
Tipping Points in the Department of Defense's Experience With Psychologists in Primary Care

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Psychologists played a crucial role in the successful implementation of integrated behavioral health care services in Department of Defense (DoD) primary care clinics. On the front lines of policy development, training programs, clinical care, and program evaluations, psychologists successfully promoted integrated care as a core component of the DoD patient-centered medical home. We review the development of integrated care and discuss the roles of psychologists in the DoD to provide an exemplar of the impact psychologists can have on the implementation and sustainment of integrated care.

Keywords: integrated care, collaborative care, patient-centered medical home, behavioral health, mental health

The Department of Defense (DoD) Military Health System serves 9.7 million active duty and retired Service members and their families through direct care at military treatment facilities and local, regionally managed civilian networks. Of these 9.7 million eligible beneficiaries, 3.3 million receive services in military facility primary care clinics. The demographics of these enrollees are more balanced than one might think given a military population. There is a relatively equal mix of males and females (see Table 1) enrolled in these clinics, and their ages range from birth to over 65 years.

Using the Quadruple Aim (see Table 2) as a guide, the DoD works to improve population health, experience of care, mission readiness, and health-care cost management. To achieve the Quadruple Aim, the DoD has developed patient-centered medical homes (PCMH) in most military primary care treatment facilities. Integrating behavioral health¹ personnel, the majority of whom are psychologists, as full-time PCMH team members has been an important focus of the DoD's implementation of the PCMH. In clinics with 3,000–7,499 enrollees, care is being delivered by one full-time behavioral health provider using a primary care behavioral health (PCBH) model of service delivery that also incorporates activities usually performed by a care facilitator in a care management model of service delivery. Integrated behavioral health care service delivery in clinics with 7,500 or more enrollees is done with one full-time behavioral health provider and one full-time care facilitator

using a blended model of care that combines the PCBH model with a care management model of service delivery.

The PCBH model is a population health based model of care in which the medical team and the behavioral health provider share information regarding patients. There is a shared medical record, treatment plan, and standard of care (Hunter & Goodie, 2010; Strosahl, 1998). Assessment, intervention, and health care services are provided, typically in 15–30-minute appointments, along the full spectrum of problems patients bring to the clinic. In addition to common mental health concerns like depression and anxiety, the behavioral health provider provides services addressing areas such as chronic pain, health risk behavior, medical nonadherence, weight management, smoking cessation, and sleep disturbances (see Hunter, 2013, for additional details on PCBH model components).

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¹ *Behavioral health* is being used as a generic term to include services for health behavior change (e.g., weight loss, substance dependence/abuse/misuse), behavioral medicine interventions (e.g., chronic pain management), and general mental health services (e.g., for problems such as panic disorder).



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A care management model is a population-based model of care focused on a specific clinical problem (e.g., depression). The care management model incorporates the use of specific clinical practices (e.g., set screening and assessment measures used at specific intervals of treatment or monitoring) that systematically and comprehensively address how behavioral health problems are managed in the primary care setting (see Nutting et al., 2008, for additional details on care management model components). Typically, the care facilitator has some form of systematic interface with a behavioral health specialist with prescriptive privileges (e.g., weekly case review and treatment change recommendations).

Psychologists played significant roles at various levels of the DoD in developing policy and training programs,

conducting research, providing clinical care, and conducting program evaluations of integrated behavioral health care services in primary care. We discuss the roles psychologists played in the implementation of integrated care and the tipping points that have strengthened the role of behavioral health providers in the DoD PCMH. These efforts have broad applicability to what psychologists can bring to other health care systems.

The Reality of Primary Care Through a Physician's Eyes

Some of the most striking observations about the value of integrated care have been made by physicians who have seen its impact on their practices. Below is a typical day of an internist (Kevin A. Dorrance) prior to the transition to integrated care:

The day begins with the usual review of my schedule, with several well-known patients coming for a variety of chronic conditions and a few new patients who will need a reasonable chart review. I recognize a name that creates a visceral response resulting from my inability to remedy his condition and the likelihood that I will not have any greater success today.

The empirically based treatments, mostly pharmacologic interventions, have not led to any relief of suffering and have likely added to the list of symptoms. The list of medications has increased over the past several years as the patient has navigated his way from one specialty medical consultant to another without any collaboration or reasonable coordination. In my heart, it is clear that I do not have the answer for this patient because he probably needs something I have not been trained to provide. I have contributed to this patient's suffering and added him to the rolls of the group commonly referred to as "high utilizers."

When the services provided to patients are not matched appropriately with their conditions, we see increased and inappropriate utilization of health care services across a spectrum of disciplines. The risk to these patients grows as they undergo testing and treatments that are unnecessary, and eventually the odds of unintended consequences can lead to a bad outcome. After years of caring for patients like the ones on today's schedule, and knowing that what they needed could not be found in one of my medical

Table 1
January 2012 Military Health System Enrolled Primary Care Demographics

Age (years)	n	Female (%)	Active duty (%)	Retired (%)	Family members (%)
0-4	307,188	49			100
5-14	478,689	49			100
15-17	121,014	49			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
Total	3,351,178				

^a For these age groups, the totals of the percentages of active duty, retired, and family members do not equal 100% because of rounding.

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textbooks or in a pharmacologic intervention, the frustration grows even more.

It has become clear to me that the vast majority of my patients' conditions have a behavioral component. Many others have been suffering from depression, anxiety, or other mental health problems and the somatic symptoms that tend to accompany these conditions. My training simply did not prepare me to help the majority of my patients. I was trained to treat acutely ill patients, and to help care for them in a compromised state with chronic conditions. Healing was to a great extent not part of the daily life of an internist. When I was cognizant of this, I referred to psychologists for help. But these referrals were often met with skepticism or outright refusal by the patient. In addition, when my patients did follow through on referrals to specialty mental health, I rarely received feedback from the mental health specialist. So what was the answer? Thankfully, I was exposed to the innovative concept of integrating behavioral health providers into the primary care clinic.

DoD History of Integrated Care

The Air Force, Navy, and Army took different paths developing their integrated behavioral health care services. This phased process allowed the Services to learn from each other, building on what worked and avoiding pitfalls in service provision for the unique populations that are served in the DoD's medical treatment facilities.

Integrating psychologists into DoD primary care clinics is not new. Fifteen years ago the Air Force was the first Service to launch its integrated care program.

Air Force: The Tinker Project (1997–1998)

The Air Force originally tested integrated care at Tinker Air Force Base, Oklahoma, in 1997. The goals of this project were (a) to provide greater access to behavioral health care, (b) to increase early identification of behavioral health problems, (c) to assess the cost impact to the system, and (d) to gain experience about patient and provider satisfaction with services, methods of behavioral health delivery, and training needs. A detailed description of the implementation and results can be found in Wilson (2003). To summarize, this proof-of-concept project was a success, meeting all four goals. Lessons were learned about the importance of having behavioral health providers who are specifically trained to do this work. It was also clear that in this setting, an understanding of common medical problems and treatments as well as taking a biopsychosocial approach to screening, assessment, and intervention (i.e., traditional skills of clinical health psychologists) brought a greater breadth and depth of services.

Additional lessons learned included the importance of adapting to primary care culture, being flexible, getting to know all the staff, and getting support from primary care clinic leaders. Being a generalist and taking a "see all comers" approach, being easily accessible, working in 15- to 30-minute appointments, and managing appointment time effectively were also critical for success. To work effectively in this setting, focused assessments and interventions and different documentation standards were necessary. These became important areas of focus as the Air

Table 2
Quadruple Aim of the Military Health System

1. Readiness	Ensuring that the total military force is medically ready to deploy and that the medical force is ready to deliver health care anytime, anywhere in support of the full range of military operations, including humanitarian missions.
2. Population health	Reducing the generators of ill health by encouraging healthy behaviors and decreasing the likelihood of illness through focused prevention and the development of increased resilience.
3. Experience of care	Providing a care experience that is patient and family centered, compassionate, convenient, equitable, safe, and always of the highest quality.
4. Managing the total health care cost	Creating value by focusing on quality, eliminating waste, and reducing unwarranted variation; considering the total cost of care over time, not just the cost of an individual health care activity.



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Force moved forward with selecting a service delivery model and training for the implementation of integrated care across the Air Force.

Air Force: Behavioral Health Optimization Program (2000–2012)

Building on the success of the Tinker Project, the Air Force moved to implement the Behavioral Health Optimization Project (BHOP; “project” was later changed to “program”). This was an integrated care service that during the “project” phase sought to embed psychologists and social workers in primary care. In the Air Force, social workers function as outpatient behavioral health clinicians, providing treatment for a wide range of behavioral health problems, and therefore they could also be trained to work in an integrated care environment. Specific goals of the BHOP included (a) offering services that were acceptable to patients and their primary care providers, (b) expanding behavioral health care options to include improved shared decision-making with patients, (c) increased access to behavioral health services, (d) collaborative team-based health care management, (e) a broad range of behavioral health services within primary care, and (f) a prevention focus including early identification and treatment of behavioral health conditions. After reviewing different service delivery models, the Air Force decided to use the primary mental health care model (Strosahl, 1998; subsequently referred to as the primary care behavioral health [PCBH] model) of service delivery. This was the only model at the time that addressed the goals of implementation. It included objective competencies and benchmarks for service delivery and training, which would allow for greater fidelity in the delivery of services across clinics. In this model, behavioral health providers were embedded in the primary

care setting, served as behavioral health consultants (BHCs), and embraced a population health approach to care.

Full-time BHOP program manager. One of the early “tipping points” that contributed to the initial, and ongoing, success of the BHOP was the decision to create the Air Force BHOP program manager position, first filled by a psychologist. The BHOP program manager became the single individual whom leadership and practitioners could go to for answers to questions about the policies and the practice of the PCBH model and was responsible for managing the program across Air Force primary care clinics. The position of the BHOP program manager continues to exist today. Five psychologists have filled this position. They convened working groups, advocated for policy changes, and coordinated training for practitioners, all of which facilitated the Air Force’s continued support and expansion of the BHOP.

Manual development. In May 2000, an Air Force working group of physicians, psychologists, and social workers established recommendations and guidelines that would structure the implementation of integrated behavioral health care. The BHOP program manager used the guidance of the working group and consultations with leadership and subject matter experts to develop the BHOP manual, which was released to Air Force providers in February 2001. The BHOP manual is a “living document” intended to be adapted as experiences with integrated behavioral health care expand. The manual describes the background and rationale for introducing this care, discusses the philosophy and goals of the program, and describes the roles of the BHCs. It is important not only to define what a BHC is but also to introduce providers and leadership to the concept of population health and to describe the role of the BHC within a population health model. The BHOP manual provides specific guidance about how to practice as a BHC. It details the patient-to-BHC referral process, and it describes how to introduce BHC services to patients and primary care providers (including scripts), how to manage time throughout the appointment, documentation practices, and ways to provide feedback to the primary care provider. The BHOP manual also describes necessary administrative changes, including how to develop scheduling templates and provide guidance about how much time a BHC should spend in primary care. Overall, the BHOP manual standardizes the intended function and practice of integrated behavioral health care. This standardization is important not only for practitioners but also for primary care and mental health clinic leadership. It helps to define not only what the BHOP is but also what it is not. An updated version of the BHOP manual was released in 2011.

Initial training of the first six psychologist BHCs (much like a learning collaborative). Six Air Force psychologists and one social worker were initially trained to provide BHOP services by an external psychologist consultant. To speed widespread dissemination of the program, the Air Force implemented a “train-the-trainer” model. Not only did trainers receive feedback

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regarding the care they provided to patients and how they fulfilled the role of the BHC, but they also received feedback about how they trained psychology interns. These expert trainers were stationed at the Air Force's American Psychological Association- (APA-) accredited internships. The trainers regularly communicated with each other, sharing resources and ideas about how to effectively implement their services and provide effective training.

Psychology internship training programs.

When implementing the BHOP, it was decided that the interns at each of the Air Force's APA-accredited internships would be trained in the PCBH model. Two different models of training were introduced at the training sites. Two sites had interns work in primary care settings one day a week over six months, while the remaining site had interns spend four days a week for a full month working as a BHC. Interns at all sites were expected to meet an established set of core competencies to successfully complete the rotation. Upon graduation, 22–30 interns left the training sites and assumed psychology positions at various Air Force medical facilities, leading to wide dissemination across the Air Force in a relatively small number of years. It should be noted that there was no mandate for Air Force primary care clinics to integrate; implementation of the BHOP was encouraged, but not required, by senior medical leadership (i.e., the Air Force surgeon general).

Externship training. To further facilitate the implementation of the BHOP throughout the Air Force, leadership recognized the need to train practicing Air Force psychologists (those who completed internships prior to 2000, before the BHOP rotations first became available). In addition, Air Force social workers who did not receive the BHOP training through an internship needed an avenue for training. Therefore, a second form of training, following an

externship model, was implemented. Psychologists and social workers with an interest in implementing a PCBH model at their bases first garnered support from their local leaders (mental health chief, primary care chief, and facility medical director and/or hospital commander). No financial or personnel assets were provided, so local leaders needed to be convinced that shifting a portion of a behavioral health provider's time from the specialty mental health clinic into the primary care clinic would have tangible benefits. "Selling" the model became a joint effort between the interested psychologist and the BHOP program manager. Prospective BHCs travelled to one of the BHOP clinics staffed by one of the six "expert trainers" for three days of didactic, observational, and participatory learning. Once a set of core clinical, consultative, practice management, and administrative competencies had been demonstrated by the BHC, the BHC was able to initiate the BHOP services at his or her own base. This on-site training was followed by opportunities for continued consultation and mentoring via telephone with the expert trainer.

Challenges. After several years of using these training models, it became evident that once psychologists left the training environment (whether internship or externship), the fidelity of what was practiced in primary care settings deteriorated. These new psychologists did not have anyone to provide regular supervision related to operating as a BHC. Variable support from mental health clinic leadership posed another challenge. Although there were a few psychologists who worked full time in primary care, the majority held full-time assignments in specialty mental health clinics. Their time for the BHOP was "carved out" from their "regular" responsibilities. Unfortunately, mental health clinic leaders often withdrew support for the program when the clinical demands of the mental health clinic increased. In addition, there was no central database or formal process for identifying psychologists who had successfully completed the BHOP training and were qualified to practice in this model. No established process required formal credentialing to deliver services in this model prior to practicing. Although providers were strongly encouraged to obtain internship or externship training prior to practice, there was limited oversight. Complicating matters, some who had been trained to operate as BHCs began training others to operate as BHCs despite never having received advanced training on how to teach this model to others. There were no guidelines or regulations that determined who was an appropriate trainer.

In 2006, a new working group was formed to address methods for standardizing the implementation, training, and sustainability of the BHOP. The working group established minimum requirements for providers to consider themselves "trained" as BHCs and identified who could be an "expert trainer." Additional BHCs became designated as "expert trainers" through this process and were placed in locations that could provide externship training. Developing other expert trainers relieved the psychology internship sites from the difficult responsibility of providing the BHOP training to both interns as well as licensed providers who needed externship training. Over time, additional pol-

icies were implemented, such as inspection criteria for BHCs that included peer review of their work and formal (enforceable) policies for the implementation and practice of the BHOP in Air Force medical facilities. These policies corresponded to the guidance in the BHOP manual.

Even with the internship and externship trainings, the Air Force could not meet the growing demand for BHCs. So, in addition to active duty service members working as BHCs, over the years the Air Force hired over 20 psychologist contractors to work as full-time BHCs. The Air Force also invested in contracting psychologist expert trainers, who travelled throughout the world, wherever there was a BHOP provider, to train or enhance the training of BHCs and to speak with local leadership to both provide and receive feedback about the BHOP.

Today, the Air Force has 86 BHCs (56 psychologists and 30 social workers) in 65 military treatment facilities, which is 88% of all Air Force military treatment facilities (M. Neilsen, personal communication, September 27, 2013). The involvement of psychologists with the development of the BHOP manual, the BHOP program manager position, and standards for BHOP practice and training, along with the investments in expert psychologist trainers, combined to serve as tipping points that have expanded the integration of psychologists in primary care settings. Without these factors, the fidelity and commitment to the PCBH model could not have been sustained. The implementation of the PCBH model in the Air Force was well received by physicians and patients (Runyan, Fonseca, & Hunter, 2003) and was shown to be effective for targeting a broad range of clinical concerns (Bryan et al., 2012) including insomnia (Goodie, Isler, Hunter, & Peterson, 2009) and posttraumatic stress disorder (Cigrang et al., 2011).

A morning in the life of a BHC. As described above, the PCBH model of integrated primary care requires substantial shifts in the practice of most psychologists who have trained and practiced primarily in specialty mental health settings. The day-to-day schedule and activities of a psychologist practicing in this model look dissimilar to those of a psychologist in a specialty outpatient mental health practice. To illustrate the differences, the following paragraphs describe a typical “day in the life” of a BHC in a military primary care clinic.

7:30–7:45 a.m.: Prepare for day’s patients. Briefly review referral information and recent electronic medical record notes. Notice that the 2:00 p.m. new patient appointment, Mrs. Garcia, was referred by Dr. Chu for assistance with managing diabetes. It is unclear whether she was referred to or completed the medical center’s diabetes education classes.

7:45–8:00 a.m.: Daily huddle with members of PCMH team. BHC asks primary care providers whether any of today’s patients might benefit from a same-day BHC appointment. Physician Assistant (PA) Stein states that he is seeing retired Master Sergeant (MSgt) Lambert, a patient with emphysema, at 8:30 a.m. PA Stein advised him to quit smoking in the past, but the patient has been unsuccessful. The BHC mentions that she would be happy to work the patient into a same-day appointment slot that morning or

see the patient in a scheduled appointment later in the week. To address any reluctance that the patient has to see the BHC, the BHC encourages PA Stein to frame the referral in the following way: “I’d like to introduce you to the clinic’s Behavioral Health Consultant. She has helped a lot of my patients quit smoking. Even if you don’t think you’re ready to quit right now, the two of you might come up with some ideas about how to make it more do-able for you down the road.” BHC asks Dr. Chu about the patient scheduled at 2:00 (Mrs. Garcia; new referral for diabetes management). Dr. Chu stated that Mrs. Garcia attended diabetes education classes “years ago” but was unwilling to attend again, stating they take “too much time” and “I know all the information already.” Mrs. Garcia was willing, however, to meet with the BHC.

8:00–8:30 a.m.: New patient appointment with a 24-year-old active duty female for marriage problems that have worsened since her recent return from deployment. After conducting a focused assessment, a plan is developed for the patient to invite her husband to attend several joint BHC appointments to improve their communication. The BHC completes the medical note, including recommendation for the referring provider to reinforce the message that learning different ways of communicating is an important step in strengthening the marriage.

8:30–8:55 a.m.: New patient appointment with 68-year-old female, Mrs. Taylor, who was referred for bereavement (husband died 3 months prior). The referral question asked whether this patient should be evaluated for antidepressant medication. Assessment reveals that Mrs. Taylor is feeling sad most days, has eliminated most social activities, and has been eating poorly and losing weight. Other neurovegetative signs of depression were not significant, and she was not experiencing suicidal ideation. The intervention includes education about the grief process and strategies that can hinder or help when grieving. The patient and BHC develop a plan of increasing social activities, to include attending religious services at least twice in the upcoming month, calling a friend twice per week, and arranging to go out for lunch once per week. She also plans to buy easy-to-prepare breakfast foods and make efforts to eat something each morning. Anti-depressant medication does not appear to be needed. A follow-up appointment is planned in one month. No time for charting or feedback to the primary care provider yet.

8:55–9:05 a.m.: The BHC knocks on PA Stein’s exam door to follow up on request to meet MSgt Lambert. PA Stein invites the BHC into room and they have a brief discussion about the shared goal of helping MSgt Lambert quit smoking. MSgt Lambert isn’t able to stay for an appointment that morning but is willing to come back the following week.

9:05–9:30 a.m.: Second follow-up appointment with Captain (Capt) Perez, referred for assistance with weight management. Start appointment 5 minutes late due to prior consultation. BHC reviews food diary that Capt Perez completed since his appointment 3 weeks prior; they identify his pattern of overeating snacks when first arriving home after work. They develop behavior change plan of

packing a piece of fruit to eat mid-afternoon, eliminating from the home one of his typical after-work snack foods (mixed nuts), and storing out of sight another typical snack food (cookies). The appointment lasts 15 minutes (9:05 to 9:20 a.m.), leaving time to complete the note and give feedback to the patient's primary care provider ("Capt Perez is doing a great job of tracking his eating patterns and has lost 5 pounds since you referred him. He's still struggling with snacking after work. When you see Capt Perez, I'd recommend you ask how he is doing with eating a healthy afternoon snack before leaving work, and keeping his "high risk" snacks out of sight or not in the home at all.").

9:30–10:00 a.m.: Charting and feedback with primary care providers. BHC discusses with Mrs. Taylor's primary care provider the opinion that Mrs. Taylor's symptoms appear consistent with normal bereavement (not major depression) and that she might benefit more from behavioral intervention (i.e., increasing social activities, improving eating habits) than medication at the current time.

10:00–10:30 a.m.: Follow-up appointment scheduled for patient with depression. Patient does not show for appointment. The patient previously reported recent suicidal ideation with no plan or intent. BHC calls patient to assess safety. Patient states he "forgot" the appointment. He was not in acute distress and there were no increased risk indicators. Patient reschedules for later in week. BHC charts this information and uses remaining 15 minutes to circulate around the clinic, strengthening rapport with clinic staff.

10:30–11:15 a.m.: "Improving Sleep" class. BHC provides 45-minute educational class for six patients experiencing sleep problems. Content of class includes overview of relationship between behaviors and sleep, review of sleep hygiene and stimulus control principles, and development of individualized plans for sleep behavior change. (This class is part of a rotating series offered weekly, with topics including relaxation training, goal setting for health behavior change, and managing worry).

11:15–12:00 p.m.: Complete charting for class participants; further consultation with primary care providers from morning patients.

12:00–1:00 p.m.: Lunch.

The remainder of the day continues much like the morning. The BHC sees patients referred for job stress, panic disorder, headaches, stress, chronic pain management, and of course, Mrs. Garcia for diabetes management. There are interruptions by providers requesting that the BHC squeeze in an extra patient that day. Clearly, a typical day as a BHC involves close interactions with other members of the medical team. The pace of the BHC's activities mirrors the rapid pace of primary care, allowing for a larger number of patients to receive behavioral health services, consistent with a population health model of care. Ten to twelve patient appointments, punctuated by multiple brief consultations with team members, represents a typical day for the BHC. Patients with more significant needs are referred to specialty care for more intensive services.

Through this model, BHCs and primary care providers collaboratively manage the care of the majority of patients with behavioral health needs.

Navy: Behavioral Health Integration Program (2003–2005)

In the 1990s, the Navy had favorable experiences placing psychologists on aircraft carriers. This experience, combined with the U.S. Surgeon General's *Mental Health: A Report of the Surgeon General* (U.S. Department of Health and Human Services, 1999) suggesting the need for integrated behavioral health services, prompted the Navy to examine this need further. In 2000 they commissioned a report from the Center for Naval Analyses (Harris & Tela, 2002) on behavioral health care delivery models to examine the viability and benefit of integrating behavioral health providers into primary care. This report recommended that Navy Medicine implement a pilot program that integrated behavioral health providers into primary care. Acting on the recommendation in 2003, the Navy launched their Behavioral Health Integration Program (BHIP). Following the Air Force lead, they used a PCBH model of service delivery and adapted the Air Force BHOP manual for Navy use. The program was launched in seven clinics, primarily using psychologists as BHCs. Primary focus was given to targeting (a) improved problem recognition, (b) collaborative primary care provider and BHC care and management of psychosocial problems in primary care, (c) immediate access to BHC services, (d) better fit between the care patients seek in primary care and the services offered, and (e) improved triage to specialty mental health for problems that require specialty services. The Navy hired two civilian psychologists with expertise in this area to assist with the development of the project and the training of the BHCs. Although the demonstration program showed initial promise in its two years of operation (Harris & LeFavour, 2005), the Navy at that time chose not to pursue the further integration of psychologists into primary care because of system changes related to the deployment of substantially more Navy troops in support of Operation Iraqi Freedom. The Navy shifted psychology resources that could have gone to primary care clinics to the Navy's deployment health centers. Thus, psychologists filled a greater role in specialty mental health settings than in primary care settings in the Navy at that time.

Army: RESPECT-Mil

The Army developed and implemented a different model of primary care integration than the PCBH model pursued by the Air Force and the Navy. In 2004, the Army began the Re-Engineering Systems of Primary Care Treatment of Depression and PTSD in the Military (RESPECT-Mil) program in the Army. RESPECT-Mil was based on the three-component model (Oxman, Dietrich, Williams, & Kroenke, 2002), which seeks to improve primary care systems by (1) preparing the practice, (2) adding a nurse care facilitator, and (3) enhancing the interface between primary and mental health care.

In contrast to the PCBH model of care, which is designed to target all behavioral health problems that may present in primary care, RESPECT-Mil uses a care management model to enhance the identification, assessment, and treatment of depression and posttraumatic stress disorder (PTSD), two of the most common behavioral health concerns that present in military primary care settings. A more detailed description of RESPECT-Mil components can be found in Engel et al. (2008). Collaboration with mental health occurs with the assistance of a nurse care facilitator and an external psychiatry consultant. The care facilitator helps the primary care team monitor symptom severity, treatment adherence, and clinical risk. Although care facilitators do not provide therapy or treatment, during follow-up phone calls they help with problem solving, goal setting, and use of coping strategies. The care facilitator regularly staffs cases with a psychiatrist, who functions as an external consultant and provides recommendations for the primary care team regarding medication management. The care facilitator serves as a liaison between the patient, the primary care team, and the psychiatry consultant to facilitate the coordination of care.

Since the inception of RESPECT-Mil, 93 primary care clinics at 40 installations have implemented the program worldwide. Depression and PTSD were screened for at 3.17 million clinic visits, with 13.1% of these being positive for depression or probable PTSD diagnoses (L. Baliton, personal communication, October 7, 2013).

RESPECT-Mil demonstrates the success of a care management model for targeting two common behavioral health problems in the primary care setting. In care management models like RESPECT-Mil, psychologists do not work in primary care; they see patients in a specialty mental health clinic, and there are no significant changes in how they traditionally provide behavioral health services.

DoD-Level Involvement

Despite the early work done in the Air Force, Navy, and Army, the DoD Military Health System had no shared vision or implementation strategy for integrating behavioral health services into primary care. The need for an enterprise-level vision and strategy was amplified when the report of the Department of Defense Task Force on Mental Health (2007) recommended the integration of mental health professionals into primary care settings to improve the access and outcomes of behavioral health care.

It was clear that if the DoD was going to move forward with a shared vision and strategy, there needed to be a DoD-level lead, similar to the Service-level lead the Air Force put in place with the creation of the BHOP manager position. To that end, a DoD program manager for behavioral health in primary care position was created. A psychologist (Christopher L. Hunter) who had broad experience working in primary care, training others to work in primary care, conducting research, and developing benchmark standards for service delivery was hired to lead this effort. The first objective for this program manager was to bring Army, Navy, and Air Force subject-matter experts

together into a mental health integration working group. The group's mission was to develop clinical, administrative, and operational standards and policy for integrated care across all three Services.

Mental Health Integration Working Group (MHIWG)

The MHIWG was formed in 2008. The group had representation from the largest Services (i.e., Air Force, Navy, and Army) and across specialties (i.e., family medicine, psychology, social work, and psychiatry), with psychologists comprising the majority of group membership. The group met monthly for 22 months. Early in the process it became clear that members were applying different operational definitions to the same terms/concepts. To enhance accurate communication, the group operationally defined commonly used terminology and service delivery models. To ensure that future actions were scientifically based, the group reviewed relevant research and agreed to a set of evidence-informed conclusions about integrated behavioral health care. These conclusions served as a foundation on which the group established recommendations in the areas of (a) staffing, (b) evidence-based screening, assessment, and intervention, (c) expert trainer and behavioral health provider core competencies, and (d) Service-level program oversight and evaluation for integrating behavioral health providers and care facilitators into primary care. A detailed description of the recommendations can be found in Hunter and Goodie (2012). Of note, the group agreed that a blended model of care, combining the PCBH and care management models, was ideal. Therefore, the group recommended that in larger primary care clinics, a blended model of care combining the service delivery of a BHC and a care facilitator would provide the most comprehensive evidence-informed approach. In smaller clinics, a BHC would incorporate the activities of a care facilitator into the services the BHC delivered.

The Funding Problem

The MHIWG recommendations were briefed to key DoD stakeholders and policymakers (e.g., deputy surgeons general for the Air Force, Army, and Navy and the deputy assistant secretary of defense for clinical and program policy). The goals were to ensure that the recommendations were clear, to obtain buy-in, and to draft formal policy based on the MHIWG recommendations. Although policymakers agreed with the recommendations, they were unwilling to put them into formal policy. Funding was the primary concern. Without funds to meet minimum staffing levels, any policy mandating additional staff would result in an unfunded mandate, requiring the Services to pull funds from other areas to meet new policy standards.

The Funding Solution—A Tipping Point

In 2010 the Military Health System conducted a review of current programs to determine needed changes to meet key health care goals aligned with the Quadruple Aim. Development and implementation of the DoD PCMH was identified as a primary health care delivery target that would

significantly enhance the ability to meet Quadruple Aim goals. Building on the PCMH development work started in 2008; the DoD engaged in a final push to make PCMH rollout across the DoD a reality. This push included numerous meetings within DoD personnel, finance, and policy communities to ensure that a cohesive plan was in place to support and evaluate PCMH implementation. During this time, the DoD program manager for behavioral health in primary care, at key meetings, advocated for the importance of funding behavioral health personnel as key team members of the PCMH. The argument for funding was based on data from Army, Navy, and Air Force behavioral health services in primary care, emerging data from the Department of Veterans Affairs, and other civilian research. The argument was geared to the items shown in Table 3, which had been identified by the Military Health System as specific targets for improvement. The data suggested that integrating behavioral health services into primary care could lead to improvements on these items. These were part of a larger set of DoD Quadruple Aim strategic imperatives focused on improved mission readiness, enhanced clinical outcomes, improved patient and provider satisfaction with care, and health care cost management. This work, with the support of other invested individuals, was the tipping point leading the DoD to approve new funding as part of the DoD PCMH rollout for training and hiring 470 new full-time PCMH behavioral health personnel, which started in early 2012. This new funding did not impact specialty mental health clinic funding or staffing levels.

Policy

Securing funds to hire behavioral health personnel for the PCMH was the tipping point for moving forward with drafting policy. The DoD program manager for behavioral health in primary care transformed the MHIWG recommendations into a draft DoD policy document. Working for 9 months, a work group comprising psychology, psychiatry, and primary care experts transformed this draft policy into a document detailing minimum standards, competencies, and program evaluation for integrated care within and

across the Services. After the initial draft was complete, it went through additional review and edits from multiple system stakeholders, and after a time period of 3 years from the start of the initial draft, it was signed into policy as Department of Defense Instruction 6490.15: *Integration of Behavioral Health Personnel (BHP) Services Into Patient-Centered Medical Home (PCMH) Primary Care and Other Primary Care Service Settings* (U. S. Department of Defense, 2013).

Measuring Impact

As a result of the phased implementation of the PCMH and the staggered integration of behavioral health providers and care facilitators, there is a unique opportunity to evaluate outcome metrics with and without integrated care in the PCMH. Variables of interest at the system, clinic, provider, and patient levels include both process (e.g., percentage of patients screened for depression) and outcome (e.g., response to depression treatment) measures that align with the Quadruple Aim and Military Health System strategic imperatives. A detailed list of measures under consideration can be found in Hunter and Goodie (2012).

Through a Physician's Eyes Continued: The Path to Integrated Care

Perhaps the most important impact, besides the impact on the health of the patient and the population of patients, is the impact on the practice of the health care providers. Again, the anecdotal experiences of one internist (Kevin A. Dorrance) capture this impact:

The PCMH was the beginning of my journey. I now had a holistic foundation to expand our care and focus on real prevention and healing. The BHC was an integral part of the PCMH health care team. Patients were more likely to agree to see a BHC knowing they could receive same-day services in primary care and would not have to navigate the specialty mental health clinic systems. I received same-day verbal and written feedback on my patients from the BHC. The feedback usually included ideas on how we could jointly address patients' difficulties in the future and what I might say and do with these patients in upcoming appointments.

Table 3
Expected Impact of Behavioral Health Integration in the PCMH

1. Better identification and management of those at risk for suicide.
2. Decreased use of emergency services for behavioral health concerns.
3. Improved PCMH staff and patient satisfaction with health care.
4. Recapture of family member behavioral health services from purchased network care.
5. Lower per-member per-year health care cost.
6. Improved evidence-based care for anxiety and depression.
7. Increased percentage of enrollees engaged in healthy behaviors (e.g., quitting smoking).
8. Increased behavioral health screening, referral, and engagement.

Note. PCMH = patient-centered medical home.

The BHC opened up possibilities to help patients with behavioral and psychological conditions. I no longer felt the need to always start with testing and medications. Together, we have a better means of helping patients heal.

Integration and growth do not come without cost. The question of what I had to sacrifice in order to implement BHCs within our medical home is legitimate and significant. However, integration has been less of a sacrifice than many might think. When I considered the consumption of resources of traditional health care services, the integration turned out not to be much of a sacrifice at all. The high utilizer becomes a key consumer of BHC services rather than traditional primary care elsewhere in our General Internal Medicine Service and in our specialty clinics. As a result, what might initially seem like a financial and organizational challenge is not. With our BHC patients on the road to prevention and healing, we now have more opportunity to provide primary care services to our other patients and reduce the overall demand for services.

When we examined our historical workload it was apparent that our current staffing resources were inadequate to support the current level of effort. However, when we looked more analytically at the nature of the problems many of our patients were being seen for, it became clear that a different approach was necessary. It was not easy to convince the medical staff that hiring a BHC would not only reduce overall workload and make it unnecessary to hire additional registered nurses and other professional staff to support traditional primary care but that it would also improve the overall well-being of many of our patients. I struggled with both management and my PCMH teams as the decision was made to continue to pursue and build an integrative model of care with the BHC as a core element.

We have now been providing this level of care for over 3 years and grown the service to include other supporting disciplines (e.g., dietitians, health educators, social workers), all within the primary care clinic. The demand for these services has grown tremendously, and the PCMH teams continue to rely heavily on the BHC across the spectrum of health care.

Conclusions and Recommendations

Psychologists played a significant role in developing and initiating integrated care programs, evaluation, training, and policy in the DoD. At the same time, there is still much to be done, and psychologists will continue to play a significant role as the DoD moves forward. Based on our experience there are several recommendations for psychologists to consider, depending on what role they are playing in integrated care (Hunter, 2013; Hunter & Goodie, 2012):

1. Establish a rationale for integrated behavioral health that is clear, evidence-based, and considers the financial and operational barriers within a given system.
2. Include relevant health care professions within the system (e.g., primary care providers, psychiatrists, psychologists, and social workers) when developing a service delivery model and standards. The views brought by various professions can strengthen the program and improve important system stakeholder buy-in.
3. Establish operationally defined and agreed upon integrated care constructs to facilitate communication and shared vision. Do not assume that integrated, collaborative, or other delivery-specific terms are being used consistently across or within professions.

4. From the start, include key management, personnel, and finance individuals in program development. Without funding and management support, even the best plans can get shut down.

5. Identify key primary care and behavioral health supporters that can lead their professions in program development. Having strong primary care and behavioral health advocates who can provide key finance, personnel, and management stakeholders with the expected return on investment, scientific data supporting the proposed effort, and personal real-world stories of patient and provider satisfaction and change can facilitate movement of the operational and clinical parts of the system in the same direction.

6. Remember that timing is important. Determine when leadership may be receptive to a proposal for a new service delivery model. Move forward when you can present a clear rationale and answer difficult questions in thoughtful ways.

7. Develop a set of administrative and clinical standards that are observable and can be enforced. Develop methods to ensure the work force is trained to the clinical and administrative standards. Fidelity to a model of service delivery is needed if desired outcomes are to have a chance to be realized.

8. Develop manuals addressing the clinical, administrative, operational, and financial components to guide practitioners and administrators and inform them about what the integrated care will and will not do.

9. Develop a set of process and outcome metrics and an effective evaluation design. Demonstrating return-on-investment results to management, providers, and patients promotes ongoing support efforts and assists with changing service delivery when expected outcomes are not reached.

Psychologists have played a significant role in establishing integrated care as an important and valued component of the DoD PCMH. As the nation faces significant changes in its health care system, the diverse contributions of psychologists in the DoD, from direct clinical care to policy development, suggest that psychologists are critical for implementing integrated care in systems throughout the United States.

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