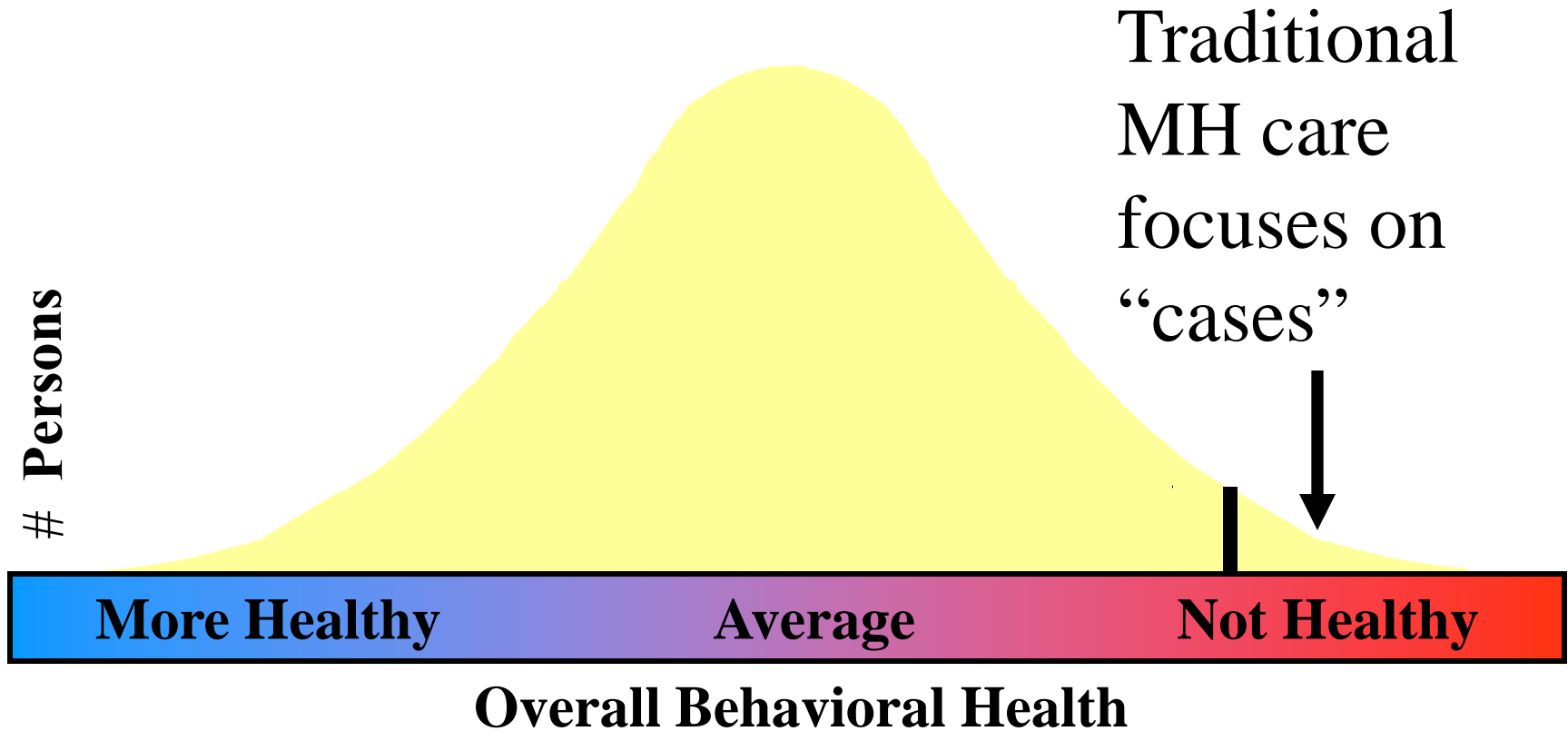

US Air Force Integrated Care: BHOP and Beyond

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Choosing a Model of Integration

- Consider the population
 - Active duty military (and dependents)
 - Outsourcing services costs a lot of money
 - Goal is to maintain health and readiness
 - Early identification and prevention were the targets
- A fully integrated care system – financing was less of a constraint comparatively
- Providers at military treatment facilities under direction of AF Surgeon General

Behavioral Health Continuum



Behavioral Health Continuum

**Disease
Free**



**Subthreshold
Disease**



**Clinical
Disease**



Healthy

**Reduced
Performance**

Diseased

Disease and normality are not distinct entities, they are arbitrary cut-off points along a continuum (Rose, 1992)

Definition of Terms

- **Behavioral Health Consultant:**

A behavioral health provider who has received specialized training in a *consultative* model of behavioral healthcare and works as a consultant to primary care providers and patients regarding a *wide array* of behavioral health needs in a primary care setting.

Key Elements in Integration Model

- Behavioral Health Consultant (BHC) becomes part of PC healthcare team
- Patients seen at PCP's or PCP Nurse's request
- BHC is a consultant; PCP remains responsible for patient's overall healthcare
- No *written* informed consent; no separate MH record

Key Elements in Integration Model

- Brief, focused assessment and intervention
- Target functioning and QOL
- Shared decision-making with patient
- Same day feedback to PCP
- Patient education, self-management strategies and skill building techniques
- Short appointments (30 minutes); Limited number of visits

Key Aspects of Consultative Model

- 30 Minute Visits
- Typically only a few visits
- Problem focused assessment and treatment
- Symptom focused assessments to measure outcomes
- Use PHQ for initial assessments and PHQ-9 for follow-ups
- Allow time for practice
- Manage high utilizing patients, chronic pain patients
- PCP remains in charge
- Shared documentation to facilitate collaboration
- Shared decision making with patient
- Increase personal responsibility

Common Services Provided by BHC Consultant

- Diagnosis and Problem Definition
 - Recommendations for psychopharmacology to PCP
- Provide BH Treatment
 - Establishing self-management / Behavioral activation plans
 - Providing feasible new strategies for managing physical, emotional and behavioral aspects of health
- Adherence to Medical Regime; Relapse Prevention

The Air Force Approach: An Implementation Project

1. Established Model of Consultative Behavioral Health Care
 - Involved all stakeholders from the outset
 - Comprehensive BHC Services Manual
 - Establish clear guidelines for primary BH care
 - Provide clinical and practice management tools to BHCs

The Air Force Approach: An Implementation Project

2. BHC Training – *Train the Trainers* Model

- Four Pilot Sites: Psychology residency programs
- Education and clinical training to core competencies
- Onsite training – See One, Do One (and then another and another, with feedback)
- Trained BHCs to practice, then to Train

3. Evaluation

- Patient and provider satisfaction
- BHC Practice description

Training to Develop Core Competencies

- Strategically selected sites, as well as clinicians to train
- Used nationally recognized expert for initial training and model development
- Training and competencies established over time
- Ongoing support and follow-up

Core Competencies

Clinical Practice Skills

1. Defines BHC Role to patient
2. Rapid Problem Identification
3. Limited Problem Definition
4. Uses Appropriate Assessments
4. Focuses on Functional Outcomes
5. Uses Self-Management/Home Based Practice

Core Competencies

Clinical Practice Skills

6. Interventions are Concrete and Supportable by PCP
7. Understands Biopsychosocial Model
8. Basic Knowledge of Medicines
9. Knowledge of Best Practice Guidelines

Core Competencies

Documentation Skills

1. Write Clear, Concise Chart Notes
2. Get Notes/Feedback to PCM Same Day Pt is Seen
3. Chart Note is Consistent with Verbal Feedback

Core Competencies

Consultation Skills

1. Focus on and respond to referral question
2. Recommendations tailored to PC work pace
3. Conduct Effective Curbside Consultation
4. Aggressively f/u with PCP When Indicated
5. Recommendations reduce PCM Work Load

Core Competencies

Consultation Skills

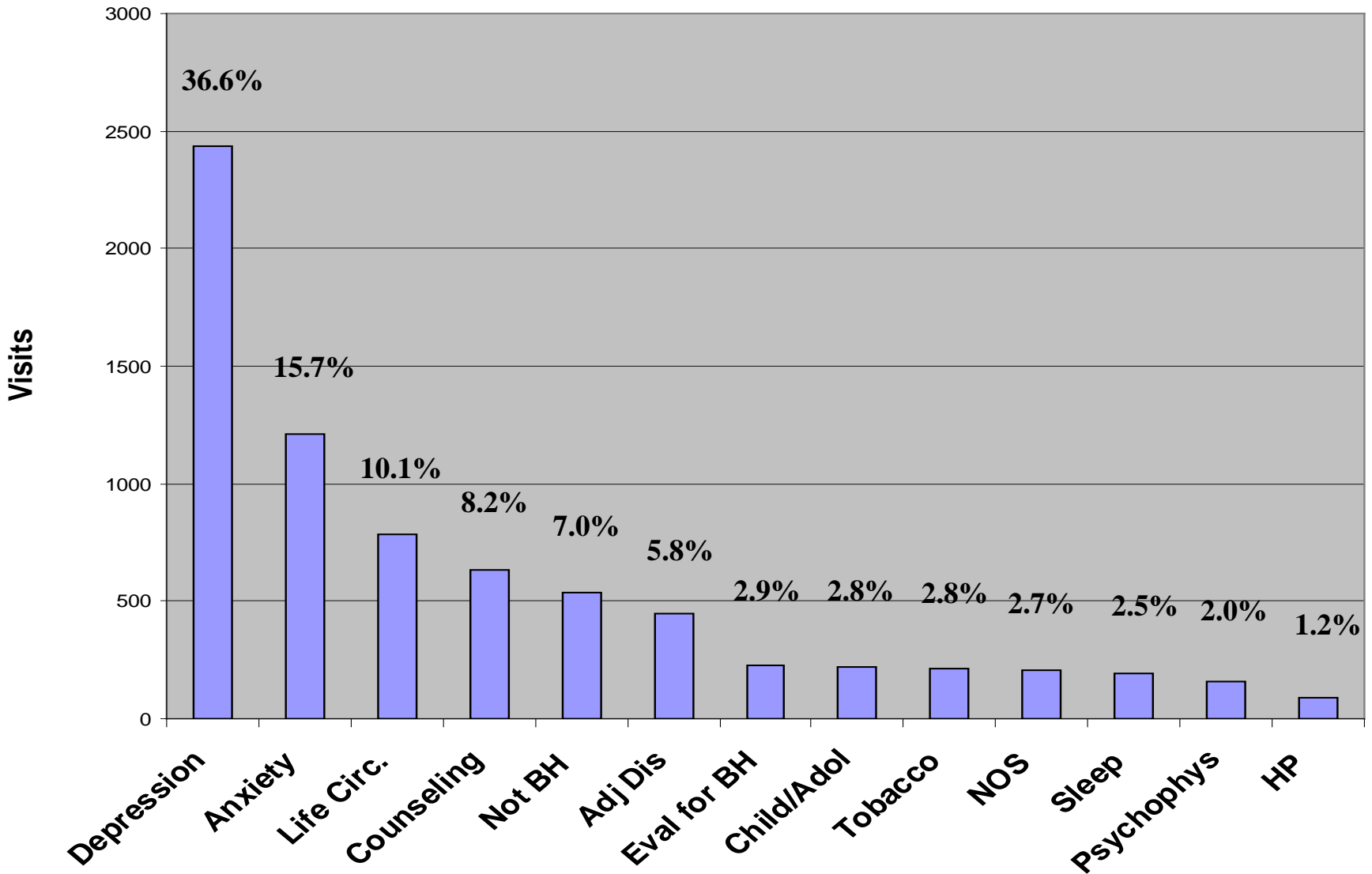
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4. Aggressively f/u with PCM When Indicated
5. Recommendations reduce PCP Work Load

BHOP Findings

- *Disease Management: A Novel Approach for Mental Health Disease Management: The Air Force Medical Service's Interdisciplinary Model*

Christine N. Runyan, Vincent P. Fonseca, John G. Meyer, Mark S. Oordt, G. Wayne Talcott. *Disease Management*. September 1, 2003, 6(3): 179-188.

Common BHC Diagnoses



Satisfaction with Integrated Care

- 100% of PCPs were highly satisfied
- 100% would definitely recommend integrated care to colleagues
- 97% of patients were satisfied or very satisfied

(n=23 PCPs ~68% of those assessed; n=76 patients)

Current Status

- BHOP has a dedicated officer in SG's office to oversee integration
- Comprehensive manual under update and revision
- Developing certification and specific credentials for both BHCs and BHC Trainers
- 40 Medical facilities have an integrated BH provider, coverage ranges from 1 day – 5 days/week
- Approximately 30 pre-doctoral psychology interns and some social workers receive training annually

Compendium of Primary Care and MH Integration in Federal Agencies, Jan 2008

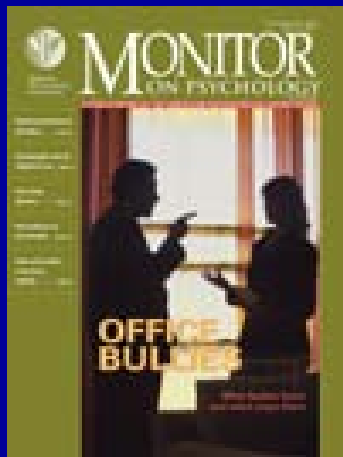
Current Status

- FY 03 – FY 05: Integrated care estimated to save 1.7 M - with no incremental overhead
- 100% depression screening in primary care being done collaboratively with PCPs and BHCs
- FY 03 – FY 05, USAF Medical Services averaged 8953 primary care BH appointments per fiscal year

Compendium of Primary Care and MH Integration in Federal Agencies, Jan 2008

Other Integration Initiatives

Monitor on Psychology
Volume 37, No. 7 July/August
2006



Psychologists match their behavioral health expertise with the medical needs of Jordan Valley Community Health Center's predominantly poor, mostly uninsured or underinsured patients.

Making integrated health care a reality
Psychologists and physicians team up at a community health clinic.

By Christopher Munsey
Monitor Staff

Think Globally, Act Locally: Other Integration Initiatives

- CentroMed
 - FQHC in San Antonio Texas
- Jordan Valley Community Health Center
 - FQHC In Springfield, Missouri
 - SAMHSA Transformation Grant for Missouri
- Mid-State Health Center
 - FQHC Look-Alike in Plymouth, NH

In Summary

- Based on the epidemiology of mental health, one patient at a time is an insufficient approach to the burden of mental disease
- Need both the population level and individual level interventions
- It is not an either / or solution as neither strategy alone can effectively reduce the burden of mental illness
- The real question is how and when to apply each

What We Didn't (and Won't) Learn in School:

Training Providers Using a Consultative Model of Integrated Care

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Before Training

- Don't Forget the Medical Providers
 - Educate on the model and what they can expect
- Train according to how to make their practice more effective and efficient
 - Core Knowledge Competencies
 - Core Clinical Competencies
 - Core Program-Level Competencies

Before Training

- Make it east to do the right thing
 - Using clinic-wide screenings and algorithms
- Examine the clinic's readiness for integration and available support
 - Behavioral Health Assistants
- Know the financial model of the clinic and the constraints
 - Coding and reimbursement for BH visits

Before Training

- Acknowledge the hurdles to overcome
 - We do not speak the same language or practice similarly
 - Ensure common understanding of goals and model
- Pre-Training Core Competencies
 - Cognitive-behavioral techniques
 - Dialectical behavioral therapy skills
 - Psychopharmacology knowledge
 - Motivational Interviewing Techniques
- Integrated Care is Not for everyone ...

Does this Sound Fun or Painful? ...

A Day in the Life of a BHC

- All PCPs in setting have access to refer
- Triage nurses and medical assistants can also pull in a BHC for emergencies
- Schedule 10 patients / day with 4 -5 additional 'walk-in' appointments available for same day consultations
- Accepts all referrals from providers, clarify inappropriate referrals on the back-end
- Wide range of presenting problems
- Expect the unexpected

Training BH Providers

- Must have both didactic and experiential components
- All Training Targets Core Competencies
 - Clinical Practice Skills
 - Documentation Skills
 - Consultation Skills
 - Training and Administrative Skills if relevant
- Shadowing PCPs at the outset

Training BH Providers

- Familiarize trainees with resources, screening tools, assessment tools (symptom based assessments), and BHC Handouts
- Handouts on everything from depression and anxiety to hypertension and diabetes
 - Using handouts – A BHC Prescription
 - Use existing or develop based on evidence
- See One, Do One Model of Training

Training BH Providers

- Documenting the BH visit
 - EMRs
 - Coding BH visits
- Giving feedback to PCPs
- Real-time feedback to BH trainee is key component in developing skill-set
- The Backbone of BH Consultation -- The 30 Minute Consult

The 30 Minute Consultation

In The 30-Minute Consult / Interview is a Good Strategy for Brief, Focused Interventions ... May not be the standard of care for specialty mental health treatment

Components of a Consult

1. Introduction (~2 Minutes)
2. Functional Analysis (~15 minutes)
3. Summary (~ 2 Minutes)
4. Patient's Ideas on Intervention Target (~ 2 Minutes)
5. Behavioral Change Plan (~10 Minutes)

Introduction

- Purpose: Sets the stage for the appointment
- Tell Them Your Profession and Your Role
- Discuss the Structure of Appointment
 - Get a snapshot
 - Discuss possible intervention strategies and what seems doable to you right now
 - Develop a plan
- Discuss Possible Outcomes of the Evaluation
 - No follow-up, follow-up, referral, etc.
- Ensure Understanding and Clarify any Questions

Functional Analysis

- Based on Referral Question (Primary Reason for Visit)
 - Clarify patient's understanding for visit
 - Define Problem
 - Duration, Intensity, Frequency
 - What Makes Problem Better or Worse
 - Current Interventions and Outcomes
 - Be aware of cardinal signs of more severe disorders
 - Minimize open-ended questions, Limit reflective statements
 - Focus on the Present

Functional Analysis

- What is the Functional Impairment?
 - Work, Performance or Relationships
 - Family Relations
 - Social Activities
 - Recreational Activities
 - Exercise
- Assess for Changes In:
 - Sleep
 - Energy
 - Concentration
 - Appetite

Functional Analysis

- Other Habits
 - Caffeine Consumption
 - ETOH Consumption
 - Tobacco
 - OTC Medication or Supplements
- What does a Typical Work Day Look Like?
- What does a Typical Week-End Look Like?
- What Would Change if Problem was Improved (Gone)?

Problem Summary

- Empathy is critical
 - Hooks the Patient Into the Interaction ...or Loses them
- Make Sure You Have Understood Problem
- Add education into summary as appropriate
- Get Feedback from patient (Did I get it right?)
 - Ties together information received
 - If on target, then weave in some interpretive statements

Identify Target Intervention

- Ask patient to identify one or two changes that would impact his/her life the most
- Be specific in selecting goals
- How would he/she know they were improving?

Change Plans

1. Behavior Change Plan

- ❑ Provide “big picture” of recommendations
- ❑ Offer Several Options, Shared-Decision Making
- ❑ Provide rationale for interventions
- ❑ Follows from functional assessment

2. Typical Change Plans

- ❑ Reasonable changes to increase self-efficacy
- ❑ Patient (and PCP) Management Focused
- ❑ Use educational materials / handouts
- ❑ Clear, measurable targets
- ❑ “Behavioral Prescriptions”

Follow-Ups

- There is nothing magic about 50 minutes
- There is nothing magic about once/week
- Give them time to practice change plan
- Let plan dictate when follow-up occurs (may be sooner than one week or much longer)
- Be creative – use of telephone follow-ups, coordinate with next PC visit, etc.
- Stick to 30 minute structure ... patients will learn the structure and respond accordingly

Final Notes on Training

- Ongoing consultation and support can be effective to maintain integrity of service
 - Consider turnover rates
 - Consider train the trainer models
- Peer review and consultation opportunities
 - Establishing the standard of care
- In house quality improvement to determine satisfaction (patients and providers) and level of impact
 - Are the goals for this integration effort being met?
- Group Medical Appointments