Integrating Primary Care and Mental Health in the Army

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Fifteen months ago, a family from the 82nd Airborne Division said their goodbyes from their North Carolina home at Fort Bragg. They weren't moving to another state, and they weren't moving together. Their goodbyes were to each other as one member of that family was going to war nearly halfway around the world. This was not just an isolated incident but a scene repeated thousands of times on military parade fields and in home front yards across the state of North Carolina. It has become a familiar scene in the years since September 11, 2001. Life has changed for everybody since that eventful day, but it has especially changed for the soldiers and families stationed at Fort Bragg, North Carolina.

Fort Bragg is one of the largest and busiest posts in the United States Army. Its lead position on the Global War on Terrorism has produced great sacrifice from the soldiers on the front lines and from the families at the home front. These sacrifices can be measured in dollar costs, time away, and in lives lost, but they can not be so easily measured by the numerous stressors on the families or the soldiers who have deployed to combat. Soldiers and families must cope with a wide variety of stressors which may manifest themselves in problematic behaviors. One study that did identify a response by soldiers to the stressors of combat showed a need for greater access to mental health resources within the military.[1] In response to this need, the Fort Bragg medical system has taken the lead to battle against these stressors by becoming a center of excellence for the recognition and treatment of depression and posttraumatic stress disorder (PTSD) in the military.

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RESPECT-MIL (Re-engineering Systems of the Primary Care Treatment of Depression and PTSD in the Military) is a carefully-designed system that helps identify and treat soldiers who may have depression or PTSD. It was first developed for civilian practices with a primary care emphasis to better identify and treat depression.[2] The system uses a 3-component model (see Figure 1) and works when a well-prepared primary care practice teams up with a nurse care facilitator and a behavioral health professional. The nurse care facilitator and behavioral health professional facilitate the care of patients who have been identified with depression and are being treated by a primary care practitioner. Implementation begins when primary care and behavioral health champions lead a 3-hour training session for clinicians and administrative staff. Nurse care facilitators complete 2 days of training and then continue ongoing training as they interact with their initial patients. Champions use academic detailing and case-based "lunch and learns" to reinforce concepts. The core elements of the 3-component model are (1) routine screening for depression and PTSD; (2) diagnostic assessment with structured questionnaires for all those screening positive; (3) patient engagement, education, and eliciting treatment preferences; (4) proactive follow-up by the primary care clinician and RESPECT care facilitator; and (5) enhanced support by a mental health specialist through supervision of the

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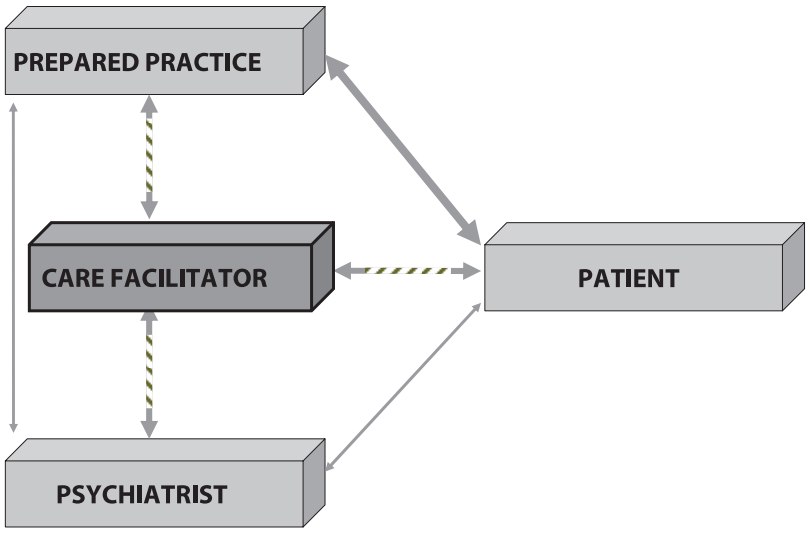
Figure 1.
Components of the RESPECT-Mil Model



care facilitator and availability for curbside consultation. (See Box 1.) Patients with complicated illnesses (eg, significant suicide risk) or who prefer specialty care are referred to mental health providers. For patients treated in primary care, the care facilitator reinforces the primary care clinician's treatment plan through telephone follow-up that addresses treatment adherence, self-management goals, and symptom response using structured questionnaires. The care manager is supervised by a psychiatrist and communicates any recommendations for management changes to the primary care clinician. This proactive treatment model increases the intensity of follow-up (see Figure 2) and has been demonstrated to increase guideline concordant care for depression and improve patient outcomes.[3] Because of its success in the civilian community, key leaders in the Army medical department put together a study at Fort Bragg to assess the model's feasibility within the military health care system.[4]

Box 1.
RESPECT-Mil Care Processes

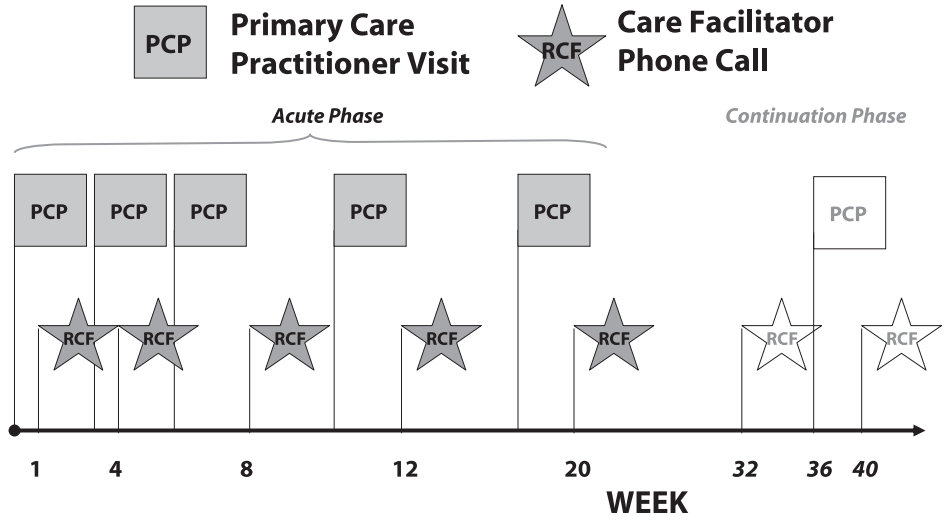
- ★ Routine Screening
  - ★ On arrival at sick call medic/nurse screens patient for depression and posttraumatic stress disorder as part of measuring vital signs
- ★ Assessing Screen Positives
  - ★ Screen positives complete PHQ-9 depression questionnaire and posttraumatic stress disorder checklist to guide diagnosis
  - ★ Primary care providers score and complete diagnosis
- ★ Treat Those With a Potential Diagnoses
  - ★ Assess suicide risk
  - ★ Elicit relevant history
  - ★ Share diagnosis with patient, offer treatment and referral to care facilitator
- ★ Systematic Follow-Up
  - ★ Primary care continues to manage
  - ★ Care facilitator provides additional telephone follow-up
  - ★ Communication and treatment advice by team psychiatrist

The adaptation of the civilian model to one in the military included the addition of a screen for PTSD in response to the needs apparent in this important population. Another important modification was to mandate evaluation by a mental health specialist for any solider in treatment who had an upcoming deployment. This evaluation is an extra measure of safety for deploying soldiers.

In February of 2007, the first clinic at Fort Bragg began full implementation of RESPECT-MIL to include complete screening of all soldiers enrolled in General Roscoe Robinson Health Clinic, which serves soldiers and families of the 82nd Airborne Division. The soldier population for this one clinic alone is approximately 17 000. Since the beginning of February 2007, nearly three-quarters of all soldiers visiting the Robinson Health Clinic have been screened for depression and PTSD. Of the entire population of soldiers screened, just under 20% screened positive for either depression or PTSD. Of those soldiers who screened positive, roughly one-third were false positives and another one-third were already being treated for their depression or PTSD within the military behavioral health care system. The final one-third of those positive screens were newly identified depressive disorder or PTSD. About half of the soldiers chose to participate in RESPECT-MIL while the other half went to behavioral health. Only a small percentage chose no referral at all.

The RESPECT-MIL care model involves a paradigm shift from one clinician-one patient interactions to a team care model that features telephone follow-up and evaluation. It also requires a change in cultures from one where medical and mental health services are delivered relatively independently to one involving greater collaboration. Because these represent important changes in medical care delivery, we typically begin implementation with small-scale pilots (eg, the most highly motivated clinicians in a care site) and then gradually expand to involve more clinicians and more clinical sites at the base. These implementation challenges are quite similar to those seen in the private sector. Challenges that may be unique to the military include a highly mobile patient population, highly mobile clinical staff, and primary care services designed more for acute rather than longitudinal care. We have dealt with these later challenges

Figure 2.
Typical Frequency of Patient Contacts



in part by developing a greater capacity for ongoing training of new staff.

This initial experience to date has been very valuable. It has allowed for a process improvement within a military primary care clinic where a systematic approach to behavioral health needs is being addressed and is also becoming a part of the routine health care approach and culture of care at Robinson Health Clinic. It has also spread to 3 other clinics at Fort Bragg and beyond the state of North Carolina to other sites within the Army medical department as they begin to implement RESPECT-MIL. As part of this initial roll-out we plan to implement the program at 15 Army posts, including 3 in Europe. We have seen the valuable contribution of a nurse care facilitator expand the ability for primary care practitioners to treat depression and PTSD in such a way that more nurse care facilitators are being hired to meet the demand. Primary care practitioners initially concerned about the increased workload are now providing positive anecdotes about their improved ability to identify and care for depression and PTSD in soldiers. The result is that after 15 months of being in combat soldiers are returning home to their families in North Carolina, and they are also returning to a medical community that is improving its ability to help them deal with some of their health needs. In this way we can begin to address their needs and build a better military family right here at home. **NCMJ**

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