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Lessons on Integrated Care from the VA and DoD

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Moderators:

Brie Reimann, Deputy Director, CIHS

Roara Michael, Associate, CIHS

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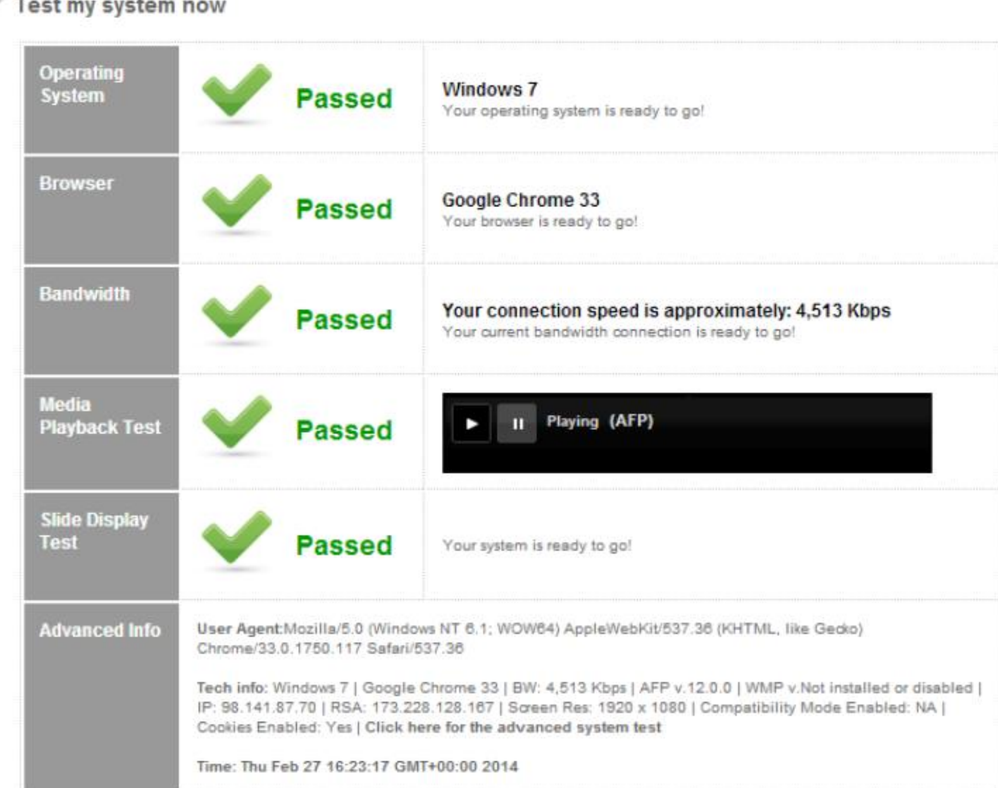

Before We Begin

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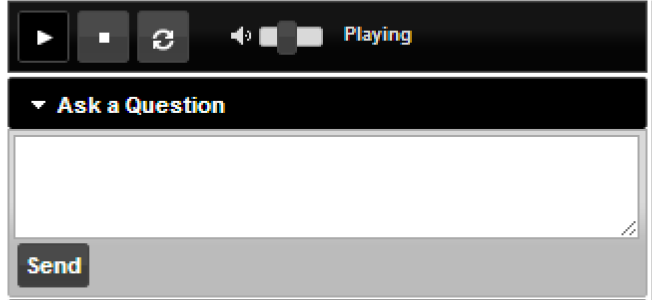

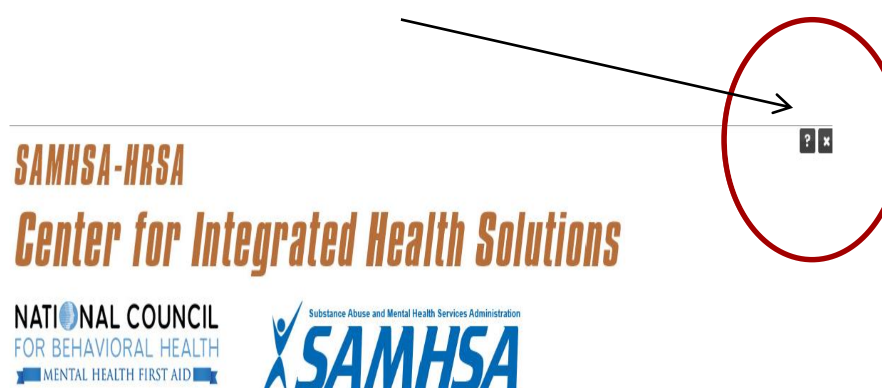

Today's Purpose

- Become familiar with the various clinical, workforce and operational strategies implemented within the VA and DoD.
- Gain access to practical VA and DoD developed tools and resources that can be utilized in other integrated care settings.

Today's Speakers

Sarah Lucas Hartley, PhD
Program Director, Primary Care-Mental Health Integration & Behavioral Medicine
Salem VA Medical Center

Edward Post, MD
National Medical Director, Primary Care-Mental Health Integration Program
Department of Veterans Affairs, Office of Primary Care Services at VA Central Office.

Christopher L. Hunter, Ph.D., ABPP
DoD Program Manager for Behavioral Health in Primary Care
Defense Health Agency

LESSONS ON INTEGRATED CARE FROM THE VA AND DOD: *SALEM VA MEDICAL CENTER*

Sarah Lucas Hartley, PhD

Program Director, PC-MHI & Behavioral Medicine

Salem VA Medical Center

SALEM VAMC PRIMARY CARE PATIENTS

Average panel size per PCP: 1,000

Gender: 6.7% female, 93.3% male

Patients living in rural location: 52%

Patients with diabetes: 28%

Patients with hypertension: 54.2%

Patients who are obese: 35%

Patients who see PC-MHI: 19.4%

Patients who see specialty MH: 30.8%

Patients with antidepressant prescription: 25.9%

Patients with 1+ antidepressant prescription(s) from PCP: 9.3%

WHAT IS PC-MHI?

- Co-located collaborative care entails both mental health and primary care practitioners being physically present in the primary care setting with shared responsibility for evaluation, treatment planning, and monitoring outcomes.

- Care managers interact directly with patients and provide ongoing evaluation, and maintain active communication that enables responsibility for mental health treatment to remain in the primary care setting.
  - Monitoring adherence to treatment, treatment outcomes, and medication side effects
  - Decision support
  - Patient education and activation
  - Assistance in referral to specialty mental health care programs, when needed

PC-MHI STAFFING

3 Psychologists
2 LCSWs
2 LPNs
1 MSA
0.3 Psychiatrist
0.3 Psych Tech

1 Psychology Post-doc
1-4 Psychology Interns rotate through

Serving:

Salem VAMC Primary Care (16,694 pts)

2 Rural Outpatient Clinics (7,412)
Same-day PC-MHI access via video telehealth

Salem VAMC Specialty Medical Clinics

Collaborating in PACT (VA's term for patient-centered medical home)

Warm Hand-off from PC Team
- Positive MH Screen
  - SI/HI
  - Alcohol Use (AUDIT)
  - Depression (PHQ-2)
  - PTSD
  - Military Sexual Trauma
  - Intimate Partner Violence (E-HITS)
- Provider Request
- Patient Request
- Chart Review

Primary Care Walk-in Patient

Primary Care Telephone Call

Shared Medical Appointments

Curbside Consultation with PCPs

Case Finder

Available via warm hand-off, phone, pager, instant messaging

"Do Not Disturb" is not an option

Same-day MH Intervention, Screening, & Triage

No Scheduled Follow-up: Provide PC-MHI Contact Information

Brief Follow-up with PC-MHI
- Individual
  - Face-to-face
  - Video telehealth
  - Telephone
- Group
  - Face-to-face
  - Video telehealth

Specialty Mental Health Referral
- Psychiatry
- Psychotherapy

Medication Care Management

INITIAL APPOINTMENT

- Brief Clinical Interview
- Screening Instruments
  - PHQ-9 (depression)
  - BAI (anxiety)
  - PCL (PTSD)
  - Pain Outcomes Questionnaire (pain)
- Assessment of motivation to engage in treatment
- Treatment planning with patient
- Treatment planning/consultation with PCP (ideally)
- Referrals made and patients leave with follow-up appts

MHI Screening Questionnaire

Name:_______________________ Last 4 of SS#:_______Phone number:_____________

1. Please circle areas you may need help with:
   DEPRESSION ANXIETY ANGER TRAUMA SUBSTANCE ABUSE
   CHRONIC PAIN CHRONIC ILLNESS OTHER ____________________
2. Please circle services are you are interested in.
   COUNSELING PAIN MANGEMENT COACHING RELAXATION TRAINING
   MEDICATION SMOKING CESSATION GOAL SETTING
3. Are you currently receiving counseling of any kind? YES NO
4. How far do you live from the Salem VAMC? _________________________
5. Please circle any of the following areas you live CLOSER to: LYNCHBURG
   STAUNTON DANVILLE WYTHEVILLE
6. How often can you come in for sessions?
   WEEKLY BIWEEKLY MONTHLY
7. Have you ever thought about suicide? If so, when __________
8. Have you ever attempted suicide? If yes, when ____________
9. In the PAST MONTH:
   ►Have you thought about killing yourself: YES | NO
   ►Have you thought of harming or killing a specific person or people: YES NO
10. Compared to how I feel normally, my thoughts of hurting myself, killing myself or killing someone are (circle): LESS ABOUT THE SAME WORSE A LOT WORSE
11. Do you have a plan of how you would kill yourself or someone else:
12. Do you have the means to carry out this plan(s):
13. Do you plan to act on these thoughts over the next week?

FOLLOW-UP

- Brief individual therapies with co-located staff
  - CBT for Chronic Pain, Insomnia, Depression, & Anxiety; Brief Alcohol Intervention; Motivational Enhancement; Tobacco Cessation; Relationship Skills; Biofeedback
- Groups
  - Stress Management; Healthy Sleep Group; Chronic Pain Psychotherapy; Chronic Illness Self-Management; Anxiety Coping; Depression; Tobacco Cessation; Healthy Relationships
- Care management (CM)
  - Often in concert with antidepressant rx
  - PC-MHI psychiatrist provides psychopharmacologic e-consultation
  - Telephone CM delivered by non-MD PC-MHI staff w/ weekly oversight meeting

SHARED MEDICAL APPOINTMENT STAFFING

<u>Interventional Groups</u>

- **Coronary Artery Disease Group**
  - PACT provider and nurse, PharmD, Physical Therapy, PC-MHI staff
- **MOVE! Weight Management**
  - Dietitian, Kinesiotherapist, PC-MHI staff
- **Metabolic Assistance Group Intervention Clinic (MAGIC)**
  - PACT provider and nurse, PharmD, Dietitian, PC-MHI staff
- **Women's Lipid Group**
  - Women's health PCP, PC-MHI staff, PharmD
- **Tobacco Cessation**
  - PharmD or NP, PC-MHI staff

<u>Educational Groups</u>

- **Opioid Education**
  - PACT provider and nurse, PC-MHI staff
- **Pain School**
  - Center for Interdisciplinary Pain Management, PM&R, PC-MHI, Dietitian
- **Diabetes Education**
  - Dietitian, PharmD, PC-MHI staff

DEPRESSION

- 19% of PC-MHI patients have a Depression diagnosis
- Brief depression therapies and care management provided by PC-MHI
- New antidepressants and depression diagnoses tracked by case finder

BISL

MH Newly Diagnosed Depression Case Finder #

(658) Salem, VA

VA HEALTH CARE Defining EXCELLENCE in the 21st Century

SSN	Site	Patient Name	Indicator	Date Entered	Provider	Clinic Location	MH T
			F43.12 - POST-TRAUMATIC STRESS DISORDER, CHRONIC	7/19/2016		SAM/MH/CTS IND B168	
			F43.12 - POST-TRAUMATIC STRESS DISORDER, CHRONIC	7/20/2016		WYTH/MHC/SW CONWAY	
			F33.0 - MAJOR DEPRESSIVE DISORDER, RECURRENT, MILD	7/20/2016		DANV/CVT/PCMHI/SAM SMK PAT	MENT
			F43.12 - POST-TRAUMATIC STRESS DISORDER, CHRONIC	7/20/2016		SAM/MH/CTS/TELEPHONE-X	MENT
			BUPROPION HCL 150MG 12HR SA TAB	7/19/2016		DANV/MHC/HEJAZI	MENT
			TRAZODONE HCL 100MG TAB	7/19/2016		DANV/MHC/HEJAZI	MENT
			ESCITALOPRAM OXALATE 10MG TAB	7/21/2016		LYNCH/MHC/PSYCHIA 4 IND	

- Patients with in-person or telephone follow-up within 4 months of new antidepressant prescription (from any VA source): 83.8%

ANXIETY, PTSD, INTIMATE PARTNER VIOLENCE

12.8% of PC-MHI patients have an Anxiety diagnosis

IPV Screening Using E-HITS

- 25-28% positive screens
- Follow-up by PC-MHI includes safety planning and provision of community resources

PTSD Screening Using PCL

- Referrals receive appointment for PTSD clinic intake before leaving Primary Care

Date: ______________ Time: _________

Name: ________________________ Last 4 of SSN:__________ Date of Birth: _____________

This assessment is voluntary. Please indicate your willingness to take this assessment by checking Yes____ or No____. Do you consent to this information being part of your medical record? Yes____ or No ____.

E-HITS*:
Please circle how often your partner did each of these things in the past 12 months? (Cut point is 7).

1. Has your partner ever physically hurt you in the past 12 months?
1. Never
2. Rarely
3. Sometimes
4. Often
5. Frequently

2. Has your partner ever insulted you in the past 12 months?
1. Never
2. Rarely
3. Sometimes
4. Often
5. Frequently

3. Has your partner ever threatened to harm you in the past 12 months?
1. Never
2. Rarely
3. Sometimes
4. Often
5. Frequently

4. Has your partner ever screamed or cursed at you in the past 12 months?
1. Never
2. Rarely
3. Sometimes
4. Often
5. Frequently

5. Has your partner ever forced you to have sexual activities in the past 12 months?
1. Never
2. Rarely
3. Sometimes
4. Often
5. Frequently

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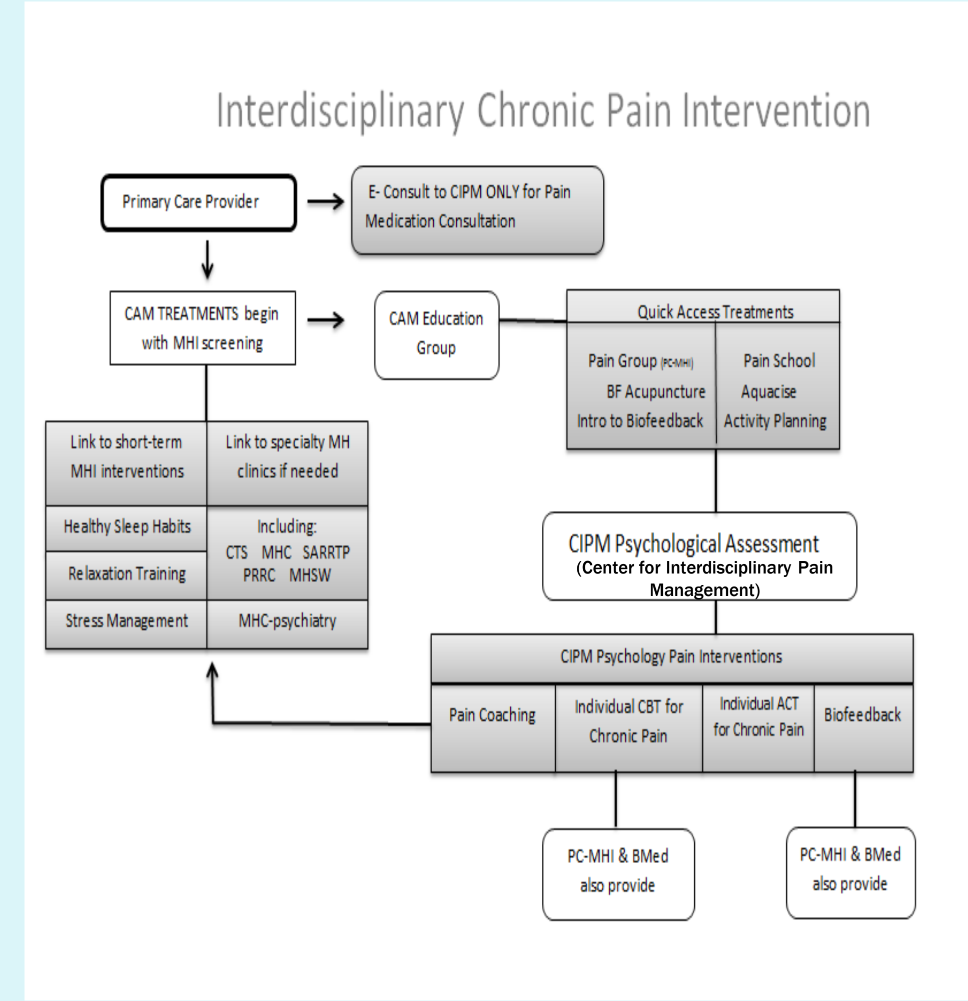
CHRONIC PAIN

- 8-13% patients are on some opioid medication (down from 20% in 2014)
- Shared appts with PCPs when patients are being tapered off opioids
- CBT-Chronic Pain
  - Individual
  - Group
- Biofeedback
- ACT-Chronic Pain
- Educational Pain School



PUTTING IT ALL TOGETHER TOWARDS INTERDISCIPLINARY CARE

- Elements of team collaboration
  - Huddles / daily interaction → Joint treatment planning & execution
  - Systematic screening, as well as qualitative casefinding (e.g., distress)
    - Screening for MDD, AUD, and PTSD at 93 to 99%
  - Prescribing / e-consultation
  - Shared medical appointments (e.g., CAD, pain school)
- Magnitude and dimensions of program
  - 6372 PC-MHI encounters (FY 2015)
  - Mean PC-MHI encounters / unique user = 1.9
  - Reach of program into enrolled primary care population
    - 19.4% of PC population had 1+ PC-MHI encounters
    - 34.2% of PC population had PC-MHI encounter(s), or PCP encounter with MH dx

Integrated Behavioral Health in Primary Care: Important Considerations for Any System

July 28, 2016

Christopher L. Hunter, Ph.D., ABPP

Department of Defense Program Manager for Behavioral Health in Primary Care

The opinions and statements in this presentation are the responsibility of the author, and such opinions and statements do not necessarily represent the policies of the U.S. Department of Defense, the U.S. Department of Health and Human Services, or their agencies.

Overview

1. Background/Context Military Health System
2. Policy/Standards/Training
3. Clinical Pathways
4. Take Home Message

Military Health System

-**Hunter, C. L.**, Goodie, J. L., Dobmeyer A. C., & Dorrance, K. A. (2014). Tipping points in the Department of Defense's experience with psychologists in primary care. American Psychologist, 69, 388-398.

-**Hunter C. L.**, & Goodie, J. L., (2012). Behavioral health in the department of defense patient-centered medical home: History, finance, policy, work force development and evaluation. Journal of Translational Behavioral Medicine, 2, 355-363.

People We Serve

Age	Total	% Female	% Active Duty	% Retired	% Family Members
0-4	307,188	49%	N/A	N/A	100%
5-14	478,689	49%	N/A	N/A	100%
15-17	121,014	49%	N/A	N/A	100%
18-24	559,098	39%	60%	0%	40%
25-34	723,752	41%	67%	0%	33%
35-44[a]	444,297	49%	56%	6%	37%
45-64[a]	571,348	46%	11%	45%	43%
65+	145,792	52%	0%	49%	51%
Grand Total	3,351,178				

[a]Total percentage of Active Duty, Retired and Family Members does not equal 100% due to rounding

Policy/Standards

- DoD Instruction 6490.15
- Program Standards
  - Model of Service Delivery
  - Staffing Ratios
  - Expert Trainers
  - Training Standards
  - Program Managers
  - Oversight Committee

www.dtic.mil/whs/directives/corres/pdf/649015p.pdf

Department of Defense
INSTRUCTION

NUMBER 6490.15
August 8, 2013

USD(P&R)

SUBJECT: Integration of Behavioral Health Personnel (BHP) Services Into Patient-Centered Medical Home (PCMH) Primary Care and Other Primary Care Service Settings

References: See Enclosure 1

1. PURPOSE. In accordance with the authority in DoD Directive 5124.02 (Reference (a)), this instruction:

a. Establishes policy, assigns responsibilities, and prescribes procedures for attainment of inter-Service standards for developing, initiating, and maintaining adult behavioral health services in primary care.

b. Establishes:

(1) BHP staffing requirements and behavioral health models of service delivery for primary care.

(2) BHP competency training and clinical and administrative BHP standards required for the delivery of these services in primary care.

(3) Service and DoD-level structures for planning and evaluating primary care behavioral health services.

2. APPLICABILITY. This instruction applies to OSD, the Military Departments, the Office of the Chairman of the Joint Chiefs of Staff and the Joint Staff, the Combatant Commands, the Office of the Inspector General of the Department of Defense, the Defense Agencies, the DoD Field Activities, and all other organizational entities within the Department of Defense in direct care, non-deployed settings.

Training

- Service Clinical Practice Manuals
- 4 Day Benchmark Training
- In Clinic Benchmark Training
- Ongoing Quarterly Program Evaluation
  - Every Provider, Every Appointment
  - Standardized Documentation
  - EHR Data Pulls

PRIMARY CARE BEHAVIORAL HEALTH SERVICES:

BEHAVIORAL HEALTH OPTIMIZATION PROGRAM (BHOP)

Practice Manual
August 2014

Clinical Pathways
What Is Your End Game?

Design Problems Really Can Slow You Down

Clinical Pathways

- Method of screening/assessment/intervention for a well-defined group
- States the goals and key elements of care
- Based on Evidence-Based Medicine guidelines, best practice and patient expectations by facilitating the communication, coordinating roles and sequences of multidisciplinary care team activities
- Goal is to improve quality of care, reduce risks, increase pt satisfaction and increase the efficiency in the use of resources

Clinical Pathways

- Developed by behavioral health and physician PCMH leads
- Designed to increase use of BHCs as part of standard care
- Designed to improve outcomes & patient & PCP satisfaction with care
- 8 Pathways developed
    - Alcohol Misuse
    - Anxiety
    - Depression
    - Diabetes
    - Obesity
    - Chronic Pain
    - Sleep Problems
    - Tobacco Use

Clinical Pathway

1. Identify patients for the pathway
2. Connect the patients to the pathway
3. Intervene in an evidence based way
4. Outcomes…is it working

Clinical Pathway Evaluation

How do you know if what you are doing is working?

Clinical Pathway Evaluation

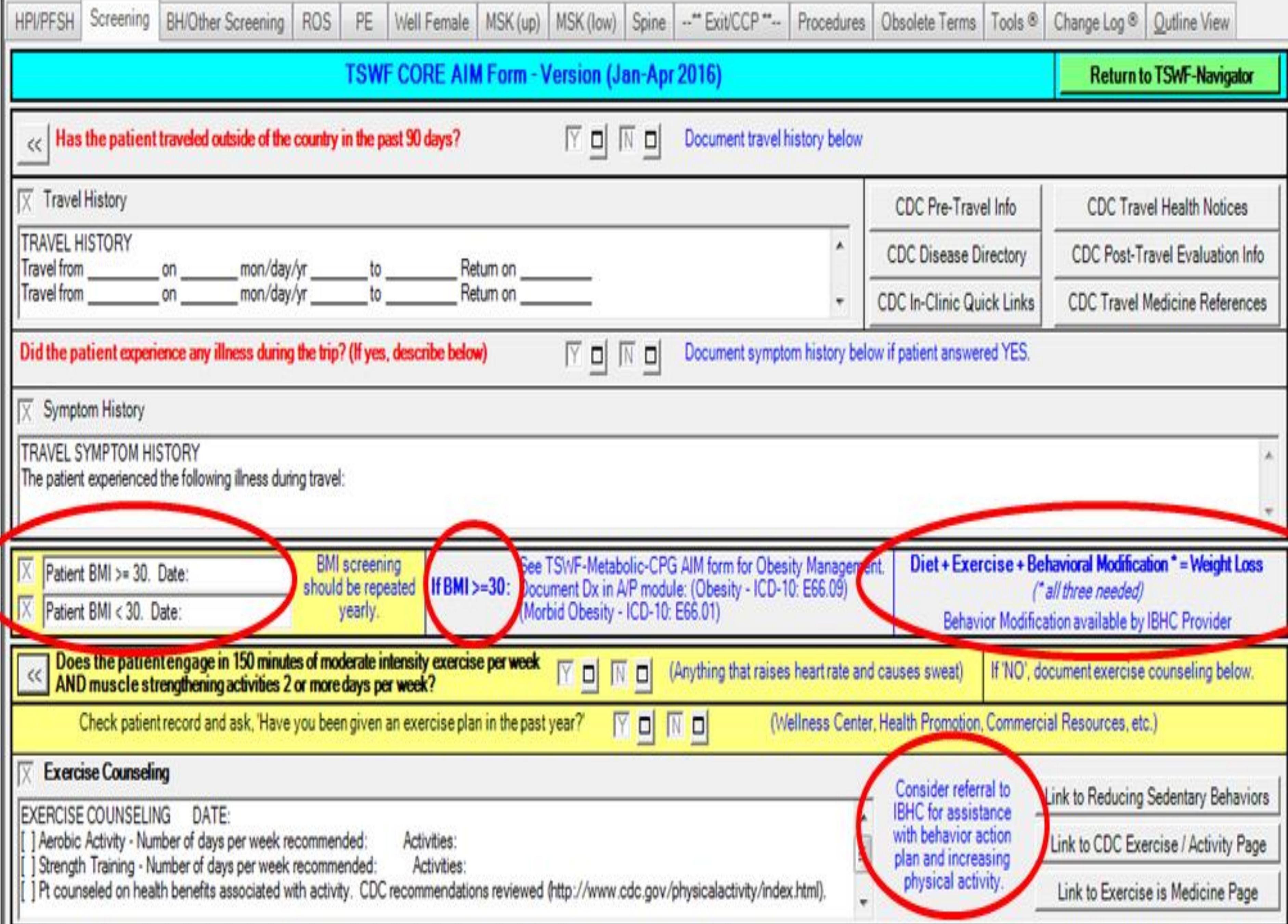
- Program Evaluation Targets
  - Process Metrics (obesity as an example)
    - How many patients seen by primary care providers (PCPs)
    - Of those how many screened (e.g. BMI)
    - Of those how many 30+ on BMI
    - Of those how many received what service
      - Referral to BHC for behavioral weight intervention
      - Referral to specialty behavioral medicine service outside the clinic

Clinical Pathway Evaluation

- Program Evaluation Targets
  - Outcome Metrics (obesity as an example)
    - Change in BMI
    - Change in % of total weight lost
    - Change on biological measure (e.g., BP, Lipids, HbA1c)

Clinical Pathway Evaluation
Clinical Systems/Processes

- Standard Clinical Operating Procedures
  - Screening/Assessment
    - Seamlessly woven into clinical care
    - Can be executed by staff other than the PCP
    - Valued added clinical data for PCP
  - Electronic Health Record
    - Easy documentation and clinical prompts
    - Data can be efficiently pushed/pulled electronically from the record


HPI/PFSH
Screening
BH/Other Screening
ROS
PE
Well Female
MSK (up)
MSK (low)
Spine
--** Exit/CCP **--
Procedures
Obsolete Terms
Tools ®
Change Log ®
Outline View
TSWF CORE AIM Form - Version (Jan-Apr 2016)
Return to TSWF-Navigator
Has the patient traveled outside of the country in the past 90 days?
Document travel history below
Travel History
TRAVEL HISTORY
Travel from ________ on ______ mon/day/yr ______ to ________ Return on ________
Travel from ________ on ______ mon/day/yr ______ to ________ Return on ________
CDC Pre-Travel Info
CDC Travel Health Notices
CDC Disease Directory
CDC Post-Travel Evaluation Info
CDC In-Clinic Quick Links
CDC Travel Medicine References
Did the patient experience any illness during the trip? (If yes, describe below)
Document symptom history below if patient answered YES.
Symptom History
TRAVEL SYMPTOM HISTORY
The patient experienced the following illness during travel:
Patient BMI >= 30. Date:
Patient BMI < 30. Date:
BMI screening should be repeated yearly.
If BMI >=30:
See TSWF-Metabolic-CPG AIM form for Obesity Management.
Document Dx in A/P module: (Obesity - ICD-10: E66.09)
(Morbid Obesity - ICD-10: E66.01)
Diet + Exercise + Behavioral Modification * = Weight Loss
(* all three needed)
Behavior Modification available by IBHC Provider
Does the patient engage in 150 minutes of moderate intensity exercise per week AND muscle strengthening activities 2 or more days per week?
(Anything that raises heart rate and causes sweat)
If 'NO', document exercise counseling below.
Check patient record and ask, 'Have you been given an exercise plan in the past year?'
(Wellness Center, Health Promotion, Commercial Resources, etc.)
Exercise Counseling
EXERCISE COUNSELING DATE:
[ ] Aerobic Activity - Number of days per week recommended: Activities:
[ ] Strength Training - Number of days per week recommended: Activities:
[ ] Pt counseled on health benefits associated with activity. CDC recommendations reviewed (http://www.cdc.gov/physicalactivity/index.html).
Consider referral to IBHC for assistance with behavior action plan and increasing physical activity.
Link to Reducing Sedentary Behaviors
Link to CDC Exercise / Activity Page
Link to Exercise is Medicine Page

Clinical Pathway Evaluation

- Population Impact
  - Are the people who could benefit from care being treated
  - Are those treated getting better
  - Does getting better impact healthcare use/overall functioning

Take Home Message
Standards/Training

1. Develop agreed upon **clinical/administrative standards**…observable & can be enforced
-Develop methods to ensure **workforce** is **trained** to clinical/administrative standards
-Fidelity to service delivery model for desired outcomes to have a chance to be realized

2. Develop **manuals** addressing clinical, administrative, operational & financial component.
- Guide practitioners/administrators on what services they will & will not do

Take Home Message
Clinical Pathway

1. Determine the unmet need in your clinic
2. Engage health care team & leaders in clinical pathway discussion
3. Deliver detailed clinical pathway standard operating procedure
   -Who, does what, when, for how long?
4. Train all staff on clinical pathway
5. Determine monitoring process and outcome metrics of the pathway
6. Report pathway impact on a set schedule

Discussion

Discussion Questions

1. **Workforce:** How are you supporting the move to team based care? How do you maximize the behavioral health clinicians' roles in primary care?
2. **Clinical:** How are integrated clinics identifying and addressing issues of trauma and suicide ideation?
3. **Clinical:** Can you share the standard practice of care (what triggers a referral), guidelines and screening tools?
4. **Operational:** How are you maximizing your EHR to support Clinical Pathways? (examples)
5. **Operational:** What challenges have you seen with documentation and what strategies have you used to support consistent documentation?
6. **Cultural Competency:** Are there ways you address the unique needs of racial/ethnic populations?
7. **Resources:** What are some resources that you find beneficial in your agency?

Featured Resources: VA

- Pocket Card-Clinical Practice Guideline for the Management of Major Depressive Disorder
- Primary Care-Mental Health Integration (PC-MHI) Functional Tool

Featured Resources: DoD

- Chronic Pain Clinical Pathway Outline
- Obesity Clinical Pathway Overview
- Tobacco Cessation: How to Change?

CIHS Tools and Resources

Visit www.integration.samhsa.gov or e-mail integration@thenationalcouncil.org

Questions ?

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Please take a moment to provide your feedback by completing the survey at the end of today's webinar.