Building Interprofessional Teams: Lessons Learned from the Veterans’ Health Administration

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Faculty Disclosure

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

The opinions presented do not represent the viewpoint of the Veterans Health Administration.
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:

◎ Discuss common barriers experienced by professionals attempting to integrate new disciplines into existing teams.

◎ Describe at least three strategies to avoid pitfalls or overcome common barriers experienced when integrating new team members and changing practice patterns.

◎ List improvement strategies that may be helpful in advancing teamwork at their own site.
Bibliography / Reference


Learning Assessment

A learning assessment is required for CE credit.
A question and answer period will be conducted at the end of this presentation.
Who we are and why we care about teams:

Laura

Andy

Steve
Integrated Care

THE VA APPROACH
How is the VA's experience is it relevant?

Risk adjusted capitated model but with increasing sharing with other systems and intense focus on wRVUs; So dependent on workload and “billing”

Defined population with disease burden equal to or greater than the Medicaid population

Higher prevalence of mental disorders than the general population

Usually once in the system (beginning in early adulthood), stay in the system

Regardless fiscal model, adjustment to collaborative team practice hinges on the development of effective interprofessional relationships

Bottom line: treating mental health conditions in a stepped care manner conserves specialty resources for those who need them most, improves the identification and treatment of those with previously unrecognized needs and leads to high patient and staff satisfaction.
INTEGRATED CARE: “...Unifies care for physical and mental concerns”

“...avoid Premature Orthodoxy”

Mental Health Services in the Medical Home

“... the Patient Centered Medical Home will not reach its full potential without adequately addressing patients’ mental health needs. Doing so, however, will likely shift responsibility for the delivery of much mental health care from the mental health sector into primary care...

...a change that many stakeholders will likely oppose.”

VA Medical Home: The Patient Aligned Care Team (PACT)

- **Specialty Care Team Members**: Cardiology, podiatry, etc.
- **Interdisciplinary Team Members**: MH, BH, SW, pharmacy, etc.
- **Core Primary Care Teamlet Members**: PCP, RN CM, Health Tech/LVN, Clerk.
- **Non-VA Providers**
- **Community**: Public health agencies, non-profit agencies, other social assets.

Includes significant others and caregivers.
Post-Deployment Integrated Care Initiative

Models for Integrated Post-Combat Care

Post Deployment Clinic Model

• Dedicated space
• Dedicated staff
  – Small group of dedicated, experienced primary care providers
  – Primarily see recent combat veterans
• Close partnership with
  – Social Work
  – Mental Health
• Consultation to specialty services
Post-Deployment Integrated Care Initiative

Primary Care Clinic

- Polytrauma Program
- Pain Clinic
- Dental
- Suicide Prevention Coordinator
- Case Manager
- Mental Health
- Orthopedics
- Rehab Med/Prosthetics
- Comp & Pension
- Women’s Health
- Primary Care
- OEF/OIF Veteran
Models for Integrated Post-Combat Care

Cohort Model

- Selected primary care providers are identified to develop skills and expertise
- Most OEF/OIF patients are assigned to these providers
- Representatives from other disciplines similarly identified
Post-Deployment Integrated Care Initiative

Models for Integrated Post-Combat Care

Consultative Model

- OEF/OIF veterans are assigned to all primary care providers
- Most providers care for few combat veterans
- Medical, Mental Health and Social Work resources with specialized knowledge and skills are identified to assist in a consultative role
VA Primary Care Mental Health Goal:
Improve health of the population by addressing mental health needs in primary care

Key Objectives:
- Provide open access to mental health care
- Conserve specialty resources for those who need them
- Reduce stigma by co-locating in PC
- Make MH care a routine part of primary care
- Organize mental health care as a stepped care model
INTEGRATED CARE IN VA:
Core Components

Co-located Collaborative Care (PCBH)
- Embedded mental health clinicians are part of medical home team
- Consultative advice, assessment, brief interventions
- Uncomplicated mental illness, Substance Use Disorders,
- Other conditions (insomnia, stress, chronic pain, obesity, etc)
- Initially based on White River Junction VA model of 2004

Disease specific Care Management (CoCM)
- Guideline based treatment support, usually via telephone
  - Patient activation and education for self management
  - Ongoing structured assessment, monitoring treatment adherence
  - Behavioral activation
  - Referral Management when indicated
- Based on IMPACT, RESPECT and other RCTs
PCMHI’s role on the PACT

Population-Based, Stepped Care
Clinical pathway following universal screening
Support Patient Self-Management
Provide brief assessment and MH interventions
Support MH treatment provided by PCP
MH subject matter expert in PACT
Support PACT after MH care completed
(MH treatment plan is brief, problem focused and part of PACT care plan, not separate)
Discipline-specific PACT includes Integrated Care for physical and mental health in one setting

- Evaluation and treatment for mild to moderate mental health conditions (depression, substance misuse, anxiety, PTSD)
- Follow-up evaluation for positive MH screens
  - Behavioral health interventions for chronic disease
    - Care management
    - Referral management

Secondary and Tertiary Care:
- Outpatient Care for treatment resistant, severe or complex illnesses
  - PTSD specialty treatment; Substance dependence treatment
  - Treatment of serious mental illness (including MHICM)
  - Full spectrum of psychosocial rehabilitation and recovery services
    - Inpatient psychiatric care
    - Residential treatment
    - Supported and therapeutic employment
    - Homeless programs
    - Behavioral Health Interdisciplinary Program (BHIP)

- Screening for mental health conditions
  - Initiation of pharmacological treatment for mild to moderate mood symptoms
  - Co-management of Veteran care with PC-MHI and specialty MH providers
  - Health Behavior and Prevention
  - Emphasis on wellness

 PRIMARY CARE
 PC-MHI
 SPECIALTY MH BHIP
PC-MHI Outpatient Encounters, Unique Patients, and New Patients, October 2007 – December 2017, by Month
<table>
<thead>
<tr>
<th>Calendar Year</th>
<th>Unique Patients who Received PC-MHI Encounters</th>
<th>Primary Care (PACT) Patients</th>
<th>Prevalence of Receipt of PC-MHI</th>
</tr>
</thead>
<tbody>
<tr>
<td>2013</td>
<td>240,462</td>
<td>4,027,424</td>
<td>6.0%</td>
</tr>
<tr>
<td>2014</td>
<td>277,579</td>
<td>4,026,609</td>
<td>6.9%</td>
</tr>
<tr>
<td>2015</td>
<td>295,972</td>
<td>4,076,079</td>
<td>7.3%</td>
</tr>
<tr>
<td>2016</td>
<td>315,527</td>
<td>4,074,926</td>
<td>7.7%</td>
</tr>
<tr>
<td>2017</td>
<td>332,327</td>
<td>4,109,536</td>
<td>8.1%</td>
</tr>
</tbody>
</table>

Data provided by Dr. John McCarthy, Director - PCMHI Evaluation Office
Same Day PC/PCMHI Access

Good steady increase but we have a way to go to hit 75%...
Challenges TO WORKING AS A TEAM
Common Challenges to Integration from Early Years of VA Implementation

Staffing
◦ Not enough
◦ Missing a key role (Therapy, Prescription Privileges, Care Management)
◦ Lack of clerical or administration support

“Overselling”
Delays in getting patients into more intensive MH services
Attitudes and knowledge of MH leaders and colleagues
Poor understanding of roles; lack of available training
Tendency to form a Mini-Mental Health Clinic
Leadership support
Systems challenges

NB: Few of these challenges are specific to team work.
What are your challenges to teamwork?
Lessons from High Performing Teams

Goal: Identify essential ingredients of high performing integrated teams.

- Discover how they overcame barriers to integration
- Learn their perceptions of what makes them successful now
- Garner advice from these expert teams on how to assist other teams

Methods:

- Competitive selection process for team attendees
- Attendees came with their team, variety of disciplines, roles
- Structured exercises and group discussions used to gather team input
- Captured output of all exercises and discussions
- Rapid, informal, team-based qualitative analysis
Essential Characteristics of Successful Team Function

Program staff work well together and have clearly defined roles and shared goals.

Programs have/hire the ‘right staff’ with the right attitudes/characteristics:
- Flexible/Adaptable
- Open-Minded
- Reliable/Team Player
- “Can Do” Attitude
- Patient-Centered
- Enthusiastic and Persistent
- Good Communication Skills

Leaders support the program

Program staff are embedded in clinics and communicate with PC staff.
How did they get there?

Attitude and characteristics of the mental health professional
MHPs had to learn new roles AND adjust to that new role
MHPs built relationships and engaged other staff
Program leaders had the right data
Correct stakeholders were engaged, supportive
Being “tenacious with a smile”
PCP needs were met through open access and real-time consultation
Sufficient staffing

NB: Many of these comments are about teamwork!
How do we overcome or avoid pitfalls in the way of true collaboration?

Case 1: Dr. Jones is a psychologist who has just come from an internship and postdoc where he worked on a successfully integrated primary care team. His first job is at a new academic primary care practice where the medical director, Dr. Janis, became interested in integration after attending a CFHA conference. She is convinced in the value of integration and is eager to see benefits. Dr. Jones has been in his new job for about 4 weeks and he has only seen a few patients on Dr. Janis’ panel. He’s wondering what he is doing wrong because he was always busy in his previous positions. He has tried to drum up business but the PCPs, other than Dr. Janis, don’t seem too interested.

Questions:
What is the pitfall?
How could this have been avoided?
What should Dr. Jones do now?
How do we overcome or avoid pitfalls in the way of true collaboration?

Case 2: The Danville Clinic is a large, busy and growing primary care clinic that is well staffed with PCPs, nurses, and a team of behavioral consultants that includes psychologists, social workers, a psychiatrist and an advanced practice nurse with psychiatric expertise. Despite this wealth of resource, team members frequently disagree as to treatment plans and which patients should be seen by which member of the team. PCPs are saying that they no longer bother to start medications because no matter what they prescribe, it will be changed by the mental health team. The clinic director is concerned about the growing discontent in the clinic but unsure what to do. There never seem to be enough hours in the day!

Questions:
What is the pitfall?
How could this have been avoided?
What should the clinic manager do now?
How do we overcome or avoid pitfalls in the way of true collaboration?

Case 3: The Smithtown Primary Care Clinic providers love their integrated mental health team. At any indication of a mental health symptom, they can call in a behavioral health consultant and know that they won’t need to worry again about the patient’s care. In fact, Dr. Everhart was just bragging to a friend that he can’t remember the last time he had to write for a psychotropic med!

Questions:

Is there a pitfall, is so, what is it?
If there is a pitfall, how could this have been avoided?
Should anything be done differently now?
How do we overcome or avoid pitfalls in the way of true collaboration?

Case 4: The Doctors’ Hospital has decided to add a psychologist to the primary care team. Dr. Bennetti, a psychologist, was just reassigned from the general mental health clinic. He got the assignment based on seniority and was thinking that working in primary care will be a piece of cake because he will get all the “easy” patients. He has an office in primary care and a clinic grid that is set to schedule patients every hour. He has been sitting in his office (with the door closed) waiting for a consults. He has mostly spent his time reading journals and surfing the internet since his assignment in primary care began. His supervisor is noticing that Dr. Bennetti’s productivity is quite low but he is aware that integrated psychologists need to have open access and time to consult with the team.

Questions:
What is the pitfall?
How could this have been avoided?
What should Dr. Bennetti’s supervisor do now?
Strategies TO ADVANCE TEAMWORK
Person centered, team based, coordinated, whole health oriented care
Veteran centered, team based, coordinated, Whole Health oriented care

For All Veterans

Key Clinical Challenges:
- Pain Care Transformation
- Opioid Safety
- Stepped OUD Care
  (all primary drivers of suicide risk)
Veteran centered, team based, coordinated, Whole Health oriented care

For All Veterans
Veteran centered, team based, coordinated, Whole Health oriented care
For All Veterans

Primary Care PACT

Academic Detailing/Pharmacy

Pain

CM/CC ICM

PCMHI Mental Health

SUDs
Veteran centered, team based, coordinated, Whole Health oriented care

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SUDs

Whole Health
Person centered, team based, coordinated, whole health oriented care
The Foundations of Team Based Care

Person centered, team based, coordinated, whole health oriented care

Whole Health
The Foundations of Team Based Care

Person centered, team based, coordinated, whole health oriented care

Case management/
Care coordination
Telehealth
Secure IT connection
The Foundations of Team Based Care

Person centered, team based, coordinated, Whole Health oriented care
The Foundations of Team Based Care

Person centered, team based, coordinated, whole health oriented care

Whole Health
The Foundations of Team Based Care

Person centered, team based, coordinated, whole health oriented care

Shared Mission
Commitment
Clear Goals/Objectives
Role Clarity (Individual and Team)
Team as Form/Team as Function
Connection and Integration
High Performing Teams

Clearly Define Roles

- Service Agreements
- Understand differing scopes of practice
- Communicate roles to all team members
- Understand what each person needs to do his/her job
- Some flexibility should be built in
- Consider shadowing and/or collateral appointments
High Performing Teams

Leadership Support

◦ ‘Hire hard, manage easy’ i.e., “Get the right people on the bus!”
  ◦ In addition to professional competency, flexibility and adaptability are essential
  ◦ “Can do” attitude
  ◦ Reliability
  ◦ Excellent communication and relationship skills
  ◦ Life long learners

◦ Set expectations for teamwork and collaboration
◦ Value interprofessional practice and the varied strengths of individuals and disciplines
◦ Be sure to include all the stakeholders when developing/changing practice
◦ Support structures and processes that are designed to foster teamwork
High Performing Teams

Foster Professional Relationship Building
- Preserve some time for both teamwork and team building
- Work toward a shared vision of the team and its mission
- Ensure that team meetings include roles for all the members (may need a formal structure)
- Develop shared expectations for intra-team communication
- Ensure psychological safety (development of group rules, insist on respectful language)
- Expect some disagreements
  - Forming, Storming, Norming
- Consider how to handle turn over and orient new members
- Social interchange is important; allow some time for team members to share personal information when appropriate
- “Breakfast Tacos” or other specialties to share
- Hang out in the break room or other shared space when possible
- Consider informal get togethers
Group Discussion and Questions: What has helped or will help your team advance?
Session Evaluation

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

Thank you!