Technological Bridges to Care: Improving Access to Quality Integrated Behavioral Health Care through Innovation and Interprofessional Collaboration

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Faculty Disclosure

The presenters of this session have NOT had any relevant financial relationships during the past 12 months.
Conference Resources

Slides and handouts shared in advance by our Conference Presenters are available on the CFHA website at http://www.cfha.net/?page=Resources_2018

Slides and handouts are also available on the mobile app.
Learning Objectives

At the conclusion of this session, the participant will be able to:

• Define prevalent behavioral health provider retention barriers and concerns in integrated primary care (including those found in rural/underserved settings)
• Identify innovative solutions to address and actively prevent behavioral health provider burnout and isolation
• Discuss strategies that improve access to quality and interprofessional behavioral health services
  • Technologically based communication methods
  • Collaborative models of consultation and service delivery
References


A learning assessment is required for CE credit.

A question and answer period will be conducted at the end of this presentation.
Cabin Creek Health Systems

- Rural FQHC (6 community health centers / 4 part-time school-based health centers)

- Provides fully integrated primary care services to rural / underserved communities in central/southern West Virginia

- Services:
  ◦ Primary Care
  ◦ Behavioral Health (1 full-time BHP at most sites, trainees add coverage)
    ◦ BHPs (psychologists, social work, psychiatry newly added)
  ◦ Dental
  ◦ Pharmacy

- Behavioral Health Team:
  ◦ 9 BHPs
    ◦ 7 doctoral psychologists
    ◦ 1 LICSW
    ◦ 1 full-time postdoc trainee (psychology)
    ◦ 1 psychiatrist
  ◦ 2 part-time psychology practicum students (extra coverage)

- 5-day coverage at every site (most sites have 1
Practice issues & threats to retention

- BHP Isolation
- Cultural Implications
- Demands on competency
- Issues w/ Interprofessional Collaboration
- Burn out

Goals of BH Program at CCHS:
- Contribution to rural workforce development in WV (recruitment/retention)
- Improved access to quality integrated behavioral health services for patients and teams
- Innovation in access, integrated care, and BHP (and other staff/provider) wellness
Practice issues & threats to retention: **BHP Isolation**

BHPs may be the only BHP on-site

- Pressures to carry the community on your shoulders alone
  - Risk for other clinic members to have misconceptions of what a BHP does, if there’s no frame of reference

- Lack of peer support, consultation, or affiliation

- Lack of opportunities for professional collaboration in the BH domain
  - Tendency to have to build programs and projects alone
  - Low access to opportunities for collaboration on research, scholarly pursuits, etc.
  - Lack of mentors for professional growth

- Limited support for crisis back-up
Practice issues & threats to retention: Cultural Implications

- Stigma toward BHPs and BH services can feel alienating and negative
  - By patients: “I’m not seeing her; I’m not crazy!!”
  - By staff: “Are you analyzing me right now?!” “I bet you make the best friend and give free therapy to all of your friends.”
  - Stigma is higher with regard to referrals to specialty mental health, resulting in poor follow-through even when these services are availability in the community (pressure to take them in afterwards)

- In some cultures, some disclose the perspective that medicine and/or faith are more effective than BH services

- In rural and other underserved areas, there may be cultural bias and stereotypes that are upsetting, harmful, and alienating to witness
  - Racism, sexism, anti-LGBT rhetoric, and misperceptions of definitions like rape, abuse, assault, harassment, etc.
Practice issues & threats to retention: Demands on competency

- IPC includes referrals for ALL behavioral health presenting complaints
  - BHPs may or may not have competency to meet referral needs

- PC teams have expectations of BHPs as the BH expert on all things BH
  - Pressure to do it all, all of the time...
    - Disapproval of referrals out – “why that one and not this one?!”
    - If an ECP, additional stress may occur when imposter syndrome is present

- PCP expectation for medication consultation/expertise

- Rural Considerations
  - BHPs are generalists, asked to provide specialty treatment due to lack of community services

- Risk of suboptimal provision of clinical services
Practice issues & threats to retention: Issues w/ Inter-professional Collaboration

- Difficulty defining the BHP role (what we do, and don’t do)
  - Seems to be a long-term effort with both long-term and new providers
  - If a BHP’s role evolves to include other non-clinical activities, it may warrant re-teaching and redirection

- Potential hardship with effective communication during handoffs or other collaborative patient care activities

- Difficulty navigating clinic member relationships and clinic culture
Practice issues & threats to retention: 
**BHP Burnout**

- Increased stress related to clinical service demands
  - Potential to feel like you can never do enough
- Struggle to balance access and established services (typical for rural IPC)
- Feeling overwhelmed
- Potential consequences to interprofessional relationships
- Threat to healthcare quality
- Threat to patient safety
Innovative Solutions

- Successful execution of a system-wide psychiatry Project ECHO system facilitated by behavioral health providers

- Utilization of internet based messaging systems to address provider isolation and streamline care and crisis management efforts during service delivery across health system sites
  
  ◦ Google chat – isolation (peer consultation/support) and initiating consults for crisis support and resources
  
  ◦ EHR chat – interprofessional collaboration

- Tips for integrating psychiatry into IPC setting (community health centers)

- Programmatic tips to initiate the launch of a collaborative care model for tele-psychiatry services in an integrated care setting.
Innovations in the field = Solutions

- Technology has presented new opportunities for innovative interprofessional team work in IPC.

- BHPs working in rural and other underserved areas especially benefit from these advancements as they may resolve problems associated with practice issues and threats to retention.
Technology-based strategies:

- System-wide psychiatry consultation project (ECHO) to bridge gaps in care
  - Addresses psychiatric competency limits for PCPs and BHPs
  - Resolves affiliation and isolation for BHPs

- Internet messaging systems to resolve isolation
  - Addresses provider isolation and streamlines care and crisis management efforts during service delivery across sites

- Collaborative care model for tele-psychiatry and integrated psychiatry in IPC
  - Promotes effective interprofessional team work to meet psychiatric needs of patients
  - Improves patient discomfort with seeing a mental health specialist due to in-house services
Extension for Community Healthcare Outcomes (Project ECHO)

ECHO at CCHS:

- Biweekly hour long consultation with panel of experts (12-1pm to promote participation)
  - Panel from West Virginia University- Morgantown Department of BMed & Psychiatry
  - Psychiatrist
  - Child psychologist (specialty mental health)
  - Adult psychologist (specialty mental health)

- PCP or BHP identifies a case that may benefit from an ECHO presentation

- BHP and BHP care coordinator collaborate on case presentation
  - Obtain medication suggestions and/or ideas on potential psychotherapy interventions to implement with patients.
  - Decreases felt isolation and other aspects contributing to burn out via consultation with other mental health providers
  - Improves quality of care by decreasing potential competency issues
  - Provides a platform to work through cultural issues and get guidance on possible means of navigating these

- Psychiatrist available PRN to consult on emergent cases
  - BHP or PCP is able to call psychiatrist on her cell phone as needed
28 y/o male (previously established with BHP and PCP) presented to PCP for hospital discharge follow up.

Pt.’s dx include: Schizoaffective disorder, borderline personality disorder (per hx), polysubstance abuse, chronic pain, hepatitis C, asthma, and degenerative joint disease involving multiple joints.

Challenges of treatment: transportation issues, inconsistent medication compliance, polypharmacy, a great deal of failed medications, and substance use.

PCP and BHP agreed patient was a good candidate for ECHO. BH Care Coordinator reviewed chart and drafted presentation. BHP reviewed, refined, and submitted for ECHO
The ECHO team provided health center with the below recommendations:

- Could look into depot injections for antipsychotic medications
  - Psychiatrist will send some training materials and articles to the group and be available for consultation PRN
- Possibly add Wellbutrin to patients medication list
- Other than that medications look good
- Continue to try and manage his anxiety surrounding hallucinations
- Continue with motivational interviewing on why medicine is important and encouraging him that he is doing well on it
- Continue to manage his anxiety by helping patient develop coping strategies on how to distract patient from hallucinations
- In general Hub thinks you are managing the case perfectly and to keep doing what you are doing
Patient presented to PCP with adverse reaction (extreme mood dysregulation) after first dose of newly prescribed sertraline to help treat MDD – PCP was concerned, stressed, overwhelmed

- BHP saw patient for brief evaluation (med and treatment history)
- BH Care Coordinator reviewed chart and drafted presentation
- BHP reviewed, refined, and submitted for ECHO
- Psychiatry expert provided recommendation:
  - Attempt prescription of Prozac (5mg)
  - Monitor reaction: if similar response, consider potential underlying mood disorder (other than depression) and resubmit to ECHO for continued consultation and management
- Provider endorsed increased confidence, less stress, and relief
Internet-based messaging

- Online Chatting (Google Chat, Google Hangouts)
  - Allows for...
    - Team collaboration
    - Immediate access to back-up support without leaving your patient
    - Social support and connection between BHPs across
  - Example: Google Chat at CCHS
    - One-to-one chats: Direct, personal, and private chatting
    - BHP Group Chat: Entire BH Team (including trainees) on same chat
    - BH Care Coordination Group Chat: Whole team plus BH CC
    - BH Training Group Chat: BH supervisors and BH Training Director
Case Examples: One-to-one chats

- Life/peer support
- Coordinating research
- Reaching out and giving support
- Supporting professional development
- Supervision support
- Directing training and IPE
Chat examples... "BHP" Group Chat

- Coordinating coverage during BHP absence
- Peer support during difficult clinical events
- Peer support
- Social planning
- Celebrating successes
  Empowering and including BH team members as a director
“BH Care Coordination” Group Chat

Planning urgent psychiatry phone consults

Feedback on referral options

Mandated Reporting Decision Making

Managing Crisis Situations: SI/HI and Hospitalization

Planning urgent psychiatry phone consults

Feedback on referral options

Mandated Reporting Decision Making
Case Example: “BH Supervisors” Chat

Coordinating student recruitment

Student management support

Supporting guiding supervision

Supervision skill development
EHR-based Communication
EHR-based Communication

HIPAA compliant “chat” correspondence via HER

- Allows for prompt immediate communication across all staff despite clinic location or staff role
  - Example: Notification of patient arrival and readiness for appointment post intake form completion
  - Example: PSR notified BHP that patient indicated experiencing anxiety related to PTSD triggers in waiting room
  - Example: Post clinic emergency staff trauma response - PSRs initiated a mental grounding exercise (categories)
- Efficient means of notifying BHP of handoffs (saves time and allows easy back and forth planning)
- Allow BHPs to alert PCPs about reverse handoffs for urgent medical/medication needs
- Enables PCPs to include all BHPs on-site in handoff chats to allow for handoff ping pong

- Patient cases (like HIPAA compliant emails)
  - Increases flow of communication between providers (don’t physically need to be with provider to provide brief and confidential information related to shared patients)
  - Allows PCPs the ability to notify BHPs of missed handoffs
  - Patient support staff able to notify BHPs of patient messages and urgent requests
Collaborative care model for integrated psychiatry

What Integrated Psychiatry IS...
- A fully-integrated collaborative and inter-professional model of psychiatric care
- A team-based approach to psychiatry
  - Patient, Psychiatrist, BHP, PCP, BH Care Coordinator, and care team
- A combination of psychiatric stabilization, consultation, and established services
- Treat those appropriate for PC in PC, refer cases needing specialty care to specialty care

What Integrated Psychiatry ISN'T...
- A full replacement of PCP medication management of behavioral health and psychiatry
- A specialty psychiatric practice dropped into a primary care system
- Co-located psychiatry private practice
- Doesn't work or sustain on a traditional referral model
  - If a psychiatrist keeps all referrals, they will have no access in a few months and we have the exact same problem as now...
Integrated Psychiatry at CCHS

Population:
- Children, adolescents, adults (including geriatric)
- Will provide MAT services in the future

Schedule:
- Mix of scheduled intakes and follow-ups throughout most of the day
- Additional time slots protected for...
  - Open access for urgent work-ins
  - Consultation requests from providers (handoffs/coaching calls)

Services:
- Psychiatric medication treatment (for complex cases)
  - Referral to specialty care when able (attempt to keep the ones who have barriers to care)
- Stabilization of patients w/ plan to return patients to PCPs for management
  - Provide support to PCPs providing medication management
  - Will take patients back if needed to stabilize again or attempt riskier med changes
  - Will keep some complex patients that are unable to be treated by PCPs or referred out
- Urgent psychiatric consultation with PCPs and BHPs
  - Able to coach providers via Athena and telephone as needed
  - Consultation via Athena patient case
Tele-psychiatry in Primary Care

- Used when a health system can only contract a psychiatrist or needs them to provide services in multiple sites or difficult to access sites

- What’s needed to build a service
  - Designated room and staff
  - MA facilitates labs, vitals, and escorts patient to and from room
  - MA facilitates urgent consults or handoffs with BHP on site
    - MA should be trained in crisis intervention in case no BHP available

- Challenges:
  - Stigma
  - Discomfort
  - Technological glitches
  - Rapport and assessment issues
Aspired Impacts of Innovations

• Minimized risk for burnout and threats to recruitment/retention
  • Decreased professional and social isolation (despite distance)
  • Expanded competency through consultation and cross training
  • Enhanced opportunity for peer/colleague collaboration
  • Reduced risk during remote supervision and practice

• Increased engagement of interprofessional team members
  • Improved communication and relationships
  • Enhanced team collaboration
  • Improved systems effectiveness

• Improved Access to Quality Care
  • Non-traditional options for bridging access to specialty care
  • Enhanced competency of medical providers (BH knowledge expansion)
Learning Assessment

• 1) List at least 3 behavioral health provider retention barriers and concerns in integrated primary care

• 2) Identify at least 2 innovative solutions to address issues that contribute to behavioral health provider burnout and isolation

• 3) Identify at least 2 strategies that improve access to quality and interprofessional behavioral health services
Q&A...
Session Evaluation

Use the CFHA mobile app to complete the evaluation for this session.

Thank you!