Healthcare Transformations in Primary Care Behavioral Health
Disclaimer

• The views expressed in this presentation are solely those of the author and do not reflect the official policy or position of the Uniformed Services University, the Department of the Air Force, the Department of Defense, or the United States Government.
Learning Objectives

1. Participants will be able to explain how primary behavioral healthcare transformation in a large military system has demonstrated benefits for managed healthcare costs, demographically diverse patients, and a wide range of healthcare providers.

2. Participants will be able to identify challenges and opportunities for applying lessons learned from military treatment environments to civilian integrated behavioral health in Patient Centered Medical Homes.
Panelists

- Maj Elizabeth Najera, Ph.D.
  - Chief, Behavioral Health Optimization Program, Air Force Medical Operations Agency and Enhancement Project Site Leader
- Mario G. Nicolas, Ph.D.
  - Deputy Program Manager, Air Force Medical Operations Agency
- Maj Matthew K. Nielsen, Psy.D., ABPP
  - Past Chief, Behavioral Health Optimization Program, Air Force Medical Operations Agency, Enhancement Project Lead
- Kathryn E. Kanzler, Psy.D., ABPP
  - Director, Integrated Behavioral Health, UT Medicine Primary Care Center and former USAF Health Psychologist/Behavioral Health Consultant Trainer
- Capt Ryan R. Landoll, Ph.D., ABPP
  - Assistant Professor of Family Medicine, Uniformed Services University and USAF Behavioral Health Consultant Trainer and Enhancement Project Site Leader

Not presenting: Kathryn K. Waggoner, Psy.D., ABPP, past Deputy Program Manager, Behavioral Health Optimization Program, Air Force Medical Operations Agency
Overview

• Understanding the Behavioral Health Optimization Program (BHOP)
  • Maj Elizabeth Najera and Dr. Mario Nicolas
• Innovation in BHOP Service Delivery
  • Maj Matthew Nielsen
• Translating BHOP into Civilian Patient Centered Medical Homes
  • Dr. Kathryn Kanzler
Behavioral Health Optimization Program (BHOP): Overview

Maj Elizabeth Najera
Chief, Behavioral Health Optimization Program
Air Force Medical Operations Agency (AFMOA)
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Overview

- What is BHOP?
- Why Primary Care?
- History
- Internal Behavioral Health Consultant
- Behavioral Health Care Facilitator
- Impact of BHOP
What is BHOP?

- Behavioral Health Optimization Program (BHOP) is the Air Force’s Primary Care Behavioral Health (PCBH) program in which trained behavioral health personnel are integrated into primary care clinics with the goal of providing “the right care, at the right time, in the right place.”
Current Specialty Mental Health (MH) System:

- Reluctance to seek help
- Limited Mental Health resources
- Not easily accessible
- Delay in delivery of care
- Not ideal for prevention/early intervention
- Limited attention to medical conditions/health related behaviors
Why Primary Care?

- 67% of people with a BH disorder do not get BH treatment\(^1\)
- 80% with a behavioral health disorder will visit primary care at least once in a calendar year\(^2\)
- 50% of all behavioral health disorders are treated in primary care\(^3\)
- 48% of the appointments for all psychotropic agents are with a non-psychiatric primary care provider\(^1\)
- 30-50% of referrals from PC to outpatient BH clinic don’t make 1st appt\(^4,5\)
- 50% of primary care providers, can only sometimes, rarely or never get high-quality behavioral health referrals for patients\(^6\)

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3. Kessler et al., NEJM. 2006;353:2315-23
5. Hoge et al., JAMA. 2006;95:1023-1032  
Coaching and Partnering for Improved Performance

HISTORY

- 1997-1998: Tinker AFB Pilot
- 2000-2006: Initial Implementation
- 2006-present: Continued Implementation
- 2016: 72 of 76 Military Treatment Facilities are resourced for full-time BHOP
IBHC

- Typically a privileged social worker or psychologist
- Supports the PCMs and their patients
- Goal is to maximize clinical outcomes with limited visits
- Support the PCM and the patient in developing and implementing an effective and comprehensive health care plan
- Accessible to primary care team for curbside consultation
- See a wide range of both mental health and medical conditions (chronic pain, diabetes management, hypertension, high utilizers etc.)
IBHC Primary Duties

- IBHC Primary Consultation Duties:
  - Brief 20-25 minute visits
    - Targeted assessment & evidence-based behavioral interventions/skills training
  - Typically 1-4 appointments per episode of care
    - Continuity visits are exceptions
  - Provide feedback to PCMs. PCM maintains “ownership” of patient’s care
  - If needed, assist PCM in identifying appropriate referrals
  - Conduct psycho-educational classes
BHCF Primary Duties:

- Monitor patient compliance with psychotropics for Depression and Anxiety
- Mostly t-cons with patients to check on:
  - Side effects
  - Adherence to PCM and/or IBHC treatment plan
  - Monitor symptom progress through screeners (PHQ-9, GAD-7, PCL)
- Identify barriers to compliance with medication
- Get patient into the PCM as needed for medication management and to the IBHC as needed for skill training and problem solving
Impact of BHOP

- 2015 feedback from 263 PCMs, & 631 patients
  - 89.5% of patients “very satisfied” or “extremely satisfied”
  - 95% of patients “probably” or “definitely” would recommend
  - 93% of PCMs found services “very helpful” to patients
- Less than 10% of patients seen in BHOP have been referred to specialty mental health
Contact Information

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Common Challenges in Training Behavioral Health Consultants

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Overview

- Primary Challenge
- Other Challenges
- Key Considerations
Primary Challenge

- The “Specialty Mental Health” Mindset
  - Over-assessment of diagnostic signs/symptoms
    - diagnosis > functioning
  - Individual/case-based approach vs. population focus
  - Emphasizing emotion vs. using content/structure to build rapport
  - Limited understanding of what can be accomplished in one-visit
Other Challenges

- Misinterpretation of elapsed time

- 5 A’s:
  - Assess: Comprehensive vs. targeted assessment
  - Advise: prescribe/direct vs. collaborate
  - Agree phase: limited collaboration
  - Assist: limited collaboration
  - Arrange: generally OK

- Limiting MI components

- Limited trust in providing “small step” interventions
Key Considerations

- Use of detailed core-competency tool
- Phased training
- Strive for “meta-understanding” of the model
  - Query contrast between specialty MH vs. PCBH
- Approach chart-review with a different mindset
  - Concise charting
  - Note emphasizes objective markers (cognitions/behaviors) and contextual factors associated with presenting problem/overall functioning
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Shifting the Mental Health Access Point to Primary Care Behavioral Health

A One Year Pilot Study

Major Matt Nielsen
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Problem

Supply and demand mismatch

- Increase in AF beneficiary outpatient mental health (MH) therapy prevalence rates
  - 10.1% in FY12 and 12.3% in FY15
- Insufficient mental health personnel to meet demand
  - Limited financial resources
  - MH clinic providers available for patient care ~52% of day
- Access to specialty MH care is difficult
  - Limited TRICARE approved providers in the community
  - ~1/4 of AF clinics fail to meet 7 day access to care >90%
- Increase in TRICARE community purchased care costs by 15.7% from FY14 to FY15
  - $36M in FY14 to $42M in FY15
Method

**FY15 pilot study at 3 Military Treatment Facilities**
- Lackland, TX - 54,000 beneficiary population
- Keesler, MS - 26,000 beneficiary population
- Shaw, SC - 14,000 beneficiary population

**Reallocate a MH provider and technician from the MH clinic to BHOP to offset increased demand (zero sum)**

**All mental health related care seen in BHOP first unless specifically screened criteria is met:**
- Risk to self or others
- Need of special duty evaluation or psychological testing
- Command directed evaluations
- Presenting problem is substance misuse or domestic maltreatment
- Patient has been treated in the clinic previously and prefers to be seen in the MH clinic

**Data was obtained for baseline (FY14) and pilot study (FY15) metrics**
Combined MTF Results

Patient Encounters

Total patient encounters AF-wide increased 5% from FY14 to FY15

Total Patient Encounters

- FY14: 23,213
- FY15: 24,952

< 22%
Combined MTF Results
Patients Treated

Total Unique Patients

- FY14: 6,132
  - MH Clinic: 2,683
  - BHOP: 3,449
- FY15: 12,865
  - MH Clinic: 6,464
  - BHOP: 6,401

Total unique patients served AF-wide increased 4% from FY14 to FY15
"If IBHC services were not available to you within primary care, would you have sought services from a mental health clinic?"

- Definitely/Probably Would Not: 30%
- Uncertain: 15%
- Definitely/Probably Would: 55%
Patients Referred from BHOP to Specialty MH Care

Referral Rate to Specialty MH Care

<table>
<thead>
<tr>
<th>BHOP Patients</th>
<th>Referred to Specialty Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>6,464</td>
<td>596 (9.2%)</td>
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I n t e g r i t y - S e r v i c e - E x c e l l e n c e - C o m p a s s i o n
FY14 compared to FY15 Purchased Care Costs

Potential savings of $3.9M to $18.9M per year if implemented AFMS-wide
Incorporation of BHT into 100% of direct patient care

Medical professionals working at the top of their license and training

* Incorporation of BHT into 100% of direct patient care
Lessons Learned

- Fidelity to the BHOP model is crucial
  - Providers following specialty MH model in primary care is less efficient and therefore less effective
  - Need better contract hiring processes that can identify contractors with better matched skills and interest for primary care behavioral health work

- Use of behavioral health technicians in BHOP
  - Need for technicians to be involved in direct patient care
  - Need for primary care clinics to provide administrative support (e.g., patient scheduling)

- Need standardized guidance for MH clinic triage and referral to BHOP practices
Translating Benefits of BHOP to Civilian Patient Centered Medical Homes

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Assistant Professor, Psychiatry & Family and Community Medicine
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Overview

• Challenges & Opportunities related to:
  – Patient Factors
  – Provider Factors
  – Financial/Admin Factors

• Tips for Translating Benefits
Observed Patient Factors

Military Population

• Captive patient population: same system/same EHR
• Relatively stable housing, income
• Overall healthier/more educated
• Unique motivations for improvement
• Patients and families are transient
• Reluctance in healthcare seeking

Civilian Population

• Fewer resources - lack of insurance, money, transportation
• Greater demand for medications
• Whole family may be involved
• Patients aren’t as mobile
• Reduced worry about “career impact”
Provider Factors

Military Providers

• Follow standardized templates, manuals, etc.
• Excellent IBHC training
• Rank (power differentials)
• No stability in job positions
• Not as much control over “how” model is developed/implemented
• Disruptions due to deployments/TDYs

Civilian Providers

• PCPs don’t know “BHOP”
• BH providers don’t know BHOP
• BHCs may wear many hats
• Lifelong relationship potential (team and patients)
• More groundwork/ownership
Financial/Administrative Factors

Military Finances & Admin
• Free healthcare
• Decisions are made “from above” (DoD/AFMOA)
• Accessible data
• No referrals needed
• Willingness to fund BHCFs

Civilian Finances & Admin
• Initial investment is difficult
• BH carve-outs for insurance
• Benefits coordination
• Need decision-maker buy-in
• Benefits coordination needed for BHC visits
• Difficult to capture metrics
• Healthcare reform
Tips for Adapting “BHOP”

• Get to know community resources
• Cultivate/keep external BHC mentors
• Make strong relationships with benefits coordinators
• Share the data from USAF BHOP with administrators
• Emphasize the “civilian” roots of BHOP & highlight PCBH successes in other healthcare systems
• Stay on top of the financials and use EHR data – show your worth in meaningful ways
• Use DoD clinical pathways
• Seek to add “BHCF” and “technician” positions
• Write grants for more flexibility
• Advocate, advocate, advocate!
Questions?

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Summary

• BHOP rooted in consultative model of integrated care from civilian healthcare
• BHOP has benefited from standardized training and implementation in large healthcare setting for nearly two decades across a wide diversity of populations and settings
• BHOP has shown ability to meet all aspects of Triple Aim
• Ability to test BHOP in context of full range of healthcare services (primary care and specialty mental health)
• Demonstrated benefits to applying primary care behavioral health within multi-tiered system
• Findings can generalize to other large managed healthcare organizations serving diverse populations
Questions?

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