Increasing Access to Specialty Mental Health Providers at the Portland VA

Medical Center By Facilitating Transfer of Stable Patients Back to Primary Care:

A Quality Improvement Project

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NRS 703B: DNP Project

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Abstract

Background: Veterans receiving mental health care through the Veterans Health Administration (VHA) increased by 90% between 2006-2019, and the demand for outpatient mental health services is expected to rise by 32% over the next decade (Government Accountability Office [GAO], 2021). The veteran suicide rate is 1.5 times greater than the civilian population (GAO, 2021; VA, 2019), and lack of access to specialty mental health (SMH) care has been identified as a contributing factor (Carroll et al., 2020; Hoster et al., 2017). One way to improve access to SMH is by transferring psychiatrically stable patients from SMH to primary care (PC) for further management which will increase availability in SMH provider schedules for patients with acute mental health needs.

Purpose: The purpose of this project was to increase SMH providers' ability to identify transfer-eligible patients and improve communication methods with PC to support the transfer of care.

Methods & Intervention: The recovery model of mental illness and the model for improvement were used to inform our project intervention and design. Our intervention included two central components: an educational presentation and a template to facilitate the transfer of care from SMH to PC. Pre-and post-intervention surveys of prescribing SMH providers provided insight into perceptions on transfer-eligibility criteria, barriers to transfer, and measured outcomes of the project. Qualitative feedback was also sought to enhance the design of the transfer of care template.

Results & Conclusion: Sixty percent of participants improved their ability to identify transfer-eligible patients, 100% of participants believed that the template would improve communication with PCPs, and 100% of participants intended to utilize the template. Results were limited by a small sample size (n=5), 55.6% participation rate, and lack PCP perspective. Next steps could include surveying PCPs on barriers to accepting SMH patient transfers, tracking use and utility of the template in the EHR, and obtaining consensus between SMH and PC on transfer eligibility to reduce variation in practices among providers. This project is likely spreadable to other VHA sites but may not be applicable in other settings.

Introduction

Problem Description

In 2020, the prevalence of adults in the United States with any mental illness and with severe mental illness (SMI) was 21% and 5.6%, respectively (The Substance Abuse and Mental Health Services Administration [SAMHSA], 2020); however, the rate of SMI among veterans appears to be higher than the general population (Pemberton et al., 2016; Trivedi et al., 2019). One-third of veterans who receive services through the Veterans Health Administration (VHA) have at least one mental health condition GAO, 2021). Of the veterans who have deployed since the September 11th, 2001, attacks, 10-15% experience depression, 13-20% experience PTSD, and up to 44% have alcohol dependence (RAND, 2019). Veterans receiving mental health care through the VHA increased by 90% between 2006-2019, and demand is expected to rise; the Department of Veterans Affairs (VA) projects outpatient mental health services will increase by 32% over the next decade (GAO, 2021). The COVID-19 pandemic has also contributed to an increase in mental health conditions and demand for SMH care among the U.S. population (Auerbach & Miller, 2020).

Access to timely mental health care services is imperative for recovery from mental illness and prevention of adverse outcomes. Untreated mental illness can have devastating consequences including impaired relationships and work productivity, substance use disorders, and suicide (RAND, 2019). Recent data suggest the rate of suicide among veterans is 1.5 times higher than civilians (GAO, 2021; VA, 2019), and lack of access to SMH care has been identified as a contributing factor to the high rate of suicide in this population (Carroll et al., 2020; Hoster et al., 2017). Alarmingly, the rate of Oregon veterans who die by suicide is 46% higher than the national veteran suicide rate and in 2019, one hundred and forty Oregon veterans were lost to suicide (VA, 2021). Suicide prevention is the top clinical priority for the VA (Carroll et al., 2020; VA, 2018;), and suicide rates are lower among veterans who access care at the VHA

compared to those who do not (Carroll et al., 2020; VA, 2020). Thus, improving access to SMH care at the VHA is an important strategy to address this disparity and meet the growing demand for services.

Available Knowledge

Transitioning stable patients from SMH back to PC is one strategy to improve access to SMH services because it increases provider availability for patients with more acute mental health needs. Many major health care systems, including the VHA, have begun to research and implement initiatives to facilitate this transition (Blasi et al., 2021; Fletcher et al., 2021; Smith et al., 2021). The evidence currently available on this topic primarily consists of non-experimental, qualitative studies and quality improvement (QI) projects. The VHA has been piloting an initiative called FLOW (not an acronym) at various sites throughout the U.S. to increase and improve transitions from SMH to PC by utilizing electronic health record (EHR) data to help identify stable patients (Fletcher et al., 2019; Hundt et al., 2021; Smith et al., 2019). Initial results are promising, and a large, randomized trial is underway to evaluate the effectiveness of FLOW in increasing access to SMH (Hundt et al., 2021).

A recent review of the literature identified commonly described transition practices and implementation strategies that facilitate the movement of patients from SMH to PC (Blasi et al., 2021). Assessing for stability based on standardized criteria was identified as an important transition practice in the majority of studies and includes no psychiatric hospitalizations or emergency visits in the last 12 months, no recent medication changes, no current risk of harm to self or others, no prescriptions for antipsychotic medications, and patient support for the transition to PC (Blasi et al., 2021). VHA initiatives also specify that a patient taking more than three psychotropic medications, lithium, or valproic acid (when accompanied by a bipolar diagnosis) would be ineligible for transfer (Fletcher et al.; 2019; Hundt et al., 2021; Smith et al., 2019). Educating providers on stability criteria, as well as involving stakeholders in designing, evaluating, and improving transition processes were common implementation strategies (Blasi et al., 2021). Improved communication between SMH and PC is also needed to facilitate care

coordination and transfer (Chang et al., 2014; Durbin et al., 2012; Koenig et al., 2013). One qualitative study conducted at a VHA Medical Center found that utilizing the EHR was the most efficient way to coordinate and transfer patient care between providers (Koenig et al., 2013) while other studies found that a lack of standardized communication processes is a barrier to communication (Chang et al., 2014; Durbin et al., 2012). These findings suggest that integrating a stakeholder-informed, standardized tool into the EHR to facilitate transferring patients from SMH to PC would be beneficial.

Rationale

The recovery model of mental illness and the model for improvement were used to inform our project intervention and design. Though there is no one standardized definition of recovery, a review of the literature supports a consensus that recovery is a process of change that is person-centered and encompasses themes of hope, empowerment, and purpose (Ellison et al., 2016). The recovery model posits that people with mental health conditions can improve their health, symptoms, functioning, and lead a fulfilling life (Ellison et al., 2016; SAMHSA, 2012); thus, the need for SMH services may not be indefinite. The VHA has adopted the recovery model as the guiding principle for all of its mental health services and promotes a "stepped care" approach (VA, 2015). When more intensive or specialized services are needed, veterans can "step up" to specialty care and then "step down" to PC once recovery or maximum clinical benefit has been achieved (Fletcher et al., 2019). Therefore, transitioning stable patients from SMH to PC is both aligned with the recovery model and care delivery system at the VHA.

The recovery model is also promoted in clinical practice guidelines including those by the National Institute for Health and Care Excellence (NICE) which encourage the return to primary care for further mental health management when the patient has responded to treatment and remains stable (NICE, 2014; NICE, 2020). Since recovery is patient-centered, the decision to transition to PC is made by patients in conjunction with their providers. Thus, improving processes to facilitate the transfer of care may not only improve access to timely SMH but also signify that progress has been made on the

veteran's journey to recovery. The model for Improvement (MFI) was used as a framework for designing this project. The MFI sets specific aims, establishes measures, then identifies and tests changes that could result in improvement using the Plan-Do-Study-Act (PDSA) cycle (Institute for Healthcare Improvement [IHI], 2022). The MFI has proven to be an effective tool for large and complex systems (Langley et al., 2009), so it is an appropriate choice to use at the VHA because we can start with testing changes on a micro level and then spread successful changes on a macro level in future PDSA cycles (Langley et al., 2009).

Specific Aims

By January of 2022, at least 50% of participating providers will report that their ability to identify patients appropriate for transfer from SMH to PC has improved as a direct result of this project. Providers will also report that as a result of our intervention, communication methods between SMH and PC to support the transfer of care will be improved.

Methods

Context

In 2012, the VHA launched a novel, team-based outpatient SMH delivery model called the behavioral health interdisciplinary program (BHIP). BHIP is an interdisciplinary team composed of mental health professionals (psychiatrists, psychologists, nurses, social workers, pharmacists, counselors, therapists, and peer specialists) and support staff working together to focus on veterans' mental health and well-being. The central principles of BHIP are to be collaborative, veteran-centered, and coordinated. Care delivery is based on the recovery model, evidence-based treatments, and veteran-driven goals. BHIP also strives to provide access to care, care-continuity, and to manage care transitions. BHIP teams assure ongoing access to care by streamlining processes and coordinating care for veterans as well as managing veteran panels. National guidelines propose a specific staffing ratio of 6.6-7.5 full-

time employees per panel of 1,000 veterans on the BHIP teams, but individual locations may vary based on local resources and needs (Weaver, n.d).

Our setting is the Portland VA Medical Center, which has four BHIP teams. Each team has a case manager, a mix of therapy providers (such as counselors, psychologists, or social workers), and prescribers (psychiatrists or psychiatric mental health nurse practitioners [PMHNP]). There are 2-3 prescribers on each team (totaling 11). When prescribing providers feel their patient is ready to step down to PC for further medication management, they are responsible to initiate the transfer of care to PC. The PC provider can choose not to accept the transfer in which case the patient continues to be followed by SMH. Prescribing providers generally see four new patients per week, and there is currently no data available on BHIP team panel size to compare it to VA Central Office recommendations. Although national VHA initiatives are being piloted to transfer stable patients from BHIP to PC, at this time there are no initiatives or standardized processes happening locally. Currently, there is not a widely known, agreed-upon criteria for what signifies stability in our setting. These factors contribute to a patient panel size that is continually growing and increased wait times for veterans to access care.

Intervention

Our intervention was conducted via a PDSA cycle by a PMHNP student in her doctoral year. It included two central components: an educational presentation and a template to facilitate the transfer of care from SMH to PC (see appendix A for project timeline). A pre-intervention survey (see appendix C) was distributed electronically to BHIP prescribing providers to assess their perceptions of transfer-eligibility criteria and barriers to transfer, which helped us to plan our educational presentation. Results from this survey and how our findings compare to the literature and national VHA initiatives were shared during the educational presentation. Pre-intervention survey data was used to inform the initial draft of a template to facilitate the transfer of care which was also shared during the presentation. The presentation was given to BHIP prescribers during one of their regularly scheduled meetings. Qualitative

feedback was sought from stakeholders regarding survey results, template draft, and presentation content which helped us to study our intervention and plan the next steps. Attendees had the opportunity to submit feedback to the PMHNP student for two weeks after the presentation was completed. Next, a post-intervention survey (see appendix D) was distributed electronically to assess the outcomes of our intervention and contained an updated version of the template with adjustments made based on stakeholder feedback.

Study of the Intervention

We know our intervention had an impact through our post-intervention survey design (see appendix D) which elicited input from providers on whether they have used or plan to use the transfer communication tool, their satisfaction with the intervention process, and if their ability to identify transfer-ready patients improved as a direct result of our intervention. If the transfer communication tool gets adopted into the clinic's EHR, it would demonstrate stakeholder support and belief in its utility to improve access to SMH. We assessed for any simultaneous, related initiatives to evaluate if our outcomes were confounded by other influences. Feedback from stakeholders was elicited throughout our project and field notes were taken by the PMHNP student, which elucidated any unexpected benefits or drawbacks to our project and its potential for generalizability to other settings.

Measures

In accordance with the Model for Improvement, the effectiveness of our intervention was evaluated based on outcome, process, and balancing measures (IHI, 2022).

Outcome Measures	A) The percentage of providers who report their ability to identify transfer-ready patients has improved. B) The percentage of providers who intend to adopt or try the transfer communication tool. C) The percentage of providers who feel communication of transfer-readiness with PC will improve as a result of our intervention. These outcomes were measured through Likert-scale responses and displayed graphically.

Process Measures	A) The number of BHIP providers who received the educational training out of the total eligible providers. B) The number of BHIP providers who completed either or both of the pre-and post- training surveys out of total eligible providers. This assessed the utility of this QI project at the implementation site and the validity of its findings.
Balancing Measures	A) Qualitative feedback from providers on ways to improve the template, which was analyzed throughout the PDSA cycle for trends and used to inform iterative project revisions. B) Percentage of providers who felt the communication tool would increase their workload or time spent on documentation.

Analysis

A root-cause analysis (see appendix B) was conducted to examine the influences leading to challenges in accessing SMH in our setting and to inform our project. Responses from both surveys (see appendices C and D) were tabulated and presented graphically (see appendices E and F). Qualitative data was evaluated for trends and categorized by theme (see results section). Pre-survey data was shared with providers and qualitative feedback was obtained based on our quantitative findings. To evaluate outcome measures, the number of Likert-scale responses marked as either "agree" or "strongly agree" in the post-intervention survey were totaled and divided by the total number of responses.

Ethical Considerations

Ethical considerations are necessary in quality improvement efforts to mitigate staff burden and prevent patient harm (Hunt et al., 2021). To minimize clinician burden, surveys and presentations were brief and the educational presentation was scheduled at a convenient time for providers. To protect anonymity, names were not collected on surveys and narrative responses were presented thematically. To prevent patient harm, this proposal was submitted to the VHA and OHSU Institutional Review Boards, and no protected patient information was elicited or used in any aspect of this project.

Results

On November 3rd, 2022, the pre-intervention survey (appendix C) was sent to nine Portland based BHIP prescribing providers. The decision was made to exclude the team based in Hillsboro, OR as they

operated out of a different clinical site from the project location and did not have meeting times that aligned with the Portland teams. Five out of nine (55.6%) providers responded, and the main takeaways were that despite unanimous agreement that the VHA national criterion for transfer to PCP were appropriate, not everyone used those criteria themselves. The biggest barriers to transfer were the patient not being appropriate based on criteria, the belief that the PCP would not be willing to take the patient despite meeting the criteria, and the patient not wanting to transfer (See Appendix E, Figure 4).

A single educational presentation and discussion was conducted virtually on November 15th, 2022, at a regularly scheduled provider meeting time and the same 5 survey respondents attended. A brief PowerPoint presentation was shared (see appendix G) that included results from this project's literature review on transferring patients from SMH to PCP, information about the VHA national initiative FLOW, results from the pre-intervention survey (see appendix E), and a template to initiate transfer of care to PC (see appendix D). Qualitative feedback elicited during the discussion revealed a few important themes. First, that the number and dosage of psychotropics a patient is taking is a limiting factor for transfer. Second, there is wide variability between individual PCP's comfort in managing psychotropic medications. Finally, although efficiency of communication with PC to initiate transfer was not identified as a top barrier in the pre-intervention survey, the providers felt the template would be helpful.

The post-presentation survey (see appendix D) was sent to the five meeting attendees on 1/19/23 and received a 100% response rate. Sixty percent of participants felt their ability to identify transfer-eligible patients improved, and 100% percent of participants had a better understanding of VHA nationally identified criteria. One hundred percent of providers strongly agreed that they intended to adopt or try the template and that it would improve communication with PCPs. None of the providers felt the template would create more work or would add to their documentation time, and 100% of respondents were satisfied with the project's efforts.

The biggest contextual elements of this project were that there are no organizational processes in place to transfer patients from BHIP back to PCP and no transfer criteria that are universally agreed upon by both psychiatric and primary care providers. BHIP and PC operate out of different clinics and do not hold joint meetings on this subject. The perspectives of the PCPs, as well as the 4 out of 9 (44.4%) BHIP providers who did not engage in this project are data that are missing.

Discussion

Summary

Our project achieved its aims of improving providers' ability to identify patients eligible for transfer back to PCP and creating a tool that would improve communication between SMH and PCP to support transfer of care. These efforts align with the recovery model of mental health and the VHA's "stepped care" approach to treating patients in the most appropriate care setting. Our project also revealed some of the biggest barriers in transferring patients (patient eligibility, willingness to transfer, and variability in PCP's willingness to accept transfers), some of which may be modifiable, and some may not. This project served as a useful starting point to guide future PDSA cycles on improving patient transfers from SMH to PC with the benefit of minimizing clinician burden to participate in the project.

Interpretation

The direct involvement of BHIP prescribing providers and the qualitative nature of our QI project allowed us to explore site-specific barriers to transferring patients back to PC and perceptions on transfer-eligibility criterion. This project directly involved stakeholders in evaluating and improving transition processes which is supported by the literature (Blasi et al., 2021). Our findings on barriers to transfer were consistent with the available knowledge on the subject within the VHA system (Fletcher, et al., 2019; Smith et al., 2021), and suggest that PC and patients should be included in future efforts to transfer patients back to PC as they are key partners in the process. Input from all three parties about parameters for transfer would be useful in creating standardized processes that are inclusive of all

stakeholders' needs. To our knowledge, there were no concurrent initiatives regarding transferring patients from SMH to PC that would confound our results. The initial impact of this project is likely small, and at this time the number of successful transfers generated by our template cannot be measured. However, the knowledge obtained in this QI project can be utilized to inform next steps to facilitate more transfers from SMH to PC and the template could be formally integrated into the EHR and tracked if the clinic chooses.
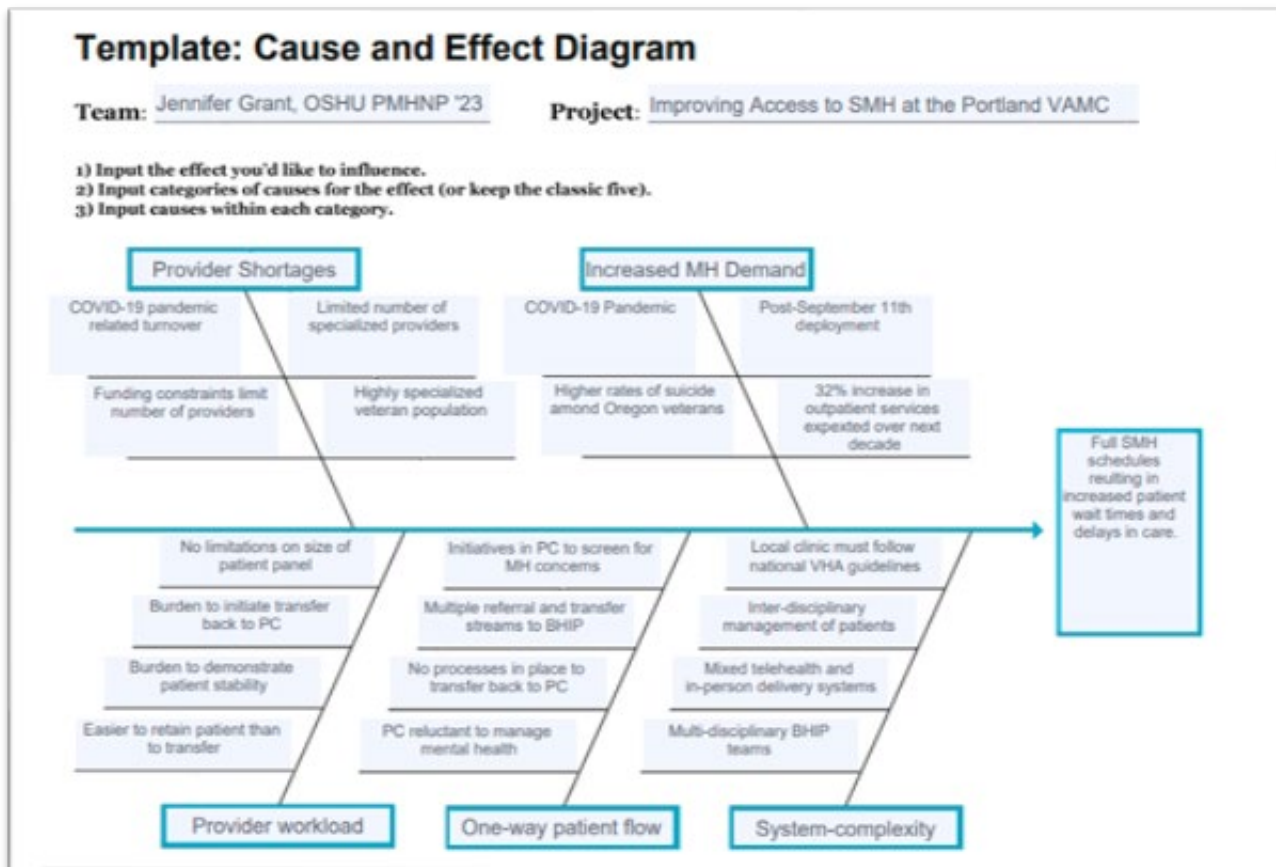
Limitations

Our findings have several key limitations. First, our sample size of five providers was small. It represented just 55.6% of prescribing providers in the Portland BHIP clinic and excluded the Hillsboro clinic. Second, all of the participants were female which could bias our findings due to possible differences in experiences between genders. Third, our project did not include perceptions from the PCPs who would be accepting the transferred patient. Since PCP willingness to accept the transfer was identified by SMH providers as the biggest barrier (besides patient eligibility criteria), knowing PCP barriers to accepting the transfer and why there are differences among PCPs would be informative.

Conclusions

This QI project was a useful first step in identifying barriers to transferring patients to PC and improving communication with PC with little provider burden. Since the care delivery model is standardized throughout the VHA nationally, this project could easily spread to other VHA settings. Applicability outside the VHA is unknown but might be feasible in similar large healthcare systems where "stepped care" models are used. Next steps could include surveying PCPs on their barriers to accepting SMH patient transfers and tracking the use and utility of the transfer communication tool through the EHR. Future efforts could include bringing together leaders from both the BHIP and PC clinics to get consensus on what types of patients are eligible for transfer to reduce variation among individual providers and set expectations for patients about their trajectory of care.

Appendices

Appendix A: Prospective Project Timeline with Corresponding PDSA Cycle and DNP Course

DNP Project Timeline (Final presentation date March 2023)	May '22	June '22	July '22	Aug '22	Sept '22	Oct '22	Nov '22	Dec-Mar '22-'23
Finalize project design and approach (plan) (703A)					x			
Complete IRB determination or approval (703B)						x		
Conduct pre-intervention survey (plan) (703B)						x	x	
Design first Iteration of transfer tool and conduct educational presentations (do)(703B)							x	
Finish any remaining educational presentations (do) and conduct post-intervention survey (study) (703B)							x	x
Final data analysis (study) and design second iteration of transfer tool (act) (703B)								x
Write sections 13-17 of final paper (703B)								x
Prepare for project dissemination (703B)								x

Appendix B: Root-Cause Analysis Diagram

Template: Cause and Effect Diagram

Team: Jennifer Grant, OSHU PMHNP '23   Project: Improving Access to SMH at the Portland VAMC

1) Input the effect you'd like to influence.
2) Input categories of causes for the effect (or keep the classic five).
3) Input causes within each category.

Provider Shortages

- COVID-19 pandemic related turnover
- Limited number of specialized providers
- Funding constraints limit number of providers
- Highly specialized veteran population

Increased MH Demand

- COVID-19 Pandemic
- Post-September 11th deployment
- Higher rates of suicide amond Oregon veterans
- 32% increase in outpatient services expexted over next decade

Full SMH schedules reulting in increased patient wait times and delays in care.

Provider workload

- No limitations on size of patient panel
- Burden to initiate transfer back to PC
- Burden to demonstrate patient stability
- Easier to retain patient than to transfer

One-way patient flow

- Initiatives in PC to screen for MH concerns
- Multiple referral and transfer streams to BHIP
- No processes in place to transfer back to PC
- PC reluctant to manage mental health

System-complexity

- Local clinic must follow national VHA guidelines
- Inter-disciplinary management of patients
- Mixed telehealth and in-person delivery systems
- Multi-disciplinary BHIP teams

Appendix C: Pre-Intervention Survey

1. Below are the eligibility criteria identified by VA national initiatives to transfer patients from BHIP to primary care. In the table below, please indicate whether you believe the criterion is appropriate for inclusion and whether you currently use the criterion in considering transfers.

	This is an appropriate transfer criterion	I use this criterion in considering transfers to PCP
No psychiatric emergency room visits in the last 12 months.	Yes/No	Yes/No
The patient is not taking an antipsychotic medication or lithium.	Yes/No	Yes/No
The patient is not taking valproic acid/anticonvulsant with a concurrent bipolar diagnosis.	Yes/No	Yes/No
No medication changes in the last 6 months.	Yes/No	Yes/No
The patient is taking three or less psychotropic medications.	Yes/No	Yes/No
The patient agrees to the transfer.	Yes/No	Yes/No
The patient is not currently experiencing thoughts of suicide or homicide and does not have an active suicide flag.	Yes/No	Yes/No

Please provide any comments you might have about the criterion listed above:

2. Are there any *additional* criteria that you would like to see included?
No
Yes (please specify)

3. Were you aware of the national criteria identified above prior to completing this survey?
Yes
No

4. What are the two greatest barriers you face in transferring a patient back to primary care? (please select *only two* of the following).
-Efficiency of communication with PC to initiate transfer
-The patient does not fit the criteria above/is not stable for transfer
-The patient is taking a controlled substance (e.g. stimulant, benzodiazepine)
-The patient has an active substance use disorder
-My belief that PC is unwilling to take the patient for another reason. Please elaborate (for example, a specific diagnosis or prescribed medication, etc.).

5. Are there any other barriers you face in transferring patients back to primary care? If so, please explain:

Appendix D: Post-Intervention Survey

1. Please consider to what degree you agree or disagree with the following statements about the transfer of care template below:

Template:
I am recommending [Patient Name] for further management of mental/behavioral health medications in the primary care setting. Their current mental health medications include [name and dosage of psychotropic medications]. The Veteran meets eligibility for transfer based on the following criteria:

-The Veteran agrees to the transfer of care.
-The Veteran has not had a psychiatric emergency room visit or psychiatric hospitalization in the last 12 months.
-The Veteran has not had psychiatric medication changes in the last 6 months and is taking three or less psychotropic medications.
-The Veteran is not taking medications in the antipsychotic drug class, or in the mood stabilization drug class (with a concurrent bipolar diagnosis).
-The Veteran is not currently experiencing thoughts of suicide or homicide and does not have an active suicide flag.

[Patient Name] has made significant progress in their mental health recovery and is ready to conclude their episode of care with the BHIP department. The Veteran has 6 months of refills for their current psychiatric medications and has been instructed to contact primary care at least 1 month before needing a refill.

I intend to see [Patient Name] for one more follow-up, and if things remain stable, I will include you in the closing note for this episode of care. Please let me know if you have any questions or concerns.

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
I intend to adopt, or at least try using this discharge template.					
This standardized discharge template will improve communication between BHIP and PC to support transfer of care.					
Using the discharge template will create more work or take me longer to complete my documentation.					

2. Please indicate to which degree you either agree or disagree with the following statements:

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
As a result of this project, I have improved my ability to identify patients appropriate for transfer from BHIP to PC.					
As a result of this project, I have a better understanding of what criteria are used nationally to identify patients appropriate for transfer from BHIP to PC.					
Overall, I am satisfied with this initiative's efforts to facilitate transfer of patients from BHIP to PC to increase access to BHIP services.					

Appendix E: Pre-Intervention Survey Results (N=5)

Q1 Below are the eligibility criteria identified by VA national initiatives to transfer patients from BHIP to primary care. In the table below, please indicate whether you believe the criterion is appropriate for inclusion and whether you currently use the criterion in considering transfers.
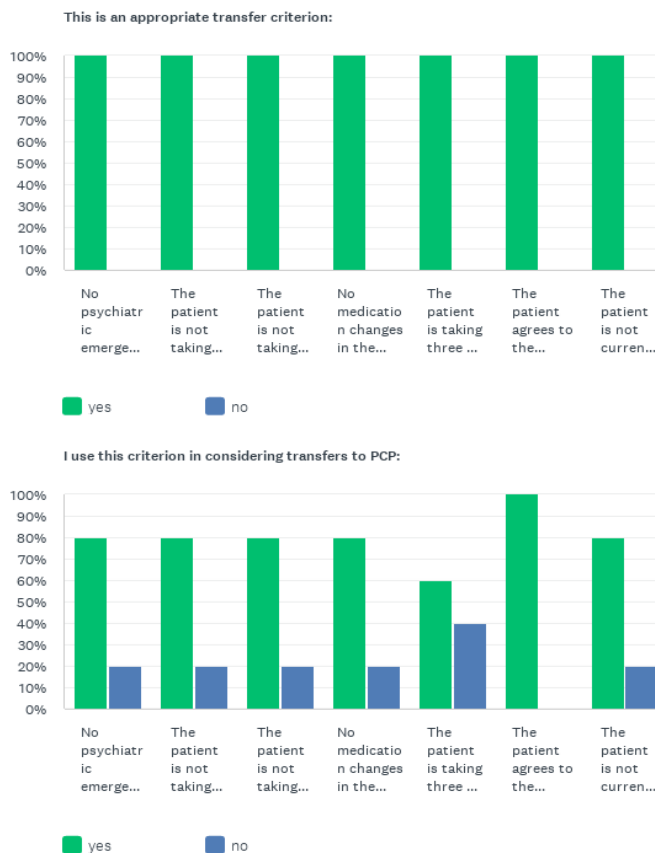
Figure 1

Q2 Are there any additional criteria that you would like to see included?
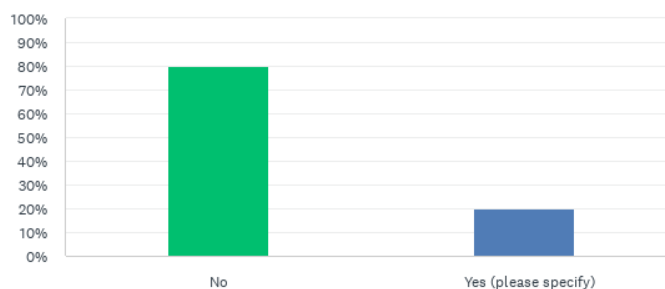
Figure 2

Q3 Were you aware of the national criteria identified above prior to completing this survey?
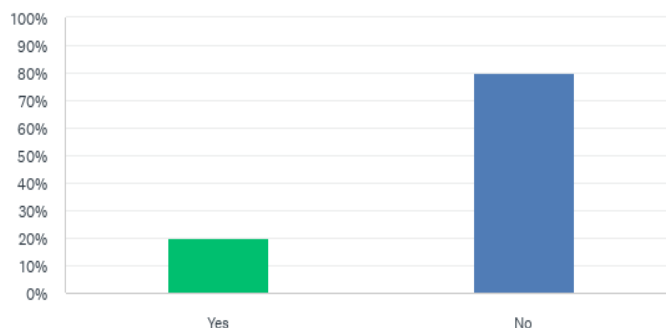
Figure 3

Q4 What are the two greatest barriers you face in transferring a patient back to primary Care? (please select only two of the following).
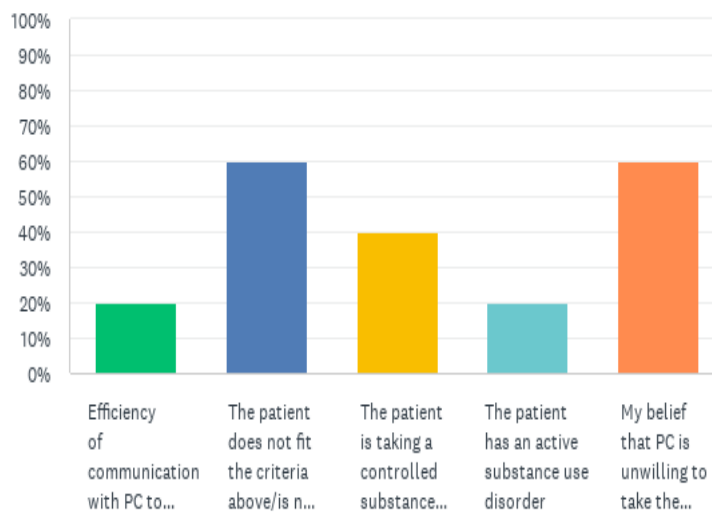
Figure 4
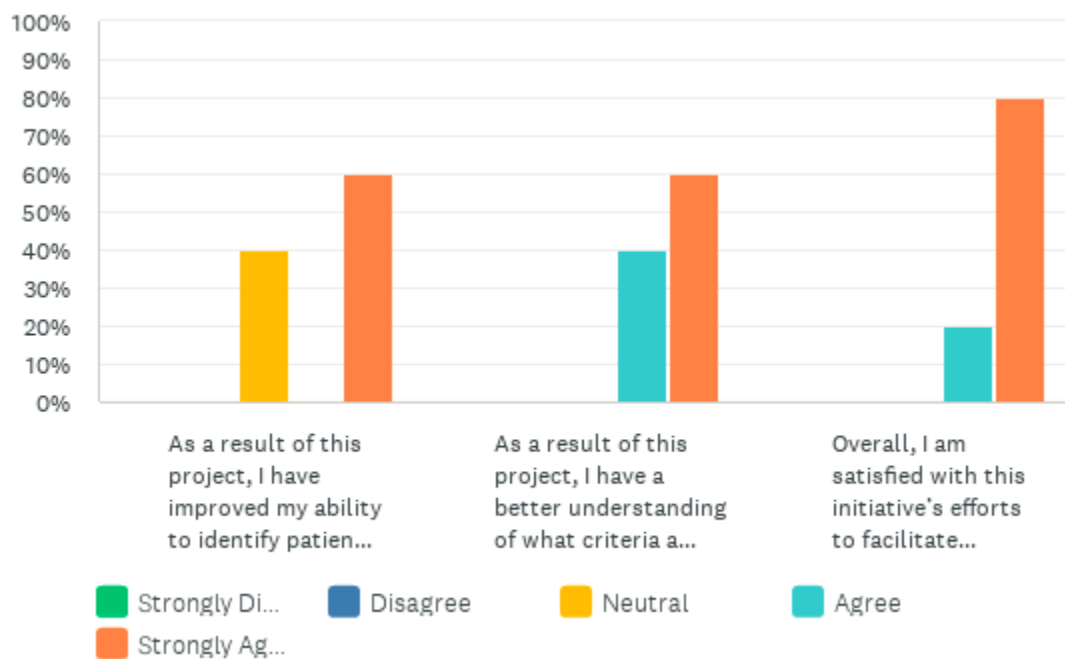
Appendix F: Post-Intervention Survey Results (N=5)
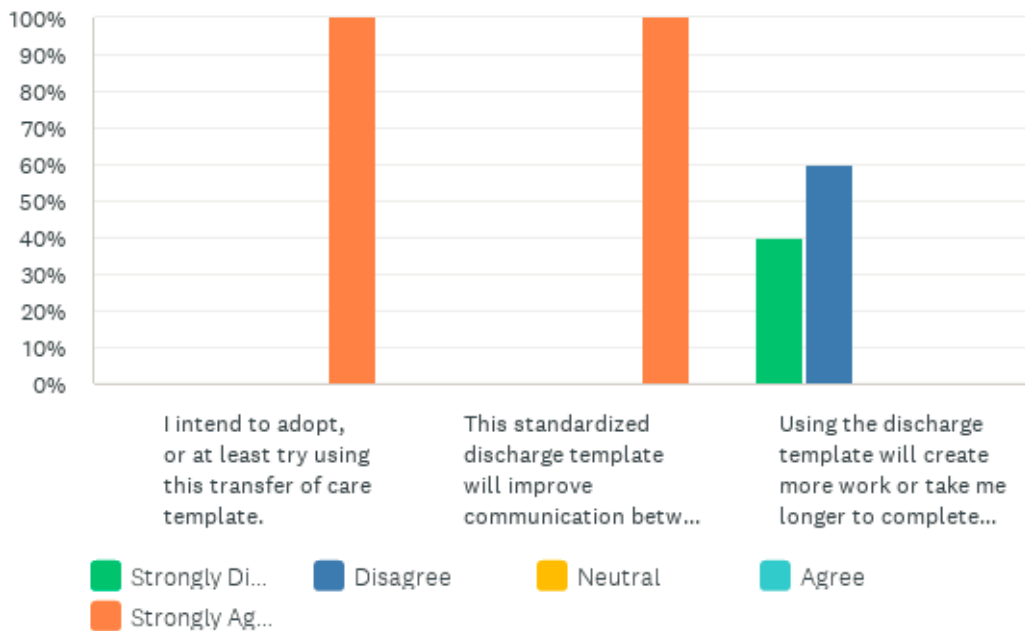
Figure 1

Figure 2

Appendix G: Educational Presentation

Slide 1

TRANSFERRING PATIENTS FROM SPECIALTY MENTAL HEALTH BACK TO PRIMARY CARE:
A QUALITY IMPROVEMENT PROJECT

Jenn Grant, BSN, RN
DNP, PMHNP Candidate '23

Slide 2

WHAT DOES THE LITERATURE SAY? [1]

TRANSITION PRACTICES & IMPLEMENTATION STRATEGIES

- Assessment of recovery and stability →
- Patient engagement
- Shared treatment planning →
- Care coordination
- Follow up and support
- Medication management
- Train and educate stakeholders →
- Use evaluative/iterative strategies →

FOCUS OF THIS PROJECT

Standardized criteria to identify appropriate patients [14]

Standardize processes for exchanging information between MH and PC
- Use agreed-upon standardized templates for progress notes and methods of communication [12]

Involve stakeholders in evaluating and improving transition processes [3]
- Seek input from MH and PC providers about criterion for transition and content of transition letters/progress notes

Slide 3

VHA NATIONAL INITIATIVE: FLOW

FLOW
VA U.S. Department of Veterans Affairs

- A program designed to facilitate transition of stabilized/recovered mental health patients back to PC
  - Pilot project in south Texas (VISN 17) [3,5]
  - In alignment with the "stepped care" and recovery models
  - Uses EMR to identify eligible patients based on specific criteria
- Current implementation trial underway in VISN 19 (Rocky Mountain Network) at 9 VA hospitals and clinics [5]
  - Three-year timeline
  - Anticipated 6-7% of specialty mental health patients will be transitioned successfully to PC

Slide 4

HOW DOES OUR DATA COMPARE TO NATIONAL INITIATIVES?

National Criteria for Transfers (FLOW Project)

- No psychiatric ER visits or hospitalizations in the last 12 mo
- Not taking an antipsychotic or Li+ Not taking Suboxone
- Not taking valproic acid/anticonvulsant with a concurrent bipolar dx
- No medication changes in the last 6 mo
- Not taking more than three psychotropic medications
- Veteran agrees to the transfer
- No current SI/HI, and does not have an active suicide flag

- Survey results suggest that while these criterion are unanimously perceived as appropriate, not everyone uses them in considering transferring a patient to PC
  - Exception for veteran agreement (total consensus)
  - Greatest variation in the taking ≤ 3 psychotropic medications
- Thoughts on PCP's perception of these criteria being reasonable for them to assume care?

Slide 5

POTENTIAL BARRIERS

- Efficiency of communicating with PCP to initiate transfer
- Veteran doesn't meet criteria
- Controlled Substance Rx
- Active SUD
- My belief that PC is unwilling to take the patient for another reason.

Slide 6

TEMPLATE TO INITIATE TRANSFER OF CARE

I am recommending [Patient Name] for further management of mental/behavioral health medications in the primary care setting. Their current mental health medications include [name and dosage of psychotropic medications]. The Veteran meets eligibility for transfer based on the following criteria:

☐ The Veteran agrees to the transfer of care.
☐ The Veteran has not had a psychiatric emergency room visit or psychiatric hospitalization in the last 12 months.
☐ The Veteran has not had psychiatric medication changes in the last 6 months and is taking three or less psychotropic medications.
☐ The Veteran is not taking medications in the mood stabilization or antipsychotic drug class.
☐ The Veteran is not currently experiencing thoughts of suicide or homicide and does not have an active suicide flag.

[Patient Name] has made significant progress in their mental health recovery and is ready to conclude their episode of care with the BHIP department. The Veteran has 6 months of refills for their current psychiatric medications and has been instructed to contact primary care at least 1 month before needing a refill.

Please let me know if you agree to the transfer of care and if I can answer any questions. Once the transfer is agreed to, a conclusion of care note will be completed. (version 1)

I intend to see [Patient Name] for one more follow-up, and if things remain stable, I will include you in the closing note for this episode of care. Please let me know if you have any questions or concerns. (Version two based on provider feedback).

Slide 7

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