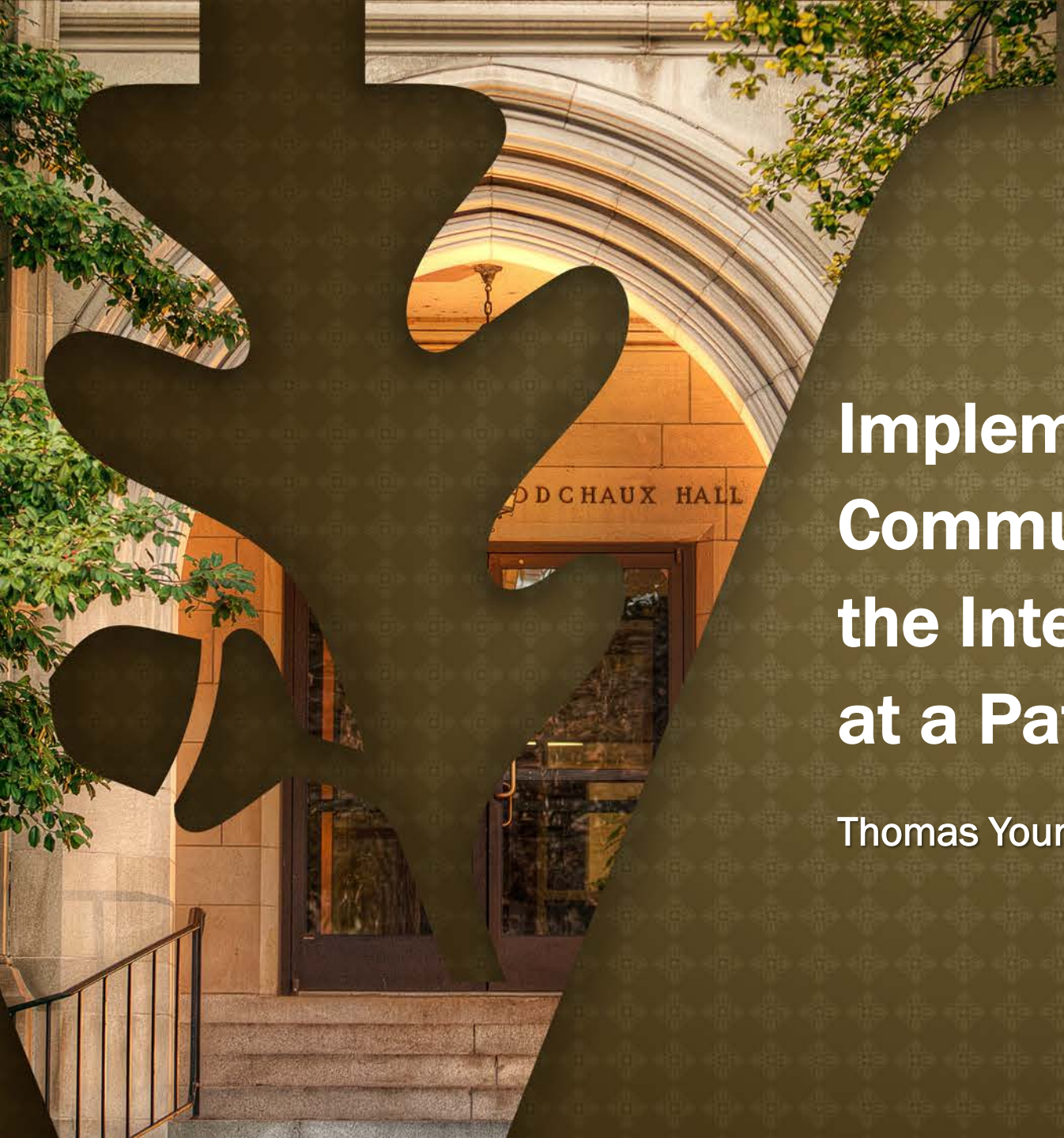


# Implementation of Standardized Communication: An Intervention for the Integration of Behavioral Health at a Patient-Centered Medical Home

Thomas Young, PMHNP-BC

# Introduction – Mental Health

- **Chronic** and **complex** disorders
  - **wide-ranging** in both who they effect and how they affect them
- Most psychiatry occurs in the primary care setting
  - 60% of patients seeking depression treatment (Barkil-Oteo, 2013)
  - Primary care providers (PCPs) prescribe 79 % of antidepressant prescriptions in the United States (Barkil-Oteo, 2013)
- Around 66% of PCPs state they are unable to find effective mental health services for their patients (Cunningham, 2009)

# Introduction – Integration as a Solution

- Increases access to mental healthcare and improves the quality care given
  - (Yogman et al., 2017).
- Encourages holistic or whole patient framework
- Reduced costs for patients
  - (Unützer & Park, 2012).
- Decreased PCP burnout
  - (Hsiung et al., 2019)
- Improved patient satisfaction regarding care
  - (Unützer et al., 2002; Woltmann et al., 2012; Vickers et al., 2013; Richardson et al., 2014; Asarnow et al., 2015; Rapp et al., 2017; Camacho et al., 2018).

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# Background – Clinic System

METRO NASHVILLE PUBLIC SCHOOLS

# Background

- Around ~6-8 weeks wait time to see behavioral health for initial consultation (from brief chart review)
- Average of 2.09 contacts per week with most occurring over text or phone from queried interdepartmental tracker
- Exacerbated by COVID due to behavioral health practitioners working from home

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# Problem Statement

- The MNPS Employee and Family Health Care Centers are an occupational health site with integrated behavioral health resources
- There is not currently a standardized process for determining when a patient needs a referral or performing a timeliness triage based on patient severity.

# PICOT Question

- For primary care providers within the MNPS clinic system (P), does the creation of a patient pathway with standardized communication (I) increase the number of collaborative contacts with behavioral health specialists (O) over a four-month timeframe (T) as compared to the current system (C)?

*Insert Photo/Illustration credits here*

# Purpose and Objectives

- To implement a clinical pathway which will standardize the referrals and communications from primary care to behavioral health
- Objectives:
  1. Design and implement a clinical pathway for referrals and communications
  2. Describe current system practices including methods and frequency of communications between primary care and the psychiatry specialists.
  3. Utilize survey to describe PCP attitudes and inform implementation session.
  4. Hold one implementation session for PCPs and referral coordinators with the purpose of disseminating the pathway information
  5. Monitor contacts over a four-month timeframe via querying the interdepartmental communication tracker

# Concepts

- **Electronic Consultations (E-Consultations or E-Consults)**
  - A communication over a shared EHR for the purpose of collaboration or treatment guidance (Lowenstein et al., 2017).
- **Warm Handoffs**
  - Interactions that serve to transfer information from one healthcare professional to another. (Whitebird et al., 2014; Raney, 2015; Ramanuj et al., 2018).
  - For this project, warm handoffs refer to discussions between a PCP and a behavioral health specialist prior to a referral
- **Help screen**, increase the **collaborative relationship**, and **guide treatment goals.**

# Concepts

- **Patient Centered Medical Home (PCMH)**
  - A holistic care site that often houses multiple types of services or specialists (Gerrity, 2016; Grazier et al., 2016).
- **Patient Pathway or Clinical Pathway (CPW)**
  - Translated guidelines into sets of steps that help with reducing variation and improving outcomes (Lawal et al., 2016)

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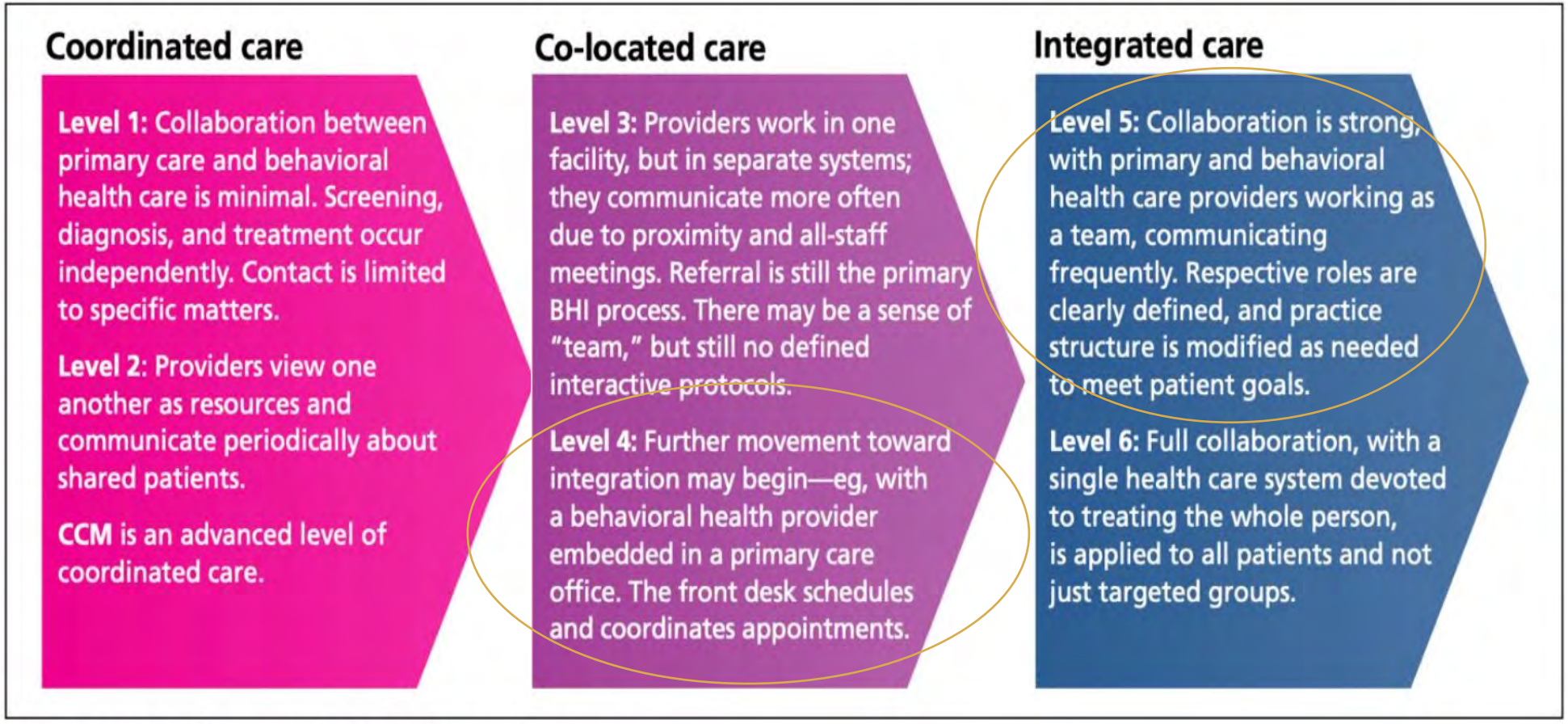
# Concepts – Levels of Integration




BHI, behavioral health integration; CCM, collaborative care model.

*(Rajesh, Tampi & Balachandran, 2019)*

# Framework

1. Diffusion of Innovation (DOI) — adaptation of innovations (Sanson-Fisher, 2004).
2. Health Action Process Approach (HAPA) — predicting an individual's response to change adaption (Zhang et al., 2019).

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# Synthesis of the Evidence: Evidence Search

- January 2010-October 2020
- Keywords: *primary health care, mental health, psychiatry, delivery of health care, delivery of health services, integrated, mental health services, referral and consultation,* and *primary health care* which yielded 3,905 results
- Primarily Pubmed and Google Scholar
- Randomization not required but a preferred element
  - Two exceptions on publication date were made for Unützer et al. (2002) and Kravitz et al. (2006) as both are high quality randomized control trials exceedingly relevant to the project at hand.

*Insert Photo/Illustration credits here*

# Synthesis of the Evidence: Evidence Search

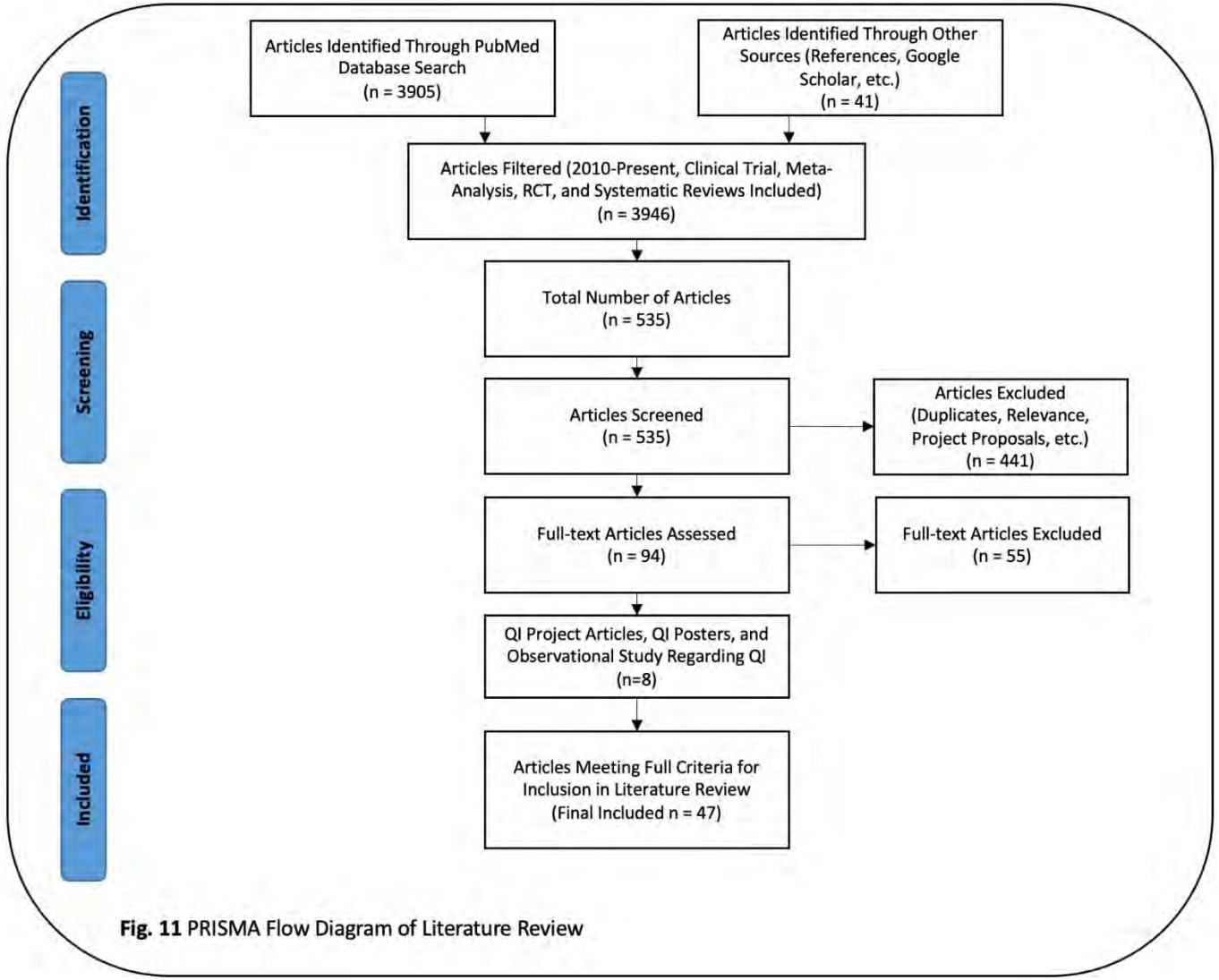



**Fig. 11** PRISMA Flow Diagram of Literature Review

# Synthesis – Common Themes

1. Benefits of Integrated Behavioral Health Care
   - *(Unützer et al., 2002; Gardner et al., 2010; Unützer & Park, 2012; Woltmann et al., 2012; Vickers et al., 2013; Coventry et al., 2014; Richardson et al., 2014; Asarnow et al., 2015; Gold et al., 2017; Overbeck et al., 2016; Hartveit et al., 2017; Muse et al., 2017; Rapp et al., 2017; Baxter et al., 2018; Camacho et al., 2018; Ma & Saw, 2018; Moise et al., 2018; Possemato et al., 2018; Hsiung et al., 2019; Rajesh, Tampi & Balachandran, 2019; Youssef et al., 2019; Bogucki et al., 2020)*
2. Importance of Primary Care Attitudes and Roles
   - *(Kravitz et al., 2006; Anthony et al., 2010; Faghri et al., 2010; Piek et al., 2011; Unützer & Park, 2012; Corrigan et al., 2014; Sun et al., 2015; Overbeck et al., 2016; Hunter et al., 2017; Golberstein et al., 2018; Hensel et al., 2018; Maconick et al., 2018; Wakida et al., 2018; Anjara et al., 2019; Hsiung et al., 2019; Park & Zarate, 2019)*
3. Value of Communication and Coordination of Care
   - *(Mehrotra et al., 2011; Unützer & Park, 2012; Davis et al., 2013; Vickers et al., 2013; Sanchez et al., 2014; Whitebird et al., 2014; Raney, 2015; Sun et al., 2015; Overbeck et al., 2016; Hunter et al., 2017; Lowenstein et al., 2017; Golberstein et al., 2018; Hensel et al., 2018; Kates et al., 2018; Moise et al., 2018; Ramanuj et al., 2018; Anjara et al., 2019; Bogucki et al., 2020)*

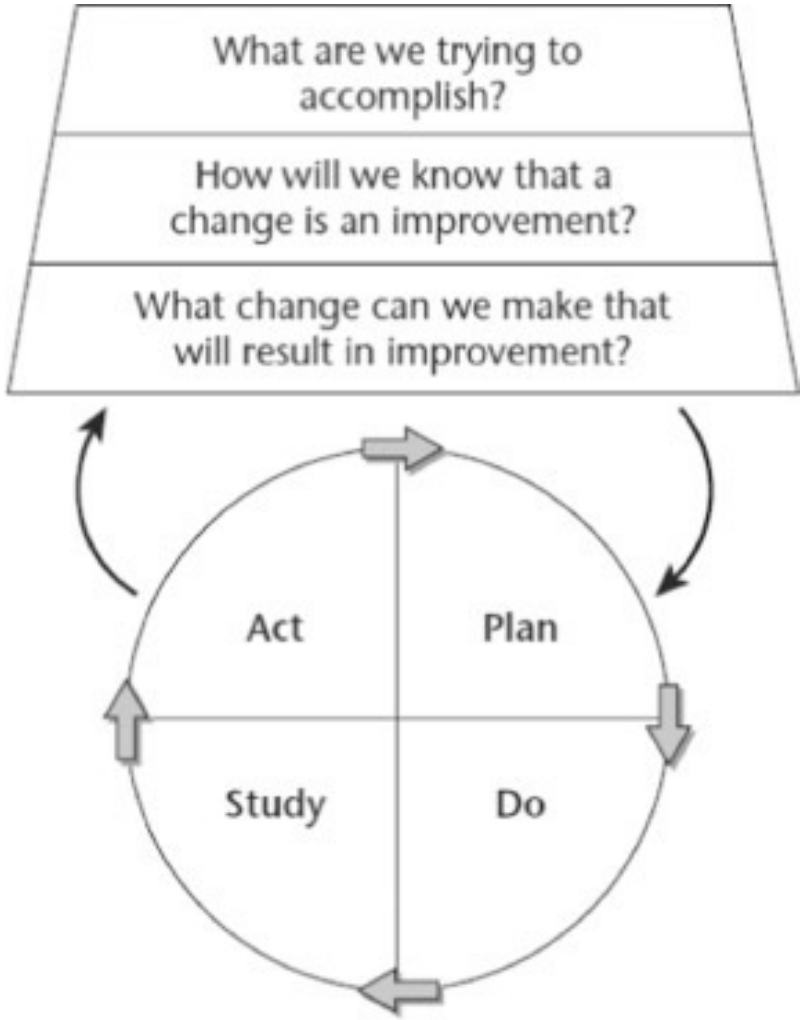
# Methods

- **Project Design:** quality improvement project used PDSA framework
- **Setting**
  - MNPS Employee & Family Health Care Centers
  - Patient-Centered Medical Home model
  - Patient population includes teachers (majority female, middle to low SES, highly educated, health literate) and their family members
- **Participants**
  - 13-16 PCPs
  - Majority female, majority Caucasian, highly educated (Master's), majority FNPs

*(U.S. Department of Health and Human Services, 2021).*

# Methods — Plan-Do-Study-Act

- Plan:
  - Create tool for e-consults, warm handoffs and referrals
- Do:
  - Gather data on attitudes of PCPs via survey
  - Use survey results to prepare for implementation session
  - Disseminate tool through education session
- Study:
  - Query the interdepartmental communications tracker for quantitative data
  - Gather qualitative data through focus group with PCPs
- Act:
  - Determine new changes needed and start cycle anew




*(Christoff, 2018)*

# Methods — Intervention

- Designed a clinical pathway for standardized communications and referrals from primary care to behavioral health
- Based on suicide algorithm for primary care, current literature, and screening tools
- Adjusted through input by QI coordinator, behavioral health team, academic committee, and management
- Sought to combine body of evidence with clinical care
- 15-20 minutes during provider meeting

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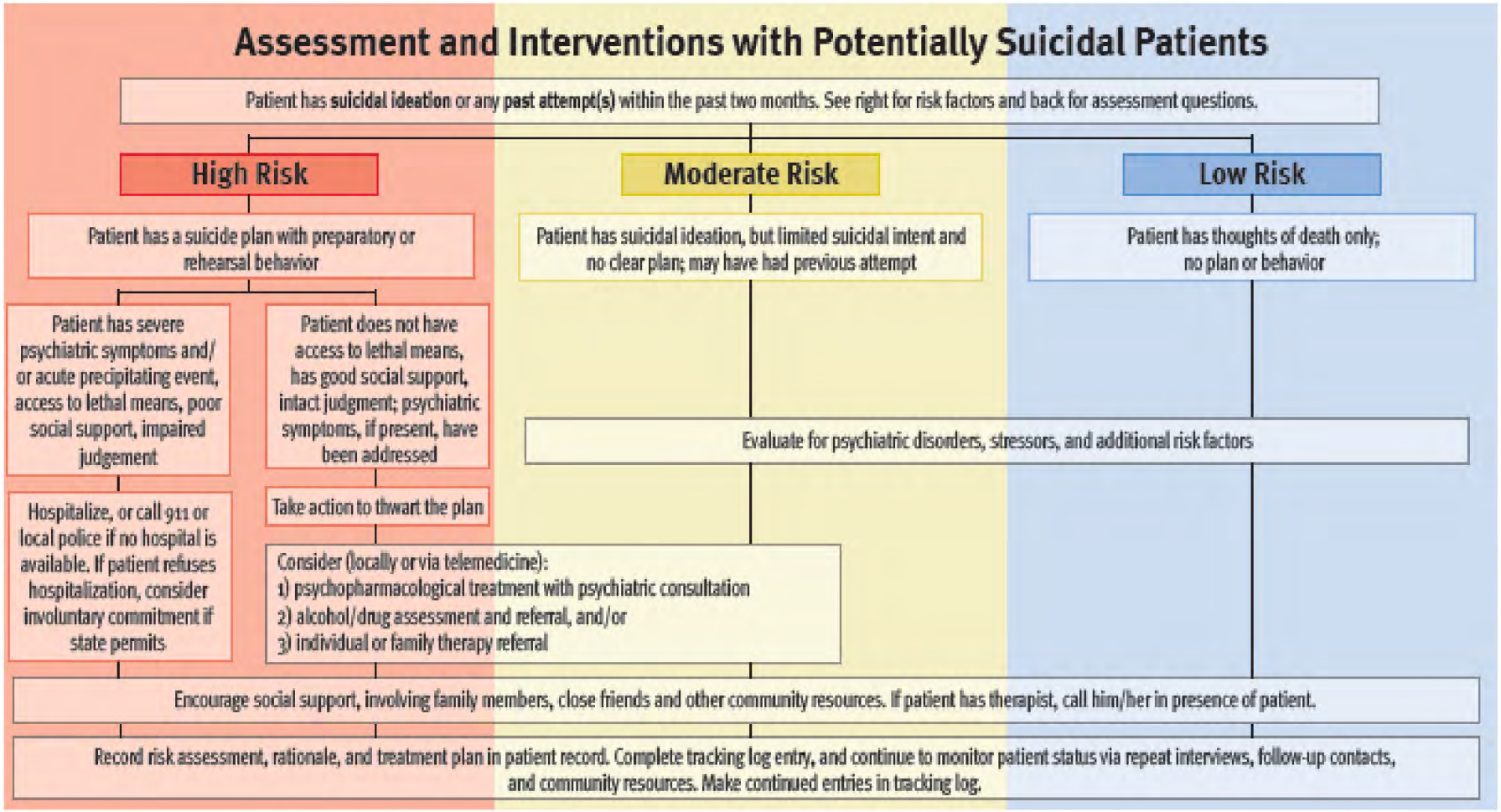
# Suicide Algorithm




## Suicide Risk and Protective Factors[1]

### RISK FACTORS

- **Current/past psychiatric disorders:** especially mood disorders, psychotic disorders, alcohol/substance abuse, TBI, PTSD, personality disorders (such as Borderline PD, Antisocial PD, and Obsessive-Compulsive PD).

  *Co-morbidity with other psychiatric and/or substance abuse disorders and recent onset of illness increase risk.*
- **Key symptoms:** anhedonia, impulsivity, hopelessness, anxiety/panic, insomnia, command hallucinations, intoxication. For children and adolescents: also oppositionality and conduct problems.
- **Suicidal behavior:** history of prior suicide attempts, aborted suicide attempts or self-injurious behavior.
- **Family history:** of suicide, attempts, or psychiatric diagnoses, especially those requiring hospitalization.
- **Precipitants/stressors:** triggering events leading to humiliation, shame or despair (i.e., loss of relationship, financial, or health status – real or anticipated).
- **Chronic medical illness** (esp. CNS disorders, pain).
- **History of or current abuse or neglect.**

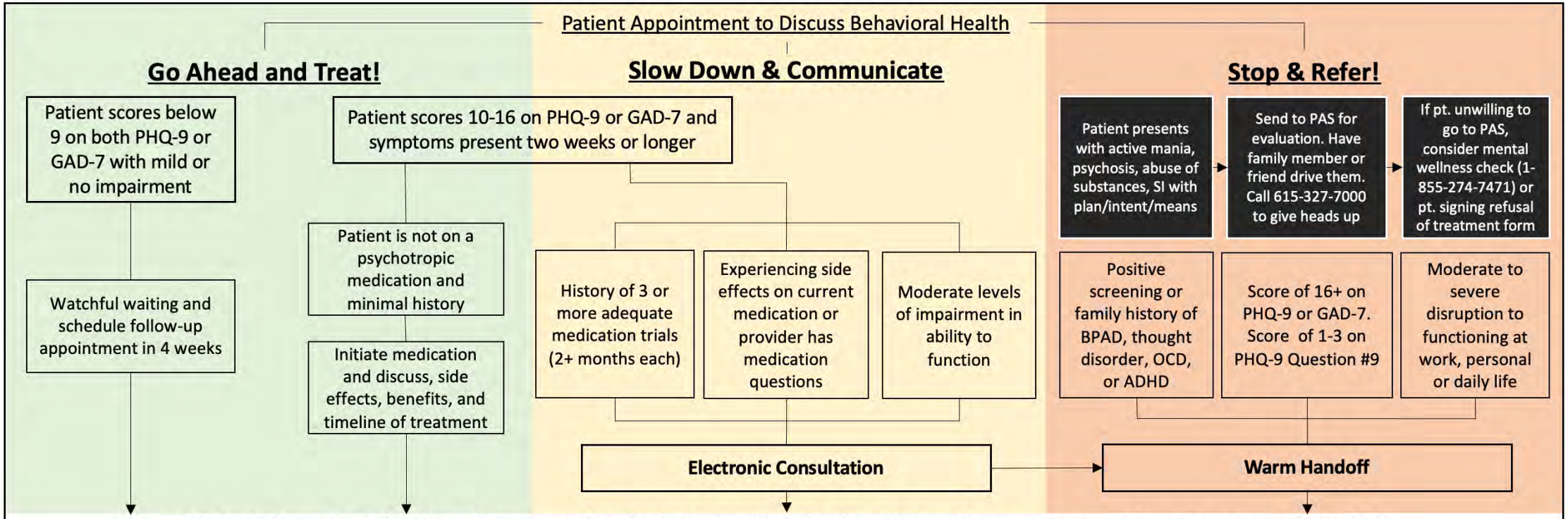
### PROTECTIVE FACTORS

Protective factors, even if present, may not counteract significant acute risk.

- **Internal:** ability to cope with stress, religious beliefs, frustration tolerance.
- **External:** responsibility to children or beloved pets, positive therapeutic relationships, social supports.

*(Western Interstate Commission on Higher Education (WICHE) and Suicide Prevention Resource Center (SPRC). (2009) Suicide Prevention Toolkit for Rural Primary Care: A Primer for Primary Care Providers. Boulder, Colorado: Western Interstate Commission on Higher Education.)*

# Clinical Communications & Referral Tool




Work to rule out physical etiology of symptoms (thyroid, diabetes, low iron levels, etc.). Record assessment, rationale, and treatment plan in EPIC.

Connect with therapy resource or up number of sessions. Certificated staff can utilize EAP (1-888-297-9028), tele-therapy through Karla (google "Karla MNPS), or through insurance (go to psychologytoday.com and search). Support staff can utilize EAP (1-888-297-9028) and through their insurance (go to psychologytoday.com).

Encourage mindfulness (google "Headspace for educators" for free subscription, MBSR course on website), exercise, sleep hygiene, engaging with social support system and activities, reducing substance use, and establishing activities/hobbies.

## Considerations

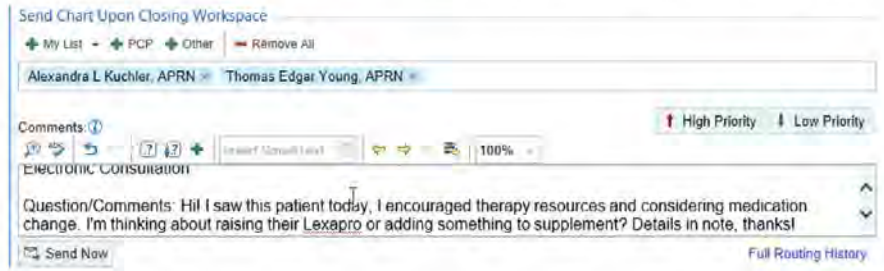
- Screening tools and clinical judgement help screen, communicate severity, and monitor progress. Examples include the PHQ-9, GAD-7, and MDQ. Question #9 on PHQ-9 regards suicidal ideation.
- An **electronic consultation or e-consult** is a staff message with the patient chart cc'd that asks specific questions regarding use of medications, available resources, or ongoing management.
- A **warm handoff** is a staff message sent to the behavioral health practitioners and referral coordinators that includes the patient chart cc'd and any other relevant information.
- Patients who desire ongoing daily management on the following medications should be referred out: Ambien, Lunesta, Ativan, Alprazolam, Clonazepam, and Valium.

# Clinical Communications & Referral Tool – Backside

- Examples of electronic consultations and warm handoffs with steps
- See framework section

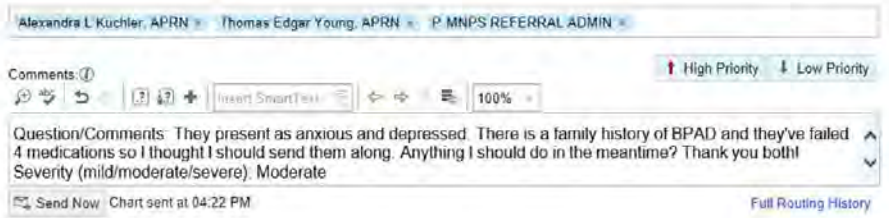
**Electronic Consultations** or e-consults are used to ask the behavioral health providers questions regarding available resources, diagnostic criteria, and psychotropic management. To perform an electronic consultation, follow these steps:

1) Finish the patient and before signing the note under the "wrap up" tab, go to the follow-up section.
2) Enter the names of the behavioral health providers in the recipient section
3) Under comments, use the smart phrase ".MNPSBHEC" and add any additional relevant information.
4) Expect a response within 24-48 hours from one or both behavioral health providers depending on schedule.




**Warm Handoffs** used to arrange referrals for ongoing treatment with the behavioral health team. Follow these steps:

1) Finish the patient note and before signing the note, under the "wrap up" tab, go to the follow-up section.
2) Enter the names of the behavioral health providers and the referral coordinators in the recipient section
3) Under comments, use the smart phrase ".MNPSBHWH" and add any additional relevant information.
4) Expect a response within 24-48 hours from one or both behavioral health providers depending on schedule.

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# Methods — Data Analysis

1. Survey Regarding PCP Attitudes –RedCap
2. Querying Interdepartmental Communications Tracker
3. ~~Focus Group~~ → Individual Feedback Sessions

# Results

1) Initial Survey Results
   a) Practice Characteristics
   b) Depression Care Questionnaire
   c) Mental Illness Management Scale
2) Number of Communications
3) Individual Feedback Sessions

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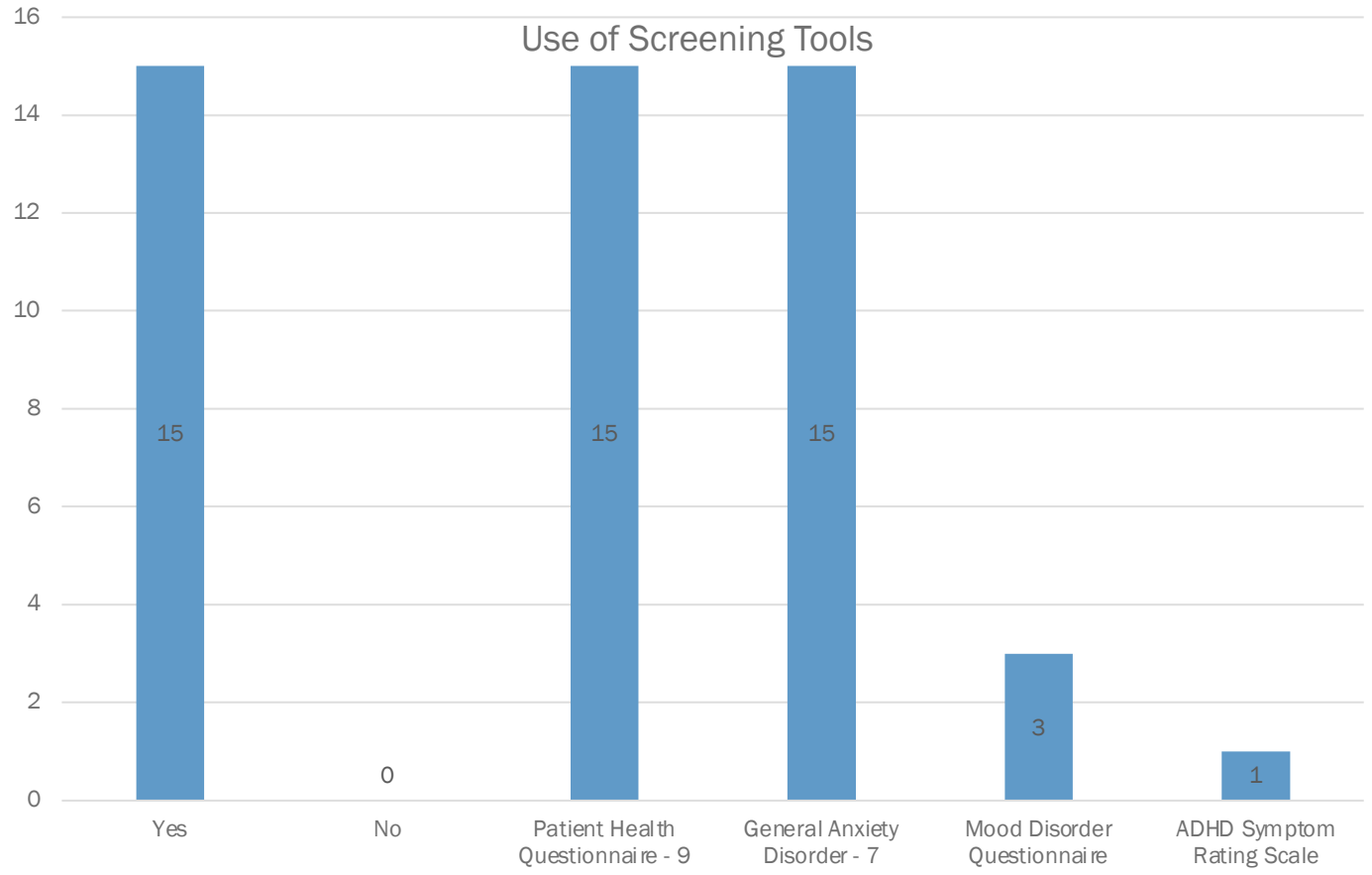
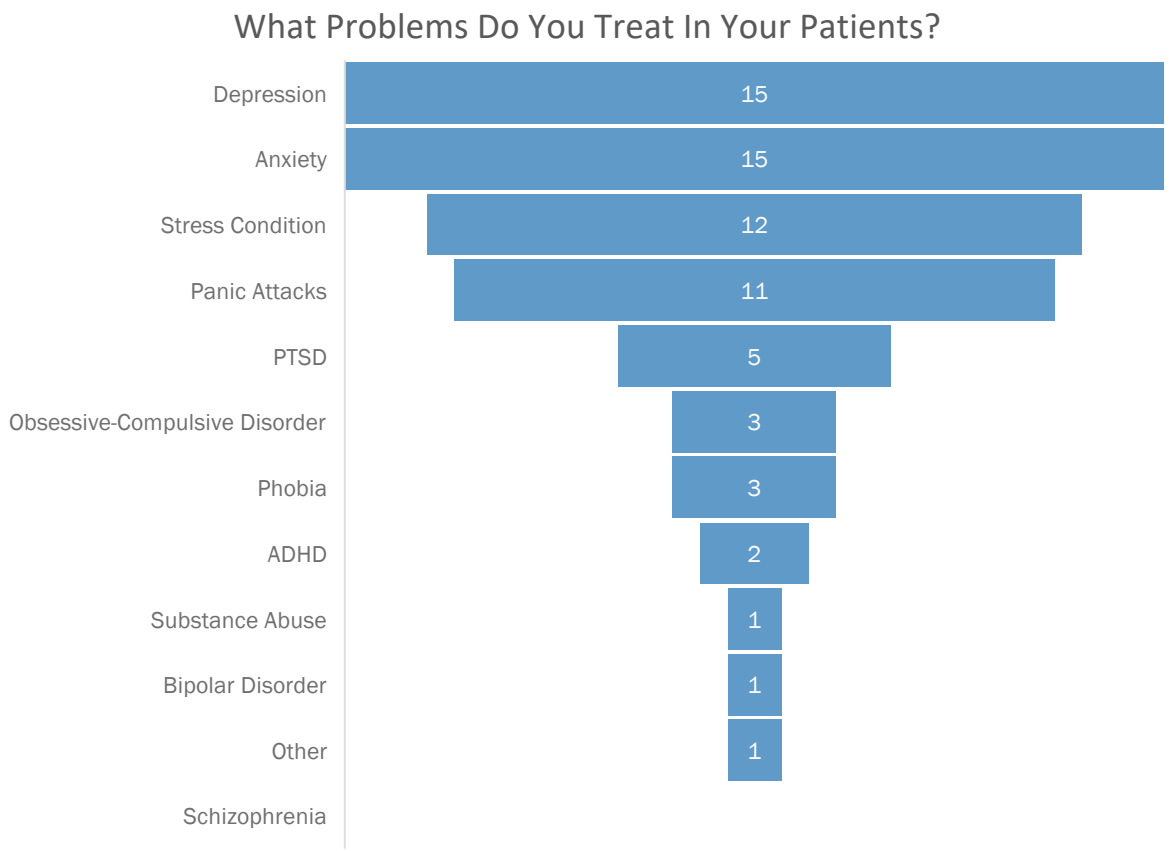
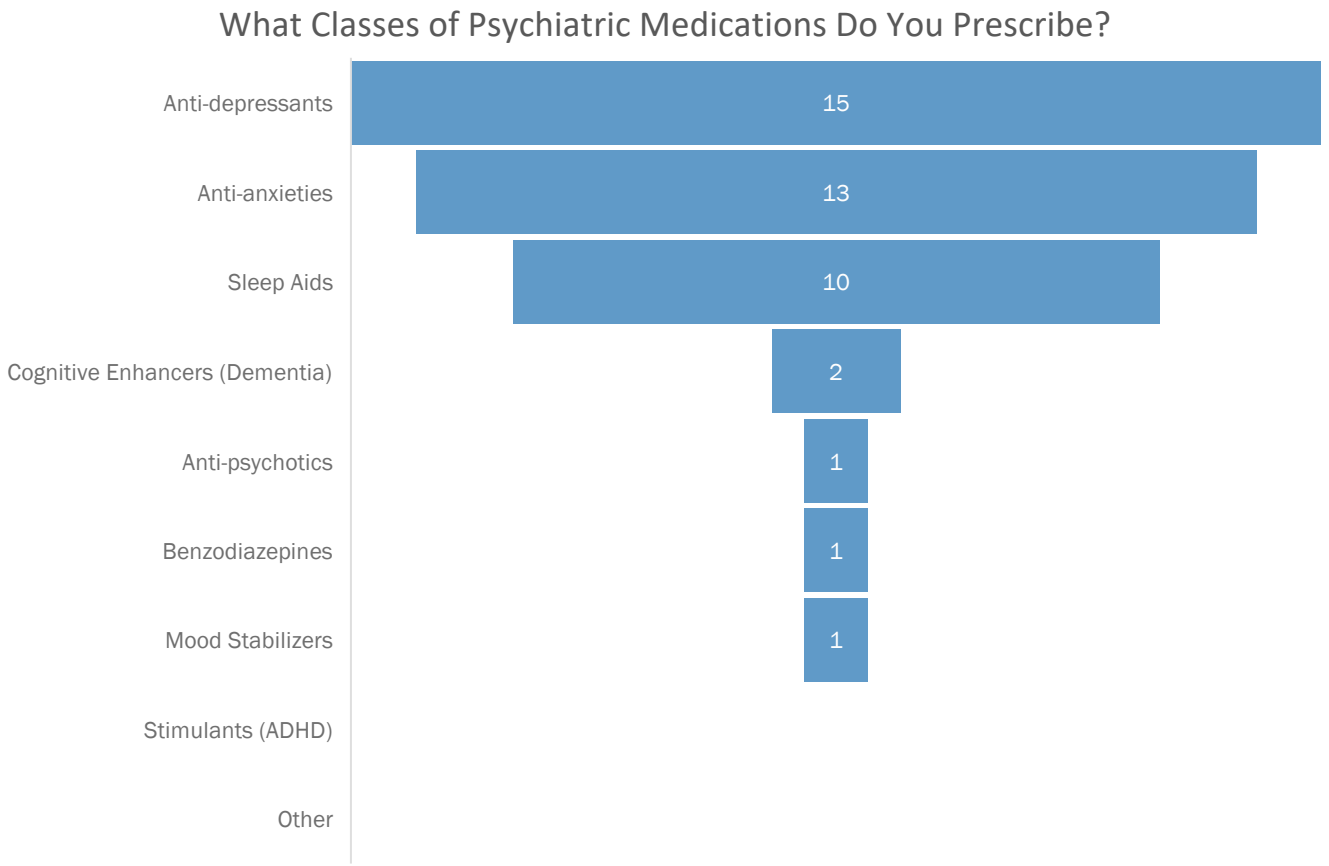
# 1a) Survey Results — Practice Characteristics



# 1a) Survey Results — Practice Characteristics



# 1a) Survey Results — Practice Characteristics

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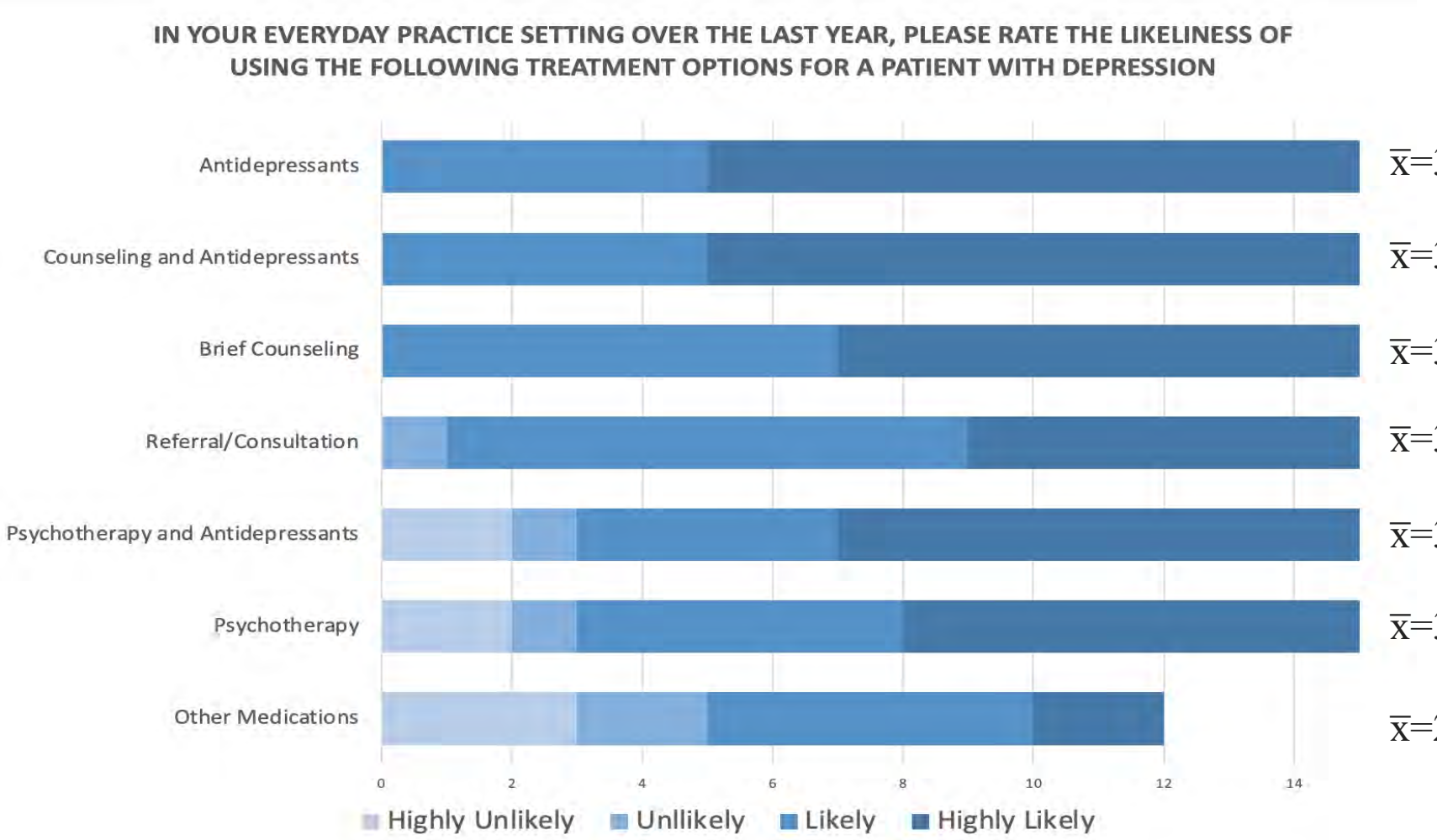
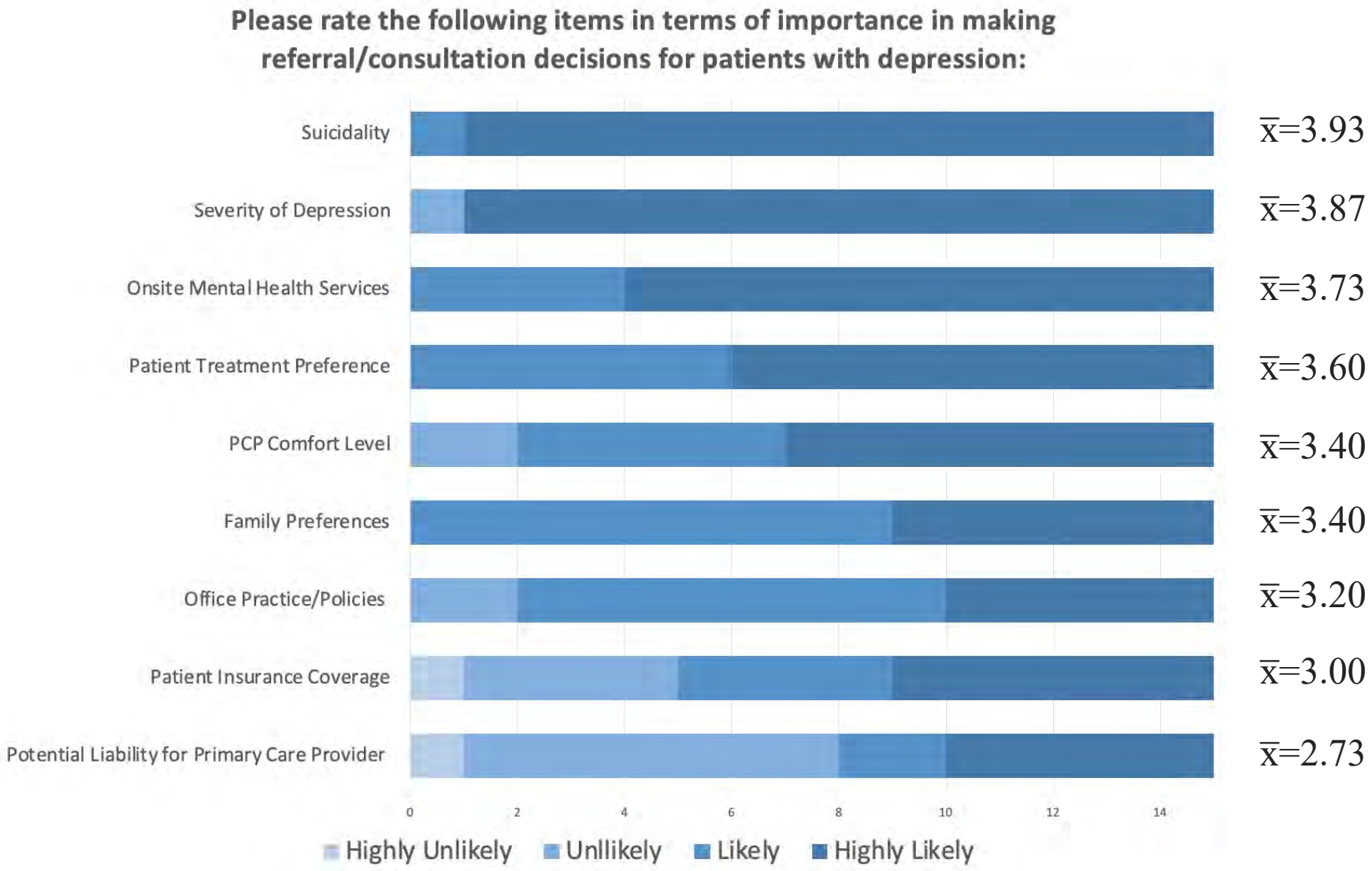
# 1b) Survey Results — DCQ



# 1b) Survey Results — DCQ




$\bar{x}$=3.93

$\bar{x}$=3.87

$\bar{x}$=3.73

$\bar{x}$=3.60

$\bar{x}$=3.40

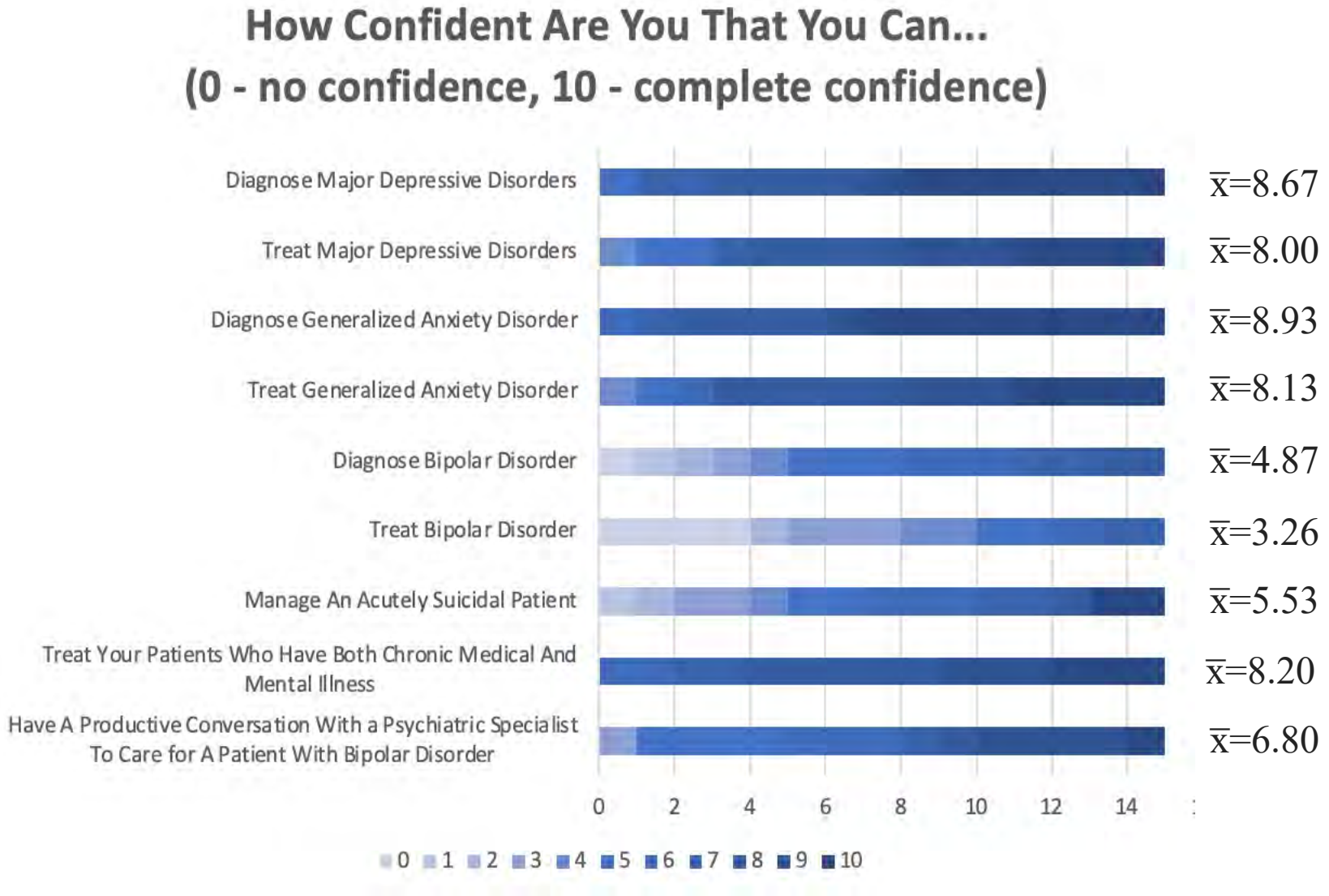
$\bar{x}$=3.40

$\bar{x}$=3.20

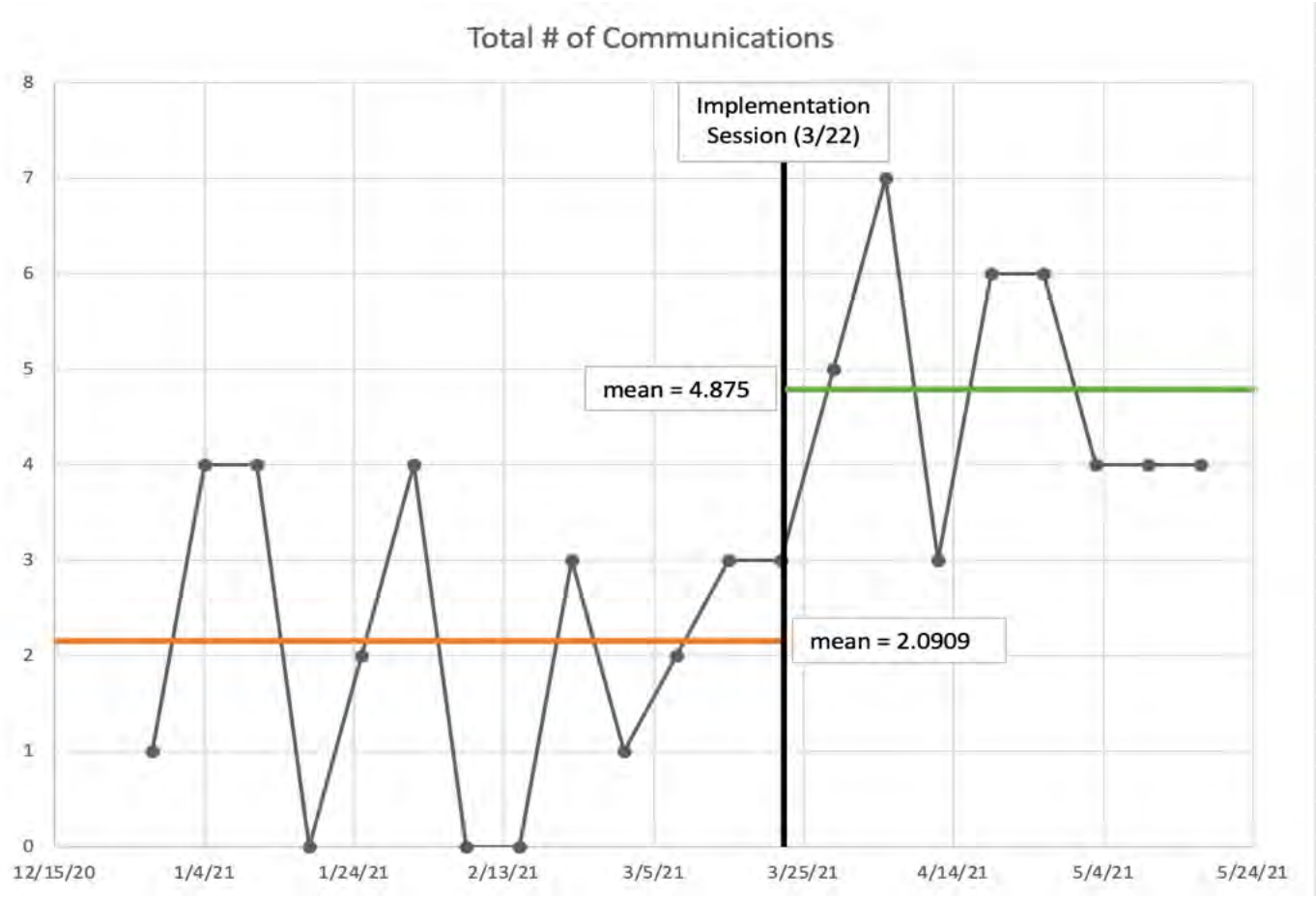
$\bar{x}$=3.00

$\bar{x}$=2.73

# 1d) Survey Results — MIM Scale



# 2) # of Communications

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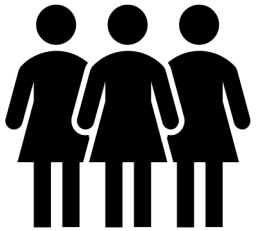
# 3a) Individual Feedback Sessions



6 interviews were conducted (46.2%).

Each interview lasted around 10-15 minutes and were conducted primarily over the phone or virtual meetings.

Topics included the communication guide, electronic consultations, warm handoffs, and general coordination

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# 3b) Individual Feedback Sessions

a) Benefits of electronic communications in providing treatment direction and next steps
b) Need for clarity in electronic communication process
c) Ongoing concerns regarding behavioral health capacity, wait times, and navigation of patient resources

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# Discussion — Results

- Survey results:
  - Primary care providers (PCPs) utilize rating scales
  - Confident in treating depressive and anxiety-based disorders
  - Lower comfort level with acute suicidality and bipolar
  - Importance of suicidality and depression severity in making referrals/consultations

- Collaborative contacts doubled from $\bar{x}$=2.09 pre-implementation to $\bar{x}$=4.875 post-implementation

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# Discussion — Results

- Timely responses from behavioral health
- Good individual relationships with behavioral health providers
- Issues with capacity and wait times
- Electronic consultations & warm handoffs benefited:
  - Treatment guidance
  - Reaffirming provider's clinical judgement
  - Increasing provider confidence in treatment
- Potential low utilization of the communication guide
  - Perception of being more beneficial for inexperienced providers

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# Discussion — Aim and Frameworks

- The aim of this project was to increase the frequency of communications between primary care and behavioral health
- The frequency of collaborative contacts increased

1. Diffusion of Innovation (DOI) — adaptation of innovations
2. Health Action Process Approach (HAPA) — predicting an individual's response to change adaption

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# Discussion — Links to the Literature

- Reaffirmed the benefits of integrated care on the provider side for helping provide treatment direction
  - The impact on confidence level → resend validated scales
  - Measurement of patient effects → outside project scope
- Reaffirmed the effects of primary care attitudes on referrals/consultations
- Benefits of clear communication channels

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# Discussion — Strengths & Limitations

## Strengths

- Firm foundation in change theories including the DOI, HAPA, and PDSA models
- Support from key stakeholders
- Strong literature support and use of AIMs model
- High participation level

## Weaknesses

- Higher convenience of one-on-one feedback sessions
- Feedback session self-selection
- The project did not monitor or measure the impact on patients

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# Discussion — Future Site Implications

## Access to Mental Health Services

- Consider use of lunch and learn to discuss navigation of resources
- Encourage setting expectations of timeliness for patients
- Consider hiring third psychiatric nurse practitioner

## Furthering of Collaborative Relationships

- Reinforce use of electronic communications and warm handoffs through reminders
- Consider monthly case coordination or review

## Primary Care Provider Support

- Consider lunch and learn sessions or expert panels for topics such as suicidality, short therapeutic interventions, medication management, etc.
- Continue use of electronic consultations to support providers in treatment direction

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# Discussion — Dissemination Plan

- Finalized paper and findings summarized in 2-page brief report
  - Send to stakeholders including the QI coordinator, clinic manager, medical director, and client representative
- Positive feedback from the sessions will be emailed out to the primary care providers to encourage further utilization
- Send out to colleagues within VUSN/VUMC network with interest in behavioral health integration
- Second round of surveys to capture attitudinal changes
- Consider submitting to academic journals for publishing

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# Conclusion

- Feasible to increase the frequency of electronic communications and warm handoffs through brief educational session and decision tool
- Next steps include dissemination, consideration of lunch and learns, and continued gathering of data

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# Questions or Comments?

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