FLOW:
A Clinical Demonstration Project

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(It takes a village)

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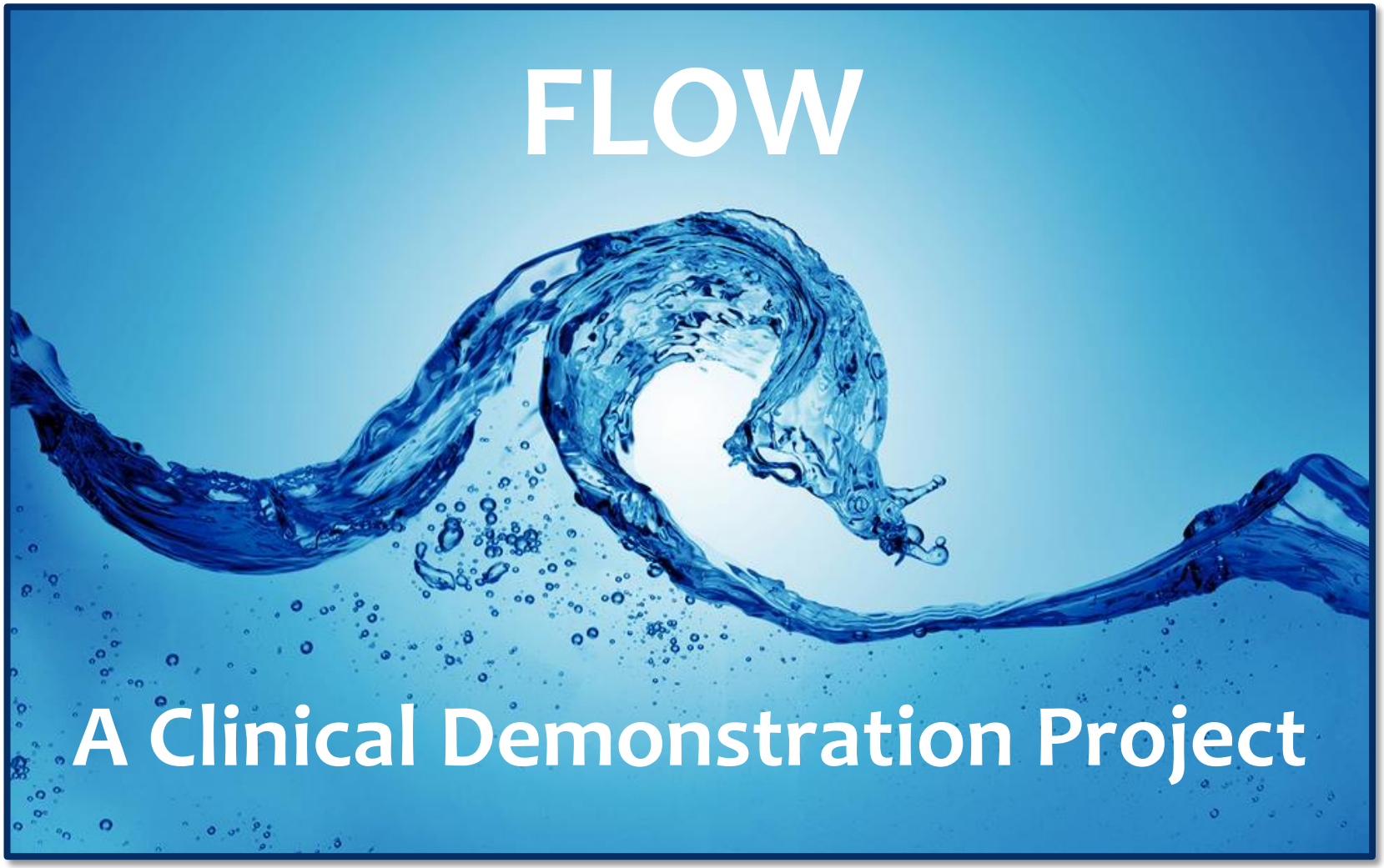
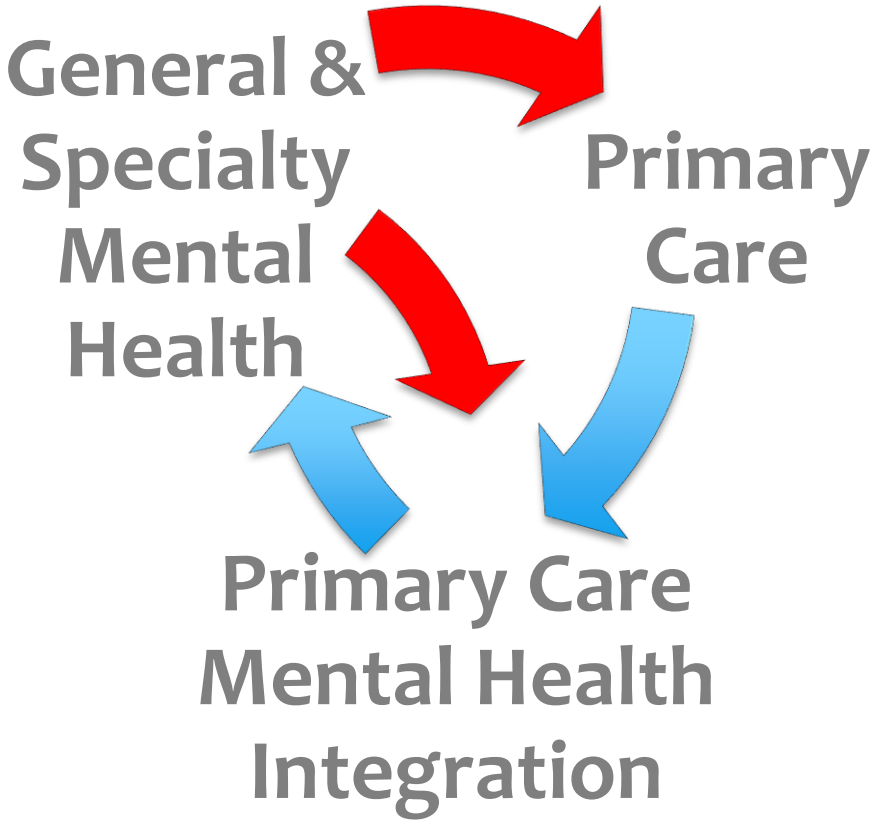


Primary Care (PC)
Primary Care-Mental Health Integration (PC-MHI)
General & Specialty Mental Health (MH)

The PROBLEM

Many facilities have strong flow between PC, PC-MHI, and MH but there is often a lack of flow from MH back to PC or PC-MHI



Solutions Must Work for All Clinics

* **Issue**
  * Transferring Veteran access from one clinic to another moves the problem but does not solve it.
* **Why transition MH patient back to Primary Care?**
  * Primarily to allow Veterans be treated in a setting that is most appropriate given their unique mental health care needs
  * Secondarily, treatment occurs in a setting that provides Veterans with the least restrictive environment, necessary medical care, and recovery-focused treatments as described later.
* **Potential Outcomes**
  * Veterans can be expected to experience enhanced outcomes
  * Improve utilization of care resources at all the clinics involved
  * Ultimately leading to increased access across the whole health care system.

Project Principles

* **Medical Necessity**
  * Legal doctrine, related to activities which may be justified as reasonable, necessary, and/or appropriate, based on evidence-based clinical standards of care.
* **Least Restrictive Environment**
  * The World Health Organization (WHO) states persons with MH disorder should be provided with health care which is the least restrictive*
* **Recovery Focus**
  * Recovery is a process of change, focused on one's strengths, through which individuals: improve their health and wellness; live a self-directed life; strive to achieve their full potential.

What's been done?

* Literature review
* Detailed project blueprint
* Created criteria for identifying stabilized/recovered patients in EMR & an associated online report
* Developed educational materials for leadership, providers, & Veterans
* Started the first pilot at McAllen CBOC in V17

Literature Review: Barriers

* Providers sometimes lack education about or confidence in the abilities of providers in other clinics
* Clinic culture and/or provider comfort with uncertainty
* Scheduling of follow-up appointments without evaluation of ongoing need
* Lack of sufficient staff to support care transition processes
* Excessively large caseloads and resource constraints in proposed transfer clinic/service

Literature Review: Facilitators

* Patient education, beginning at intake and across the care process, regarding when transitions occur
  * Suggest the shared goal is recovery/stabilization and eventual transition back to PC
* Support of leadership/key staff across involved services
* Care coordination agreements + tracking and monitoring of transitions
* Consensus on what information is necessary and sufficient in care transitions progress note
* Post transition clinical consultation must be available and timely
* Involved clinics jointly responsible for meeting performance benchmarks
* Designated care managers that track patients through transition

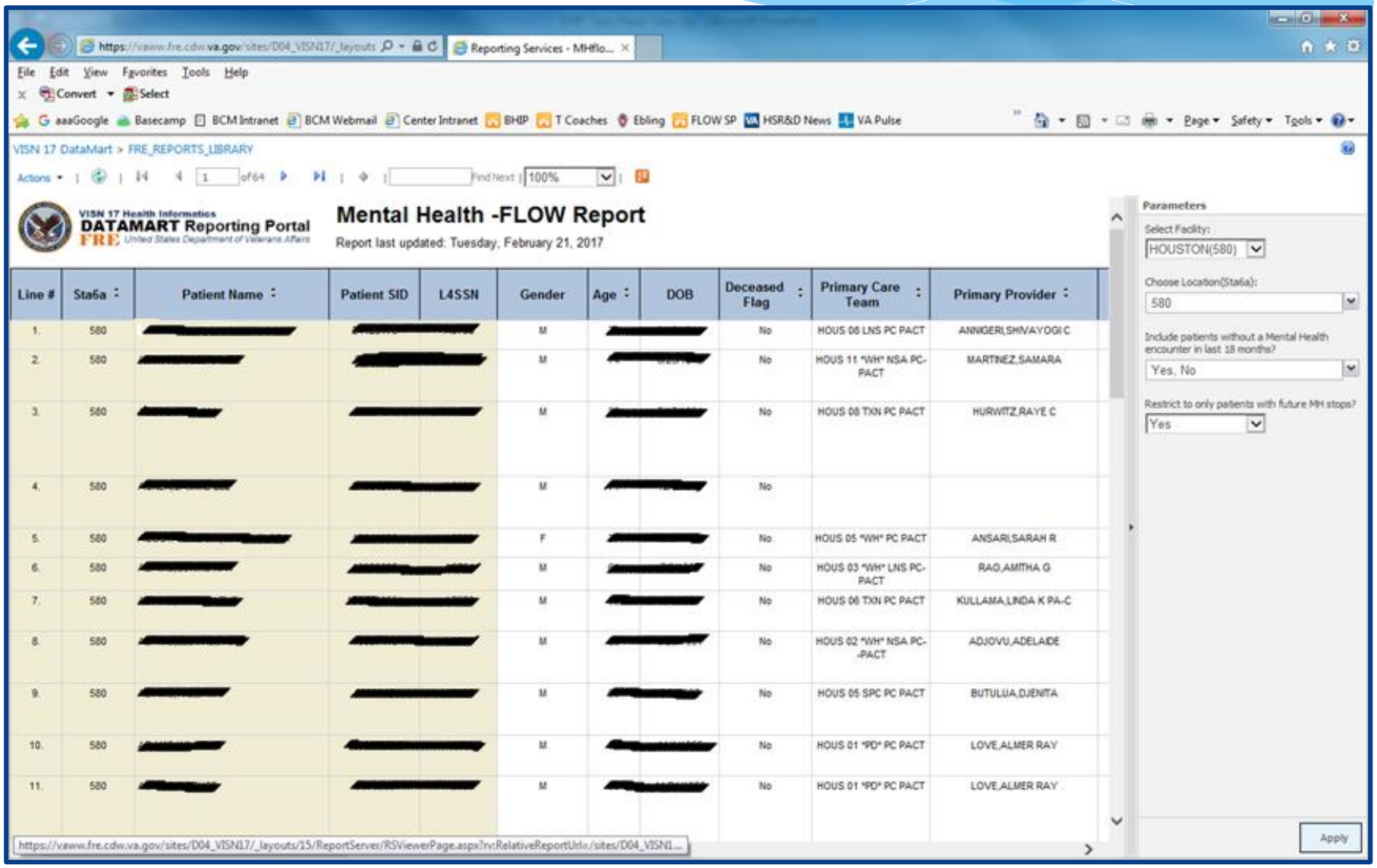
Electronic Medical Record Identification Criteria (EMR IC)

* The first step in the solution process was developing and operationalizing EMR IC so that sites can identify potential Veterans in the electronic medical record (EMR)
* **Characteristics and goal of EMR IC**
  * Criteria which are sensitive and specific enough to capture appropriate Veterans
  * If too broad, providers will find the list time consuming
  * If too narrow, Veterans who could be managed in PC will be missed
  * Critical clinical decision must always be made by providers reviewing identified Veterans

EMR Identification Criteria

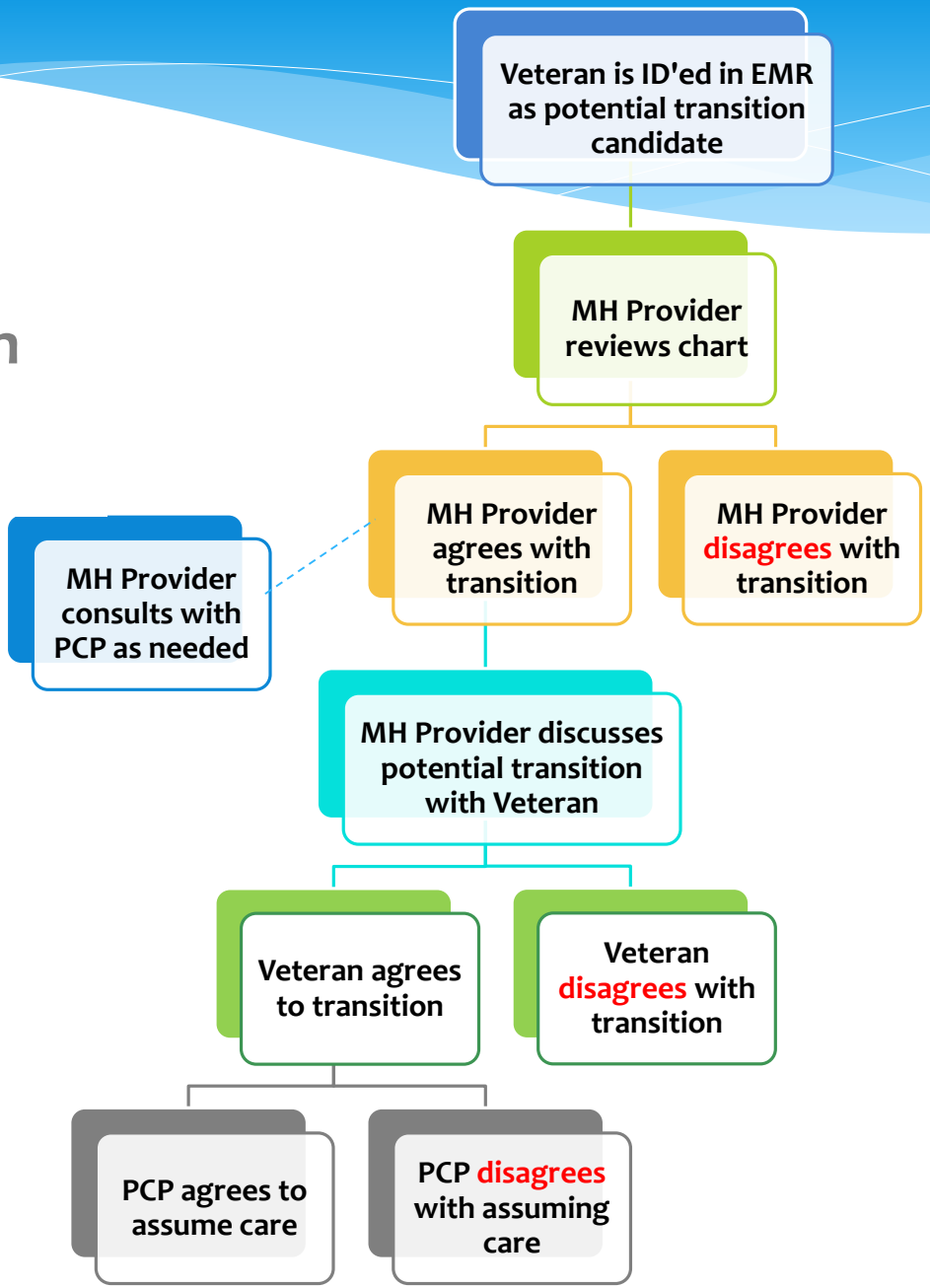
Includes: Those with a MH encounter in the past 24 months AND taking 3 or fewer psychotropic medications.

1. **Excludes:** Those taking medication in the antipsychotic class or lithium (or Depakote with a Bipolar Diagnosis)
2. **Excludes:** Any Veteran with a new psychotropic medications during the previous six months.
3. **Excludes:** Those with VA psychiatric ER visit (mental health ICD code in the primary position associated with an encounter in a VA ER) in the previous 12 months.
4. **Excludes:** Those with a VA psychiatric hospitalization in the past 12 months.
5. **Excludes:** Those currently on the High Risk for suicide list.



Line #	Sta6a	Patient Name	Patient SID	L4SSN	Gender	Age	DOB	Deceased Flag	Primary Care Team	Primary Provider
1.	580	[redacted]	[redacted]		M	[redacted]		No	HOUS 08 LNS PC PACT	ANNIGERI,SHIVAYOGI C
2.	580	[redacted]	[redacted]		M	[redacted]		No	HOUS 11 *WH* NSA PC-PACT	MARTINEZ,SAMARA
3.	580	[redacted]	[redacted]		M	[redacted]		No	HOUS 08 TXN PC PACT	HURWITZ,RAYE C
4.	580	[redacted]	[redacted]		M	[redacted]		No		
5.	580	[redacted]	[redacted]		F	[redacted]		No	HOUS 05 *WH* PC PACT	ANSARI,SARAH R
6.	580	[redacted]	[redacted]		M	[redacted]		No	HOUS 03 *WH* LNS PC-PACT	RAO,AMITHA G
7.	580	[redacted]	[redacted]		M	[redacted]		No	HOUS 08 TXN PC PACT	KULLAMA,LINDA K PA-C
8.	580	[redacted]	[redacted]		M	[redacted]		No	HOUS 02 *WH* NSA PC-PACT	ADJOVU,ADELAIDE
9.	580	[redacted]	[redacted]		M	[redacted]		No	HOUS 05 SPC PC PACT	BUTULUA,DJENITA
10.	580	[redacted]	[redacted]		M	[redacted]		No	HOUS 01 *PD* PC PACT	LOVE,ALMER RAY
11.	580	[redacted]	[redacted]		M	[redacted]		No	HOUS 01 *PD* PC PACT	LOVE,ALMER RAY

Mental Health to Primary Care Clinical Transition Process



Transition to PC

Once the Veteran and his/her clinical team have agreed on the transition to PC:

- **Veteran is given a *specific* PC appointment within 90 days of his last MH encounter**
- **Veteran has at least 6 months of refills on any current MH medications**

Quality Monitoring

* The FLOW team is creating a dashboard that tracks the flow of Veterans from:
  * PC → PC-MHI → MH → PC
* Using a specific progress note for tracking that return
* Purpose: All involved clinics should be able to see the flow of Veterans based on the principle that flow has to work for all clinics for success

Data for Quality Monitoring

		Value
Primary Care (PC)	Number of Active PC patients	
Primary Care-Mental Health Integration (PC-MHI)	Total number of new PC-MHI patients	
	Percentage of PC-MHI Patients referred to MH	
Mental Health (MH)	Total number of Active MH Patients	
Meets EMR Identification Criteria (EMR IC)	Number MH Patients who meet EMR IC	
	Percentage of MH Patients who meet EMR IC	
MH Provider agrees that Veteran is appropriate for transition to PC	Percentage of ID'ed MH Patients where provider agrees to the transition to PC	
MH Patient agrees to transition to PC	Percentage of ID'ed MH Patients who agree with their provider to transition to PC	
Transitioned Veterans who return to MH	Percentage of transitioned patients who return to MH within 6 months	

Evaluation timeline - Providers

Pre-implementation

- **Organizational Readiness to Change survey** (~3 minutes)
- **Qualitative interview** (15 min on phone)

Implementation (in 1 to 6 months)

- **2 question survey (MH Providers only)** (Reasons why a ID'ed patient was not appropriate for transition)
- **Qualitative interview** (15 min on phone)

Post-implementation (12 months)

- **Qualitative interview** (15 min on phone)

Evaluation – Veterans

Implementation
(in 1 to 6 months)

- **Qualitative interviews –** (15 min phone)
  (Reasons they accepted or rejected a transition to primary care)

Questions?
Suggestions?