VAIL
Veterans Assessment and Improvement Laboratory
VISN 22

PACT
PATIENT ALIGNED CARE TEAM

Figuring out the nuts and bolts of integrating mental health into PACT: a QI approach

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VISN 22 Veterans Assessment and Improvement Laboratory (VAIL)

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V22 Demo Lab: Veterans Assessment and Improvement Laboratory (VAIL)

- VAIL promotes structured, evidence-based PACT quality improvement at primary care practices
  - Phase 1: (FY 2011)
    - 3 medical centers (VA GLA, VA Loma Linda, VA San Diego) each pick a demonstration site
  - Phase 2: Spread (FY 2012)
    - Each medical center adds one practice
  - Phase 3: Sustainability (FY 2013)

V22 Demo Lab Focus on Mental Health (MH)

- In Phase 1, MH in PACT emerged as a major focus through two projects:
  - Economic evaluation of Ambulatory Care Sensitive conditions from VAIL (Yoon, HERC)
  - VAIL innovation proposed by GLA on integrating MH into PACT prioritized by VISN (led by Lisa Altman, MD)

Overview

- Review the problem of co-morbid mental and medical illness as described in VAIL (national, VISN, local)
- Describe primary care-mental health integration activities at Sepulveda Ambulatory Care Center (demonstration site)
  - Collocation of mental health (MH) providers into primary care (PC)
  - Investigation of communication between MH and PC using quality improvement (QI) tools

Problem: Preventable Adverse Events Among Veterans with MH, Drug Use, and Chronic Illness

- VAIL economic analysis of costs for hospitalizations and ED visits for chronic medical illness (e.g., CHF, diabetes) showed
  - A significant increase associated with also having a chronic mental health (MH) condition documented the prior year, over and above the effect of diabetes
  - Depression (OR 1.09) and drug use (OR 1.40) have most impact

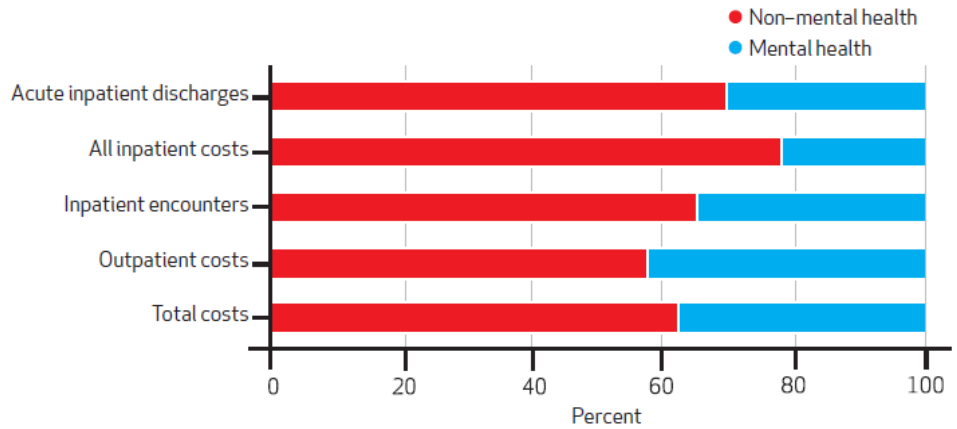
Yoon, et al. *Med Care.* 2012.

Prior Evidence: Care Among Veterans with MH/SUD is More Costly

- The 15.4% veterans with MH/SUD account for 32.9% of VA costs (2007)
- Most costs are for medical, not MH care

EXHIBIT 2

Mental Health And Non-Mental Health Service Use And Costs By Veterans With One Of Five Psychiatric Diagnoses Who Received Treatment From The Veterans Health Administration, Fiscal Year 2007

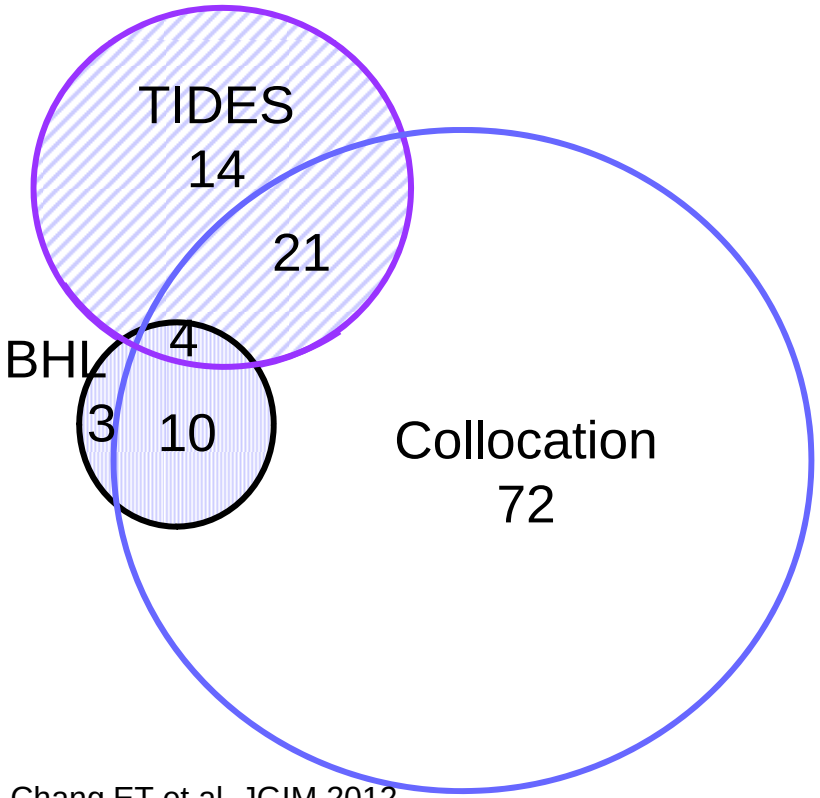


Watkins, et al. *Health Affairs.* 2011.

Possible solution: Primary Care and Mental Health Integration

- VA endorsed collocation and collaborative care models (CCM) to integrate PC/MH in 2006
- CCM (e.g., TIDES, BHL) improves outcomes and is cost-effective
- Half of the sites implemented collocation rather than CCM

National Model Spread, 2007



Chang ET et al. JGIM 2012.

Prior Evidence:
Collocation Alone is Not Effective

- VA encouraged adoption of “collocated collaborative care”
  - Evidence suggests in most sites, this is simply collocated, *not* collaborative, care
- Meta-analysis: **Bi-directional communication** is a critical component of collaboration
  - Improves outcomes in primary care patients with mental illness
  - Results in joint care planning

Foy, et al. *Ann Intern Med.* 2010; 152: 247-258.

Setting:

Sepulveda Ambulatory Care Center

- A multi-specialty academic community-based outpatient clinic that:
  - Serves 16,000 veterans in Los Angeles, CA
  - Has trainees in internal medicine, psychiatry, and psychology
  - Has 2 primary care PACT teams
  - Has specialty mental health and substance use outpatient services in a different building from primary care
- Historically has tried to integrate MH and PC

Local Problem: Focus Groups Led to Recognition of Collaboration Issues

- Focus groups (Sep 2011) of 1) MH patients; 2) PCPs; 3) social workers
- Cross-cutting themes—pts and providers
  - Issues with MH specialists' continuity and availability when scheduled
  - Issues with PCP comfort with MH care/communication
  - Perceived long wait time for new MH consult (months)
- PCPs
  - Lack of understandable MH treatment plan
  - "Not a lot of coordination of care"

Local Problem: Led to Recognition of Collaboration Issues at Sepulveda Clinic

- Local management identified MH follow-up of stable MH patients as a potential access barrier
  - Attempt to transfer patients chronically followed in MH for transfer of responsibility to their PCPs for management of stable MH disorders
  - Project revealed major resistance from PC and MH as well as practical problems
  - No standard way to guide communication

VAIL Projects

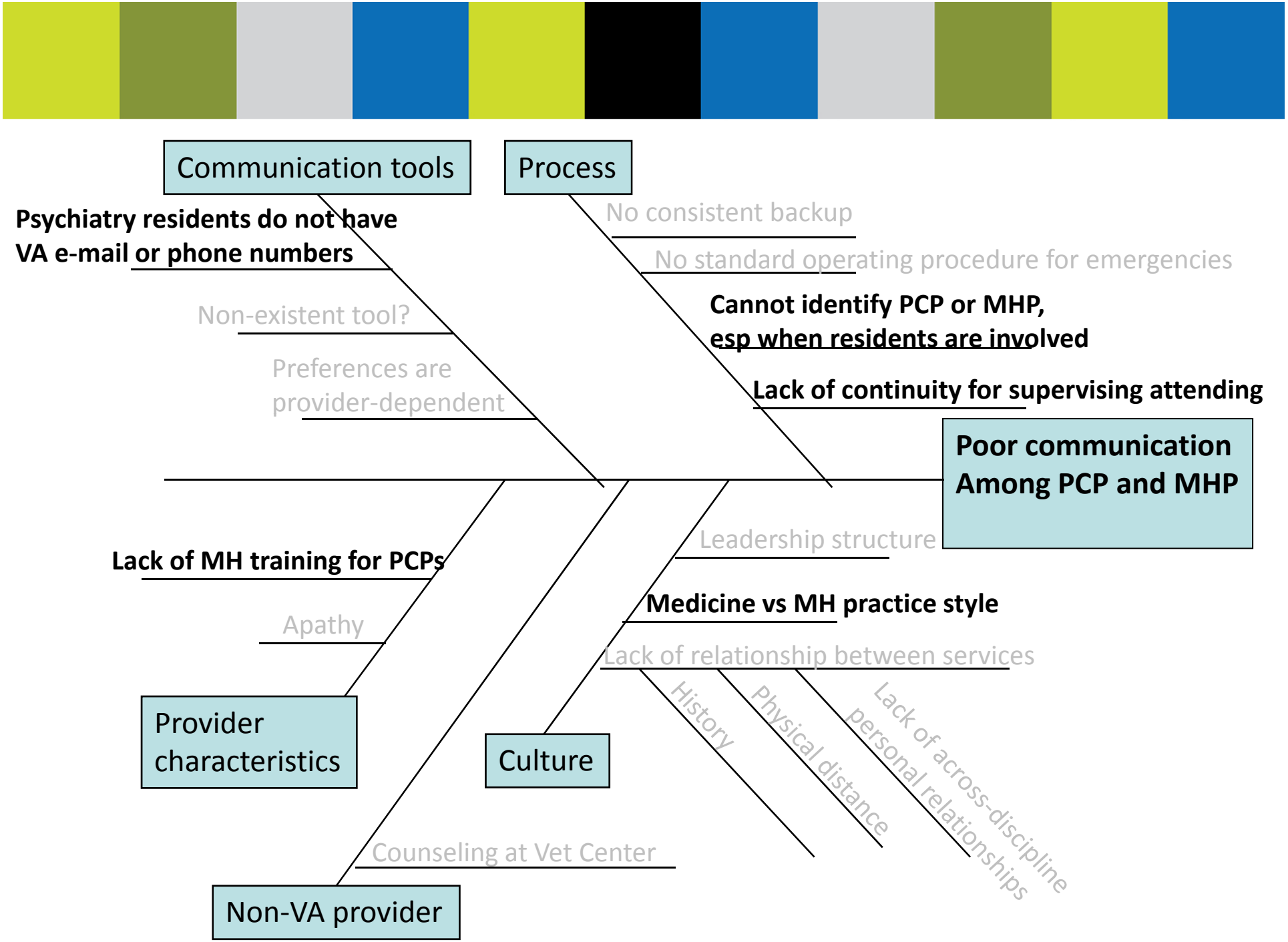
- Collocation of MH providers into PC
  - Improve access for new consults
- Investigation of communication between MH and PC for shared patients using quality improvement (QI) tools

Step #1: Project Initiated through the Sepulveda Quality Council

- Interdisciplinary project workgroup formed
- Includes 11 members
  - Primary care providers, psychiatrists
  - Researchers
  - Administrators
- Began meeting monthly with intervening “homework”

Step #2: Used QI Tools to “Diagnose” the Communication Problems

- Workgroup brainstorming and focused interviews
  - Fishbone diagram: root cause of problem
  - Flow mapping of communication strategies: describe process
- Chart review
  - Patients followed in both MH and PC
  - Consult requests to MH
- Survey of MH and PC providers


Communication tools
Psychiatry residents do not have VA e-mail or phone numbers
Non-existent tool?
Preferences are provider-dependent
Process
No consistent backup
No standard operating procedure for emergencies
Cannot identify PCP or MHP, esp when residents are involved
Lack of continuity for supervising attending
Poor communication Among PCP and MHP
Lack of MH training for PCPs
Apathy
Provider characteristics
Leadership structure
Medicine vs MH practice style
Lack of relationship between services
History
Physical distance
Lack of across-discipline personal relationships
Culture
Counseling at Vet Center
Non-VA provider

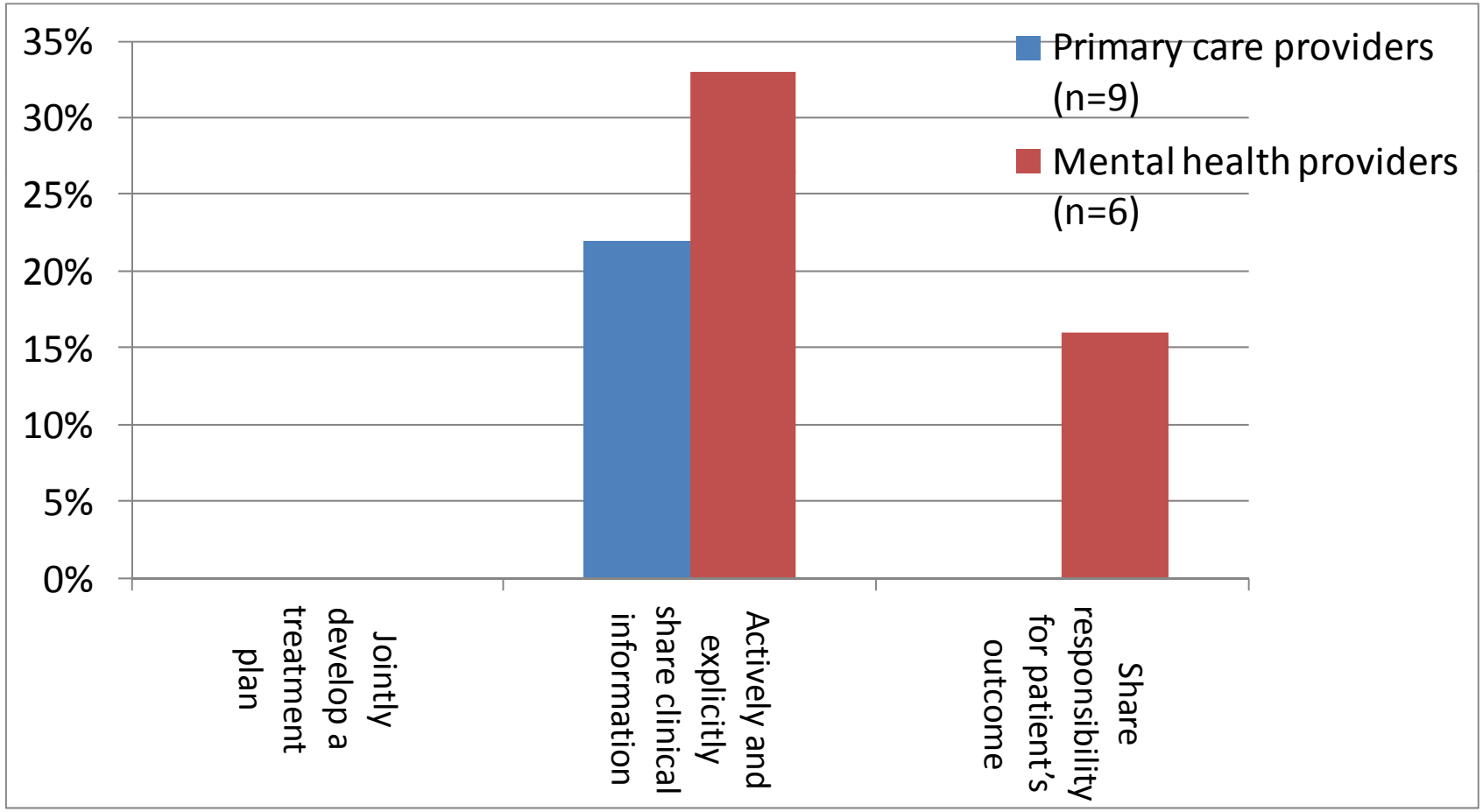
Top barriers: PCPs and MHPs agree on the problems

- **Who is on the patient care team?**
  - Who is the correct attending?
  - Who is the correct resident?
  - Who is the backup in case the above are not able to be reached?
- **How do you contact the other provider?**
- **What is the role of the team members?** (MHPs believe that PCPs are uncomfortable with MH therapies)
- **What do you do in case of emergencies**? (PCPs believe that MHPs are inaccessible during emergencies)

Survey: What are some barriers to collaboration?

- Primary care providers perceived barriers
  - "Not having enough providers to do therapy"
  - "Unable to reach a MH provider when paged by beeper and even sometimes overhead pages"
- Mental health providers perceived barriers
  - "PCPs have indicated an aversion to prescribing any psychiatric medications to psychiatric patients, even if they routinely prescribe these medications for other problems."
  - **"There is NO communication. When I have attempted to talk with MDs, most are confused what I'm even attempting to achieve."**

Survey: Over the last 3 months, did you perform the following for at least half of your patients:



Step #3: Rapid Review For Innovative Evidence-based Strategies

- Literature showed
  - Integrated treatment plans for shared patients
  - Regularly scheduled joint case conferences
  - Joint patient consultation
  - Multidisciplinary team meetings

Step #4: PDSA a Tool for Joint Care Planning for Complex MH & PC Patients

- Integrated treatment plan template identifies
  - Which provider is primarily responsible for guiding care overall?
  - Who is the backup provider?
  - What are the treatment goals for MH & PC problems?
- PDSA cycles revealed that process is helpful to providers caring for shared patient but too time-consuming
  - Low acceptability rate

Step #5: PDSA a Tool for Joint Grand Rounds

- Joint grand rounds
  - Provides opportunities for PCPs and MHPs to interact learn from each other
  - Educates providers on common PC and MH issues
  - Provides a platform for discussion about systems-, provider-, and patient-level issues for PC-MH integration
- 1st PDSA cycle in November

Collocation of MH providers to PC

- Modeled loosely after WRJ Collocated Collaborative Care
- Offers same-day access
- 0.8 FTEE psychiatrist, two 0.5 FTEE RNs, 0.5 FTEE LCSW, one 0.3 FTEE psychologist
- Group therapies offered in primary care
  - Meditation, mindfulness, coping
- Developed new consult note, working on treatment plan note
- Guided by weekly interdisciplinary meetings under VAIL

Initial results (Feb-July 2012)

- Strong uptake of Mental Health Integrated Care (MHIC) consults, average 46 consults/month initiated by Primary Care
- Number of specialty MH consults initiated by Primary Care has dropped by 83%
- Average days to specialty MH consult completion has decreased from 28.3 to 8.3 days
- Average days to MHIC consult completion is 5.2 days

What do providers think about collocation?

- Lead psychiatrist: “Trust is being developed” between primary care and mental health providers
- Primary care providers happier about same-day and on-site access to mental health providers for emergencies

Next steps

- Tackling logistical barriers for provider communication (e.g., resident contact information)
- Assessing patient satisfaction for collocated model of care
- Developing outcome measures that capture symptom severity for mental health disorders and chronic medical illnesses
  - E.g., visit frequency, unnecessary ED visits, and hospital length of stays

Conclusion

- Integrating mental health into primary care may be difficult
- Joint clinical/research partnership
  - Learning, QI-oriented organizational culture
- Fosters success in integration efforts

PC/MH Provider Communication Workgroup

- Workgroup members:
  - Wendell Ching, MD, Maria Davis, NP, Sue Donovan, RN, Jackie Fickel, PhD, Megan Johnson, MD, MPH, Kevin Jou, MD, Randy Mervis, MD, Mai Pham, MD, Lisa Rubenstein, MD, MSPH, Susan Vivell, PhD, MBA, Maria Zambrano, NP
- Advisory group members:
  - Cathy Alessi, MD, Ed Chaney, PhD, Dana Melching, LCSW, Marti Waite, LCSW, Sarah Minden Weil, LCSW

Sepulveda PC/MH Integration Workgroup

- Leaders:
  - Lisa Altman, MD, Steve Ganzell, PhD, Ali Kazim, MD
- Facilitators:
  - Danielle Higgenbotham, JD, Robin Sohmer
- Workgroup members:
  - Wendell Ching, MD, Sue Donovan, RN, Jackie Fickel, PhD, Megan Johnson, MD, MPH, Maria Zambrano, NP, Marti Waite, LCSW, Alisa Doner, Fredalin Braden, RN, Sarah Duman, PhD, Teri Davis, PhD, Evelyn Chang, MD, MSHS, Javier Quintana, MD, PhD

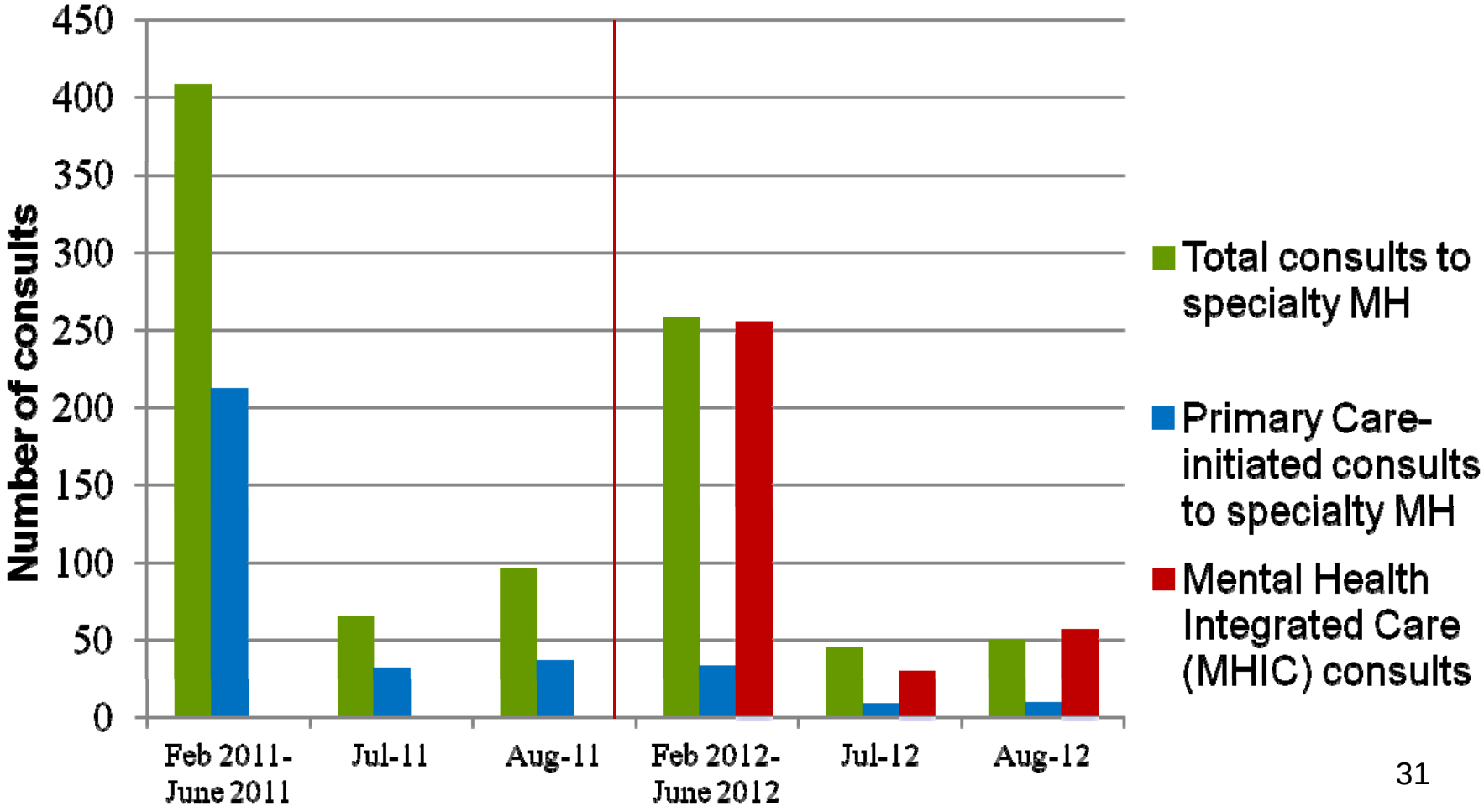
VAIL products: manuscripts and presentations

- Yoon J, Yano E, Altman L, et al. Reducing costs of acute care for ambulatory case-sensitive medical conditions: the central roles of comorbid mental illness. *Med Care.* 2012.
- Chang ET, Rose DE, Yano EM, et al. Determinants of Readiness for Primary Care-Mental Health Integration (PC-MHI) in the VA Health Care System. *JGIM.* 2012.
- Chang, ET and Rubenstein LV. A quality improvement approach to communication among primary care and mental health providers at the VA. Poster Presentation. Academy for Healthcare Improvement. May 2012.
- Chang ET, Rose DE, Yano EM, et al. Determinants of Readiness for Primary Care-Mental Health Integration (PC-MHI) in the VA Health Care System. Oral Presentation. Society of General Internal Medicine. May 2012.
- Chang ET, Rose DE, Yano EM, et al. Determinants of Readiness for Primary Care-Mental Health Integration (PC-MHI) in the VA Health Care System. Oral Presentation. Academy Health. June 2012.

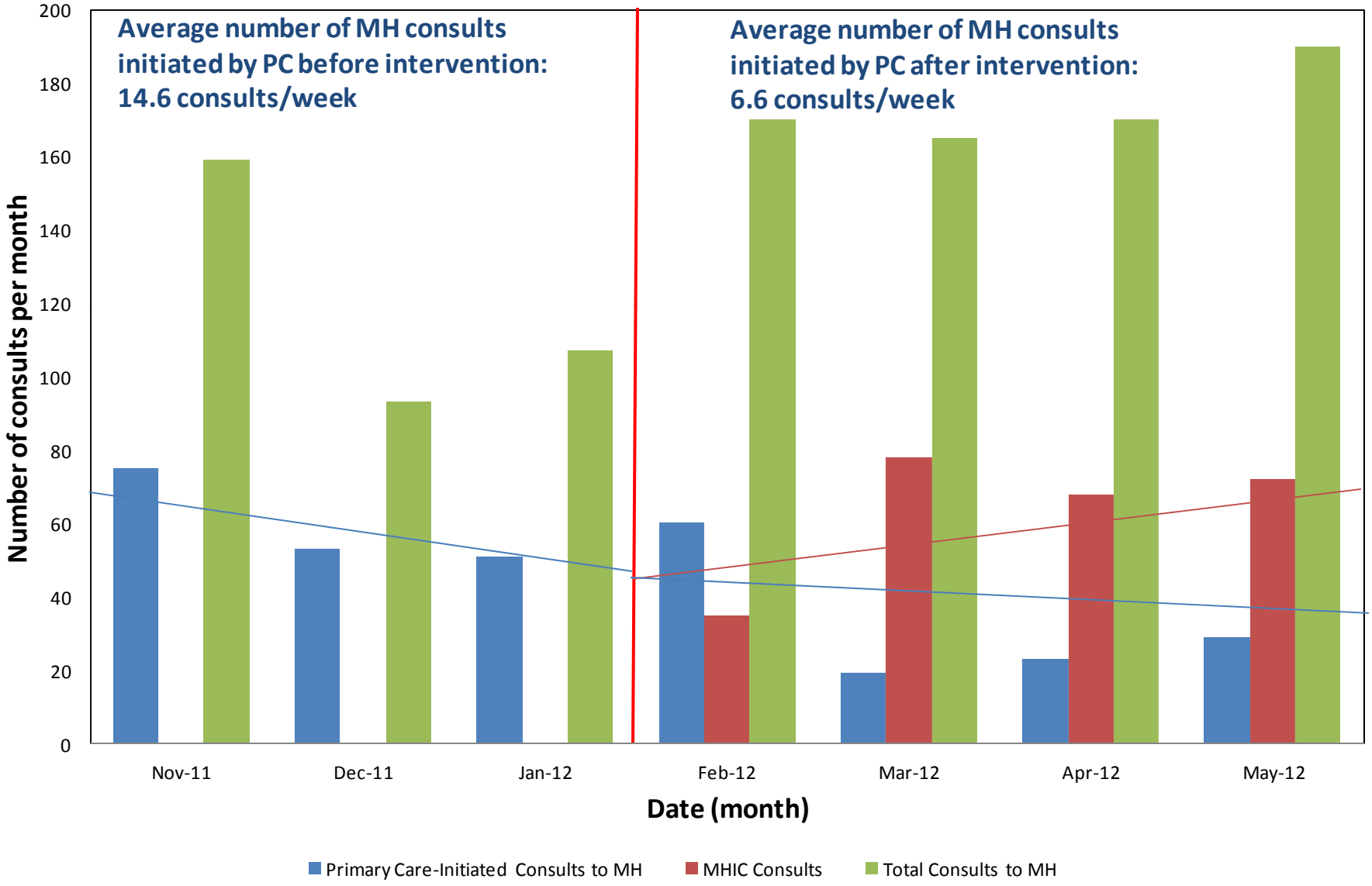
Thank you!

- Any questions? E-mail us at:
- Evelyn.Chang@va.gov
- Lisa.Rubenstein@va.gov

Number of completed consults to Sepulveda Mental Health (MH): 2011 vs 2012



Number of Consults to Sepulveda Mental Health (Nov 2011 - May 2012)



Implementation of a Patient Aligned Care Team (PACT) for OEF/OIF Veterans with PTSD: Bridging Primary & Behavioral Health Care

Elif Sonel, MD Barbara H. Hanusa, PhD, Erin Kelly, BS,
Kathryn Zimmerman, RN, BSN, CCRC, Stacy Faulkner, RN, BSN
Jon Walker, MS, Cathleen Appelt, PhD, Cassandra Brown, RN,
John Kasckow, MD, PhD & Gretchen Haas, PhD

PLEASE SELECT THE OPTION THAT BEST DESCRIBES YOUR PACT TEAMS:

A. CONSISTING OF PRIMARY CARE STAFF ONLY
B. CONSISTING OF PRIMARY CARE STAFF WITH INTEGRATED BEHAVIORAL HEALTH (BH)
C. CONSISTING OF PRIMARY CARE STAFF WITH INTEGRATED SPECIALTY STAFF
D. CONSISTING OF PRIMARY CARE STAFF WITH INTEGRATED SPECIALTY AND BH STAFF
E. DO NOT HAVE DEDICATED PACT STRUCTURE IN MY CLINIC

Patient Aligned Care Team Model (PACT)

- **The PACT Model represents an advance in coordinated, pro-active & customized care beyond conventional care models within Primary Care clinics.**

- **OEF/OIF/OND Clinic is a post-deployment clinic serving Veterans from the recent war**

Patient Aligned Care Team Model

- In Pittsburgh, we have been developing an integrated PACT model of care within the OEF/OIF/OND Primary Clinic since November 2010 as part of our project.
- In this time frame the OEF/OIF/OND clinic also evolved into a PACT team and has been shaped by our study into an integrated Behavioral Health-Primary Care PACT model.
- In our study, a subset of Veterans with PTSD diagnoses has been targeted by a randomized clinical trial comparing outcomes between the two PACT structures within the same clinic, as well as comparing outcomes with all other Primary Care locations in VAPHS.

PTSD Diagnosis as a Marker of High Risk

Why did we choose Veterans with PTSD as our focus for the trial?

- **High incidence of co-morbid medical, mental health and substance abuse issues**
- **Disproportionate use of medical and surgical services compared to Veterans without PTSD**
- **High rates of medical and psychiatric admissions**
- **High rates of suicide**

PTSD Diagnosis as a Marker of High Risk

In Pittsburgh

- PTSD diagnosis is carried by 206 of the 838 Veterans (25%) served by the OEF/OIF/OND clinic.
- And yet, Veterans with diagnoses of PTSD constituted 79 of the 144 (54%) medical, surgical or psychiatric hospitalizations of all OEF/OIF/OND Veterans, more than twice the expected rate.
- OEF/OIF/OND Veterans with PTSD diagnoses constituted 17% of all suicide attempts and 33% of all completed suicides in FY2011.

The Integrated PACT Model for the PTSD Veterans in the OEF/OIF/OND Clinic

- Direct Access to the RN Care Manager (Intense care management-ICM)
- Individual, pro-active care management
- Tracking of health outcomes
- Preventative health maintenance
- Integrated and inter-disciplinary care management for medical and behavioral health care.

The Integrated PACT Model for all Veterans in the OEF/OIF/OND Clinic

An active interdisciplinary team that meets weekly consisting of;

- **Psychologists and psychiatrists**
- **Primary Care providers and nurses**
- **Social workers**
- **Rehab, pain, and sleep specialists as needed**
- **Behavioral Health nurse practitioner**

Providing integrated and inter-disciplinary management for medical and behavioral health care for veterans but;

Without the added benefit of direct access to a dedicated RN and customized and pro-active care the study provides.

The PACT Model for all Veterans in the OEF/OIF/OND Clinic

Another unique feature is the close tie between Primary Care and Behavioral Health care in Pittsburgh

- **All new OEF/OIF/OND Veterans are referred to the Behavioral Health Lab (BHL) for pre-visit screening**
- **Pre-visit screening phone call includes**
  - **Screening with standardized mental health surveys**
  - **Encouragement and application of motivational interviewing techniques to help veterans attend their scheduled appointment.**
  - **If any mental health red flag, or possible Traumatic brain injury is identified, a same day BH and/or TBI evaluation is arranged.**

Funded Project to Study the PACT Model at Pittsburgh VAHCS

Implementation Aims

- **Descriptive component of the PACT implementation:**

  Success stories, obstacles, time frame, patient experiences and satisfaction with care

- **Implementation component of creating a novel Behavior Health-Primary Care integrated PACT model with intense care management (ICM).**

Funded Project to Study the PACT Model at Pittsburgh VAHCS

Research Aims

- **Clinical Trial within the OEF/OIF/OND clinic**

Compare Usual PACT model to an Intense Care Management (ICM) added model of PACT.

Compare both PACT models to pre-PACT implementation.

- **Administrative Data Analysis**

Compare service use and attendance between the OEF/OIF/OND Veterans with PTSD diagnoses treated within the integrated PACT model to OEF/OIF/OND Veterans treated at all other primary care clinic sites in Pittsburgh.

Research Components

- **Clinical Trial**
  - **Measure the impact of the ICM-PACT on attendance, health care usage and satisfaction with care compared to care received in the evolving PACT model clinic.**
  - **Focusing on OEF/OIF/OND Clinic Veterans with PTSD as our high risk registry**

Research Components

- Randomized control trial focusing on Veterans with PTSD receiving care from the OEF/OIF/OND Clinic to compare
  - Veterans who receive usual care in the developing PACT model clinics within Primary Care, and
  - Veterans who receive care in the same location but with the benefit of adding access to a dedicated RN Care Manager who facilitates integrated medical and behavioral health care (ICM-PACT).

Research Components

Role of the Intense RN Care Manager (ICM)

- Encouraging and helping patients overcome barriers to attendance prior to all appointments.
- Helping Veterans identify medical, social, or mental health issues to be addressed in their upcoming appointments.
- Pro-active calls to the veterans at a minimum on a monthly basis, or as indicated by the medical, or psychiatric need.
- Documenting these calls and bringing the issues to the weekly inter-disciplinary team meetings.
- Informing the Veterans and documenting the inter-disciplinary team discussion points.

Research Components

Outcomes

- Service use with a focus on decreasing high cost ED and inpatient admissions
- Attendance at scheduled medical and behavior health appointments
- Satisfaction with care received
- Self assessment of well being, work-life adjustment and PTSD severity

Research Components

Methods

- Participants are recruited in the clinic either through referrals by the clinic team, or self referral
- After signing informed consent, completing paper surveys the Veteran is randomly assigned to treatment.
- The Veteran receives a letter and a phone call to inform him/her of the assignment
- For those assigned to ICM care, the dedicated RN Care Manager assesses needs and begins relationship with participant.

Research Components

- Follow up surveys are completed 6 & 12 months after randomization
  - We anticipate that the last 12 month survey will be collected in May 2013.
    - Surveys measure PTSD symptoms, combat exposure, work-life adjustment and quality-of-life
  - One-on-one interviews; with patients to learn their experiences with PACT care and PTSD

Today we will be presenting preliminary data on service use and appointment attendance.

Preliminary Results

Preliminary results being presented today compare

- **Percentage of primary care and behavioral health appoints that were attended.**
- **Number of hospital admissions and ED visits within 6 months of PACT care.**

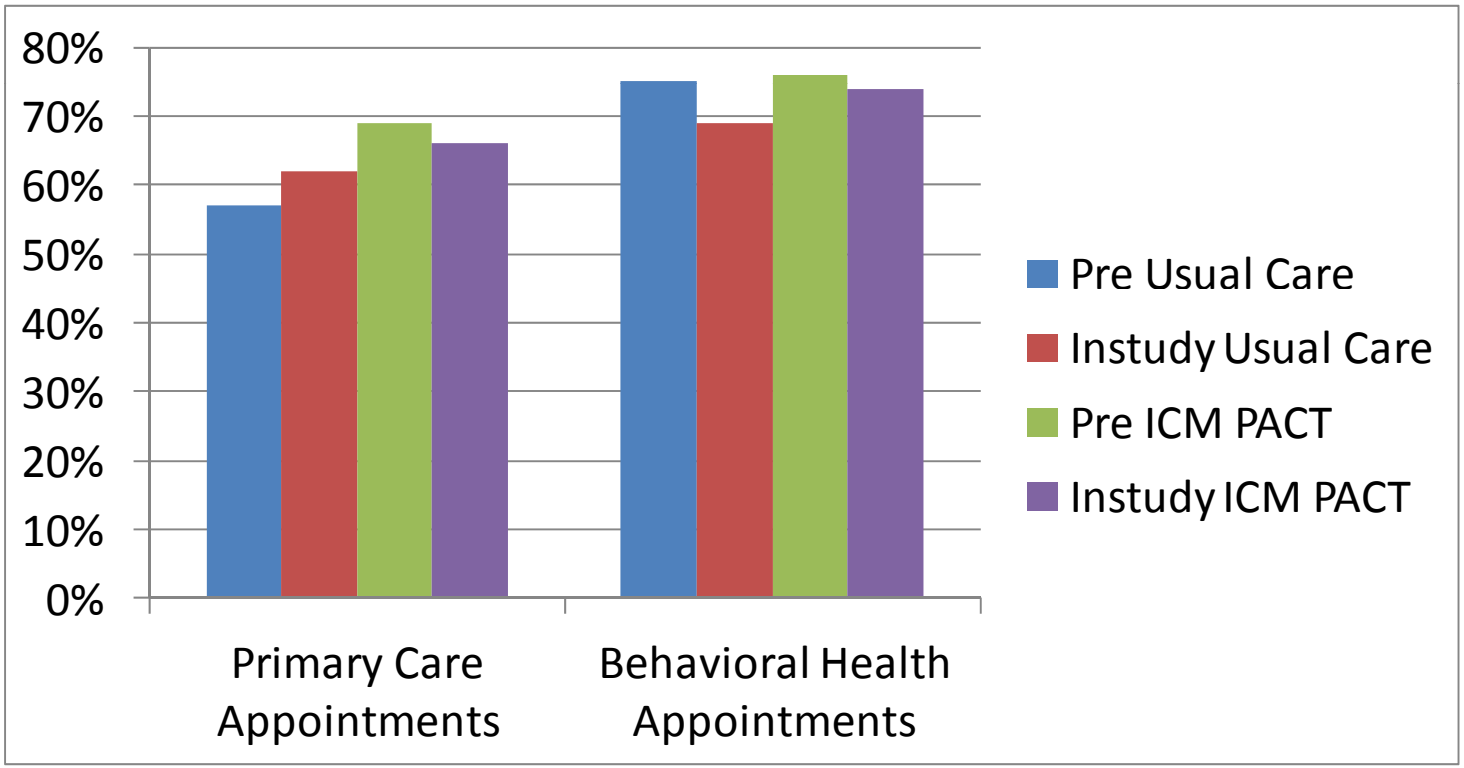
Preliminary Results

Percentage of Appointments Kept

- Compare 1 year before and after randomization -in study data for the same patients
- Separate analyses for primary care and behavioral health visits
- Compare Usual PACT Care with ICM-PACT

Preliminary Results

Percentage of Scheduled Appointments Kept



Preliminary Results

ER visits and hospitalizations after randomization

	Number of ER Visits	Number of Hospitalizations
Usual Care (n=30)	5 (17%)	2 (7%)
ICM PACT (n=44)	8 (18%)	4 (9%)

Administrative Data Analysis

Ongoing Larger Administrative Study

- Compare service use and attendance between the OEF/OIF Veterans with PTSD diagnoses treated within the in our integrated OEF/OIF/OND PACT clinic to OEF/OIF Veterans treated at other primary care clinic locations in Pittsburgh. (1 other main site and 5 CBOC's)

Will include the same measures –

- Appointments scheduled and kept
- ER visits and hospitalizations

Administrative Data Analysis

Greater numbers of Veterans will allow us to compare an our integrated PACT model clinic with clinics that are developing "conventional" PACT teams

- **Comparisons will also be made between PTSD patients w/ non-PTSD patients**