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2016

Integrated Care: Improving Coordination of Care Between Primary Care and Psychiatric Services

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Recommended Citation
Fu, Eunice, "Integrated Care: Improving Coordination of Care Between Primary Care and Psychiatric Services" (2016). *Family Medicine Block Clerkship, Student Projects*. 120.
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Swanton, VT
December 2015 - January 2016

The Problem:

It is evident that the **majority of the highest utilizers of medical care are affected by mental health issues**, with depression and anxiety being the most prevalent.[1] **Patients with serious mental illness** (schizophrenia, bipolar disorder, major depressive disorder) in the US **can die on average 8-25 years earlier** than the general population due to the exacerbating effects of psychiatric symptoms on the most common medical conditions (e.g. hypertension and hyperlipidemia), and vice versa. Furthermore, psychiatric symptoms can increase sedentary lifestyle, impede treatment adherence, and increase risk of substance abuse.[2]

Multiple studies have shown that PCPs have mixed success in recognition and management of mental illness on their own, and thus **an integrated model of primary and mental healthcare is ideal to increase acceptability and availability of mental health services.**[1]

However, there is a growing body of research demonstrating **high rates of dissatisfaction with primary-specialty communication.**[3] Failure of coordinated care is associated with major delays in diagnosis, significant functional impairment, economic burden, and mortality.[4]

In a series of open-ended focus groups conducted by the Veterans Health Administration nationally, **3 of the top 5 themes for quality improvement** discussed by specialty and primary care providers **centered around aspects of communication.**

Public Health Costs

Substance Abuse and Mental Health Administration estimated that the U.S. national expenditure for mental health care combined with lost earnings and public disability insurance payments associated with mental illness was more than $467 billion in 2012.[5]

AAFP states that 10% of Medicaid funding and more than 20% of state and local funding was spent on mental health care in 2008.[6]

Vermont ranks 4th for the highest State Mental Health Agency per capita mental health services expenditures, spending $291.7 million in fiscal year 2013.[7]

Poorly managed mental illness increases utilization of crisis services and frequency of psychiatric hospitalization. **Vermont allocated $26.5 million in grants to just inpatient behavioral health and crisis/emergency mental health services** in 2015.[8]

Northwestern Counseling and Support Services (NCSS) is one of the few organizations providing psychiatric services in Franklin and Grand Isle Counties. In 2015 alone, the Behavioral Health Division

- *served 2,659 clients, providing a total of 18,237 hours of care*
- *estimated 36% patients were prevented from needing ED services*[9]

Community Perspective

Prior to one-time referrals and increased efforts in care coordination, there was a “lack of engagement in referrals – a “just take them” attitude vs. working alongside…We were sometimes used as a place for conversations that PCPs find too difficult or felt insufficiently trained in.”The goal of the new model and referral protocol was to give “support for PCPs”, exhibit “responsiveness”, and offer “specialist recommendations on chronic mental health conditions…It’s important to have a warm hand-off.”

Discussion with Program Manager for NCSS Crisis, Integrated Health and Outpatient Services

“So many of our patients are managed on multiple psych medications, and I needed another opinion to see if there was anything I hadn’t thought of yet. There wasn’t a clear process of how to make referrals. When we couldn’t access records from NCSS, it was difficult to know what had happened after the referral…We would see new prescriptions at the next visit and not know the reasoning behind it. Sometimes it would cause friction because we didn’t know who was prescribing and managing what medications. We may have stepped on some toes.”

Family Physician, Swanton clinic

“Lack of access to psychiatry services is a HUGE barrier for people in this county. From what I understand, one of the only organizations offering psychiatry is Northwestern Counseling. This [one-time psychiatry consultation] is really helpful for people who want to see a trained psychiatrist to see if they need adjustments to their medications and then be referred back to their PCP for ongoing care. The process can be long (LOTS of paperwork and it can take several weeks to get in) which sometimes makes it difficult for people to follow through.”

MAT Counselor, part-time placement in Swanton clinic

“Before the integration of data, there would be a lot of time wasted reviewing the same problems that the primary doc had already covered but the psychiatrist didn’t know about, and vice versa. So many hours for the providers, for the patient and me sitting in both conversations. I would have double the documentation. Now that they get each other’s information, communication has been great…When the treatment plans disagreed, we would have to have a big meeting – counselors, home providers, case managers, psychiatrist – to discuss what worked best for the patient.”

Home provider for NCSS clients

Laying New Groundwork

Beginning January 15, 2015, NCSS implemented a new care coordination model to address :

- 2 additional staff positions to support co-management
- sharing of records between offices: psychiatric and psychosocial evaluations, ongoing psychiatric notes, and crisis contact notes
- increased effort to establish mutual patients' understanding that records will be shared when signing NCSS consent to treatment
- notification to PCPs if proper authorization is not obtained for records protected by Statute 42 CFR Part 2 (substance abuse)
- one-time psychiatry consults to better support PCPs with complicated diagnoses, overt psychosis, and treatment-refractory depression and anxiety with clarification of referral process

Intervention and Methodology

- Letters sent to primary care offices to inform about the new care coordination model and the PCP’s role in implementation
- Presentations and workshops conducted to educate PCPs on referral protocol to facilitate one-time psychiatric evaluation
- after 1 year of implementation, a 10-question follow up survey was sent out to 17 primary care offices in Franklin and Grand Isle Counties to evaluate effectiveness of the new model (survey was developed by NCSS Integrated Health and Outpatient Services Program Manager)
  - *both paper and electronic (Survey Monkey)*
- Responses were aggregated, and survey was re-evaluated and a second version for future follow up developed
- Data and new survey presented to NCSS Integrated Health and Outpatient Services Program Manager

Results and Response

Out of 21 total responses from providers in this group:

Overall opinion of the new care coordination model:

- 86% say that receiving NCSS records has improved patient care
- 90% believe the new care coordination model is beneficial

Logistical process:

- 90% understand the process to make referrals
- 52% received NCSS records in a timely fashion; 28% inconsistently receiving records, 20% not receiving records at all (Fig 1)
- only 14% believe non-crisis referrals have been seen within 2 weeks, 62% believe the wait is much longer than 2 weeks, and 24% say they have no way of knowing whether a patient has followed through the referral (Fig 2)

Structures of care:

- 81% utilized Community Health Team members to facilitate referrals

Suggestions for improvement:

- *Feedback on problems or delays in the referral process*
- *Need for access to counseling records*
- *Need systematic way to identify mutual patients and ensure that all records are shared*

Note: some responses are from providers in the same primary care office

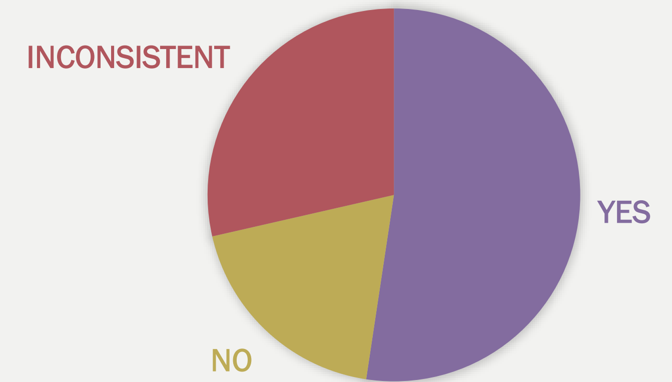

Fig 1

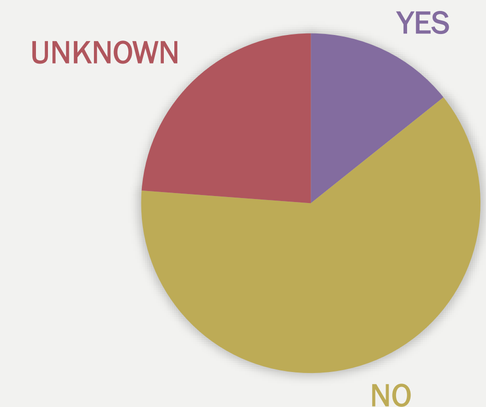

Fig 2

Intervention Effectiveness and Limitations

Effectiveness

The evaluation survey demonstrated overwhelming overall approval of the new care coordination model and agreement among providers that improved access to NCSS records benefited patient care.

Given the general comments, the new coordination efforts made by NCSS have increased desire for more CHT presence in the office as well as motivation to proactively share their own records with NCSS.

Limitations

- current survey has no quantitative items to track change as implementation continues over time or as new changes are added to the model
- binary yes/no choices along with a few phrases that were not clearly defined caused some confusion for participants and forced "in-between" qualitative answers, making data interpretation less straight forward
  - *e.g. "timely fashion" = 1 week? 2 weeks? 1 month?*
  - *responses forced even though it was apparent previous answers made the next question inapplicable*

Future Interventions/Projects

- Ongoing evaluation of the care coordination model:
  - *Based on the limitations of the original survey, a new survey was developed, incorporating 5-point Likert scale to help quantify change in perception over time and enhance ease of response.* ***Please see attached document.***
  - *This survey could be sent out in 6 months to re-evaluate care coordination to obtain both qualitative and quantitative data*
  - *Eventually, it would beneficial to obtain perspectives from other players in the model: patients, home providers/caregivers, counselors.*
- Based on provider responses, future improvement projects could include:
  - *developing a flagging system for mutual patients (e.g. pop-up before closing an encounter on EMR or a sticker/label for paper charts to remind providers or office staff to share pertinent notes from that visit)*
  - *notification protocol for referral paperwork receipt and status of patient to prevent losing patient to a "referral process void"*
  - *expanding NCSS psychiatric records to include counselor's notes*
  - *moving all offices towards one EMR platform to reduce time required to share information*

References

1. Vickers KS, Ridgeway JL, Hathaway JC, Egginton JS, Kaderlik AB, Katzelnick DJ. *Integration of mental health resources in a primary care setting leads to increased patient access.* Gen Hosp Psychiatry. 2013 Sep-Oct; 35(5):461-7.

2. Kilbourne AM, Bramlet M, Barbaresso MM, Nord KM, Goodrich DE, Lai Z, Post EP, Almirall D, Verchinina L, Duffy SA, Bauer MS. *SMI Life Goals: Description of a randomized trial of a Collaborative Care Model to improve outcomes for persons with serious mental illness.* Contemporary Clinical Trials. 2014 Sep;39(1):74-85.

3. Zuchowski JL, Rose DE, Hamilton AB, Stockdale SE, Meredith LS, Yano EM, Rubenstein LV, Cordasco KM. *Challenges in Referral Communication Between VHA Primary Care and Specialty Care.* Journal of Gen Int Med. 2015 Mar; 30(3): 305-311.

4. Kim B, Lucatorto MA, Hawthorne K, Hersh J, Myers R, Elwy AR, Graham GD. *Care coordination between specialty care and primary care: a focus group study of provider perspectives on strong practices and improvement opportunities.* J Multidiscip Healthc. 2015 Jan; 8: 47-58.

5. Insel, Thomas. “Director’s Blog: Mental Health Awareness Month: By the Numbers.” National Institute of Mental Health. May 15, 2015. http://www.nimh.nih.gov/about/director/2015/mental-health-awareness-month-by-the-numbers.shtml.

6. *Mental Health Care Services by Family Physicians.* American Academy of Family Physicians. 2011. http://www.aafp.org/about/policies/all/mental-services.html#cost.

7. *SMHA Mental Health Actual Dollar and Per Capita Expenditures by State (FY2004 - FY2013).* National Association of State Mental Health Program Directors Research Institute, Inc. May 2015. http://kff.org/other/state-indicator/smha-expenditures-per-capita/

8. *FY 2016 Budget Detail Report.* Vermont Department of Mental Health. Jan 2015. http://mentalhealth.vermont.gov/sites/dmh/files/report/budget/FY16/Budget_Detail_Report_FY16.pdf.

9. *2015 Outcomes Report.* Northwestern Counseling and Support Services. http://www.ncssinc.org/assets/files/Outcomes%20Report%202015%20-%20For%20Web(2).pdf.