Interprofessional Approach to Caring for Persons with Serious Mental Illness in a Dedicated Primary Care Clinic: An Innovative Model of Integration at the Medicine in Psychiatry Service (MIPS) Clinic

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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:

1. Learn about the Medicine in Psychiatry Service model of integrated care

2. Identify several steps to forming an effective and collaborative interprofessional team

3. Highlight case examples describing some of the interprofessional approaches to treating patients with serious and persistent mental disorders in a primary care setting
Bibliography / Reference


8. Xyrichis A, Lowton K. What Foster or Prevents Inteprofessional Teamworking in Primary and Community Care? A Literature Review. International Journal of Nursing Studies 20018;45;140-153

A learning assessment is required for CE credit. A question and answer period will be conducted at the end of this presentation.
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The Problem: we operate in a health system made up of silos

- People with serious mental illness
  *die almost 25 years earlier* than others

  *due to poorly treated medical conditions*
  - poor access to medical care
  - social needs such as safe housing and transportation
  - stigma in the health system
The Answer:
develop a way to eliminate silos

• People with serious mental illness
deserve integrated care

- Decreased costs
- Better adherence to treatment
- Fewer admissions, ED visits
- Patient engagement
- Increase staff satisfaction -> decrease burnout
MIPS CLINIC
History of Medicine in Psychiatry Services (MIPS)

1993
• Dr. Roger Boulay, Dr. Eric Caine

2017
• Behavioral Health embedded into clinic

A simple vision:
• To provide primary care for SMI in a dignified manner
• Teaching others the passion and reward of taking care of vulnerable populations through team based care
• Medical clinic for the Med/psych residency program
MIPS Clinic

- CPEP (psych ED)
- Inpatient Psychiatry
- Strong Ties (CMHC)
- Medical ED
- RPC (state hospital)
- Other PCP's
- Lazos Fuertes (Spanish-speaking clinic)
- Strong Recovery (SUD tx)
MIPS Clinic Data

- Unique patients 1582
  - 34% Medicaid MC
  - 31% Medicare FFS
  - 9% Medicaid

- Total number visits 8,454 (2017)

- Top Psychiatric diagnosis:
  - 23% Schizophrenia
  - 19% Schizoaffective disorder
  - 16% Bipolar disorder

100% have a mental health diagnosis
MIPS Top Diagnosis

- 43% Hypertension
- 21% Hyperlipidemia
- 20% Diabetes
- Schizophrenia + HTN 52%  Schizophrenia + DM 27%
- Schizoaffective + HTN 51%  Schizoaffective + DM 28%
- Bipolar + HTN 41%  Bipolar + DM 18%
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Creating an Interprofessional Team at MIPS

- Team Players
- Organizational Changes
- Community Collaboration
- Developing Shared Goals
- Interpersonal Relationships
IT TAKES A TEAM

- Embedded health home care managers
- Community Health Workers

Social Needs

- Embedded therapist and psychiatrist
- Psychiatry residents

Behavioral Needs

Clinic and Staff Needs

- Outpatient Access Specialists
- Leadership

Health Needs

- MDs, NPs, nurses
- Pharmacist
- Transition care manager
- Trainees
Organizational changes

- Daily huddles
- Weekly team mtgs
- Monthly provider and clinic mtgs
- Monthly Collaborative Care sessions
Interpersonal Relationships

- Team mtgs
- Debriefings
- Setting examples
- Emotional support
- Multidisciplinary training
- Interprofessional education

Mutual Trust and Respect

Psychological Safety

Conflict Resolution
Developing Shared Goals

Patient-centered care plan ➞ innovation and change

Shared Vision and Objectives

Patient input

Roles and Responsibilities

Feedback
IT TAKES A VILLAGE

- Warm hand-offs for referrals
- Interclinic team mtgs
- Inpatient MIPS collaboration
- Patient support network
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Case of Mrs. L

- 54 yo Caucasian female with history of ESRD, opiate dependence on methadone and active illicit Benzodiazepine dependence
- Has been enrolled in Methadone maintenance program for past 20 years
- Many losses in the past 5 years
- Declining health over the last several years
Biopsychosocial Model

ESRD on Dialysis
CHF Neuropathy
Arteriovenous Fistula
DJD
Hyperphosphatemia

Opiate Dep on Methadone
Benzodiazepine Dep
Anxiety
Depression

Limited Supports
Unresolved Grief
Mrs. L Points of Care

ED VISITS INCLUDE MEDICAL AND PSYCHIATRIC
MIPS VISITS INCLUDE MENTAL HEALTH
Collaboration of Care

• Outreach between PCP and Hospital setting by RN Care Manager
• Communication between MIPS, Strong Recovery and ED’s
• Coordination of care with family and significant other
• Outreach to family for collateral
• Coordination of care with Strong Recovery and MIPS
Mrs. L Update

• Three ED visits thus far in 2018
• Working in therapy through some unresolved grief
• Stable in community SUD program and attending programing on regular basis, set to get “take home” privileges very soon
• Repaired relationship with daughter and granddaughter
• Prioritizing health needs
Case of Mr. ‘Why’

• 43 yo AA male with history of AIDS, Stage V CKD – intermittent hemodialysis, hypertension, schizophrenia
• History of homelessness, incarceration, substance use
• FREQUENT ED visits (both medical and psychiatric)
• Limited supports in community, hx of developmental delay and non-compliance with traditional mental health clinics
Biopsychosocial Model

Hypertension, Stage V CKD-intermittent hemodialysis, AIDS, Hx of GSW, Bilateral transmetatarsal amputations,

Developmental delay, Schizophrenia, Crack cocaine abuse

Limited Supports, Homeless, Hx of Incarceration, Limited engagement in traditional mental health clinics
Mr. ‘Why’ Emergency Department Use

Emergency Room Utilization By Year

December 2015
MIPS/ED began coordination of care

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How to get Mr. ‘Why’ in MIPS?

• Strong collaboration with hospital ED’s and MIPS staff
• Primarily coordinated by care manager
• Goals ???: Have pt engage outside ED setting, improve health (mental and physical)
• Establish rapport and trust with patient
When Mr. Why comes into clinic...

- No appointment necessary
- Front desk notifies nursing staff and care manager and therapist
- Nursing staff triages level of need
- Material needs are addressed – food, clothing, housing
- Rapport building with staff, familiar faces, building trust
- Medications are given – limited amount. Long-acting Haldol injection given.
- Assess mental health needs
Behind the scenes for Mr. Why...

• Situational discussions – when Mr. Why was dysregulated, refused medical care, etc => Debriefings. But also regular follow-up, celebrating accomplishments. Everyone is invested in his care.

• Coordination with medical ED, dialysis issues

• Collaboration with inpatient MIPS, nephrology, ethics consultation

• Community outreach
Mr. ‘Why’ update

- Continues to be medically and psychiatrically fragile
- Attempts to prepare Mr. Why for last stages of life, discover needs and wants
- Ongoing effort to find stable housing
Future

Outcomes
Assess
Sustain
Replicate
Improve
Innovate
Questions?
Session Evaluation

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

Thank you!