Re-Engineering Healthcare Integration Programs (REHIP)

Planning for Primary Care & Psychological Health Care Integration

A DCoE-Funded Tri-Service Demonstration Project
**Report Documentation Page**

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**Standard Form 298 (Rev. 8-98)**
Prescribed by ANSI Std Z39-18
Overview

- Purpose
- Background
- Approach
- Way Forward
Purpose

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

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

1. Narrow et al., Arch Gen Psychiatry. 1993;50:5-107.
Unmet Need

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

Unmet Need

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

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

![Pie chart showing the percentage of cost contributions by different conditions.]

- Depression 17%
- Obesity 13%
- Arthritis 12%
- Back or Neck Pain 12%
- Anxiety 11%
- Other 36%

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1. Merikangas et al., Arch Gen Psychiatry. 2007;64:1180-1188
2. Original source data is the U.S. Dept of HHS the 2002 and 2003 MEPS
Potential for Offset: Service Use & Missed Work

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


Twice as many sick call visits & missed work days
Lower Cost When Treated

– Medical cost ↓17% for those receiving BH tx\(^1\)
  • *Controls who did not get BH tx cost ↑ 12.3%*

– Depression tx in PC for those with diabetes\(^2\)
  • $896 lower *total health care cost over 24 months*

– Depression treatment in PC\(^3\)
  • $3,300 lower *total health care cost over 48 months*

Buncombe County Health Center

**Decrease in Health Care Costs**

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

Cherokee Health System

After At Least 1 Primary Care Behavioral Health Visit

• 28% in medical use for Medicaid patients
• 20% in medical use for commercially-insured patients
• 27% in outpatient psychiatry visits
• 34% in outpatient psychotherapy sessions

Cherokee Data vs. Other Regional Providers

• All Lower specialist utilization
• Lower ER utilization
• Lower hospital admissions
• Lower overall costs per enrollee
Better Outcomes

- Quantitative & qualitative reviews\textsuperscript{1-4}
  - \textit{Depression}\textsuperscript{1-4}
  - \textit{Panic Disorder}\textsuperscript{1,2}
- Other Studies\textsuperscript{5}
  - \textit{Tobacco}
  - \textit{Alcohol Misuse}
  - \textit{Diabetes, IBS, Primary Insomnia}
  - \textit{Chronic Pain, Somatic Complaints}

2. Craven et al., Canadian Journal of Psychiatry. 2006;51:1S-72S.
Stepped Care for Population Health Services

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

– Care Management Model
  • Typically focused on a discrete clinical problem

  • Specific pathways to systematically address how BH problems are managed in PC

  • PC providers & care managers share information

  • Systematic interface with the outpatient mental health clinic
Models of Care

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

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

**RESPECT-Mil Systems Continuity Method**
- Reduces drop out
- Maximizes clinical efficiency
- Tracks to remission or referral to another level of care

**BHOP Embedded Specialist Method**
- PCM has expert consultants on team
- Improves PC access to psychosocial treatment
- Addresses broad range of PH problems
Re-Engineering Health Care Integration Programs
Primary Care Medical Home ~ A Prepared Interdisciplinary Practice

Primary Care Provider

Behavioral Health Team
Internal BHC ↔ Care Facilitator

Behavioral Health Team
External BHC

Patient
REHIP Proposal

• A Tri-Service demonstration project and evaluation
  o Operationalizes guidance from Mental Health Integration Working Group & Office of the Chief Medical Officer (TMA)

• Marries components from existing programs into one consistent “best practice”
  o Implements collaborative “team-medicine” approach
  o Enhances access to intensive, focused therapeutic intervention and collaborative treatment planning for a range of issues
  o Improves recognition, management, and continuity of care for depression and PTSD

• Six sites (site=base/post), two per Service
REHIP Components

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

Specialty Mental Health Care

Primary Care with greater access & treatment through Care Facilitators, Internal BHCs and External BHCs

REHIP

Routine Primary Care

Preclinical Mitigation

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

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

Distinctively…

– Multidisciplinary
– Tri-Service
– Experienced
– Fully Funded

Providing…

– Training and Support
– Manuals and Tools
– A Data Repository
– Evaluation
REHIP Summary

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

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