The Transitional Care Clinic: State of the Art Care, Training, and Research

Dawn I Velligan, PhD

Department of Psychiatry, Department of Nursing
Division of Community Recovery, Research and Training
UTHSCSA

Funded by: Methodist Health Care Ministries; 1115 Waiver DSRIP 085144601.2.3 Region 6; Patient-Centered Outcomes Research Institute; Meadows Foundation

UT Health San Antonio

Need-2011 Capitol Healthcare Report

- Hospitalizations and ER visits at high levels
- Often no psychiatrists or other trained professionals available
- Inability to get medication in a timely way and consequent rehospitalization
- High rates of uninsured/underinsured individuals >25%
- Major agencies on diversion and not taking patients

TCC Program Overview

- Individuals discharged from psychiatric hospital, ER or consult services in need of transitional psychiatric care
- Treatment for 90 days or until psychiatric care can be established in the community
- Comprehensive evidence-based services
- Engagement focused care
  - Monarch –HIPPA compliant web based appointment system
  - Outreach
  - Shared Decision Making

Goal: Keep people out of hospital and ER who can successfully be treated in a outpatient setting

Improving transitional care experience for individuals with serious mental illness

- Traditional intake system
  - Individual intake
  - Long wait if rescheduling is needed
  - Following intake, wait for an appointment with a prescriber
  - No prioritization of patients with greater need; no customized response to most pressing needs
  - High number of no shows, wasting valuable resources
  - Walk in only-long waits for consumers, may wait and not see a prescriber

Engagement-focused care

- Innovative intake process
  - Using MONARCH multiple appointments are given on the same time and day
  - Orientation to the clinic
  - Group intake-TCC Access group
    - All discharge information read
    - Run by a multi-disciplinary team to address needs for care coordination, medication and counseling
    - Appointments for MD, social work, counseling, CAT given based upon need-same day appointment for most in need
    - Individual check out
    - Allows us to prioritize patient needs and is patient focused

EBPs the rule not the exception

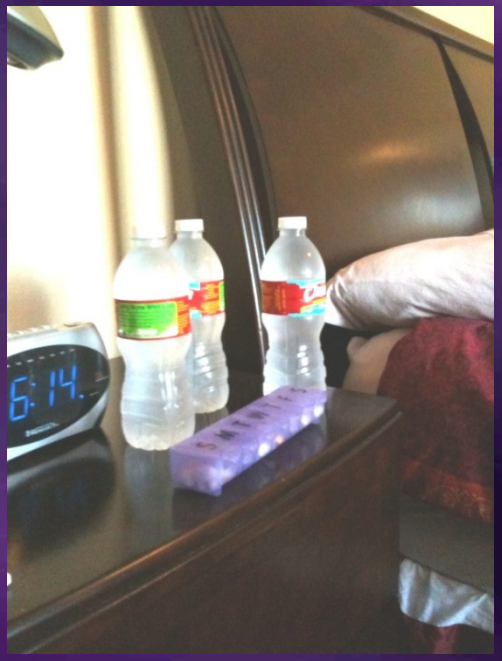
- Family Psychoeducation
- CBT for psychosis
- Cognitive Adaptation Training
- Trauma Services (CPT,ET)
- Motivational Interviewing
- Integrated treatment for dual diagnosis
- Dialectical Behavior Therapy
- Shared Decision Making
- Psychopharmacology Best Practice Guidelines
- Interprofessional Team Approach
- Multi-disciplinary Education

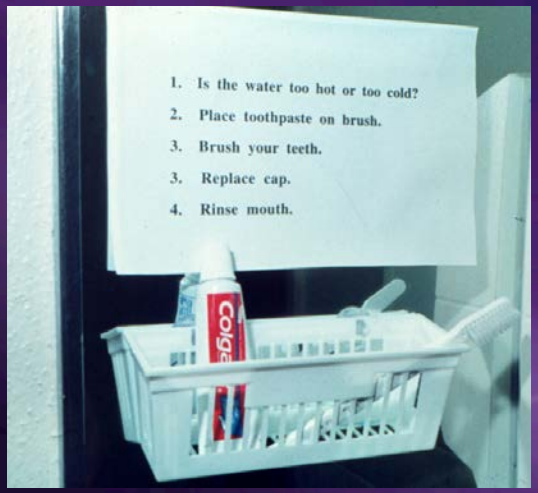
Fidelity maintained with weekly supervision by experts

Full Cognitive Adaptation Training

Checklist for Everyday

1. Shower
2. Brush Teeth
3. Use Deodorant
4. Take Medication
5. Call Thomas
6. Daily Housekeeping Task
7. Play Guitar





Maples &Velligan (2008) Am J Psychiatric Rehab 11(2):164-180

Access group and Engagement Focused Care

- Satisfaction Surveys Velligan et al., 2016;Psychiatric Services, 67(3), 259-261
  - Ratings of Good or Excellent for Group(1-5; 5 being best; Mean= 4.4; S.D. = .86; n=101).
  - Individual intake ratings slightly higher (M=4.7; S.D. = .69; n=42)
- Focus Groups Velligan, et al. (2016). *Issues in mental health nursing*, *37*(6), 400-405.
  - Access group can be uncomfortable but made them feel less alone
  - patients who felt uncomfortable still preferred group intake if it meant less waiting time to receive services.
- Engagement Focused Care
  - Engagement focused care improved Quality of Life relative to TAU (Velligan et al., 2017 Patient Preference and Adherence)

Successes

- Clinical
  - Nearly 6,000 patients served
  - Provides more than $2,400,000 in care annually
  - Estimated $6,000,000 in savings from ER diversion
  - High patient satisfaction
  - Reduction in 30-day readmission rates (.6% versus 5-6%)
- Teaching
  - 51 psychiatry residents, 13 Family Medicine Residents, 7APN students, 10 PA students, 25 counseling students, 21 social work students, 9 psychology interns, and 105 third-year medical students
- Research
  - PCORI grant
  - Meadows Foundation grant
  - UTHSCSA Kick start grant

HEALTH CARE SYSTEM REDESIGN TO MEET THE NEEDS OF UNDERSERVED POPULATIONS

BARBARA J TURNER MD, MSED, MA

JAMES D AND ONA I DYE PROFESSOR OF MEDICINE

FOUNDING AND FORMER DIRECTOR, REACH CENTER

UNIVERSITY OF TEXAS HEALTH SAN ANTONIO

The Times' estimate of 62,500 deaths in 2016 "would be a 19 percent increase over the 52,404 recorded in 2015,"

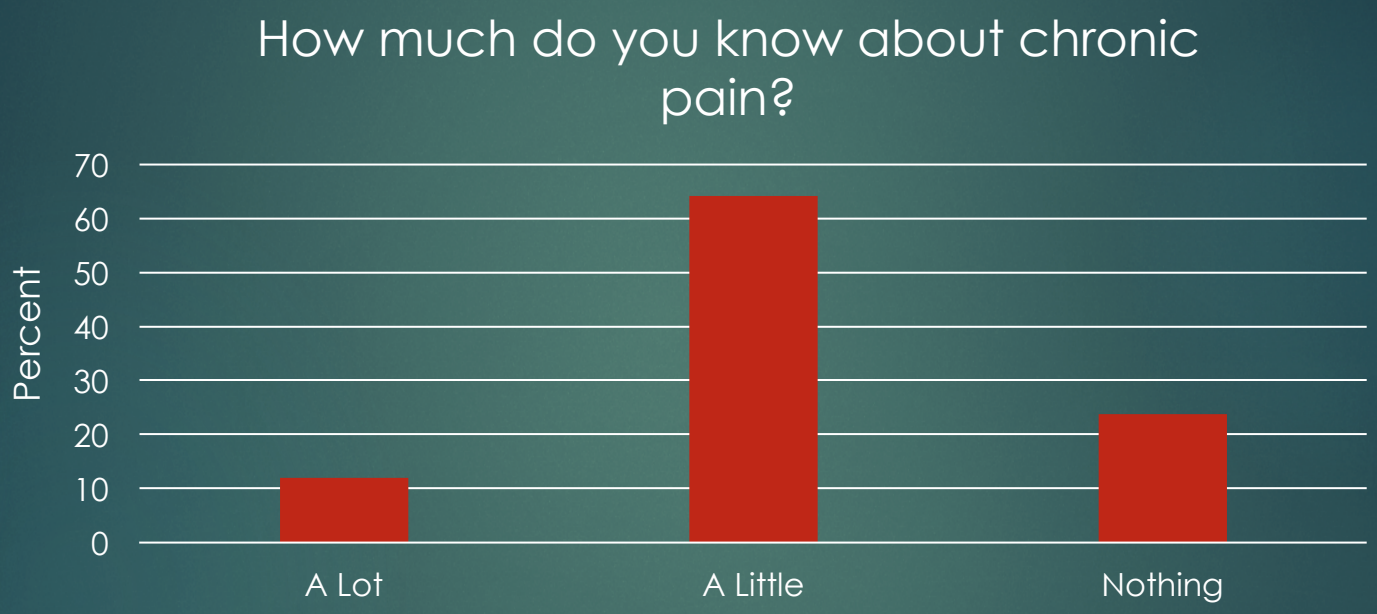
In persons with prescribed drugs, drugs from diversion to others, or otherwise illicit use
Deaths from self-harm, unintentional overdose, medication error, abuse, or non-medical abuse
Paulozzi, MMWR 2011

American Pain Society
RESEARCH
EDUCATION
TREATMENT
ADVOCACY
PUBLISHED BY ELSEVIER
The Journal of Pain, Vol ■, No ■ (■), 2017: pp 1-9
Available online at www.jpain.org and www.sciencedirect.com

Gaps in the Public's Knowledge About Chronic Pain: Representative Sample of Hispanic Residents From 5 States Turner BJ et al.

- National population-based online panel (GfK KnowledgePanel)
  - Targeted Hispanics living in 5 SW states (TX, NM, CA, AZ, NV)
  - Without chronic pain
  - Represents 8.8 million residents
- Asked level of self-reported knowledge about chronic pain
- Asked 18 questions to assess this knowledge

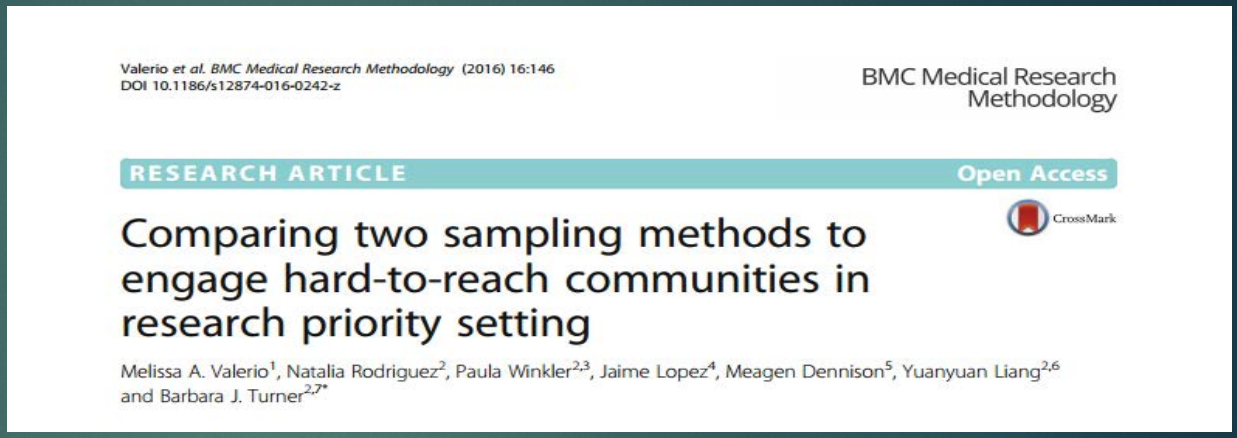
Hispanic adults without chronic pain (weighted N=8,810,704)



Knowing "a lot" associated with better knowledge about pain's impact on function, emotions, and physical activities but poorer knowledge about role of pain medications


The PURSUIT OF Pain Relief

Listening to the community



Valerio *et al. BMC Medical Research Methodology* (2016) 16:146
DOI 10.1186/s12874-016-0242-z

BMC Medical Research Methodology

RESEARCH ARTICLE Open Access

Comparing two sampling methods to engage hard-to-reach communities in research priority setting

Melissa A. Valerio[1], Natalia Rodriguez[2], Paula Winkler[2,3], Jaime Lopez[4], Meagen Dennison[5], Yuanyuan Liang[2,6] and Barbara J. Turner[2,7*]

- PCORI Methods Project
- Study subjects: Two rural, majority Hispanic communities in Texas
- Research question: **Improving outcomes of persons with chronic pain**

What are community priorities for chronic pain support?

Priorities for chronic pain care/support

Table 5 Importance and feasibility of needed pain management services and support from community stakeholders grouped by recruitment method[a] **Scale: not at all important, somewhat important, important, very important, extremely important**

Importance rating					Feasibility rating			
Category of services or support needed to improve outcomes of persons with chronic pain	Snowball sampling stakeholders mean (SD)	Purposive plus convenience sampling stakeholders mean (SD)	Diff	*P* Value[b]	Snowball sampling stakeholders mean (SD)	Purposive plus convenience sampling stakeholders mean (SD)	Diff	*P* Value[b]
Professional Chronic Pain Support	4.26 (0.63)	4.04 (0.71)	0.22	0.195	3.89 (0.84)	3.66 (1.01)	0.23	0.324
Nutrition Program	4.16 (0.96)	3.75 (1.14)	0.41	0.124	3.83 (0.86)	3.33 (1.22)	0.50	0.059
Massage Therapy	4.07 (0.78)	4.42 (0.52)	−0.35	*0.045*	3.73 (1.07)	4.00 (0.95)	−0.27	0.297
Education/Outreach	3.90 (0.71)	3.87 (0.93)	0.03	0.884	3.71 (0.82)	3.73 (0.97)	−0.02	0.929
City Improvements/Transportation	3.83 (0.71)	3.21 (0.97)	0.62	*0.004*	3.50 (0.83)	3.23 (1.09)	0.27	0.265
Non-Professional Chronic Pain Support	3.81 (0.76)	3.83 (0.85)	−0.02	0.921	3.71 (0.96)	3.60 (1.00)	0.11	0.657
Water Therapy	3.78 (0.80)	3.86 (1.08)	−0.08	0.735	3.54 (0.91)	3.35 (1.30)	0.19	0.494
Exercise/Fitness Facility	3.71 (0.59)	3.77 (0.86)	−0.06	0.742	3.66 (0.64)	3.54 (0.96)	0.12	0.552

[a]Ordered by priority rating of the Snowball Sampling Group
[b]Two-sample *t* test with unequal variances assumption

Living Better Beyond Pain

A partnership of:

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South Central AHEC

REACH CENTER
UT HEALTH SCIENCE CENTER SAN ANTONIO

UTSA ROADRUNNERS

Therapeutics

Review: Strength training, with or without flexibility and aerobic training, reduces pain in lower limb osteoarthritis

Uthman OA, van der Windt DA, Jordan JL, et al. Exercise for lower limb osteoarthritis: systematic review incorporating trial sequential analysis and network meta-analysis. BMJ. 2013;347:f5555.

ARTHRITIS & RHEUMATOLOGY
Vol. 66, No. 3, March 2014, pp 622–636
DOI 10.1002/art.38290

Impact of Exercise Type and Dose on Pain and Disability in Knee Osteoarthritis

Wiley Online Library

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Trusted evidence.
Informed decisions.
Better health.

Home > Evidence Based Medicine > Evidence-Based Health Care > The Cochrane Library > A

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Database Home

Intervention Review

Massage for low-back pain

Andrea D Furlan[1,*], Marta Imamura[2], Trish Dryden[3], Emma Irvin[1]

Database Title

Editorial Group: Cochrane Back Group
Published Online: 8 OCT 2008

Sorting Through the Evidence for the Arthritis Self-Management Program and the Chronic Disease Self-Management Program

Executive Summary of ASMP/CDSMP Meta-Analyses

May 2011

Medical News & Perspectives

June 14, 2016

As Opioid Prescribing Guidelines Tighten, Mindfulness Meditation Holds Promise for Pain Relief

Julie A. Jacob, MA

JAMA. 2016;315(22):2385-2387. doi:10.1001/jama.2016.4875

Curriculum Overview

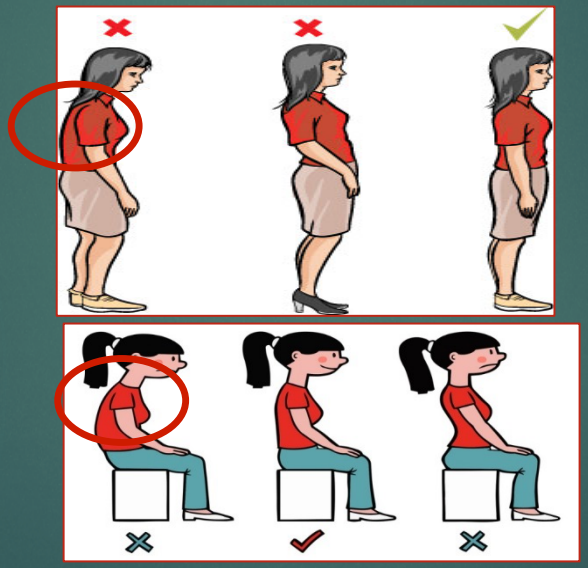
Session Number	Session Topic
1	Chronic Pain & Goal Setting
2	Pain and Physical Activity
3	Meditation and Mindfulness
4	Massage Techniques
5	Nutrition
6	Prevention and Management of Set Backs
7	Sleep Hygiene
8	Review and Continuing Successes
Appendix	Session 1-8 Exercises

Posture and walking

Research shows that these simple exercises help you with activities and reduce pain

You might get sore. That's okay! It's just a sign of your hard work!

✓ **Pay attention to your body when walking or sitting**

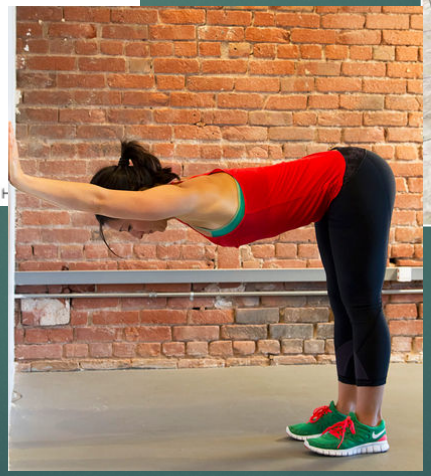


✓ **Walk 10-15 minutes a day**

Low back stretch

Easy

Medium

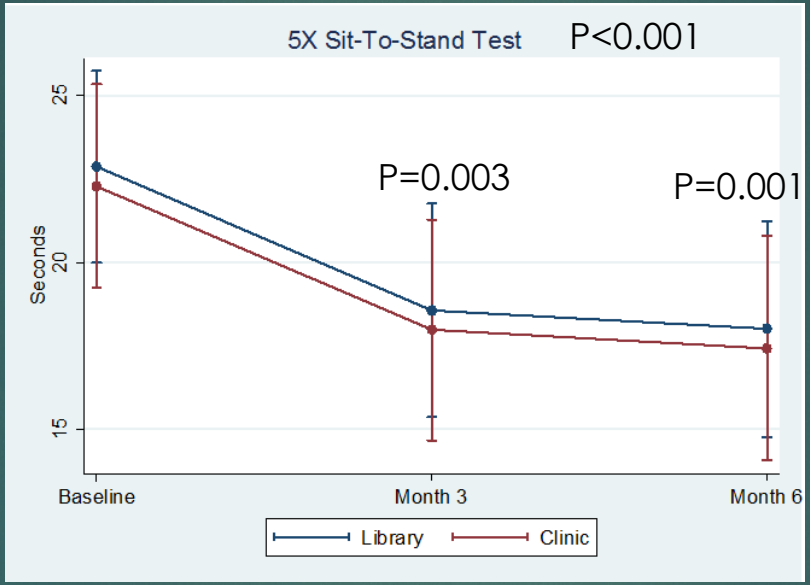


Harder

Trial of chronic pain self-management education

- Study subjects: Patients aged 35-70 prescribed opioids for chronic low back or leg pain from 2 primary care clinics and an HIV clinic
- 6 month educational intervention in two settings – in clinic from a community health worker or in community from expert lecturers
- Functional and mood measures at baseline 3, 6 months

Primary Outcome



Mixed effects models adjusted for demographics, max pain, study arm, period of assessment
P values from Chi Square for overall effect and Scheffe's test adjusting for multiple comparisons

Outcomes

- Significant improvements after 6 months in physical function (5X sit-to-stand test, mental health (PHQ-9), cognitive function (symbol digit modalities test), pain (Brief Pain Inventory).
- Participants reported that they felt more empowered to take control of their pain
- However, many wanted the support program to continue….problem of sustainability

Opportunities

- Engage the community to increase understanding about chronic pain and its management
- Develop payment models to support team-based care including chronic pain self-management education from trained community health workers
- Train primary care clinicians to educate/promote non-pharmacologic management of chronic pain
  - Ask "So what else are you doing for your chronic pain"

Engaging Communities to Address the Opioid Crisis

Lisa M. Cleveland PhD, RN, CPNP, IBCLC

Assistant Professor

UT Health San Antonio

Background

- **1/3 the cases of neonatal abstinence syndrome (NAS) in TX occur in Bexar County**
  - *NAS is a withdrawal syndrome occurring in infants prenatally exposed to opioids*
  - *Approx. 300-400 infants born with NAS annually in San Antonio*
- **Overdose death is the 2nd leading cause of maternal mortality in TX**

Projects

- *The Kangaroo Mother Care (KMC) Study*
- **The Maternal Opioid Mortality Study (MOMS)**
- *The Bexar County Neonatal Abstinence Syndrome Collaborative*
- **The Mommies Toolkit and Statewide Training Initiative**
- **Hispanic Grandparents as Primary Care Providers in the Context of Parental Substance Use**
- **Infant Feeding Experiences of Women Receiving Medication Assisted Treatment (MAT) for an Opioid-Use Disorder**
- **The Relationship between Stress and Social Support in Pregnant and Parenting Women who Use Opioids**

Kangaroo Mother Care Study (KMC)

- **Impact of KMC on stress reactivity and attachment**
  - **Mixed-methods design**
  - **Recruiting participants prenatally from community recovery programs**
    - *KMC educational session*
    - *Saliva, heartrate and survey data collected during sessions of KMC*
    - *Post-discharge f/u interviews*

Funded by the Texas Health & Human Services Commission

Written consent obtained for use of photos

Findings

- High attachment scores
- Parental role alteration was the most stressful
  - separation from the infant, not being the primary caregiver, not having alone time
- Significant reduction in within dyad heart rate
- Reduction in NAS symptoms while in KMC
- Maternal engagement

Qualitative Themes

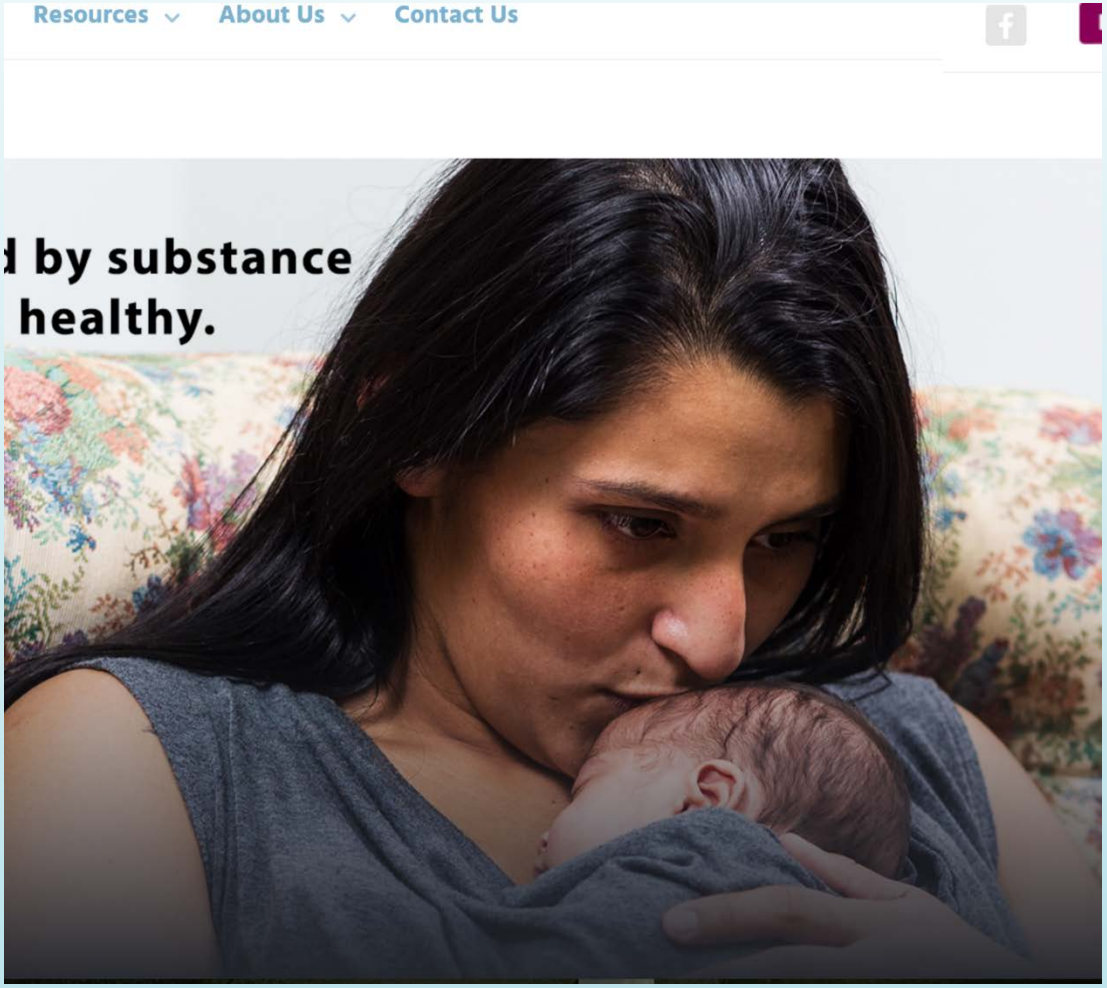
- Thematic analysis
- Four preliminary themes are emerging:
  - *Barriers to KMC*
  - *In our own world*
  - *Healing together*
  - *Going home*

"I would hold her on my chest. She would relax and I would too."

"When I was holding her skin-to-skin, [the NICU] kind of faded away. It was just me and her… in our own little bubble."

"Kangaroo care helped us heal together, recover together. It helped me forgive myself and forget and move on."

Permission granted for use of photo



The Bexar County NAS Collaborative (BCNC)

Keepingfamiliestogether.org

Future Direction

- Further exploration of the physiologic mechanism underlying findings of KMC study
  - Within dyad physiological attunement
  - Impact on emotional regulation and stress reactivity later in infancy
- Establishment of a recovery residence for pregnant/parenting women and their children

Written consent obtained for use of photos

UT Health San Antonio
Family & Community Medicine

Integrating the Primary Care Behavioral Health (PCBH) Consultation Model into Primary Care

Dr. Stacy Ogbeide, PsyD, MS
Assistant Professor/Clinical
Behavioral Health Consultant and Licensed Psychologist
Departments of Family & Community Medicine and Psychiatry
ogbeide@uthscsa.edu

Primary Care: IOM definition

- The provision of i**ntegrated**, accessible health care services by clinicians who are accountable for addressing a **large majority of personal health care needs**, developing a sustained partnership with patients, and practicing in the **context of family and community** (IOM, 1996).

What is "Behavioral Health"?

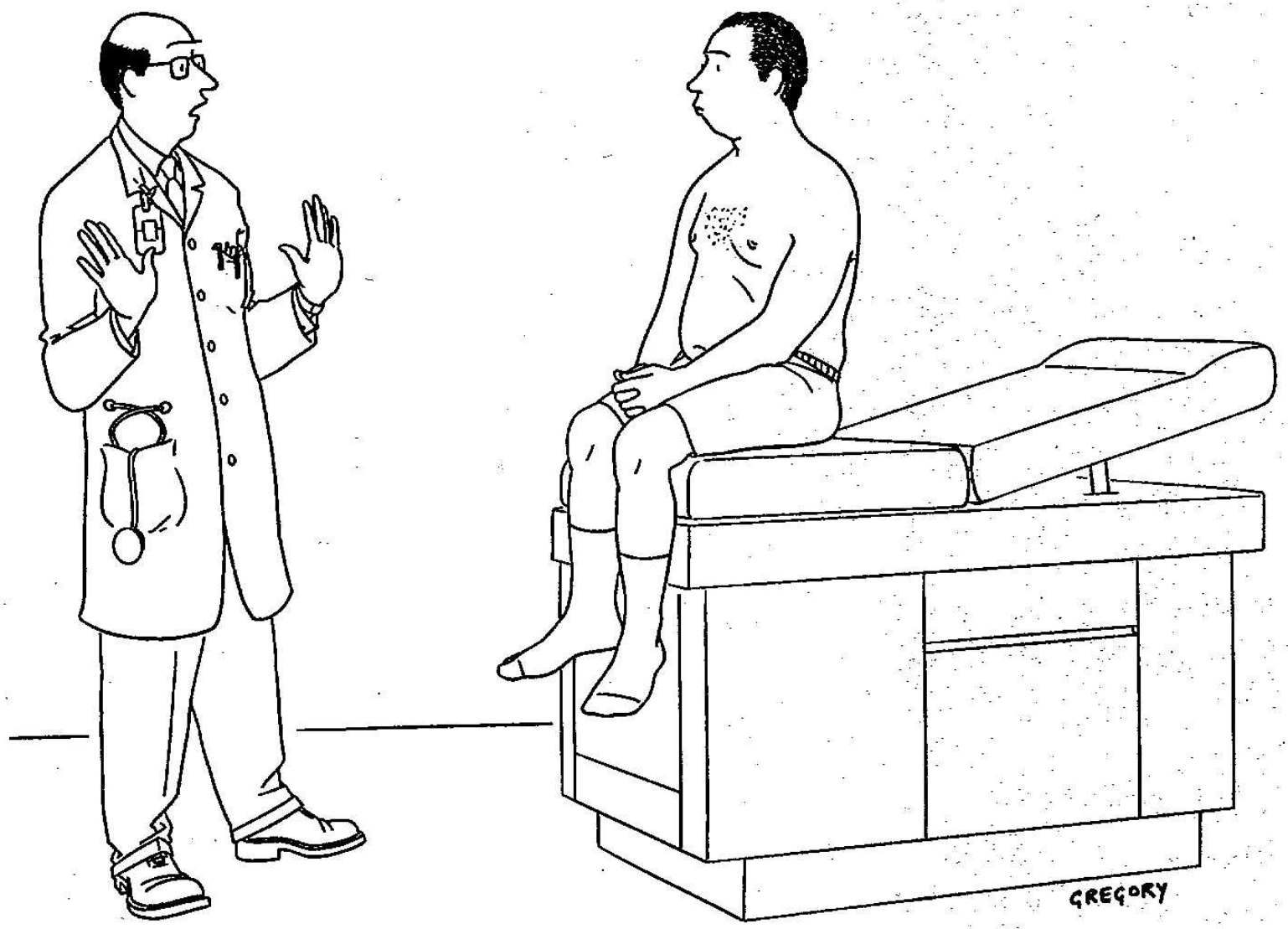
- Behavioral Health is an **umbrella term** for care that addresses any behavioral problems impacting health, including mental health and substance abuse conditions, **stress-linked physical symptoms**, **patient activation and health behaviors.** The job of all kinds of care settings, and done by clinicians and health coaches of various disciplines or training.

Source: Peek, C. J., National Integration Academy Council. (2013). Lexicon for Behavioral Health and Primary Care Integration: Concepts and Definitions Developed by Expert Consensus. In Agency for Healthcare Research and Quality (Ed.), *AHRQ Publication No.13-IP001-EF*.

Why Integrate Behavioral Health into Primary Care?

- 1) **Behavioral health problems are common**
  - Two third of primary care patients have psychiatric diagnoses or psychological symptoms that impair their function.
- 2) **Behavioral health problems are expensive.**
  - Individuals with behavioral health and substance abuse conditions cost 2-3 times as much as those without[1]
- 3) **Behavioral health problems are disabling.**
  - Behavioral health disorders account for half as many disability days as "all" physical conditions[2]
- 4) **When behavioral health is treated, costs go down and people get better.**
  - Medical use decreased 15.7% for those receiving behavioral health treatment while medical use increased 12.3%[1] for controls who did not receive behavioral health treatment

Sources: [1]Kroenke & Mangelsdorf, Am J Med. 1989;86:262-266. [2]Narrow et al., Arch Gen Psychiatry. 1993;50:5-107.



"Whoa—way too much information."

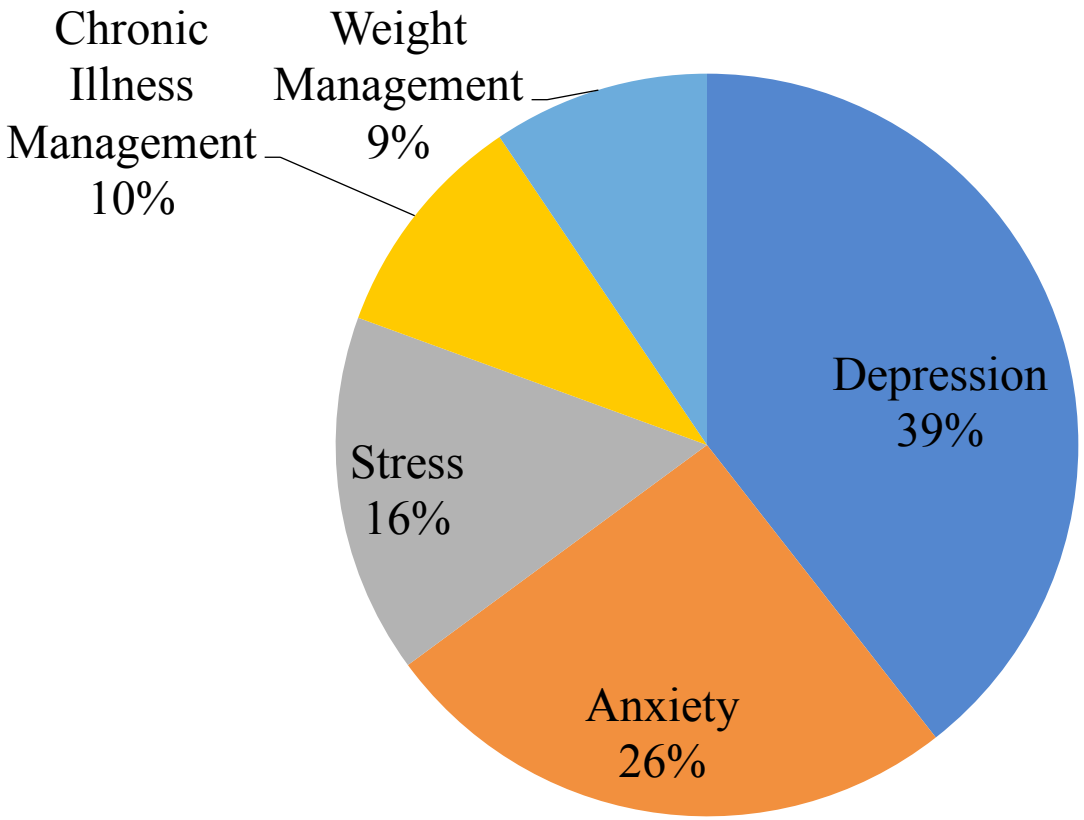
The Primary Care Behavioral Health (PCBH) Model

- Behavioral Health Consultant (BHC) within the primary care setting
- Brief Interventions & Pathway Services
  - One-on-One
  - Screening
  - Classes or workshops
  - Group visits
- Ideal ratios (PCP/BHC):
  - 4 to 1 (adults); 3 to 1 (pediatrics)
  - Homeless:1 to 2
  - 1 psychiatrist for 10 PCP

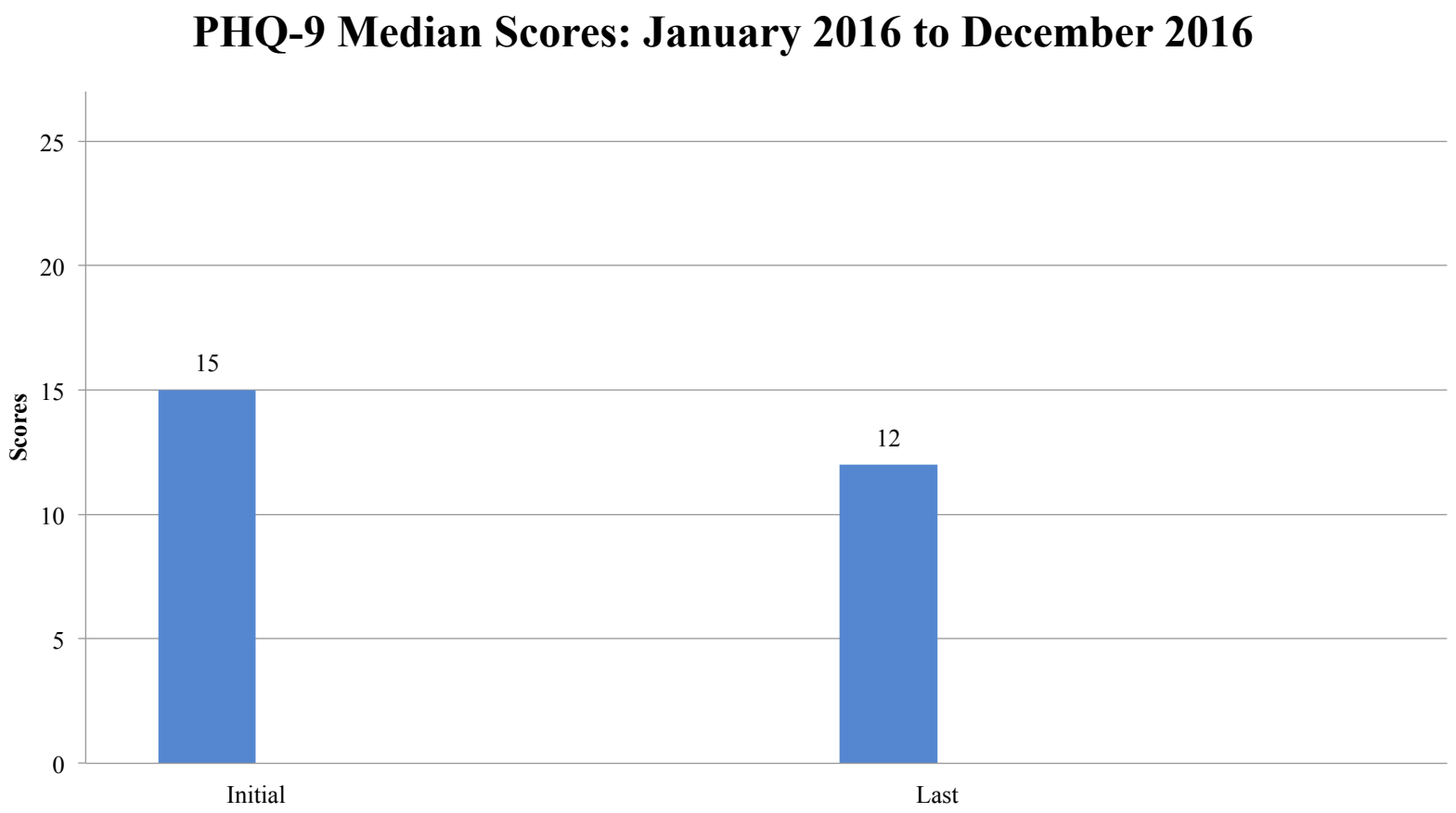
How do we integrate into a clinic?

- Hire someone who knows how to do this
- Current knowledge of primary care team
  - what do they know, what are their biases towards behavioral health
- Put the BHC in the flow (in the way!) of the PCP
  - Start with the painful problems first; relieve pressure in the schedule

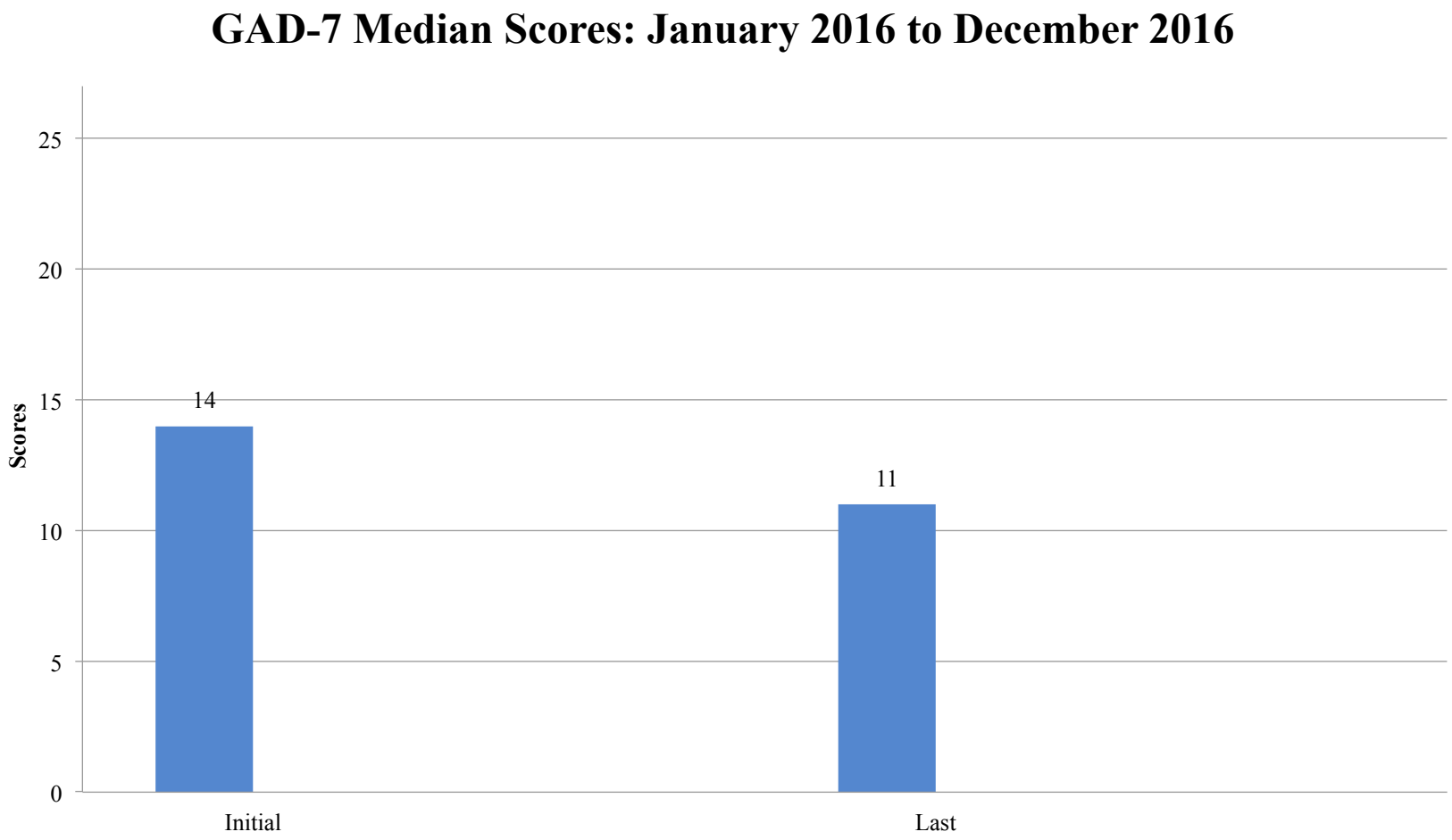
PCBH 2016 Numbers (FHC/DT)



PCBH 2016 Numbers



PCBH 2016 Numbers



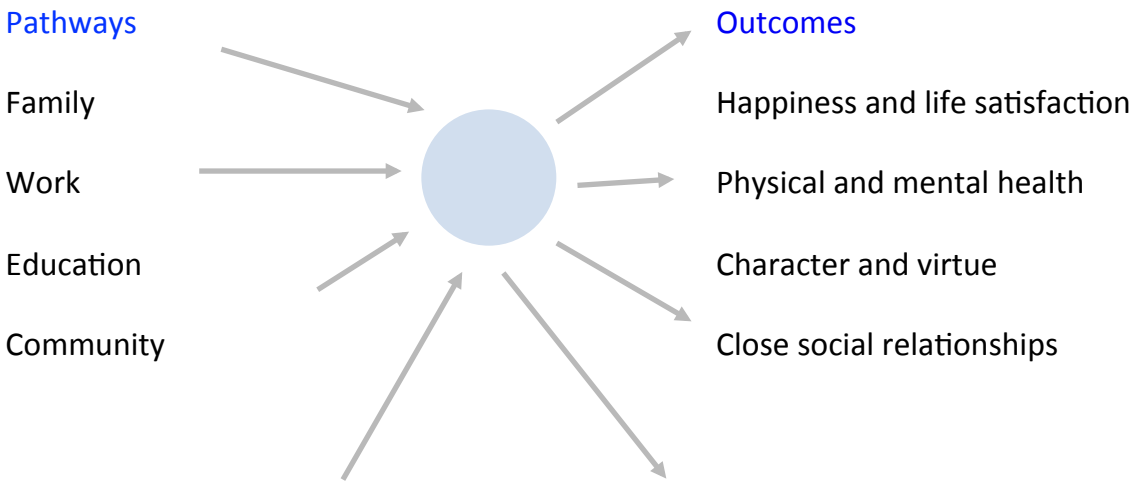
Mental health and flourishing

Robert Ferrer, MD, MPH

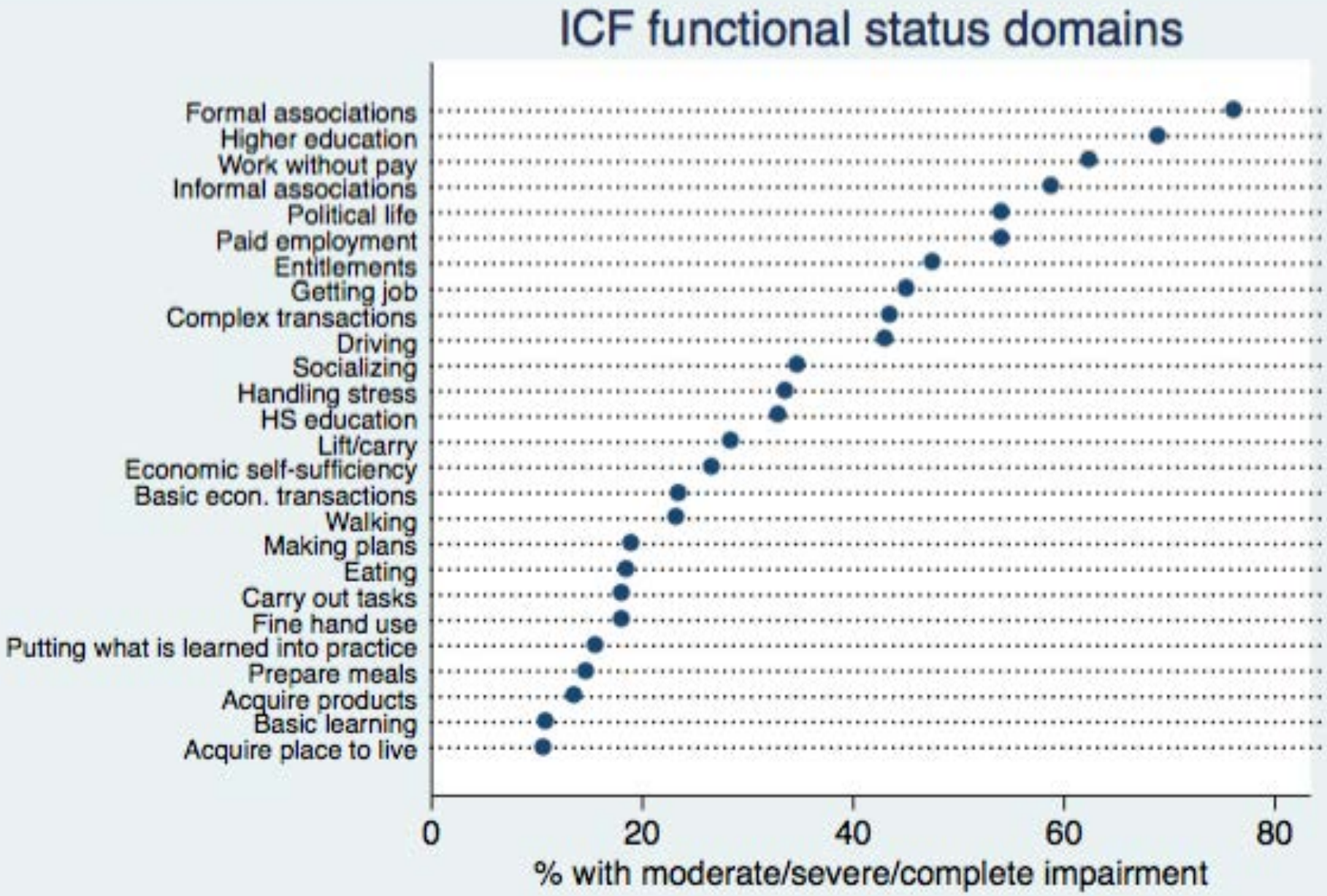
Mental illness → Mental health

Languishing → Flourishing

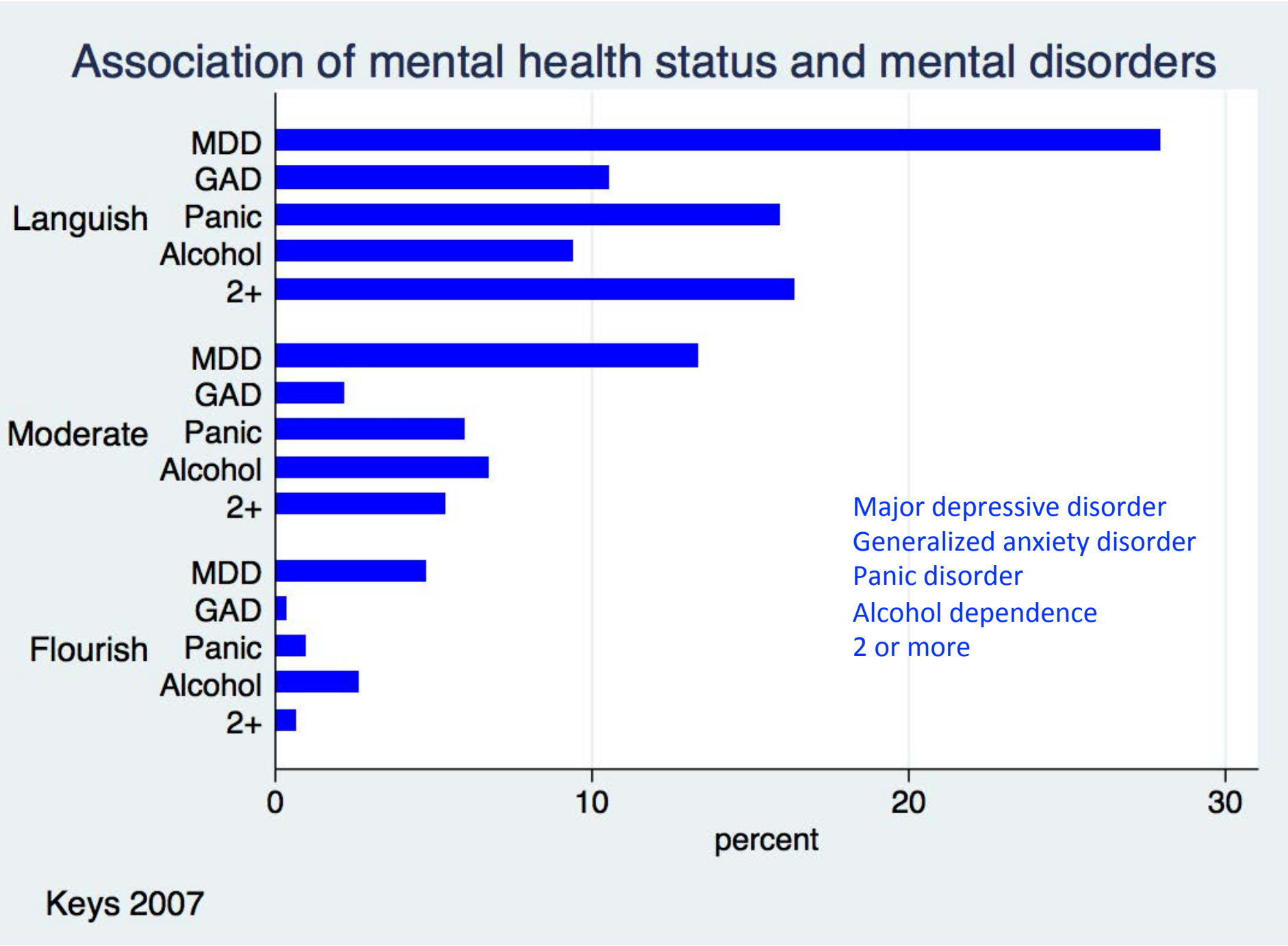
Components of flourishing



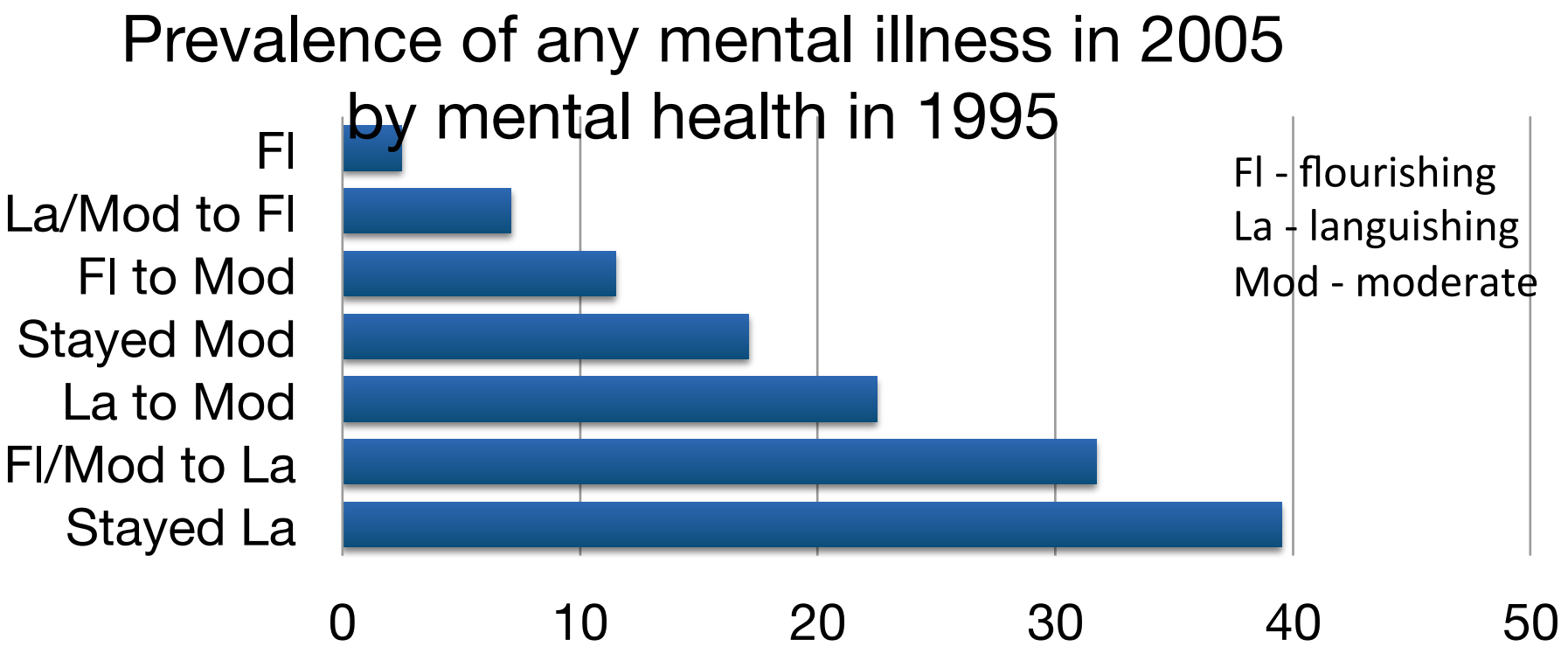
VanderWeele, PNAS 2017

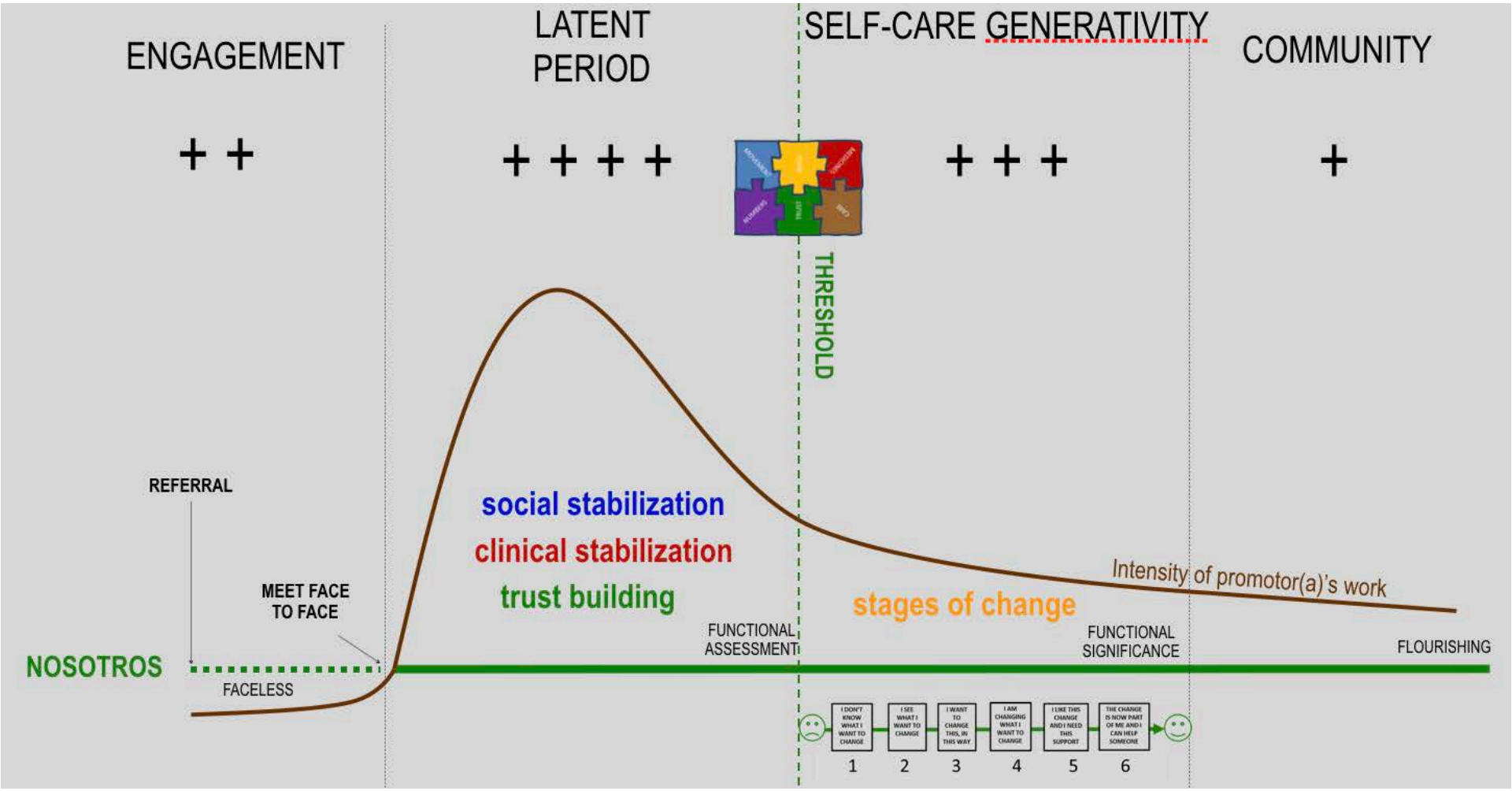


n=220 patients enrolled in a disease management program


Association of mental health status and mental disorders
Languish
MDD
GAD
Panic
Alcohol
2+
Moderate
MDD
GAD
Panic
Alcohol
2+
Flourish
MDD
GAD
Panic
Alcohol
2+
0
10
20
30
percent
Major depressive disorder
Generalized anxiety disorder
Panic disorder
Alcohol dependence
2 or more
Keys 2007

Trends in flourishing and mental health




ENGAGEMENT
LATENT PERIOD
SELF-CARE GENERATIVITY
COMMUNITY
+ +
+ + + +
+ + +
+
THRESHOLD
REFERRAL
MEET FACE TO FACE
social stabilization
clinical stabilization
trust building
stages of change
Intensity of promotor(a)'s work
FUNCTIONAL ASSESSMENT
FUNCTIONAL SIGNIFICANCE
FLOURISHING
NOSOTROS
FACELESS
I DON'T KNOW WHAT I WANT TO CHANGE
I SEE WHAT I WANT TO CHANGE
I WANT TO CHANGE THIS, IN THIS WAY
I AM CHANGING WHAT I WANT TO CHANGE
I LIKE THIS CHANGE AND I NEED THIS SUPPORT
THE CHANGE IS NOW PART OF ME AND I CAN HELP SOMEONE
1
2
3
4
5
6