having a problem, it's not just them that is affected. It's everybody that is around them. So their social network to be able to help is a good thing for the system.

Okay, and within the primary care clinic itself, you have some other people besides nurses, psychologists and psychiatrists. The military has medics; they have corpsmen. Sometimes you see registered dietitians associated with these primary care clinics. Any comments on the role that they can play in this that have an impact?

One comment that I'll make about that is a particular challenge in getting this done well is the use of military medics in these clinics. And the reason I say that is not that they're not very smart and capable because they are. But they often rotate in and out of the clinic very quickly. And often they are peers of the patients themselves. So there are unique challenges in terms of training them, helping them respond to people that they may know from the barracks, so to speak, that are receiving mental health treatment through the clinic. It's not insurmountable, but it does mean that we have to work hard to train them in methods. And in some of the busier operational posts and bases around the world, you have medics coming and going fairly quickly. And it's hard to keep them trained up in this way, but it's a very important aspect of this.

The other thing I'll say too is that in many of the clinics where we have done this, medics are involved in collecting, screening, and things like that too. So they come face-to-face with these folks and see their screening results and may be the ones that decide where they go with those screening results in terms of assessment tools and information that gets put in patients' hands. So they're a very key part of the treatment team.

And then for other members of the team, again, the better the integration, the better the care. So if we can identify specific roles and how they fit in and how they help with adding to the coordination and not to the disorganization. So the idea that you have a patient coming in and they go to a dietitian and they go this other provider and they go this other provider. And nobody really knows what's happening, but it looks on the surface that patient is getting all sorts of care. That can be highly disorganized. So again, if different members of the care team can be best integrated, that would really be helpful so everybody's on the same page with how to address the patient's needs.

Okay, so I'm told we have time for one last question. So I would like all three of the panelists to please comment. Koby, I'd like to start with you. What do you see as sort of the next steps to move this further forward? We've talked about how this will definitely improve patient engagement. We've talked about some successes that we're passing on. But are there additional things or what kind of final thoughts would you like to leave our audience with today?

Sure, thank you. Certainly, I feel just from personal experience being on the ground, and now centralized for the last couple of years doing this for seven years total, I can certainly see the benefit. I have seen and had personally many, many patients on my caseload that remained engaged in treatment and were able to go into remission from their symptoms after staying engaged. So I do believe in this model.

I know that there has been talk about it possibly going forward with family members, and I think that in some places it certainly has. I think that would be beneficial to expand it beyond just the active duty, which has been the majority of it so far. I believe in it. And I think if we can get the installations or the clinics that haven't quite gotten on board with it yet, if we can get the command to see the benefit and to be onboard with it, I see a lot of benefit in the future.

Mike?

It's a continuity piece. And we see a theme in more emerging data is that more patients are now getting at least to one visit, but keeping them in care and getting them active – so guideline concordant care and being able to monitor that in some way so they interface between primary care and specialty care. The role of the psychologist in primary care, at least in the patient-centered medical home model, is a little bit different than that of the specialist and being able to make sure that transitions happen very, very smoothly. And the care facilitator can really be a nice guardian conduit, as Dr. Engel alluded to, to really help with patients that are in specialty care, to really help be the right arm of the psychologist or the psychiatrist so that you have eyes on patients, know that they're in care, and that you can keep offering

them other services if something is not working. And so if they're only getting partially better, you can offer them something else.

That said, also use that integrated care model as a nice infrastructure for testing for new interventions like the IOM had recommended so that you have some real-time, real-world treatment that is part of this existing system of care.

What I would say is that what we're witnessing is about generational change. It's not something that happens overnight. One change that I think is gradually happening, and I sure would like to accelerate it, is just an understanding among the specialists about how this all works. I'm a psychiatrist. I work with a lot of psychologists and social workers and nurses. And there are parochial concerns all around about this. And many people see it as a zero sum game; if there are a lot of resources putting nurses into clinics, then that is taking away from money for other kinds of challenges.

So I think just greater understanding about what the roles are, and dialogs like this are very important. I struggled for a number of years trying to help people to understand the difference between what the care facilitator does and what a psychologist or a social worker might do in these clinics. They are very distinct roles. And I really believe strongly that we need each of them to be maximally successful. We need somebody who can deliver the best therapies, but we also need people who can use basic human connection strategies who are responsible for helping us to stay connected with patients and identify those that we need to be doing something different for.

Okay, well, thank you again to our presenters. We are going to archive today's presentation in the Monthly Webinars section of the DCoE website. To help us further improve webinars, we encourage you to complete the feedback tool that will open in a separate browser on your computer. To access this presentation and resource list for this webinar, visit the DCoE website at www.dcoe.mil/webinars. We will post the downloadable audio podcast and edited transcript of the closed captioned text to that link. The Chat function will remain open for an additional ten minutes after the conclusion of this webinar to network and chat.

Our next webinar will be Suicide in the Military and Veterans Population. That's scheduled for the 25th of September from 1300 to 1430. The next DCoE TBI webinar topic will be Gender Differences in TBI, scheduled for October 9th, also from 1300 to 1430.

Thank you again so much for participating and listening. And have a great day.

This concludes today's conference. Participants may disconnect at this time.