Working Together: Interprofessional Clinical Care in Action

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The Team

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- Jennifer Bean, Pharm.D., BCPS, BCPP- Clinical Pharmacy Specialist who has worked in long-term geriatrics care, home based primary care, psychiatry (acute and outpatient), and academic detailing

- R. Jill Pate, M.D.- Chief of Psychiatry, has worked with all age ranges and worked in an interprofessional private practice setting prior to working at the VA

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Disclosures

• There are no relevant financial disclosures
• Dr. Erin Patel is on the TPA Board of Directors, but is not compensated as part of this position
• Dr. Jennifer Bean is actively involved in the College of Psychiatric and Neurologic Pharmacists (CPNP) but is not compensated
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• Office of Academic Affiliations

• Members of the BHIP teams

• All interprofessional trainees
Schedule

- Drs. Patel and Bean: Interprofessional Core Competencies and Outcomes Associated with Interprofessional Care
- Drs. Rothschild and Pate: Primary Care Mental Health Integration (PCMHI)
- 3:30 - Break
- Drs. Patel, Jabeen and Bean: Behavioral Health Interdisciplinary Programs (BHIPs)
- Drs. Patel, Heidelberg, Pate, and Bean: Geriatrics BHIP Clinic
- Drs. Bean and Heidelberg: Comprehensive Care Clinic (CCC)
- Questions and Open Discussion
Prerequisites

• Participants should have an understanding of the clinical contributions of other healthcare team members, such as Psychiatrists and Pharmacists.
Objectives

- At the completion of this session participants will identify the four core competencies of interprofessional (IP) care and discuss how these can be applied to clinical and educational programs.

- At the completion of this session participants will describe research on IP care as it relates to healthcare outcomes, educational programs, and employee satisfaction.

- At the completion of this session participants will describe how to develop IP clinics within their organization, especially within VA healthcare settings.

- At the completion of this session participants will be able to implement quality improvement measurement into their IP clinics.
Interprofessional Education and Care

IP Core Competencies

IP Outcomes
Teamwork

“A team is a small number of people with complementary skills who are committed to a common purpose, performance goals and approach for which they hold themselves mutually accountable.”

Katzenbach; The Wisdom of Teams: Creating the High Performance Organization
I'll bite your stitches if you bite mine...
What’s Old is New Again.....
“During the course of a 4-day hospital stay, a patient may interact with 50 different employees, including physicians, nurses, technicians, and others. Effective clinical practice thus involves many instances where critical information must be accurately communicated. **Team collaboration is essential.** When health care professionals are **not communicating effectively, patient safety is at risk** for several reasons: lack of critical information, misinterpretation of information, unclear orders over the telephone, and overlooked changes in status.”

Joint Commission on Accreditation of Healthcare Organizations. The Joint Commission guide to improving staff communication. Oakbrook Terrace, IL: Joint Commission Resources; 2005.
“According to the Joint Commission (formerly the Joint Commission on Accreditation of Healthcare Organizations, JCHAO), if medical errors appeared on the National Center for Health Statistic’s list of the top 10 causes of death in the United States, they **would rank number 5** — ahead of accidents, diabetes, and Alzheimer’s disease, as well as AIDS, breast cancer, and gunshot wounds. The 1999 Institute of Medicine (IOM) report, *To Err Is Human: Building a Safer Health System*, revealed that between 44,000 and 98,000 people die every year in U.S. hospitals because of medical errors. Even more disturbing, **communication failures are the leading root cause of the sentinel events** reported to the Joint Commission from 1995 to 2004. More specifically, the Joint Commission cites communication failures as the leading root cause for medication errors, delays in treatment, and wrong-site surgeries, as well as the second most frequently cited root cause for operative and postoperative events and fatal falls.”
“Currently, the transformation of health professions education is attracting widespread interest. The transformation envisioned would enable opportunities for health professions students to engage in interactive learning with those outside their profession as a routine part of their education. The goal of this interprofessional learning is to prepare all health professions students for **deliberatively working together** with the common goal of building a safer and better patient-centered and community/population oriented U.S. health care system.”

“The Accreditation Council on Graduate Medical Education (ACGME) Outcomes Project is being used as a competency guide by many undergraduate programs in medicine. It incorporates general competencies of professionalism, interpersonal and communication skills, and systems-based practice, along with an expectation that residents are able to work effectively as members or leaders of health care teams or other professional groups, and to work in interprofessional teams to enhance patient safety and care quality (ACGME, 2011). Analysis of data from a 2009 ACGME multispecialty resident survey showed that formal team training experiences with non-physicians was significantly related to greater resident satisfaction with learning and overall training experiences, as well as to less depression, anxiety, and sleepiness, and to fewer reports by residents of having made a serious medical error (Baldwin, 2010).”

What’s the Problem?

- Medical errors were estimated to cost 17.1 billion dollars in 2008\(^1\)
- Treatment of psychiatric conditions was ranked in the top five most expensive medical conditions, costing an estimated 73 billion dollars in 2010\(^2\)
- Mental health disorders accounted for an annual 63.3 million outpatient visits to physicians’ offices, clinics, or emergency departments\(^3\)
- Currently, most mental health services are delivered by one provider\(^4\)

\(^1\) Van De Bos, 2011; \(^2\) Center for Financing, Access and Cost Trends, 2010; \(^3\) NCHS, 2013; \(^4\) NCHS, 2011
And?

- Effective clinical practice involves instances where critical information must be accurately communicated\(^1\)
- Poor communication between healthcare professionals is a common root cause of reported sentinel events\(^2,3,4\)
  - Medication errors
  - Diagnostic conflicts
  - Polypharmacy
  - Delays in treatment

\(^1\) The Joint Commission, 2005; \(^2\) Anderson, 2010; \(^3\) The Joint Commission, 2013; \(^4\) Maher, 2013
Interprofessional Practice in Current Climate

• Affordable Care Act
  – Accountable Care Organizations
  – Patient Centered Medical Homes

• Department of Veterans Affairs
  – PACTs
  – Behavioral Health Interdisciplinary Programs (BHIPs)
• Interprofessional Education Collaborative
• Formed in 2009
• Six disciplines came together to create core competencies for IP collaborative practice; to assist in developing higher education curriculum
  – Allopathic and osteopathic medicine, dentistry, nursing, pharmacy, and public health
• Current supporting organizations:
Interprofessional Care

- **Uniprofessional**: same discipline or profession
- **Multiprofessional**: various disciplines come together to understand a particular problem; they work *alongside* one another but do not interact with one another
- **Interprofessional**: two or more professions learn *with, from, and about* each other to improve collaboration and the quality of care; the integration and modification of different professions’ contributions in light of input from other professions

http://www.ipe.utoronto.ca/educators/definitions/html
2011- Expert Panel- Core Competencies

• 1. Values/Ethics for Interprofessional Practice

• 2. Roles/Responsibilities

• 3. Interprofessional Communication

• 4. Teams and Teamwork
Values/Ethics for Interprofessional Practice

• Work with individuals of other professions to maintain a climate of mutual respect and shared values.
  – 10 specific competencies/skills needed
    • Place the interests of pts and populations at the center of IP healthcare delivery.
    • Respect the unique cultures, values, roles/responsibilities, and expertise of other health professions.
    • Develop a trusting relationship with pts, families, and other team members.
    • Manage ethical dilemmas specific to IP pt/population centered care situations.
Ethics

• Challenges include:
  – Potentially different ethical standards across disciplines
  – Different goals, priorities, and perceptions
  – Ensuring proper consent from patients and families
  – Focus on team vs. individuality and professional identity
Roles and Responsibilities

- Use the knowledge of one’s own role and those of other professions to appropriately assess and address the healthcare needs of the patients and populations served.
  - 9 specific competencies/skills needed
    - Communicate one’s role and responsibilities clearly to pts, families, and other professionals
    - Recognize one’s limitations in skills, knowledge, and abilities.
    - Use the full scope of knowledge, skills, and abilities of available health professionals and healthcare workers to provide care that is safe, timely, efficient, effective, and equitable.
    - Forge interdependent relationships with other professions to improve care and advance learning.
Roles and Responsibilities

• Reflections:
  – Who might be on a MH care team
  – What unique skills and knowledge does each discipline bring to the team
  – How do these skills enhance patient outcomes and clinical care
  – What is your highest level of practice/scope

• Exercise- how would you describe what you bring to a team?
Interprofessional Communication

• Communicate with patients, families, communities, and other health professionals in a responsive and responsible manner that supports a team approach to the maintenance of health and treatment of diseases
  – 8 specific competencies/skills needed
    • ....communicate.....in a form that is understandable, avoiding discipline-specific terminology when possible
    • Express one’s knowledge and opinions......with confidence, clarity and respect.....
    • Give timely, sensitive, instructive feedback to others about their performance on the team.....
    • Communicate consistently the importance of teamwork in pt centered and community focused care
Communication

• Reflections:
  – Do you communicate better in written or oral formats
  – Which method do you prefer to receive information

• The problem with common psychology terms

• Discussion:
  – Giving constructive feedback to team members
    • Clinical Care
    • Behaviors
  – Receiving constructive feedback
Common Barriers to Interprofessional Communication and Collaboration

- Personal values and expectations
- Personality differences
- Hierarchy
- Disruptive behavior
- Culture and ethnicity
- Generational differences
- Gender
- Historical interprofessional and intraprofessional rivalries
- Differences in language and jargon
- Differences in schedules and professional routines
- Varying levels of preparation, qualifications, and status
- Differences in requirements, regulations, and norms of professional education
- Fears of diluted professional identity
- Differences in accountability, payment, and rewards
- Concerns regarding clinical responsibility
- Complexity of care
- Emphasis on rapid decision making
Teams and Teamwork

• Apply relationship-building values and the principles of team dynamics to perform effectively in different team roles to plan and deliver patient-/population-centered care that is safe, timely, efficient, effective, and equitable.

– 11 specific competencies/skills needed
  • Describe the process of team development and the roles and practices of effective teams.
  • Develop consensus on the ethical principles to guide all aspects of pt care and team work.
  • Apply leadership practices that support collaborative practice and team effectiveness.
  • Shared accountability
“Teamwork is the interaction or relationship of two or more health professionals who work interdependently to provide care for patients. Teamwork means members of the team:

• Are mutually dependent;
• See themselves as working collaboratively for patient-centered care;
• Benefit from working collaboratively to provide patient care;
• Share information which may lead to shared decision-making; and
• Know when teamwork should be used to optimize patient-centered care.”

Poulton, B. Teamwork and team development in health care social care.
Intentional Skills

• Bring yourself into the encounter- open, honest, genuine, personable
• Actively listen
• Check out expectations
• Diplomacy and humility
• Mutual respect
• Be fully present
• Take risks- share concerns, expectations, biases
• Value sharing
• Be open to feedback- ask for it
• Accept individual accountability
• Recognizing personality factors
• Understand and accept scope of practice and individual contributions
• Shared decision making- breaking down the hierarchy
• Find common ground in the small talk
Putting the “I” Back in Team

• Social Capital
• Perspective Taking
• Negotiating Priorities
• Resolving Conflict
• Building Relationships
Social Capital

• Goodwill available to individuals or groups...information, influence, solidarity... (Adler and Kwon, 2002)
• Norms of reciprocity and trust can be beneficial to the group (Bourdieu, 1986)
• Interpersonal trust, norms of reciprocity, and social engagement that foster community and social participation (Putnam, 1993, 1995, etc. )
• The ins and outs of a relationship- putting good in to get good out for self, team, patient, environment of care, etc.
Change Your Perspective

Perspective

PERSPECTIVE TAKING
Perspective Taking

- The ability to shift perspectives is viewed as a major developmental milestone in cognitive functioning (Piaget, 1932)
- Checking out what others know or perceive is critical (Bakhtin, 1981; Clark, 1985)
- If active perspective taking is not engaged, flawed decisions and conflicts may be the consequence (Galinsky, 2000)
- Shared decision making, common goals, reducing assumptions and biases, open communication about your perspective or priorities
Negotiating Priorities

- It is not always obvious what to offer, how to offer it or how to find out what would be worth offering (Fairman, 2012)
- A means by which people with different interests can agree on how to reconcile them (Kennedy, 1993)
- Co-creating the third option (Covey, 2012)
- Requires open dialogue, active listening, eliminating biases, perspective taking, shared goals/visions
- Shared mental set/image/goal
- Essential for effective healthcare teams
- Viewing the patient as a member of the team
Resolving Conflict

• Conflict can be viewed as an opportunity for communication/conversation, relationship building, and compromise
• Accommodation = realizing you are wrong and minimizing damage (Manning & Robertson, 2004)
• Compromising = moderately important goals + equal balance of power + strong commitment to mutually exclusive goals (Manning & Robertson, 2004)
• Poorly managed conflict can lead to medical errors, poor patient outcomes, and disruptive work environment
Building Relationships

• Relationship Centered Care (Beach et al., 2006):
  • 4 principles:
    • Relationships in healthcare ought to include the *personhood* of the participants
    • *Affect and emotion* are important components of these relationships
    • All healthcare relationships occur in the context of *reciprocal influence*
    • The formation and maintenance of genuine relationships in healthcare is *morally valuable*
Interprofessional Collaboration: Changes in the Building of Teams

- Openly discuss each others perspectives, contributions, expectations, past experiences, etc.
- Use intentional skills
- Question own assumptions- shadowing opportunities?
- Learn together and from one another
- Being a team member does not mean that you are no longer an “I”; learning how to integrate these roles
- Goal is to have everyone work at that TOP of their scope in order to improve patient care and outcomes
Components of Successful Teamwork

- Open communication
- Non-punitive environment
- Clear direction
- Clear and known roles and tasks for team members
- Respectful atmosphere
- Shared responsibility for team success
- Appropriate balance of member participation for the task at hand
- Acknowledgment and processing of conflict
- Clear specifications regarding authority and accountability
- Clear and known decision making procedures
- Regular and routine communication and information sharing
- Enabling environment, including access to needed resources
- Mechanism to evaluate outcomes and adjust accordingly
Making Group Decisions

• A situation where a group of individuals collectively make a choice from the alternatives presented to them

• Some believe that group decisions are more effective than decisions made by individuals

• Or are group decisions inherently flawed?
  – Groupthink
  – Group polarization and cohesiveness
  – Social influence
  – Focus on shared information
Problems Inherent in Group Discussions/Decisions

- Procrastination
- Bolstering
- Lack of responsibility
- Satisfy/suffice
- Getting through
- Trivialization
- Cognitive errors
Avoiding Pitfalls Associated with Groupthink

- Critical Evaluator role
- Leaders remain unbiased
- Leaders should not attend meetings
- Multiple, independent groups working on same problem
- Examination of all alternatives
- Discussion with those outside of the group
- Invite and engage experts
- Devil’s advocate
- Take risks- cognitive and behavioral
How Do We Make Decisions?

- Consensus decision making
- Voting based methods
  - Plurality (majority rules or 2/3 rule)
- Delegation
- Averaging
- Unanimous
- Random
- Leader models
  - Decide, consult, delegate, facilitate
Healthcare Decision Making

Old Model

• Withhold information to “protect” the patient
• Hierarchy bound
• Information was “controlled” by the medical profession
• Leader driven model
• No room for questioning

New Model

• All information, good and bad, and options must be presented or this leads to a disruption of the relationship
• Focus on relationship building/trust
• Patient empowerment
• Inclusion of multiple viewpoints
• No “right” answer
• Access to information from a variety of sources
Old View of Patient’s Decision Making

• Haphazard, uninformed
• Past experiences
• Focus on family and culture
• Hierarchy
• Collection of information
  – Friends, family
  – Internet, social media
Recovery is “a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential.” It includes:

- Health
- Home
- Purpose
- Community
Shared decision making (SDM) is a collaborative process that allows patients and their providers to make health care decisions together, taking into account the best scientific evidence available, as well as the patient’s values and preferences. SDM honors both the provider’s expert knowledge and the patient’s right to be fully informed of all care options and the potential harms and benefits. This process provides patients with the support they need to make the best individualized care decisions, while allowing providers to feel confident in the care they prescribe.

http://www.informedmedicaldecisions.org/what-is-shared-decision-making/
Shared Decision Making (SDM)

• “SDM is an opportunity to make recovery real. By developing and promoting SDM in mental healthcare, we can advance consumer-centered care and recovery” (Power, 2007)

• “The practitioner brings information related to the illness, treatment options, risks, benefits, and evidence base. The patient is considered an expert in his or her own values, treatment preferences, and treatment goals.” (Schauer et al., 2007, p. 56)

• According to Deegan (2007, p. 64), “SDM is founded on the premise that two experts are in the consultation room. . . neither. . . should be silenced, and both must share information in order to arrive at the best treatment decision possible”
Steps of SDM

- Recognizing decision to be made
- Identify partners in the decision as equals
- Statement of the options as equals
- Exploration of understand and expectations
- Identifying preferences
- Negotiating options/concordance
- Sharing the decision
- Follow-up

Simon et al, 2006
Shared Decision Making

• Rejects the previous hierarchical power structures in mental health with the provider “knowing all”
• Patient and Providers working jointly together
• Promote patient empowerment in decisions
• Facilitating patient responsibility
Do all patients want to engage in Shared Decision Making?

- Patients differ widely in their preference for involvement in mental health decisions

- Park et al (2014) conducted a study on Veteran’s opinions on SDM in MH
2 VA Medical Centers
239 participants in MHC
- 89% male
- Mean age 54.3
- 47% Caucasian; 47% African-American
- 56% had at least some college
- 20% working for pay
- 30% dx with schizophrenia spectrum; 32% dx with bipolar; 26% dx with depression; 12% dx PTSD
Conceptualized Three Domains of Shared Decision Making (SDM)

From Levinson and colleagues (2005)

- I prefer to rely on my psychiatrist’s/nurse practitioner’s knowledge and not try to find out about my mental illness on my own (knowledge)
- I prefer that my psychiatrist/nurse practitioner offer me choices and asks my opinion about treatments for my mental illness (options)
- I prefer to leave decisions about my mental health care up to my psychiatrist/nurse practitioner (decisions)
Results

• 85% AGREEMENT-- I prefer that my psychiatrist/nurse practitioner offer me choices and asks my opinion about treatments for my mental illness (options)

• 61% AGREEMENT-- I prefer to rely on my psychiatrist’s/nurse practitioner’s knowledge and not try to find out about my mental illness on my own (knowledge)

• 64% AGREEMENT--I prefer to leave decisions about my mental health care up to my psychiatrist/nurse practitioner (decisions)
Predictors of Greater Interest in Partnering in Decisions or Obtaining Knowledge

- Being African American
- Working for pay
- Attending some college
- Diagnosis not on schizophrenia spectrum
- Lower rating on therapeutic alliance scale
Engaging Patients in the Decision Making Team

- Shared understanding
- Common knowledge
- Trust
- Learning from each other
- Focus on feelings and relationship building
- Common goal
- Communication
- Dissolution of hierarchy
Decisional Aids

- Decisional Aids are important
  - Compensate for cognitive impairments
  - Organize ambiguous Information
  - Shared information base
    - Decisional Balance Activity to permit systematic consideration (Pro/Con List)
    - Fact sheets to share knowledge
    - Values clarification exercises to clarify consumer goals
Patient Decision Aids

• Ottawa Decision Aid
  – http://decisionaid.ohri.ca/decaids.html

• WorkWORLD

• CommonGround
Outcomes: Interprofessional Care

• IPE interventions have been associated with positive outcomes\(^1\)
  – Attitudes toward other professions\(^2\)
  – Increase in collaboration\(^3\)
  – Increased patient satisfaction\(^4\)
  – Reduced clinical error rates\(^3\)
  – Increased competency of mental health providers\(^5\)

• Other research suggests that IPE interventions are not associated with more positive outcomes compared to healthcare without IPE\(^6\)

\(^1\) Reeves et al., 2008; \(^2\) Hammick et al., 2007; \(^3\) Morey, 2002; \(^4\) Campbell, 2001; \(^5\) Young, 2005; \(^6\) Thompson et al., 2000
Outcomes: Interprofessional Care

• Why do outcome measures matter?
• What are we trying to improve?
• Where should the focus be?
  – Patients
  – Providers
  – Teams
  – Care organizations
• Turning care into dollars
We are in the Infancy of IP Care (again)

• Transition of traditional health professions education
• Move away from fee for service payment structures
• Identification of relevant outcomes
• More sophisticated measurement of team functioning
• Patient buy-in
• Removal of professional silos
Primary Care Mental Health Integration
Learning Objectives

• Explain how the VA’s PACT and mental health systems can collaborate to promote optimal patient care, lower medical expenses long term, and better patient outcomes.

• Describe the rationale and component of offering PC-MHI as a co-located, collaborative service.

• Identify ways in which PC-MHI and PACT can collaborate to reach optimal goals for meeting the current PACT initiative.
Integrated Care

• Mental Health and Primary Care Providers interact collaboratively to comprehensively meet the health needs of their patients.

• Goal of integrated care is to support the Primary Care Provider.

• Role of MH Provider in Integrated Care is quite different than a traditional approach to the provision of mental health care.
A “New” Approach

• “Primary Care Practitioners are a critical link in identifying and addressing mental disorders...opportunities are missed to improve mental health and general medical outcomes when mental illness is under-recognized and under-treated in primary care settings.” —Fmr Surgeon Gen. David Satcher

• “The greatest mistake in the treatment of diseases is that there are physicians for the body and physicians for the soul, although the two cannot be separated.” —Plato
Current Aligned VHA Programs

• Patient Aligned Care Team (2009)
• Primary Care-Mental Health Integration (2007)
• Uniform MH Services Package (2008)
Mental Health Enhancement to Support Primary Care Teams/PACTs

• Initial funding for integration of mental health in the primary care setting in FY2007

• Requirement for all sites as of FY2009 - “Blended Model”:
  – Care Management: Patient education and longitudinal monitoring, primarily of medication-based care
  – Co-located, Collaborative mental health provider: Education, consultation for the team, provide behavioral medicine and psychosocial services
PC-MHI Team Requirements

- VHA Handbook 1160.01 requires that VAMCs, very large CBOCs, and large CBOCs integrate Mental Health services into primary care venues by providing co-located collaborative care and care management. This has been an ongoing initiative across VHA.

  - TVHS began implementation of this initiative at the Nashville Campus in 2011 and expanded to York, Charlotte/Meharry, Chattanooga, and Clarksville in 2012. Medication support was added in 2013 across campuses. RN Care Managers were added in 2014 and this year we have added clinical social work to complete the PC-MHI teams.
## Future of VA Health Care

<table>
<thead>
<tr>
<th>Past VA</th>
<th>Present VA</th>
<th>Future VA</th>
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<tbody>
<tr>
<td>“What can I fix?”</td>
<td>“How can we help what is wrong with you?”</td>
<td>“How can we help you live the life you want to live?”</td>
</tr>
<tr>
<td>Physician</td>
<td>Clinical Team</td>
<td>Veteran, Family and Health Care Team</td>
</tr>
<tr>
<td>Case-Based Paper Medical Record</td>
<td>Disease-Based Electronic Medical Record</td>
<td>Whole-Person Electronic Health Record</td>
</tr>
<tr>
<td>“We’ll address your immediate concern.”</td>
<td>“You have a risky problem, please follow this plan to improve by your next visit.”</td>
<td>“We can design your personalized health plan to meet your goals.”</td>
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## Principles of the Patient Aligned Care Team (PACT)

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<thead>
<tr>
<th>Principle</th>
<th>Description</th>
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</table>
| **Patient-Driven**             | • The primary care team is focused on the whole person  
• Patient-preferences guide the care provided to the patient |
| **Team-Based**                 | • Primary care is delivered by an interdisciplinary team led by a primary care provider using facilitative leadership skills |
| **Efficient**                  | • Veterans receive the care they need at the time they need it from an interdisciplinary team functioning at the highest level of their competency |
| **Comprehensive**              | • Primary care is point of first contact for a range of medical, behavioral and psychosocial needs, fully integrated with other VA health services and community resources |
| **Continuous**                 | • Every patient has an established and continuous relationship with a personal primary care provider |
| **Communication**              | • The communication between the Veteran patient and other team members is honest, respectful, reliable, and culturally sensitive |
| **Coordinated**                | • The Primary Care team coordinates care for the patient across and between the health care system including the private sector. |
Principles of Integrated Care in VA

- Open or advanced access (temporal and spatial integration) in VA medical homes [Patient Aligned Care Teams]
- Problem-focused assessment and treatment: Tend to what the Veteran wants tended to
- On-site clinicians in primary care: Consultation, collaboration, assessment; Part of treatment team, not enhanced referral, 30 minute appointments
- Stepped care
- Measurement-based care
- Care management
- Referral management when needed
Primary Care Realities

• A Natural Fit
  – Current literature suggests 30-70% of primary care appointments have a psychosocial component.
  – Patients initially bring their mental health concerns to primary care – Patient Aligned Care Teams (PACT) in VA
  – Screening for mental health problems takes place in primary care by the PACT team (i.e. clinical reminders, interview, etc.)
  – Feedback from PCP’s within TVHS suggest PC-MHI services assist in providing optimal care to the veteran and are a great asset to their practice.
Why Integrate Mental Health Services into PACT?

Numerous randomized trials show that collaborative care modes are effective in the treatment of depression in the Primary Care setting.

**Integrated Mental Health Care:**

- Improves **identification** of prevalent mental health conditions
- Improves **access** to appropriate evaluation and treatment
- Improves treatment **engagement** and **adherence**
- Increases probability of receiving **high quality care**
- Improves clinical and functional **outcomes**
- Increases **patient satisfaction**

Machado, R.J., & Tomlinson, V. (2011). *Bridging the Gap Between Primary Care and Mental Health*. Journal of Psychosocial Nursing and Mental Health Services, 49(11), 24-29.
Primary Care-Mental Health Integration

- Two Main PC-MHI Components:
  - Co-located Collaborative Care
    - Same day access (when available), Referral Assistance, Brief Therapy, Medication Consultation
  - Care Management
    - Behavioral Health Laboratory (telephone based)

- Blended programs have **both** of these *complementary* components

- Focus on common conditions:
  - Depressive and Anxiety Disorders
  - Alcohol **Misuse and Abuse**
  - PTSD Screening/Assessment
Clarifying Roles

Take a minute to consider:

- How does integrated mental health care differ from treatment offered in a specialty mental health setting?

- How is your role as a PC-MHI provider different than your role in specialty mental health?
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<tr>
<th></th>
<th>Co-Located Collaborative MH Care</th>
<th>Mental Health Specialty Care</th>
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</thead>
<tbody>
<tr>
<td>Location</td>
<td>• On-site</td>
<td>• A different floor or building</td>
</tr>
<tr>
<td>Population</td>
<td>• Most are healthy</td>
<td>• Most have MH diagnoses</td>
</tr>
<tr>
<td>Inter-Provider Communication</td>
<td>• Collaborative &amp; ongoing consultations via PCP’s method of choice</td>
<td>• Consult reports · EMR notes</td>
</tr>
<tr>
<td>Service Delivery Structure</td>
<td>• Brief appointments (30 min) · Limited number of appointments (4-6 sessions)</td>
<td>• 50 - 90 minute psychotherapy sessions · 14 week minimum</td>
</tr>
<tr>
<td>Approach</td>
<td>• Problem-focused · Solution-oriented · Patient-centered</td>
<td>• Varies by therapy · Diagnosis-focused</td>
</tr>
<tr>
<td>Treatment Lead</td>
<td>• PCP continues to be lead</td>
<td>• MHP is lead</td>
</tr>
<tr>
<td>Principal Focus</td>
<td>• Support the overall health of the Veteran · Focus on function</td>
<td>• Cure or ameliorate mental health symptoms</td>
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Overview of PCMHI

• First line of Stepped Care Model
  (PCMHI → BHIP → Specialty MH → Inpatient → Residential Treatment)

• PCMHI team: RN Care Manager, Psychologist, Mental Health Social Worker, Psychiatric Provider (NP or MD)

• Inclusion/Exclusion Criteria

• Care Management/Telephone call center support
Behavioral Health Lab: Call Center Support

- Behavioral Health Laboratory (BHL)
  - Evidence-based clinical service supporting mental health and substance abuse management in the primary care setting
  - Associated with a significant increase in screening and identification of patients needing MH/SA services (Oslin, et. al. 2005)
    - **Depression Monitoring**: Monthly follow up using empirically supported screening tools at baseline and monthly for three months following initiation of a psychotropic medication in PACT.
    - **Referral Management**: RN care managers assist with coordination of care efforts to assist with providing education and assisting with ongoing support to veteran if needed.
The Role of the Integrated Mental Health Providers

- Mental health provider embedded in primary care clinic with shared responsibility for evaluation, treatment planning and monitoring outcomes
- Consultation to the PCP to assist with collaborative treatment planning
- Immediate evaluation as needed
- Brief treatment
- Educational function
Moving along the continuum of care: From Primary Care to Specialty MH

1. Veteran is briefly assessed by PC-MHI staff.
   - Veterans requiring short term therapy remain in PC-MHI.
   - Those determined to need long term MH care are scheduled for a GMH-BHIP intake.

2. BHIP Social Work Case Manager performs the intake assessment and works with the Veteran to determine his/her treatment goals.

3. The Veteran is then presented by the BHIP SW at one of the two weekly team meetings. Assignment to psychiatrist, if needed, occurs at this time.

4. Case is discussed by BHIP team and treatment interventions are decided. The team then assigns the MHTC using the algorithm.

5. BHIP SW Case Manager then follows up with Veteran, completes initial treatment plan, and schedules the appropriate follow-up appointments.

VETERANS HEALTH ADMINISTRATION
SPECIALTY MH

- Treatment of severe depression, anxiety, and other disorders
- PTSD specialty treatment; Substance dependence treatment
- Treatment of serious mental illness
- Full spectrum of psychosocial rehabilitation and recovery services
  - Inpatient psychiatric care
  - Residential treatment
  - Compensated work therapy
  - Homeless program

PRIMARY CARE

- Integrated Care for physical and mental health in one setting
- Evaluation and treatment for mild to moderate mental health conditions (depression, substance misuse, anxiety, PTSD)
  - Follow-up evaluation for positive MH screens
    - Behavioral health interventions for chronic disease
      - Care management
      - Referral management

- Screening for mental health conditions
- Initiation of pharmacological treatment for mild to moderate mood symptoms
  - Co-management of Veteran care with PC-MHI and specialty MH providers
General Program Flow

Patient Identification
Screening / Clinical Assessment / Casefinding

STEP 1

Patient Education and Self Care

STEP 2

Baseline Assessment

STEP 3

Treatment Recommendations

STEP 4 and above

Specialty Care

Brief Treatments

Prevention / Health Promotion

No treatment or Refusal of Care

Consultation / Brief Therapies or Referral Management

Medication Management & Brief Interventions

Watchful waiting, Stress management, Health promotion, etc.
What is Care Management?

- **Care Management** provides evidence-based and algorithm driven treatment protocols for the treatment of commonly occurring disorders in primary care, including depression and anxiety.

- Care Management involves a behavioral health provider (RN, Social Work, Psychologist) providing treatment in collaboration with the PCP and most often under the supervision of a prescribing mental health provider.

- Care management delivers a **package** of disease-specific services, not excluding:
  - Evaluation and triage, usually telephone-based
  - Algorithmic, protocol-based treatment support
  - Patient activation, education for self-management
  - Telephone follow-up including on-going assessment and monitoring of adherence to medication, treatment plan, behavioral activation, problem solving
Barriers / Opportunities to Improve

• Development and Implementation of Primary Care-Mental Health Service Agreement

• Roles of Primary Care providers and PCMHI

• Integration of PCMHI as part of PACT Team

• Opportunities for improving care
Successful Components of an Effective PC-MHI Program

- Strong collaborative system between primary care, mental health and other health care specialists
- Stepped care approached to providing a continuum of care within the PC-MHI program
- Ability to rapidly evaluate and stabilize patient in primary care clinic
- Ability to do seamless referral, if needed
- Ability to implement evidence-based treatment plans
- Ability to collect objective clinical and administrative outcome data
Summary and Conclusions

- Primary Care Mental Health Integration is an integrated care service that provides consultation and brief MH services to the primary care population
- Co-located, collaborative care has been demonstrated as the most efficacious model for integrated MH care in the primary care setting
- The shift from working as a traditional MH provider vs. PC provider is an important shift in provision of care
- Call center support allows for consistent evidenced based monitoring of symptoms
- Strong stakeholder support is critical for successful implementation
Behavioral Health
Interdisciplinary Program
Redefining Outpatient Mental Health Care and Reaching Veterans Where They Live
Within the VA

• In 2010, the OAA selected five VAMCs to establish training positions utilizing a new model of healthcare focused on Patient-Aligned Care Teams (PACTs) and the interprofessional approach.

• In 2012, the OAA requested proposals to expand clinical education for mental health professions, resulting in
  – About 86 positions for interprofessional teams in General Outpatient Mental Health Clinics and
  – 116 positions for mental health integration in Patient Aligned Care Teams

\(^1\) Department of Veterans Affairs, 2010; \(^2\) Department of Veterans Affairs, 2012
Background

- Veterans Affairs (VA) Interprofessional Mental Health Education Expansion Initiative (2012)
  - VA TVHS training positions in pharmacy and psychology

- Behavioral Health Interdisciplinary Program (BHIP)
  - Interprofessional Education (IPE)
    - Utilization of interprofessional team-based care
  - Interprofessional Clinical Collaboration
    - Comprehensive mental health care for high risk Veterans
    - Mental Health Recovery Model
TVHS Interprofessional Clinic and Didactic Lecture Series
Implementation of the BHIP at TVHS

Interprofessional Education

• Weekly didactics course
  – Topic discussions
  – Journal clubs
  – Case presentations

IP Core Competencies

- Values & Ethics
- Roles & Responsibilities
- Interprofessional Communication
- Teams & Teamwork
• **Effective, interdisciplinary outpatient** general mental health team.

• Promotes continuous access to ongoing **recovery-oriented, evidence-based, mental health care** for all eligible Veterans.

• **Comprehensive**, population-based care vs. diagnosis-based care.

• **Dynamic rollout** that is expected to change based on feedback from pilot facilities (VISNs 1, 4, 17, 22).
Goals of BHIP

Implementation

Model

– Build effective, interdisciplinary general MH/BHIP teams who provide the majority of MH care necessary for assigned Veterans.

– Provide continuous access to ongoing recovery-oriented, evidence-based, MH care.
Goals of BHIP Implementation

Veterans

– Collaborative teams assure continuity of care for Veterans

  Veterans aren’t “lost in the system”

– BHIP teams promote Veteran-Centered-Care

  “The right care, at the right time, every time.”

– Clinical and administrative staffing allowing providers to practice at the top of their licenses

  Improved access to care, including evidence-based treatments.

– Establishing well-defined MH treatment goals promotes recovery and hope for Veterans.
Goals of BHIP Implementation

Staff

– Better defined panel sizes = a more predictable workload.
– Team members support and provide coverage for other members.
– Well functioning teams draw upon the strengths and expertise of all team members, which promotes professional satisfaction.
Outpatient General Mental Health Team Staffing Model Ratio

- The developed model includes a specific staffing ratio per panel of Veterans in general outpatient mental health services and also incorporates team-based concepts.

<table>
<thead>
<tr>
<th>Employee Category</th>
<th>FTEE for MH Team Panel Size of 1,000</th>
</tr>
</thead>
<tbody>
<tr>
<td>MH Clinicians: Licensed Independent Providers</td>
<td>5.1-5.5</td>
</tr>
<tr>
<td>Admin. Clerical Support</td>
<td>0.5-1</td>
</tr>
<tr>
<td>Non-LIPs</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total FTEE</strong></td>
<td><strong>6.6 -7.5</strong></td>
</tr>
</tbody>
</table>
Teamwork

• Leverage the diversity of available providers’ skill sets to support Veterans’ treatment needs.

• Care is comprehensive and integrated: minimizes the need for Veterans to move between multiple mental health programs.

• BHIP teams have both daily huddles and recurring interdisciplinary team meetings.

• Brief (10-15 minute) daily morning huddles allow teams to focus on Veterans requiring services that day, metric performance, and daily clinic operations issues.
Administrative Team Members

• Fully integrated into BHIP team

• Assist Veterans and clinicians with:
  – Scheduling appointments & making follow-up calls to Veterans.
  – Running reports to track Veterans’ mental health visits, discharge from panels, and referrals to other levels of care.
  – Utilizing panel size databases and spreadsheets to inform team’s practice.
  – Facilitating Veterans’ completing screening instruments or self-rating scales on symptoms and functional status.
Creating BHIP Teams

- Each team will need to independently address the spectrum of general outpatient MH services.
  
  - At some facilities the “Rule of 2’s” for clinical staffing will be useful. In this scenario, a BHIP team includes:
    - 2 FTE to prescribe medications
    - 2 therapist FTE (preferably LIPs)
    - 2 additional staff
    - Team functions must include case management
  
- Individual teams should include a mixture of established providers along with new hires from the current hiring initiative.
  
- Flexibility, depending on local facility needs, is key.
  - Only one team is required at each facility
  - Whenever possible, all teams will include professional representation of both genders to support gender-specific provider requests.
Managing BHIP Teams

• BHIP teams are the “home” of Veterans for their outpatient mental health needs.
  – Services include time-limited, evidence-based, recovery oriented interventions with alignment to each Veteran’s treatment goals.

• A Veteran should be referred to specialty MH when they require more intensive and focused services for a specific condition.
  – PTSD Specialty Care
  – SUD Services
  – PRRC, MHICM for serious mental illness

• If the specialty program provides services that comprehensively address the patient’s needs, the Veteran does not need to be assigned to a BHIP team.
Directives to Address Identified Deficits

• Limited Team Based Care
• Silo Models of Care
• Need for Expansion of Mental Health Providers and Mental Health Trainee Lines
• Need for Quality Improvement
Trainee BHIP Clinic

- Started in Fall 2013
- At least 1 Psychiatry Resident, 1 Pharmacy Resident, 1 Psychology Fellow
- Panel size of 50 unique patients
- Shared Medical Appointments:
  - Intakes
  - Medication Follow-up Visits
  - Treatment Adherence Group
- Templates
- Weekly Treatment Team Meetings

Mitch Beavers, Psychology Practicum Student, Ashley Barroquillo, Psychology Fellow, Jonathan Lister, Pharmacy Resident, Clarence White, Psychiatry Resident
BHIP- MH Integrated Care Model

• Outpatient Clinics to be established over a 2-year time frame
• Each clinic to manage panel of 1000-1500 unique patients
• Team to consist of:
  – 1 Psychiatrist
  – 1 Psychiatric NP
  – 1 Psychiatry resident
  – 2 Ph.D./Psy.D.
  – 0.5 Clinical Pharmacy Specialist
  – 2 Social Workers
  – 1 RN
  – 1 Medical Support Assistant
Establishment of the First BHIP

• Started in Summer 2015
  – Intakes- SW, NP, MD
  – Medication Follow-up Visits – NP, CPS, MD
  – Treatment Team Meetings- all
  – Care Coordination- RN
  – Case Management- SW
  – Evidence Based Psychotherapy- PhD/PsyD, SW

• Templates

• Standardized Outcome Measure Assessments
Criteria for BHIP

• Need for higher level of care than PCMHI (i.e., needs EBT therapy and/or not responsive to antidepressant trial); complicated moderate and severe symptomatology

• Not needing specialty care services (i.e., SUD, PTSD); if needed, therapy services provided in specialty clinic while medication management stays within BHIP
Suggested Flow of Care

1. Primary Care MH Integration (PCMHI)
2. Behavioral Health Interdisciplinary Program (BHIP)
3. Specialty Care (PTSD, MHICMH, SUD)
4. Tertiary and Residential Care (RRTP)

Goal is to provide care at the lowest level possible.
Inclusion/Exclusion Criteria

**Trainee BHIP**
- Recent Acute admission
- Complicated presentation or treatment course
- No active psychosis
- Polypharmacy
- Interested in full range of MH services
- Not at high risk for suicide

**Regular BHIP**
- Need for higher level of care than PCMHI (i.e., needs EBT therapy and/or not responsive to antidepressant trial)
- Not needing specialty care services (i.e., SUD, PTSD); if needed, therapy services provided in specialty clinic while medication management stays within BHIP
<table>
<thead>
<tr>
<th>Time</th>
<th>Monday</th>
<th>Tuesday</th>
<th>Thursday</th>
<th>Friday</th>
</tr>
</thead>
<tbody>
<tr>
<td>1300</td>
<td>Psychiatric Diagnostic Evaluation (90 mins)</td>
<td>Therapy</td>
<td>Psychiatric Diagnostic Evaluation (90 mins)</td>
<td>Therapy Med Mgmt</td>
</tr>
<tr>
<td>1330</td>
<td></td>
<td></td>
<td></td>
<td>Med Mgmt</td>
</tr>
<tr>
<td>1400</td>
<td></td>
<td>Therapy</td>
<td></td>
<td>Med Mgmt</td>
</tr>
<tr>
<td>1430</td>
<td>Med Mgmt</td>
<td>Therapy</td>
<td>Treatment Team Meeting</td>
<td>Med Mgmt</td>
</tr>
<tr>
<td>1500</td>
<td>Med Mgmt</td>
<td>Therapy</td>
<td>Therapy</td>
<td>Med Mgmt</td>
</tr>
<tr>
<td>1530</td>
<td>Med Mgmt</td>
<td></td>
<td></td>
<td>Med Mgmt</td>
</tr>
</tbody>
</table>

- Identifying times where all members can be present
- Identifying office space
- Developing coverage plans for when members are absent, especially emergency leave
Psychiatric Diagnostic Evaluations

• Shared Medical Appointment
  – At least one prescriber and one non-prescribing trainee (i.e., MD and Ph.D. or MD, Pharm.D., and Ph.D.)
• 90 minute evaluation
• Templated interview
  – Biopsychosocial history, preliminary treatment planning, nursing assessment
• Clinic set up
  – Within Psychiatry with others mapped to Psychiatry
  – 502/188 (General MH and Trainee); for non-trainee clinic, would be 502/509
• Coding
  – 90792
  – Psychiatry as primary provider, others listed as secondary providers
  – All providers add addendum to document their involvement
Medication Follow-Up Appointments

- **Shared Medical Appointment**
  - Psychiatry Resident and Pharmacy Resident

- **30 minute appointment**

- **Templated notes**

- **Clinic set up**
  - Within Psychiatry with others mapped to Psychiatry
  - 502/188 (General MH and Trainee); for non-trainee clinic, would be 502/509

- **Coding**
  - 99213/99214
  - Psychiatry as primary provider, Pharmacy listed as secondary provider
  - Pharmacy adds addendum to document their involvement
Treatment Adherence Group

- Shared Medical/Group Appointment
  - Psychiatry Resident, Psychology Fellow, and Pharmacy Resident
- 60 minute appointment
- Psychoeducational format
- Templated notes
- Clinic set up
  - 502/558
- Coding
  - 90853
  - Psychology as primary provider, others listed as secondary providers
Psychotherapy

• 60 minute appointment

• Evidence Based Therapies
  – Cognitive Processing Therapy
  – Cognitive Behavioral Therapy (Depression, Chronic Pain, Insomnia)
  – Prolonged Exposure
  – Acceptance and Commitment Therapy

• Clinic set up
  – 502/510

• Coding
  – 90832-90837
BHIP Treatment Team Meetings

• Once weekly
• All trainees and supervisors present
• 60-90 minutes
  – Discussion of new patients
  – Discussion of patients every six months
  – Discussion of care issues

• Coding
  – 99366 (without pt present)
  – 99367 (with pt present)

• One comprehensive treatment plan documented with all providers/services

• Other Services = Telephone check-in appointments, usually Pharm.D.
  – Coding with MD or non-MD telephone codes
Potential Outcomes to Consider

Educational Outcomes

• Change in IP knowledge via pre/post assessment tools
  – Collaborative Practice Assessment Tool (CPAT)
  – University of West England (UWE) Interprofessional Questionnaire
  – Other Knowledge-based quizzes

Clinical Outcomes

• Patient Satisfaction
  – Questionnaire

• Symptom remission rates
  – As defined by validated assessment tools

• Medication changes pre/post

• ER visits/Admissions pre/post

• No show rates vs traditional psychiatry clinics
<table>
<thead>
<tr>
<th>Diagnostic Category</th>
<th>Suggested Assessment Measure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychotic Disorders</td>
<td>Brief Psychiatric Rating Scale, PANSS</td>
</tr>
<tr>
<td>Bipolar Disorder</td>
<td>Y-MRS</td>
</tr>
<tr>
<td>Movement Disorders</td>
<td>BARS</td>
</tr>
<tr>
<td>Obsessive Compulsive Disorder</td>
<td>Y-BOCS</td>
</tr>
<tr>
<td>Alcohol Dependence</td>
<td>CAGE</td>
</tr>
<tr>
<td>Substance Dependence</td>
<td>DAST-10</td>
</tr>
<tr>
<td>PTSD</td>
<td>PCL, IES-R, CAPS</td>
</tr>
<tr>
<td>Depression</td>
<td>PHQ-9, BDI, GDS</td>
</tr>
<tr>
<td>Anxiety</td>
<td>GAD-7, BAI</td>
</tr>
<tr>
<td>Sleep Disorders</td>
<td>Epworth Sleepiness Scale, Total Hours of Sleep, Sleep Efficiency</td>
</tr>
<tr>
<td>Neurocognitive Disorders</td>
<td>MoCA, SBT</td>
</tr>
<tr>
<td>Quality of Life</td>
<td>Duke Health Profile, SF-12, WHODAS</td>
</tr>
<tr>
<td>Suicidal Ideation</td>
<td>C-SSRS</td>
</tr>
<tr>
<td>Violence Potential</td>
<td>VIO-SCAN</td>
</tr>
<tr>
<td>Delirium</td>
<td>CAM</td>
</tr>
</tbody>
</table>
Quality Improvement - Year One
Study Endpoints

Primary Endpoint

- The difference in the Collaborative Practice Assessment Tool (CPAT) score at the beginning of IPE didactic lecture series and at the end of IPE didactic lecture series to assess trainee competency
Secondary Endpoints

- The difference in the University of West England (UWE) Interprofessional Questionnaire score at the beginning of IPE didactic lecture series and at the end of IPE didactic lecture series to assess trainee attitudes towards interprofessional teamwork.

- The difference in the knowledge-based quiz score at the beginning of IPE didactic lecture series and at the end of IPE didactic lecture series to assess the trainee knowledge of the core competencies.

- The patient satisfaction questionnaire score at approximately three and six months to assess patient satisfaction with the services provided in the BHIP Team Clinic.
Methodology

Study Design

• Single-center, longitudinal study including pre/post surveys

• Quality Improvement/Quality Assurance
Methodology: IPE Didactics Course

• **Inclusion Criteria**
  – Any trainee working within a mental health service
  – Professional students, residents, fellows
  – Pharmacy, psychology, psychiatry, social work, others

• **Data collection**
  – Survey packet at the beginning of the training term
    • Demographics questionnaire
    • Collaborative Practice Assessment Tool (CPAT)
    • University of West England (UWE) Interprofessional Questionnaire
    • IPE knowledge quiz
Methodology: BHIP Clinic

• Inclusion Criteria
  – Patients enrolled in the BHIP Team Clinic for at least three months

• Data Collection
  – Survey packets mailed to patients’ homes
    • Demographics questionnaire
    • Patient satisfaction survey
Results

Demographics

<table>
<thead>
<tr>
<th>Description</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total intake appointments</td>
<td>20</td>
</tr>
<tr>
<td>Male</td>
<td>17 (85%)</td>
</tr>
<tr>
<td>Average Age (years)</td>
<td>42.1</td>
</tr>
</tbody>
</table>

Patient Referral Sources

- 40% Acute Psychiatry
- 40% Primary Care
- 10% ER
- 10% Other
Results

Patients with ≥2 Comorbidities (n=9)
- Depressive Disorders: 6 (66%)
- Anxiety Disorders: 5 (56%)
- PTSD: 4 (44%)
- Other: 3 (33%)

Patients with 1 Morbidity (n=11)
- Depressive Disorders: 3 (27%)
- Anxiety Disorders: 3 (27%)
- PTSD: 1 (9%)
- Other: 4 (36%)
Results

### BHIP patient progress (n=20)

<table>
<thead>
<tr>
<th>Activity</th>
<th>Count</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Attended the BHIP Adherence Group</td>
<td>7</td>
<td>35%</td>
</tr>
<tr>
<td>Contacted by BHIP Social Worker</td>
<td>8</td>
<td>40%</td>
</tr>
<tr>
<td>Consult services requested</td>
<td>9</td>
<td>45%</td>
</tr>
<tr>
<td>Patient withdrew</td>
<td>6</td>
<td>30%</td>
</tr>
<tr>
<td>Lost to follow-up</td>
<td>3</td>
<td>15%</td>
</tr>
<tr>
<td>Completed treatment goals &amp; Discharged</td>
<td>1</td>
<td>5%</td>
</tr>
</tbody>
</table>

### Active BHIP patients

<table>
<thead>
<tr>
<th>Service</th>
<th>Count</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Receiving pharmacotherapy</td>
<td>10</td>
<td>100%</td>
</tr>
<tr>
<td>Receiving psychotherapy</td>
<td>9</td>
<td>90%</td>
</tr>
<tr>
<td>Completed psychotherapy</td>
<td>1</td>
<td>10%</td>
</tr>
</tbody>
</table>
Results

Trainee Surveys

- Initial trainee packets distributed in March
  - March
    - 3 students
    - 1 returned
  - April
    - 1 student
    - Pending end of rotation

Patient Surveys

- Initial patient mail outs distributed in March
  - 7 patients eligible
  - 5 mailed
  - 2 returned
- Additional mail outs to be sent
Limitations

• **IP Didactics Course**
  – Variation in trainee rotations
  – Return of survey packets

• **BHIP Clinic**
  – Lack of control group
  – Limited availability of individual psychotherapy appointments
  – Return of surveys
Conclusions

• An interprofessional program offering trainee education and clinical services to patients may improve overall patient care provided

• Future directions
  – Changes in patient symptoms
  – Polypharmacy
  – Medication adherence by refill history
  – Number of hospitalizations
Quality Improvement - Year Two
Methodology

• $H_0$: There will be no difference in mental health outcomes with patients who participate in BHIP compared with prior to joining clinic

• $H_{a_{1/2}}$: There will be an improvement or decline in mental health outcomes with patients who participate in BHIP compared with prior to joining clinic

• Primary Objectives
  – Evaluate mental health treatment rates (e.g. remission and response) in BHIP patients at a VAMC
Methodology

• Secondary Objectives
  – Change in scores (baseline/most recent assessment)
    • Beck Anxiety Inventory (BAI)
    • Posttraumatic Stress Disorder CheckList (PCL)
    • DASS-21
    • PHQ9
  – Change in number of psychotropic medications
  – Change in number of psychiatric emergency room visits
  – Change in acute psychiatric admissions
  – Difference in “no-show” rates
Methodology

• Single-center, retrospective, chart-review, survey study

• Panel size: not to exceed 50 or total of 250

• Study dates: October 2013 – current

• Subject referral sources:
  – PC-MHI
  – Residential rehabilitation treatment program
  – Acute psychiatry
  – Emergency room mental health providers
  – Traditional outpatient mental health clinics
Methodology

- Each veteran was provided baseline measurements during initial intake visit
  - Corresponding measurements were

• Response/remission defined as:
  - Depressive disorders
    - PHQ < 5 for one month (remission)
    - 50% reduction PHQ (response)
  - Trauma related disorders
    - PCL < 35 (remission)
    - ≥ 10 reduction in PCL (remission)
  - Anxiety disorders
    - BAI < 7 for one month (remission)
    - 50% reduction in BAI (response)
  - All other disorders
    - Depression Anxiety Stress Scale (DASS)

<table>
<thead>
<tr>
<th>Common Assessment Measurements Used in Mental Health</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Disease State</strong></td>
</tr>
<tr>
<td>Posttraumatic stress disorder (PTSD)</td>
</tr>
<tr>
<td>Major depressive disorder (MDD)</td>
</tr>
<tr>
<td>Generalized anxiety disorder (GAD)</td>
</tr>
<tr>
<td>Negative emotional states of depression, anxiety, and stress</td>
</tr>
</tbody>
</table>
Results

Completed BHIP Intake
n = 70

Criteria met for primary endpoint (remission/response)
  n = 31

Exclusions
  n = 39
  Entered clinic prior to using assessment tools (n = 16)
    Attended ‘Intake’ appointment only (n = 12)
      Initial measures not completed (n = 6)
      Currently enrolled, < 1 month (n = 2)
      Discharged due to early non-compliance (n = 2)
    Remission at time of Intake (n = 1)
Baseline Demographics

- Age (years): 52.9
- Sex: 82.7% male, 17.3% female
- Race: 91.4% Caucasian, 6.9% African American, 1.7% Hispanic

**Initial Diagnosis**

- Depressive disorder: 43%
- PTSD/trauma-related disorder: 36%
- Anxiety disorder: 7%
- Dual diagnosis: 5%
- Other: 9%
# Results

## Mental Health Treatment Rates – Remission and Response

<table>
<thead>
<tr>
<th>Disease State</th>
<th>Response (%)</th>
<th>Remission (%)</th>
<th>Total (%)</th>
<th>Mean Assessment Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Depressive disorder</td>
<td>22.2</td>
<td>27.7</td>
<td>50</td>
<td>Pre-BHIP</td>
</tr>
<tr>
<td>n = 18</td>
<td></td>
<td></td>
<td></td>
<td>Most Recent</td>
</tr>
<tr>
<td>PTSD/unspecified trauma</td>
<td>14.2</td>
<td>57.1</td>
<td>71.3</td>
<td>PHQ-9</td>
</tr>
<tr>
<td>n = 7</td>
<td></td>
<td></td>
<td></td>
<td>14</td>
</tr>
<tr>
<td>Dual diagnosis</td>
<td>0¹</td>
<td>---</td>
<td>33.3</td>
<td>PCL</td>
</tr>
<tr>
<td>n = 2 (PTSD/MDD)¹</td>
<td>100²</td>
<td>---</td>
<td></td>
<td>PHQ-9/PCL</td>
</tr>
<tr>
<td>n = 1 (PTSD/bipolar II)²</td>
<td></td>
<td></td>
<td></td>
<td>22/55</td>
</tr>
<tr>
<td>Anxiety disorder</td>
<td>---</td>
<td>100</td>
<td>100</td>
<td>PCL/DASS</td>
</tr>
<tr>
<td>n = 1</td>
<td></td>
<td></td>
<td></td>
<td>79/114</td>
</tr>
<tr>
<td>Somatic disorder</td>
<td>0</td>
<td>---</td>
<td>0</td>
<td>BAI</td>
</tr>
<tr>
<td>n = 1</td>
<td></td>
<td></td>
<td></td>
<td>47</td>
</tr>
<tr>
<td>Personality disorder</td>
<td>0</td>
<td>---</td>
<td>0</td>
<td>DASS</td>
</tr>
<tr>
<td>n = 1</td>
<td></td>
<td></td>
<td></td>
<td>78</td>
</tr>
<tr>
<td>Overall (n = 31)</td>
<td>19.4</td>
<td>32.2</td>
<td>51.6</td>
<td>DASS</td>
</tr>
</tbody>
</table>

¹Note: For dual diagnosis, the percentage refers to the proportion of individuals meeting the criteria for both conditions.

²Note: For somatic and personality disorders, the percentage refers to the proportion of individuals meeting the criteria for the respective condition.
## Results

### Reduction in Mental Health Polypharmacy

<table>
<thead>
<tr>
<th>Description</th>
<th>Percentage</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reduced number of medications</td>
<td>34%</td>
<td>20/58</td>
</tr>
<tr>
<td>Medications remained the same</td>
<td>43%</td>
<td>25/58</td>
</tr>
<tr>
<td>Increased number of medications</td>
<td>22%</td>
<td>13/58</td>
</tr>
</tbody>
</table>

### Prevention of Psychiatric Related Emergency Room Visits and Admissions

<table>
<thead>
<tr>
<th>Description</th>
<th>Percentage</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>(+) admission pre / (+) admission post</td>
<td>8.3%</td>
<td>1/12</td>
</tr>
<tr>
<td>(+) MH ER visit pre/ (+) MH ER post</td>
<td>10.5%</td>
<td>2/19</td>
</tr>
<tr>
<td>Any psychiatric admission</td>
<td>1.7%</td>
<td>1/58</td>
</tr>
<tr>
<td>Any MH ER visit</td>
<td>3.4%</td>
<td>2/58</td>
</tr>
</tbody>
</table>

### Outpatient Clinic No-Show Rates

<table>
<thead>
<tr>
<th>Description</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>BHIP</td>
<td>16.5%</td>
</tr>
<tr>
<td>Traditional MH Clinic</td>
<td>14.5%</td>
</tr>
</tbody>
</table>
Conclusions and Limitations

• Conclusions
  – Mental health treatment outcomes are improved with an interprofessional clinic
  – An interprofessional clinic significantly reduces psychiatric admissions/ED visits

• Limitations
  – Ongoing treatment
  – Increased appointment burden
Moving Forward

• Inclusion of standardized assessment measures in all BHIP clinics

• Identification and tracking of relevant outcome measures
Interprofessional Practice Outside of a VA Medical Center

- Utilization of IP principles and competencies
- Collaboration with other clinicians
- Integrated treatment planning
- Consensus diagnoses
- Co-location
  - Scheduling of appointments
- Shared EMRs
Interprofessional Practice
Outside of a VA Medical Center

• Business laws vary by state
  – NJ passed a law (P.L.2014, c.79) which permits psychologists to incorporate with other healthcare providers

• Billing
  – Fee for service by provider
  – Employee model
  – Accountable Care Organizations
    • Shared Savings Payments
  – Management Services Organizations (MSOs)
  – Mixed Models
    • Fee for service for patients and salary for consultation
Other Trainee IP Clinics

- Telemental Health BHIP Clinic
  - Serves rural patients at a Community Based Outpatient Clinic

- Comprehensive Care Clinic
  - Serves patients with co-morbid mental and medical diagnoses

- Geriatric BHIP
  - Serves older adults needing mental health care, as well as assessment
Telemental Behavioral Health Interdisciplinary Team

- Specialized BHIP Clinic
- Interdisciplinary outpatient mental health clinic via telehealth technology to a rural clinic in Tullahoma.
- All providers are trained and certified in Telemental technology.
- A trained Mental Health LPN is on the far side with the patient to conduct in person evaluation and for crisis management.
Telemental Health BHIP

**Strengths**

- Access closer to home
- Same level of service across sites
- Preparation of clinicians for new practice settings

**Limitations**

- Limited grid/bandwidth
- Some may not prefer telehealth modality
- Limited team opportunities with LPN on patient side
Purpose of Geriatric BHIP

- OAA requested applications from programs who would provide services to underserved, special patient populations
- There is a growing geriatric population, including in the VA
  - Special needs of this population
- This clinic will provide broad MH clinical services to elderly Veterans
- In addition, this clinic will allow for the outpatient management of Veterans with dementia in order to delay or defer admission to acute and long-term care settings
Creation

• 2 Distinct Services
  – Traditional BHIP for geriatric patients
  – Comprehensive assessment clinic
    • Neuropsychological assessment
    • Capacity assessment
    • Psychological/Diagnostic assessment

• Purpose/Vision:
  – To provide interprofessional care to our geriatric mental health patients

• Clinic started in August 2015; still very new
Disciplines Involved

- Psychiatry
- Pharmacy
- Nursing
- Social work
- Psychology
- Neuropsychology
- Administrative (MSA)
- Trainees
  - Psychiatry
  - Psychology
  - Pharmacy (2016-2017)
Services Provided

• Medication management
• Psychotherapy (individual, couples, and group)
• Assessment
  – Cognitive assessment
  – Neuropsychological assessment
  – Capacity evaluations
• Advanced Directives
• Other
Life Transitions Group

- 8-10 session group utilizing Interpersonal Therapy as a guideline for treatment
- Group purpose/goal: Reduce depressive symptoms associated with grief, role transitions, interpersonal conflicts, and/or interpersonal deficits. Participants will learn how to resolve disturbing life events, build social skills, and reorganize their lives. The group will teach skills that can help reduce current depressive symptoms and possibly prevent depression in the future.
• REACH = Resources for Enhancing All Caregivers Health
• Approximately 4 core sessions with caregivers of those with dementia
• Sessions target the development of caregiver skills in problem solving, positive thinking, and stress management.
• Sessions are delivered over 2-3 months by phone or face-to-face
• Has been shown to:
  – Decrease caregiver depression, burden, and frustrations
  – Reduce the number of challenging veteran patient behaviors reported
# Assessment Clinic - 1 AM/week

<table>
<thead>
<tr>
<th>Times</th>
<th>RN</th>
<th>PharmD</th>
<th>Psy</th>
<th>Psc</th>
<th>NP</th>
<th>SW</th>
</tr>
</thead>
<tbody>
<tr>
<td>7:00-7:30</td>
<td></td>
<td>P2 7-7:30</td>
<td>P1 7:00-8:00</td>
<td>P3 7-8:30</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7:30-8:00</td>
<td>P2 7:30-8</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8:00-8:30</td>
<td></td>
<td>P3 8:30-9</td>
<td></td>
<td></td>
<td>P1 8-10:00</td>
<td></td>
</tr>
<tr>
<td>8:30-9:00</td>
<td></td>
<td></td>
<td>P3 9-10</td>
<td>P2 9-10:30</td>
<td></td>
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</tr>
<tr>
<td>9:00-9:30</td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>9:30-10:00</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10:00-10:30</td>
<td>P1 10:00-10:30</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10:30-11:00</td>
<td>P3 10:30-11</td>
<td>P1 10:30-11:00</td>
<td></td>
<td></td>
<td>P3 10-10:30</td>
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</tr>
<tr>
<td>11:00-11:30</td>
<td>10:30-11</td>
<td>10:30-11:00</td>
<td></td>
<td></td>
<td>P2 10:30-11</td>
<td></td>
</tr>
<tr>
<td>11:00-11:30</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Life Transitions 11-12</td>
<td>P1 11:00-11:30</td>
</tr>
<tr>
<td>11:30-12:00</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Barriers

• Slow start

• Getting the word out about the clinic

• A geriatric state of mind

• Learning to work as a team
  – Getting to know new team members
QI Efforts

- Montreal Cognitive Assessment (MoCA)
- Lawton-Brody IADL Scale
- Katz Index of Independence in ADLs
- Zarit Caregiver Burden Scale
- Duke Health Profile
- Geriatric Depression Scale (GSD) – short form
- Quality of Life Inventory (QoLI)
- FAST score
Outcomes

• Decreased hospitalization and emergency room utilization

• Improvement in caregiver burnout

• Improvement in medication compliance

• Improvement/maintaining quality of life
“The greatest mistake in the treatment of diseases is that there are physicians for the body and physicians for the soul, although the two cannot be separated.”

- Plato
History of the Problem

• Medical comorbidity and healthcare utilization rates are increased in depression and anxiety with regard to:
  • Diabetes
  • Pulmonary disease
  • Heart disease
  • Arthritis

• Patients with depression have significantly more unexplained physical symptoms such as pain and fatigue and utilize more health resources than non-depressed patients.
History of the Problem

• PTSD is associated with increased morbidity, utilization of medical care services, and premature death

• Patients diagnosed with schizophrenia are more likely to have chronic medical conditions including:
  • Hypothyroidism
  • COPD
  • Diabetes with complications
  • Hepatitis C
  • Fluid/electrolyte disorders
  • Nicotine abuse/dependence
• The Comprehensive Care Clinic (CCC) will provide integrated clinical services to Veterans facing co-morbid medical and MH concerns which cannot be adequately managed separately
  • Diabetes
  • COPD
  • Hypertension

• Additionally, the CCC will manage Veterans with chronic pain concerns, including Veterans with a history of substance abuse who are in full and sustained remission requiring opiate therapy
In addition to trainees from MH (Psychology, Psychiatry, Clinical Pharmacy), this clinic will also include the participation of:

- Social Workers
- Primary Care Medical Residents
- Ambulatory Care Pharmacists and trainees

Trainees in the CCC will complete diagnostic evaluations of Veterans and provide comprehensive therapy services including pharmacological management of conditions, psychotherapy, and complementary and alternative medicine (CAM) techniques such as biofeedback and mindfulness.
Identification of Stakeholders

• Mental Health
  • Psychiatry
  • Psychology
  • Social Work
  • Pharmacy
• Primary Care
• Specialty Medical Services
• Veterans
Barriers

• Trainee lines

• Staffing
  – Solution: Role out the CCC in 2 phases

• Lack of a primary care champion
Phase I

- Joint effort by Pharmacy and Psychology to begin the CCC
- Clinic started September 2015
- Services offered this year:
  - Pain services
    - Second Chance Clinic
    - PCMHI pain clinic
  - Group therapy
    - Mindfulness/relaxation group
    - Coping with Chronic Illness Group
Second Chance Clinic

• Veterans with a history substance abuse who are in full and sustained remission often present with chronic pain concerns

• These Veterans may require opiate therapy for their chronic pain

• The Second Chance Clinic (SCC) is a pilot clinic to address the needs of this Veteran population
• Individual appointments will be interprofessional:
  • Pharmacy will provide medication follow-up appointment at the end of psychotherapy sessions
  • Pharmacy will be able to observe psychological interventions
  • Psychology will be able to observe medication management services

• Medication follow-up appointments and therapy appointments will be at alternating times
SCC - continued

Suboxone clinic/SATP

Second Chance Clinic (SCC)

Pain Clinic
PCMHI Pain Clinic

• Opioid Safety Initiative – targeting patients in primary care who are on high doses of opioid medications

• Services will include:
  – Joint intake between psychology and pharmacy
  – Follow-up appointments with pharmacy regarding medication management/recommendation
  – Follow-up appointments with psychology focused on nonpharmacological interventions for chronic pain, including Cognitive Behavioral Therapy for Chronic Pain (CBT-CP)
Group Therapy

- **Mindfulness and Relaxation Group** – 8 session group focused on relaxation and mindfulness strategies; appropriate for veterans with a variety of physical and mental health diagnoses.

- **Coping with Chronic Illness Group** – 8 session group developed to help veterans cope with chronic illness; veterans will learn strategies for improving and maintaining relationships, interacting with medical providers; managing painful emotions/thoughts that often accompany chronic illnesses, etc.
Phase II

• Integrated clinical services to Veteran’s facing co-morbid medical and mental health concerns which cannot be adequately managed separately.

• The Comprehensive Care Clinic (CCC) is a pilot clinic to address the needs of this Veteran population.

• Joint intake appointment with Psychiatry, Pharmacy and Psychology with additional assistance from Primary Care as needed/requested.
Phase II

- Individual appointments will be Interprofessional:
  - Psychiatry will schedule medication follow-up appointment prior to the medical appointment and address interactions of psychotropic medications with medical conditions and medications.
  
  - Pharmacy will be able to address alternative treatment interventions, patient education, and monitor adherence with Psychiatry.

  - Psychology will be able to provide psychological interventions after the medical appointment.
Outcome Measures

- Improvement in adherence to care (appointment attendance, medication adherence, etc.)
- Decreased hospitalization and emergency room utilization
- Quantitative Measurement Scales for Mental Health Diagnosis
- Health outcomes
- Quality of Life measure(s)
Conclusion

• We have started to create services to target this unique patient population

• Plan to expand services next year to include other services and services from additional disciplines

• Interprofessional and integrated care is ultimately improving patient-centered care.
Questions?

Thank you