Improving Collaboration in Mental Health Care

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Discontinuity and lack of collaboration in mental-health care results in poor outcomes. Current mental health care systems are substandard because so frequently they are removed from evidence-based, clinical practices (Knesper, 2010). The focus of this project is to implement an evidence-based collaborative care model to address the issue of mental health discontinuity and lack of collaborative care and create a practice change. Bauer et al. (2006) describes a collaborative chronic care model as care that emphasizes improving and developing a patient's illness management skills, supports provider capability and availability, and engages patients in timely, joint decision making about their illness. Collaborative care models have been used and studied in mental health settings with success and emphasize ongoing, anticipatory mental health care rather than the reactive, uncoordinated and crisis oriented care that often currently exists (Bauer et al., 2006). The goal of this practice change project is to initiate a practice change that results in holistic, effective, evidence-based, and collaborative patient-focused mental health care.

Overview of Problem of Interest

Research supports the need for collaboration and continuity in the mental health system and demonstrates how improved collaboration results in improved quality of life and outcomes in persons diagnosed with mental illness. A recent meta-analysis reviewed 37 trials of collaborative care and compared the results to the outcomes obtained from usual care. The studies found evidence of two-fold higher rates of adherence to antidepressant medication over the first six months of treatment and improved depressive outcomes that often persisted for at

least 2 years (Katon, Unützer, Wells, & Jones, 2010). Other trials of collaborative care approaches to treating depression in patients with a chronic medical illness found significant improvements in quality of care and depressive outcomes compared to usual care (Katon et al., 2010).

Care discontinuity occurs when there is lack of collaboration and coordination between all involved members of the mental health system. The mental health system consists of many interrelated components. These include private and public mental health providers, primary health care systems, emergency services and human service systems (TriWest Group, 2003). As Knesper (2010) states, "The present mental health care system is pluralistic with competing, disconnected, and autonomous subsystems and with various types of singularly focused mental health professionals (2010, p.7)."

Fragmented mental health care results in suboptimal clinical outcomes, substantial functional deficits, decreased patient satisfaction and high costs for patients diagnosed with persistent and severe mental illnesses (Bauer et al., 2006). Other effects of fragmented mental health care include increased suicide risk, increased emergency department use to treat mental health issues, and significant clinical and financial implications. Fragmented mental health care also results in costly duplication and inappropriate use of services and hospital readmissions.

Readmissions

Readmission following a psychiatric hospitalization is a costly and often preventable event that often relates to poorly coordinated care. During 2003 and 2004, almost one-fifth of Medicare beneficiaries or more than 2.3 million patients, were readmitted within 30 days of discharge (Centers for Medicare & Medicaid Services, 2012). Randomized controlled trials have

shown that improvement in health care can reduce readmission rates and focus on interventions that improve continuity of care (Centers for Medicare & Medicaid Services, 2012).

Financial Implications

There are multiple pressures for all members of the healthcare community to improve health care collaboration and continuity. The trend in government is to reduce Medicare spending and The Hospital Readmissions Reduction Program intends to reduce preventable readmissions by reducing Medicare payments to certain hospitals with relatively high preventable readmission rates (Stone & Hoffman, 2010). Policy makers have suggested bundling Medicare payments to hospitals and post-acute care providers to encourage better collaboration among providers and to enhance accountability for patient outcomes and treatment costs (Stone & Hoffman, 2010). On October 20, 2011, the Centers for Medicare and Medicaid Services finalized new rules under the Patient Protection and Affordable Care Act to help doctors, hospitals, and other health care providers improve coordinated care for Medicare patients (Centers for Medicare & Medicaid Services, 2012). Their goal is to deliver seamless, high-quality care for patients instead of the fragmented care that often results from a Fee-For-Service payment system in which different providers receive different, disconnected payments (Centers for Medicare & Medicaid Services, 2012). Improved collaboration and continuity of care improves both patient and financial outcomes.

Organizational collaboration issues

Susquehanna Health Systems Behavioral Health Department has identified a need to improve the collaboration and continuity of their mental health care services. They have identified issues with lack of communication between the inpatient and outpatient behavioral

health departments, the emergency department and the primary care providers. The emergency department continues to experience high levels of mental health patients with psychiatric and somatic complaints and primary care providers continue to experience high numbers of patients seeking mental health treatment in their offices. Both areas continue to request improved access to behavioral health services and improved communication and collaboration with mental health providers.

Uncoordinated and fragmented mental health care results in negative outcomes for the patient and for the healthcare system. Improved continuity of mental health care results in improved patient outcomes and functional status, and decreased costs to the healthcare system. Using evidence-based interventions can result in improved continuity of mental health care.

Literature Review

There are many evidenced based interventions that improve mental health continuity and collaboration of care (Butler et al., 2008). Care discontinuity occurs when there is lack of collaboration and coordination between all providers involved in a patient's care. Continuity has been defined as "a process involving the orderly, uninterrupted movement of patients among the diverse elements of the service delivery system" (Adair et al., 2005, p. 1061). Collaboration occurs between providers, ensuring that the treatment plan and provision of services is appropriate and coordinated across providers with different expertise and treatment domains (Butler et al., 2008).

Chronic care model

A chronic care model improves continuity of care (Institute of Medicine, 2006). The Substance Abuse and Mental Health Services Administration (SAMHSA) (2012) has developed

a chronic care model that creates a *Behavioral Health Home* (BHH) for a patient diagnosed with mental illness. Key interventions of the BHH to be used in this project include patient self-management support and improved system delivery and community linkages (SAMHSA, 2012). The Patient Centered Primary Care Collaborative (2008) also supports the BHH and evidence-based interventions that support continuous coordinated care. Identified interventions to improve collaborative care include the assignment of a primary mental health provider who cares for the whole patient, enhanced access to care through open access scheduling, and new options for communication between patients, their personal physician, and practice staff (Patient-Centered Primary Care Collaborative, 2008).

Improving patient self-management skills

Bauer et al. (2006) identified interventions aimed at improving patients' self-management skills through psycho-education and a Life Goals Program. The model they developed focuses on the ongoing, anticipatory management of mental health issues with an emphasis on patient-centered collaboration and wellness (Bauer et al., 2006). Productive interactions between an informed patient and a proactive healthcare team and interventions to improve a patient's engagement and self-care result in improved continuity and collaboration of care (Butler et al. 2008; Wagner et al, 2001).

Bauer, Kilbourne, Greenwald, Ludman and McBride (2008) developed and tested a program and workbook that focuses on illness and life management. The workbook draws on behavioral, cognitive and motivational interviewing techniques. This program is now used in the United States and several other countries around the world (Bauer, Kilbourne, Greenwald, Ludman, & McBride, 2008). Evidence supports the interventions outlined in the Life Goals Program. Bauer et al. (2008) note treating depression requires a bio-psychosocial approach. A

bio-psychosocial approach to illness management includes working with a provider who prescribes medications and using self-management skills to cope with the illness (Bauer et al., 2008). Bauer et al. (2008) also discovered that collaboration between care providers and the individuals they treat is the most effective approach to improving patient outcomes.

Enhanced access to care

Increased patient contact and access to care are effective interventions for improving collaborative mental health care (Bauer et al., 2006). Bauer et al. (2006) focused on enhancing access to care, continuity of care, and information flow through a nurse care coordinator. The nurse care coordinator provided aggressive follow-up for missed appointments and collaboration with other providers involved in patient care (Bauer et al., 2006). In addition to regular care, the providers in the study also offered same-day telephone response and next-business-day clinic visits on demand for problems, similar to what is now called *open access scheduling* (Bauer et al., 2006). Evidence supports open access scheduling as an intervention that improves continuity of care (Butler et al., 2008). Improved patient contacts and open access scheduling are interventions also supported by the Patient Centered Primary Care Collaborative (2008) as ways to improve continuity of care and are interventions identified for use in this change project.

IMPACT Model

A very effective model of collaborative mental health care is illustrated in the Improving Mood- Promoting Access to Collaborative Treatment (IMPACT) Model (University of Washington, n.d.). The IMPACT Model has been implemented in approximately 500 sites in the United States affecting at least 50,000 individuals (National Registry of Evidence-based Practices, 2013). Implementation of the IMPACT Model resulted in a 50% or greater

improvement in depression at 12 months, better physical functioning, higher quality of life, and greater patient and provider satisfaction (University of Washington, 2008).

The IMPACT intervention is a collaborative care approach in which a mental health provider works with the patient's regular primary care provider to develop a course of treatment (Natioanal Registry of Evidence-based Practices, 2013). Interventions in the IMPACT Model include patient education and self-management support, frequent patient follow-up, systematic outcome and diagnosis tracking, evidence-based algorithms, and close collaboration between the primary care and mental health provider (University of Washington, 2008). Interventions from the IMPACT Model and the other chronic care collaborative models will be the foundation of this project.

Purpose of Project

The purpose of the proposed practice change is to implement a collaborative chronic care model in the outpatient behavioral health department to improve collaboration between mental health and primary care providers. This improved collaboration is hoped to result in decreased symptoms of patient depression, improved collaboration between providers, fewer inpatient psychiatric admissions, decreased use of the emergency department for somatic and psychiatric complaints, and improved patient satisfaction and perception of collaboration.

Project description

The project includes several interventions all focused on improving collaborative mental health care. Many of the interventions are adapted from the collaborative care model as developed by Bauer et al. (2006) and from the IMPACT Model as developed by the University

of Washington (2008). Identified interventions to improve inter-provider collaboration include: (a) an education module for primary care providers relating to collaboration strategies, (b) improved referral and communication between mental health and primary care providers using model communication forms, (c) the psychiatric and mental health nurse practitioner (PMHNP) functioning as the primary mental health provider, and (d) the use of a psychiatric nurse-care coordinator to improve interdisciplinary and interdepartmental coordination.

To improve patient access and provide anticipatory proactive care, interventions include enhanced access to care through open access scheduling, same-day telephone response and next-business-day clinic visits on demand for problems, reminder phone calls for each appointment, and frequent patient follow-up for unstable patients or after missed appointments. To improve a patient's self-management skills, interventions include patient psycho-education through the initiation of a Life Goals Program as developed by Bauer et al. (2006), the IMPACT patient education module (University of Washington, Department of Psychiatry & Behavioral Sciences, 2013), and the Group Therapy Manual for Cognitive Behavioral Treatment of Depression (Munoz & Miranda, 2000).

Desired Outcomes

The desired outcomes of the practice change focus on improving patient outcomes through collaboration of mental health treatment. These outcomes include improved patient satisfaction and improved patient perception of continuity of care, a decrease in reported symptoms of depression, decreased inpatient psychiatric readmission rates, decreased use of the emergency department for behavioral healthcare, and enhanced access to behavioral healthcare.

Project Management

Readiness for change

"The hardest thing is not to get people to accept new ideas; it is to get them to forget old ones (Keynes as cited in Harris, Roussel, Walters, & Dearman, 2011)." A change assessment was completed in relation to the identified problem of discontinuity and lack of collaboration in the mental health department. The IMPACT Needs Assessment (see Appendix B) was completed to determine the department's visions, goals, to identify current practices, and to guide implementation. The need for a program and/or policy change was identified by the program directors of the behavioral health department and the emergency department. Other staff supporting the need for policy change includes the behavioral health nursing staff, the outpatient behavioral health psychiatric and mental health nurse practitioner and therapy staff, the assessment and referral collaborator, as well as senior management staff in the organization and Susquehanna Health Physician Group. There is significant pressure in the behavioral health department from primary care, the emergency department and senior management to improve access to care, to improve collaboration and cooperation between providers and improve continuity of care.

Interdisciplinary collaboration

Interdisciplinary teams have been defined as "individuals working together to solve problems too complex to be addressed by one discipline or multiple disciplines acting in sequence (Drinka and Clark, 2000)." Multidisciplinary teams include professionals from a range of disciplines working together to solve a problem (Harris, Roussel, Walters, & Dearman, 2011). As the goal of this project is to improve collaboration and continuity of mental health care, interdisciplinary collaboration will be a key part of this project.

The IMPACT team-building tool will be used to define the role of all team members (see Appendix C). The tool clearly defines the roles of all team members and creates an effective shared workflow that makes optimal use of existing staff resources and meets the behavioral health needs of the patient (University of Washington- AIMS Center, 2011). The tool defines the five steps needed in the team-building process necessary to sustain evidence-based collaborative care for mental health disorders (University of Washington- AIMS Center, 2011). This tool will be an important part of the proposed practice change and will be used to introduce the interventions and team to patients, identify gaps, training needs and duplication of services, create a customized and integrated behavioral health care workflow, generate an implementation plan and timeline for the project, and track program outcomes.

Risk management assessment

Risk management involves contingency planning and management of potential issues and ways to prevent risk (Harris, Roussel, Walters, & Dearman, 2011). A risk management assessment was completed related to the implementation of this project. Identified risks to the success of the project include lack of departmental and provider buy-in, lack of patient participation in the interventions, absence of the nurse-care coordinator due to illness or other emergency, difficulty with providing open access scheduling and emergency appointments, and emergency situations that interfere with the ability to fully implement the chosen interventions.

Risk reduction actions have been identified as part of the risk assessment and management plan. In the case of the inability of key staff to participate in the interventions, alternative staff will be identified in case of absence or other inability to participate. This includes coverage of the nurse-care coordinator by a nurse from the inpatient behavioral health department who can complete the necessary interventions. To reduce risk and improve provider buy-in, the importance of the project will be emphasized with all members of the behavioral

health care team and the support of the administration is already secured. To continue the support of management, proposed risk reduction actions include continuous communication with management including the progress and importance of the project and interventions. To assure all key players are aware of the proposed interventions, adequate communication and training will be provided before the intervention and adequate support will be provided during the intervention period. Tools and educational materials from the IMPACT program will be used to educate the staff and improve team building. To address barriers to open access scheduling and the ability to schedule emergency appointments, the office assistants will be directly involved in developing a plan to ensure the schedule of the psychiatric and mental health nurse practitioner will be able to accommodate these appointments.

Organizational approval process

Aside from the IRB process and approval, organizational approval will be obtained to implement the collaborative care model and selected interventions. The administrative director of the behavioral health department has already approved the proposed interventions. The project and proposed interventions was presented to the outpatient behavioral health care team at the weekly team meetings, and the project was presented and approved by the medical director of the inpatient behavioral health department.

Role of information technology

Knowing how to use technology and tools in support of projects is a key to success (Harris, Roussel, Walters, & Dearman, 2011). As Harris et al. (2011) state, healthcare organizations are confronted with multiple challenges and as a result, planned projects must capitalize on the

talents and skills of teams, support and expand program capacity, capitalize on available information technology (IT) tools, and improve operational efficiency**.** Several IT tools will be used in this project including computerized electronic prescribing of medications to coordinate with other providers, secure messaging and email to communicate with other members of the behavioral health team and for inter-departmental communication including communication with primary care and emergency providers. Automated documentation templates and computerized collaborative care plans that can be securely electronically shared are other IT tools that will be used in the proposed project. IT will also be used for tracking and recording data with Excel worksheets.

In addition, IT will used during the staff education and online ? component of the intervention. The IMPACT program has an online training component and several video modules and handouts will be used to provide education, support, and training for the interventions. Different modules will be used in the education of different key players who will be involved in the change project. The PMHNP will complete the entire IMPACT online training program consisting of 13 modules.

Materials Needed

As there are several parts to the proposed change project, there are different materials that are necessary for each part of the project. Stages of the project include staff education and training, the implementation of the patient psycho-education and life skills group, the administrative and scheduling changes, and the project outcomes evaluation. To implement the staff training, a computer with internet access and projector will be required to present power-point presentations and the online IMPACT training modules. These trainings will be completed

both during staff meetings and other designated training times. Copies of the handouts to accompany the power points and online modules will also be required.

To facilitate the patient life-skills group, the comprehensive workbook as developed by Bauer et al. (2008) has been obtained and will be used to provide the modules and exercises developed by Bauer et al. (2008). Additionally, each member of the group will receive a Group Therapy Manual for Cognitive Behavioral Treatment of Depression (Munoz & Miranda, 2000). This manual is publicly available for download and a copy will be downloaded and printed for each participant. The Project IMPACT patient education manual will also be provided to each patient (Oishi & Unutzer, 1999). This manual is available on the Project IMPACT website and is in the public domain. Each of the eight patient life-skills sessions will occur in the outpatient behavioral health group room, which will be secured for designated group times. Writing utensils for each participant will also be provided.

Materials will also be required for the program evaluation including copies of the evaluation tools and writing utensils for each patient to complete the evaluation tool. The decision was made to use paper evaluation tools instead of computerized tools due to potential lack of computer literacy of the patient population. There will be 10 patients participating in the intervention so 10 copies of each of the evaluation tools will be needed at both the beginning and conclusion of the intervention period.

Materials will also be needed to provide education and tools to each of the primary care providers involved with the patients participating in the intervention. Each primary care provider will be provided with a collaboration packet that will include a letter explaining the intervention and which patient is participating in the intervention They will also receive depression quick

reference cards, Mental Health Referral Forms (see Appendix D) , and a depression and collaborative care education module that will be downloaded from the Project Impact Website. This manual is also in the public domain.

Plans for IRB Approval

A standard Institutional Review Board (IRB) approval will be obtained for this project. The IRB at Susquehanna Health will be used. An initial meeting was already completed with a member from IRB and preliminary information was shared to determine the need to use the organizations IRB. As discussed in the preliminary meeting, the time requirement to obtain IRB approval is no less than three months from the time of project submission. Completion of an Ethics Course is recommended by the organization before submission to the IRB. The IRB template is attached in the IRB Appendix section of this paper (see Appendix A).

Plan for Project Evaluation

Outcomes

The expected outcomes of the interventions include improved patient satisfaction and perception of continuity of care, a decrease in reported symptoms of depression, decreased inpatient psychiatric readmission rates, decreased use of the emergency department for psychiatric care, and enhanced access to psychiatric care. At the start of the intervention, each patient will be asked to identify a pseudonym to use during the intervention and evaluation period. Patient progress notes, visits, contacts and other appropriate clinical information will be added to the patients chart accordingly, but for evaluation purposes, all surveys, data

compilation, and other evaluation methods will be completed using the patients identified pseudonym.

Decrease in symptoms of depression.

Symptoms of depression will be monitored with tools that quantify a treatment response. The IMPACT Model encourages providers and organizations implementing or adapting IMPACT to measure the effectiveness of their program to convince themselves that they are achieving their goals (University of Washington, Department of Psychiatry & Behavioral Sciences, 2013). Two recommended indicators include measurement of treatment outcomes and measurement of symptom reduction. It is recommended that patients receive the Patient Health Questionnaire-9 (PHQ-9) (see Appendix E) , a structured clinical assessment of depression severity, at baseline, and at 8 weeks following treatment initiation (University of Washington, Department of Psychiatry & Behavioral Sciences, 2013). The PHQ-9 can also be used to measure a decrease in symptom reduction from baseline. In multiple studies the researchers noted a 50% decrease in depressive symptoms so the goal for symptom reduction from the IMPACT Model is a 50% reduction in symptoms in at least 50% of the program participants (University of Washington, Department of Psychiatry & Behavioral Sciences, 2013).

The PHQ-9 is a publicly available tool that is well validated in many populations. In two, large studies enrolling 6000 patients (3000 from general internal medicine and family practice clinics and 3000 from obstetrics-gynecology clinics); the Patient Health Questionnaire (PHQ) was developed and validated (Spitzer, Williams, & Kroenke, n.d.). In the past decade, the PHQ-9 depression scale has gained increasing use in both research and practice (Spitzer, Williams, & Kroenke, n.d.). Sensitivity and specificity of the PHQ-9 for diagnosing major

depression were 74% and 91% with a score of 10 or higher (Arroll, 2010). Adewuya, Ola & Afolabi (2006) found that the internal consistency of questions within the PHQ-9 was 0.85. They also found the PHQ-9 had good concurrent validity with the Beck Depression Inventory (BDI) ($r = 0.67$, $P < 0.001$) and it had a good ($r = 0.894$, $P < 0.001$) one month test–retest reliability (Adewuya, Ola, & Afolabi, 2006).

An Excel based patient tracking form will be used to track patients, changes in PHQ-9 scores, treatment plan changes and contacts (See Appendix F). Change in PHQ-9 score will be tracked and the minimum target is -50% reductions in score within 8 weeks of treatment initiation in 50% of the patients. The patient tracking spreadsheet has a built in formula that displays the change in the PHQ-9 score from the initial visit or start date. After the first PHQ-9 score is entered, as soon as a PHQ-9 score is entered on a follow-up visit, the formula will display the percent that the score has changed.

Decrease in inpatient admissions and emergency department use.

The patient tracking form includes several other tracking features that will be used to track intervention related descriptive statistics. The referral column tracks any referral made to another provider. The contact columns track the type and duration of each patient contact. There are columns that include the number of inpatient admissions in the last year as well as the number of emergency room visits within the last year. Additional data tracked on the form during the intervention includes:

- the number of emergency room visits for somatic or psychiatric complaints,
- the number of inpatient psychiatric admissions or readmissions,
- and the number of times a primary care provider was contacted relating to a participant in the program.

The goal of tracking psychiatric hospitalizations and emergency room visits is to determine if applying the evidence-based interventions can reduce inpatient psychiatric readmissions and use of the emergency department for psychiatric or somatic complaints. The goal is a 50% reduction in psychiatric admissions or use of the emergency room for somatic or psychiatric complaints during the intervention period as compared with the preceding year. The inpatient census will be checked daily by the office assistant for admissions and will the office assistant will notify the psychiatric nurse practitioner and the nurse care coordinator. If a patient participating in the intervention is admitted to the inpatient unit, this information will be noted on the tracking form. An additional electronic chart review will be completed at the end of the intervention period to document each inpatient and emergency room visit.

Improved access to care.

One of the identified outcomes of the project is increasing access to mental health care. To measure if the interventions result in improved access, data relating to open access scheduling will be tracked. In open access scheduling, patients are given same day telephone response for concerns, and next business day clinic visits on demand for problems. Data will be tracked to determine if we were able to accommodate these goals. The current practice model in the outpatient behavioral health department does not guarantee next business day access to care.

Descriptive Statistics are used to present quantitative descriptions of data in a manageable form (Trochim, 2006). A chart review will be completed at the end of the intervention to document any calls that were not recorded during the intervention period. When a patient calls the outpatient behavioral health office, the office assistants will take their

information and the outpatient nurse care coordinator or the psychiatric and mental health nurse practitioner will call the patient back within the same day. If it is determined that a patient requires an in office visit for a problem, an appointment will be offered the same or the next business day. At the end of the intervention, the data will be calculated to determine the percentage of times patients received a same day phone response or next business day appointment. An Excel database will also be used to track and calculate this data with a goal of meeting these guidelines 85% of the time. Any particular reason why you chose this benchmark?

Improved Patient Perception of Continuity of Care and Satisfaction.

Two of the desired outcomes of the project interventions include improved patient satisfaction with their mental health treatment and an improved patient perception of continuity of care. Multiple measurement tools were evaluated as possible tools to measure these outcomes. The Alberta Continuity of Services Scale (ACSS-MH) was chosen due to its excellent content validity (Uijen et al., 2012). The ACSS-MH as developed by Joyce et al. (2004) was evaluated in a mental health setting, measures all three dimensions of continuity of care, and has a higher quality of measurement properties than other continuity of care measures (Uijen et al., 2012).

The ACSS-MH was developed empirically from a pool of attributes of continuity extracted from 305 theoretical and empirical research articles and 36 interviews with patients diagnosed with severe mental illness (Joyce et al., 2004). The tool was later used in a 17-month follow-up study of 486 adults with severe mental illness and was developed to measure continuity of care for mental health services from the client's perspective (Adair et al., 2005). It

includes items in three sub-domains that measure personal, team, and cross-boundary continuity (Uijen et al., 2012). The ACSS-MH has excellent internal consistency and excellent structural validity (Durbin, Goering, Streiner, & Pink, 2004; Uijen et al., 2012). It was validated in both community and outpatient mental health programs (Uijen et al., 2012). The information relating to this tool is in the public domain. These questions were adapted to construct a Perceived Continuity of Care Survey specific for use in the outpatient behavioral health department to measure continuity (see Appendix G).

To evaluate the effectiveness of the interventions, data will be analyzed similarly to the epidemiologic design followed by Adair et al. (2005). Adair et al. (2005) performed a classical prospective cohort study and grouped participants according to *exposure status* and the incidence of *disease*. In the study, the analogue for exposure status was continuity of care over the intervention period, and the analogues for disease status were health outcomes (Adair et al., 2005). In this project, the Perceived Continuity of Care Survey will be administered both at the beginning and the end of the intervention period to evaluate a possible improvement in the mean overall score (a decrease in overall score notes improvement). As similar to the study by Adair et al. (2005), data from the ACSS-MH will be further examined to determine if there is a correlation between interventions to improve continuity and collaborative care and improvement in the other identified outcomes.

Planned Implementation Steps

The Iowa Model of Evidence-Based Practice to Promote Quality Care (see Appendix H)[1] is being used as a model to guide the project interventions (Titler et al., 1998). The problem focused trigger identified was a process improvement issue of lack of collaboration in mental health treatment. It was determined that this is a priority for the organization and department. Relevant research and data relating to collaborative care was assembled, critiqued and synthesized and it was determined that there was a sufficient evidence base to pilot a practice change. Outcomes to be achieved were identified and evidence-based practice guidelines were created to improve collaborative mental health care. At project completion, the outcomes will be evaluated to determine if a practice change is warranted.

Setting for practice change

The planned setting for the project will be the outpatient behavioral health department. Collaboration will occur with other departments including the inpatient behavioral health department, the emergency department and primary care. The staff education, process change and patient psycho-education groups will all occur within the outpatient behavioral health department.

Population for practice change

The population of focus in this project will include patients in the outpatient behavioral health department with a DSM IV-TR Axis I diagnosis of major depression or bipolar disorder.

[1] Note: *Used/Reprinted with permission from the University of Iowa Hospitals and Clinics and Marita G. Titler, PhD, RN, FAAN. Copyright 1998. For permission to use or reproduce the model, please contact the University of Iowa Hospitals and Clinics at (319)384-9098.*

Additionally, they must have a history of one inpatient behavioral health admission. The intervention will be limited to a group of 10 patients who will be identified and selected by the outpatient behavioral health care team as patients who could benefit from the intervention. This will be discussed and decided during the outpatient behavioral health treatment-team meetings. Each patient chosen to participate in the interventions must also have a primary care provider in addition to the psychiatric and mental health nurse practitioner. Exclusion criteria will be similar to those used by Bauer et al. (2006) and include active substance abuse, a diagnosis of moderate to severe dementia, hospitalization on a psychiatric unit for more than six months of the last year, and the existence of a terminal medical illness with less than three years of expected longevity. Patients unable or unwilling to give informed consent or unable to participate in other ways or patients participating in any other experimental mental health studies will also be excluded from participation in the interventions.

Steps for Implementation

The intervention period will be nine weeks in duration. The first week will include identifying and scheduling patients, signing of consents, and notification to the primary care physician that their patient is participating in the project. The primary care physician will also be provided with the collaboration packet discussed earlier in this paper. The second week the implementation of the collaborative care model will begin and will continue for the following eight weeks. All of the previously mentioned interventions will occur simultaneously throughout the remainder of the nine-week intervention period. Each of the ten patients participating in the intervention will participate in a life skills group, will participate in open access scheduling, and will have contact from the nurse care coordinator. Additionally, the PMHNP and the nurse care

coordinator will collaborate with the primary care provider of each of the patients participating in the intervention. These interventions are intended to improve collaboration of care and result in improvement in each of the aforementioned outcomes.

Life skills group.

Each of the patients participating in the project will participate in an eight week life goals program using the Life Goals Workbook Program as developed by Bauer et al.(2008), the Group Therapy Manual for Cognitive-Behavioral Treatment of Depression (Munoz & Miranda, 2000) and the IMPACT Model patient education brochure (Oishi & Unutzer, 1999). The Life Goals Program supports improvements in clinical status, social function, and quality of life when used in a collaborative care setting (Bauer, Kilbourne, Greenwald, Ludman, & McBride, 2008). The life skills group will occur weekly for 75 minutes in the outpatient behavioral health group room for eight weeks, and patients will be given take home assignments to complete after each session. Each patient during the first and last weeks of the life skills group will complete the PHQ-9 and the ACSS-MH.

Process Changes.

Several process changes will be implemented during the intervention period. To improve access to care, open access scheduling will be implemented for each of the project participants. Interventions include same day telephone response for patient phone calls during business hours by the PMHNP or the nurse care coordinator and same or next business day appointments for patient problems as scheduled by either the office assistants or the nurse care coordinator. Additionally, patient reminder calls by the administrative assistants for each scheduled appointment and follow-up calls by the nurse care coordinator after missed scheduled appointments will occur. As previously noted, the nurse care coordinator or the PMHNP will

track all referrals, phone contacts, appointments, emergency room visits, inpatient admissions, contacts with the primary care provider, PHQ-9 scores and treatment plan changes on the Excel patient tracking form that will be synchronized and shared through a document workspace. Any information shared will be password protected, and emails will be sent using the secure email system. The Mental Health Communication to Primary Care Clinician Form (see Appendix I) will be completed by the PMHNP during the first week of the intervention, at the end of the intervention period, and for any identified changes in the patient's treatment plan during the intervention period. This communication form will be provided with the initial collaboration packet provided during the first week, and faxed, emailed or sent interoffice mail with the appropriate HIPPA precautions for all other times.

OK—what are your plans for dissemination when the project concludes??

Conclusion

Lack of collaboration in mental health care results in less than optimal outcomes for patients diagnosed with mental illness. Evidence has identified many consequences of a fragmented mental health system. These consequences include increased symptoms of depression and other mental health symptoms, a patients perception of discontinuous and fragmented care, low patient satisfaction with treatment, decreased access to mental health care, increased use of the emergency department for somatic and psychiatric complaints, and unnecessary patient admissions to the inpatient behavioral health unit.

The purpose of this change project is to implement evidence-based interventions that focus on improving continuity of mental health care and collaboration between mental health and primary care providers. Proposed interventions include a patient psycho-education group to improve patient self-management skills, process changes including open access scheduling and frequent patient follow-up, and the use of a nurse care coordinator and other interventions intended to improve collaboration between providers. All required approvals will be obtained prior to the implementation of the interventions, including departmental, organizational and IRB approval.

The goal of implementing an evidence-based collaboration project is to demonstrate a significant correlation between improving mental health collaboration and identified patient outcomes. The desired outcomes of the project include improved patient satisfaction, improved patient perception of treatment continuity and provider collaboration, decreased symptoms of depression, improved access to mental health care, decreased inpatient hospital readmissions, and decreased use of the emergency department for somatic or psychiatric complaints. It is hoped that the identified interventions in this project will result in clearly improved outcomes and this project will be a model for a long-term practice change and improvement in the outpatient behavioral health department at Susquehanna Health.

Heading	**Total Points Available**	**Total Points Received**
Structure/mechanics	10	9.5 a few comma faults
APA	5	5
Overview of problem	2	2
Overview of Lit Review	2	2
Purpose of project	4	4
Project management	6	6
Planned materials	6	6
Planned Implementation Steps	8	6.5 more information is need on what will be

		accomplished during the life skills sessions. Need to expand setting description.
Plans for Project Evaluation	8	7 Some benchmarks need further explanation. Some of the analyses are research oriented and go beyond what is necessary for EBP. In addition, there is no literature provided to support the need for the patient perception measure.
References	4	4
IRB Appendix	15	12 Consent form needed; HIPPA waiver incomplete; First section missing implementation steps.

64/70 Nice Work!

References

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Appendix A: Standard Review IRB proposal

Chatham University- DNP Program
NUR 704 Design Paper

IRB APPENDIX TEMPLATE

Title of Submission: Improving collaboration in mental health care.

Type of Review: Exempt ___ Expedited___ Standard Review_X__

Type of Submission: Evidence-based Practice

1. **What is the purpose of the proposed project including specific objectives:**

The purpose of this evidence-based practice change project is to implement interventions in the outpatient behavioral health department that will improve mental health continuity and collaboration. This will be accomplished by implementing interventions from evidence-based collaborative care models with the outpatient behavioral health team functioning as the center of a patient's overall mental health care. The goal of this practice change project is to initiate a practice change that results in holistic, effective, evidence-based, and collaborative patient-focused mental health care.

Background

Research supports the need for collaboration and continuity in the mental health system and demonstrates how improved collaboration results in improved quality of life and outcomes in persons diagnosed with mental illness. A recent meta-analysis reviewed 37 trials of

collaborative care and compared the results to the outcomes obtained from usual care. The studies found evidence of two-fold higher rates of adherence to antidepressant medication over the first six months of treatment and improved depressive outcomes that often persisted for at least two years (Katon et al., 2010). Other trials of collaborative care approaches to treating depression in patients with a chronic medical illness found significant improvements in quality of care and depressive outcomes compared to usual care (Katon et al., 2010).

Care discontinuity occurs when there is lack of collaboration and coordination between all involved members of the mental health system. The mental health system consists of many interrelated components. These include private and public mental health providers, primary health care systems, emergency services and human service systems (TriWest Group, 2003). As Knesper (2010) states, "The present mental health care system is pluralistic with competing, disconnected, and autonomous subsystems and with various types of singularly focused mental health professionals (2010, p.7)."

Fragmented mental health care results in suboptimal clinical outcomes, substantial functional deficits, decreased patient satisfaction and high costs for patients diagnosed with persistent and severe mental illnesses (Bauer et al., 2006). Other effects of fragmented mental health care include increased suicide risk, increased emergency department use to treat mental health issues, and significant clinical and financial implications. Fragmented mental health care also results in costly duplication and inappropriate use of services and hospital readmissions. Uncoordinated and fragmented mental health care results in negative outcomes for the patient and for the healthcare system. Improved continuity of mental health care results in improved patient outcomes and functional status, and decreased costs to the healthcare system. Using evidence-based interventions can result in improved continuity of mental health care.

Purpose of Project

The purpose of the proposed practice change is to implement a collaborative chronic care model in the outpatient behavioral health department to improve collaboration between mental health and primary care providers. This improved collaboration is hoped to result in decreased symptoms of patient depression, improved collaboration between providers, fewer inpatient psychiatric admissions, decreased use of the emergency department for somatic and psychiatric complaints, and improved patient satisfaction and perception of collaboration.

Project description

The project includes several interventions all focused on improving collaborative mental health care. Many of the interventions are adapted from the collaborative care model as developed by Bauer et al. (2006) and from the IMPACT Model as developed by the University of Washington (2008). Identified interventions to improve inter-provider collaboration include: (a) an education module for primary care providers relating to collaboration strategies, (b) improved referral and communication between mental health and primary care providers using model communication forms, (c) the psychiatric and mental health nurse practitioner (PMHNP) functioning as the primary mental health provider, and (d) the use of a psychiatric nurse-care coordinator to improve interdisciplinary and interdepartmental coordination.

To improve patient access and provide anticipatory proactive care, interventions include enhanced access to care through open access scheduling, same-day telephone response and next-business-day clinic visits on demand for problems, reminder phone calls for each appointment,

and frequent patient follow-up for unstable patients or after missed appointments. To improve a patient's self-management skills, interventions include patient psycho-education through the initiation of a Life Goals Program as developed by Bauer et al. (2006), the IMPACT patient education module, and the Group Therapy Manual for Cognitive Behavioral Treatment of Depression (Munoz & Miranda, 2000).

2. **Describe the participant population to be used including description:**

The population of focus in this project will include patients in the Susquehanna Health outpatient behavioral health department with a DSM IV-TR Axis I diagnosis and a history of at least one inpatient psychiatric hospitalization. The intervention will be limited to a group of 10 patients who will be identified and selected by the outpatient behavioral health care team. Each patient chosen to participate in the interventions must also have a primary care provider in addition to their mental health provider. Exclusion criteria will be similar to those used by Bauer et al. (2006) and include active substance abuse, a diagnosis of moderate to severe dementia, hospitalization on a psychiatric unit for more than 6 months of the last year, and the existence of a terminal medical illness with less than three years of expected longevity. Patients unable or unwilling to give informed consent or unable to participate in other way or patients participating in any other experimental mental health studies will also be excluded from participation in the interventions. Participation in all interventions is voluntary. After identification by the outpatient behavioral health team through consultation and chart review, potential patients will be invited through both a written letter as well as a face-to-face discussion of

the proposed interventions. Consent forms will be obtained from each patient by the PMHNP.

3. **A list of letter(s) of permission from any outside agency being used for project data collection:**

   All data will be obtained from patients within the outpatient behavioral health system at Susquehanna Health. An approval letter has not been obtained at this time.

4. **The approximate amount of time each participant will be expected to commit to the project:**

   Each participant in the program will meet for eight, 75-minute patient education and life skills group sessions for a total time commitment of 600 minutes, or a total of 10 hours. The overall duration of the complete intervention period is 9 weeks.

5. **How will the outcome/evaluation data will be collected and recorded without participant identifiers**:

At the start of the intervention, each patient will be asked to identify a pseudonym to use during the intervention and evaluation period and this will be used with their respective patient number, from 1-10. Patient progress notes, visits, contacts and other appropriate clinical information will be added to the patients chart accordingly, but for evaluation purposes, all surveys, data compilation, and other evaluation methods will be completed using the patients identified pseudonym.

6. **What materials or equipment will be used during the project:**

As there are several parts to the proposed change project, there are different materials that are necessary for each part of the project. Stages of the project include staff education and training, the implementation of the patient psycho-education and life skills group, the administrative and scheduling changes, and the project outcomes evaluation. To implement the

staff training, a computer with internet access and projector will be required to present power-point presentations and the online IMPACT training modules. These trainings will be completed both during staff meetings and other designated training times. Copies of the handouts to accompany the power points and online modules will also be required.

To facilitate the patient life-skills group, the comprehensive workbook as developed by Bauer et al. (2008) has been obtained and will be used to provide the modules and exercises developed by Bauer et al. (2008). Additionally, each member of the group will receive a Group Therapy Manual for Cognitive Behavioral Treatment of Depression(Munoz & Miranda, 2000). This manual is publicly available for download and a copy will be downloaded and printed for each participant. The Project IMPACT patient education manual will also be provided to each patient (Oishi & Unutzer, 1999). This manual is available on the Project IMPACT website and is in the public domain. Each of the eight patient life-skills sessions will occur in the outpatient behavioral health group room, which will be secured for designated group times. Writing utensils for each participant will also be provided.

Materials will also be required for the program evaluation including copies of the evaluation tools and writing utensils for each patient to complete the evaluation tool. The decision was made to use paper evaluation tools instead of computerized tools due to potential lack of computer literacy of the patient population. There will be 10 patients participating in the intervention so 10 copies of each of the evaluation tools will be needed at both the beginning and conclusion of the intervention period.

Materials will also be needed to provide education and tools to each of the primary care providers involved with the patients participating in the intervention. Each primary care provider

will be provided with a collaboration packet that will include a letter explaining the intervention and which patient is participating in the intervention They will also receive depression quick reference cards, Mental Health Referral Forms (see Appendix D), and an depression and collaborative care education module that will be downloaded from the Project Impact Website. This manual is also in the public domain.

7. **Where survey instruments are involved, a copy of the instrument and, for surveys not created for this project, assurance that the project coordinator has proper approval to use them:**

   All surveys used in this project are in the public domain.

   1. The PHQ-9 is available for public use (see Appendix E)
   2. The Perceived Continuity of Care Survey was adapted from questions from the ACSS-MH but specifically adapted to the outpatient behavioral health department at Susquehanna Health. Adaptations included formatting, questions specific to this intervention, and changing language to include nurse practitioner instead of psychiatrist only. This document is also in the public domain (see Appendix G).

8. **How will participant anonymity OR confidentiality be maintained: <**

. At the start of the intervention, each patient will be asked to identify a pseudonym to use during the intervention and evaluation period so his or her identity remains anonymous. Patient progress notes, visits, contacts and other appropriate clinical information will be added to the patients chart accordingly, but for evaluation purposes, all surveys, data compilation, and other evaluation methods will be completed using the patients identified pseudonym. Additionally, all interprovider communication will be secure and HIPPA compliant. All communications, groups,

and other correspondence will be treated with the same confidentiality that exists with all patient interactions and information in the behavioral health setting.

9. **Describe the plans for securely storing data records during and after the project**:

   Records will be stored electronically on a secure, password protected computer in the psychiatric mental health nurse practitioners locked office in the outpatient behavioral health department. Only the psychiatric nurse practitioner uses this computer. The computer system is protected with log-on passwords, as well as biometric fingerprint security. Information will be stored in a password protected and encrypted file within the computer for five years. After five years, the files will be permanently deleted from the computer.

10. **Who will be given access to the stored data:**

    No other staff members will have access to the stored data. No other staff members use the computer in the psychiatric nurse practitioners office or have the password to that computer system as it contains other protected health information.

11. **Please attach the consent form and/or cover letter if you are planning to use one**:

    I will be using Susquehanna Health's consent form for this project.

    Consent will be obtained for all patients participating in the intervention.

    Cover letter attached (see Appendix J)

Appendix B

Implementing IMPACT
Exploring Your Organization

VISION & GOALS

1. **What is our organization's vision for the IMPACT program?**

   Program options

   - A primary care-based depression care program
   - A component of an existing chronic disease management /population care management program
   - Other

   Program scope

   - Number of sites, practices, providers, patients

   Target population considerations

   - Age, gender
   - Languages
   - Special needs, comorbid medical/psychiatric/substance abuse problems
   - Insurance benefits

2. **What are our organization's goals for the IMPACT program?**

   Possible motivating factors for improving depression care and implementing the IMPACT program

   - Improved health outcomes – depression, functioning, other
   - Increased patient satisfaction
   - Increased provider satisfaction
   - Increased employer/purchaser demand
   - Improved HEDIS or other performance indicators
   - Financial incentives for quality care

Appendix C

Integrated Behavioral Health Care
Team Building Process

AIMS CENTER
Advancing Integrated Mental Health Solutions

This team building tool was developed based on experience helping more than 500 organizations adapt, implement, and sustain evidence-based collaborative care for common mental disorders. Our experience has taught us that for integrated care programs to succeed, clinics need to clearly define the roles of all team members and create an effective shared workflow that makes optimal use of existing staff resources and meets the behavioral health needs of the unique patient population served by each clinic.

There are 5 steps in the team building process:

1. Individual Team Members Complete a Staff Self-assessment
2. Identify Gaps, Duplication of Services, and Training Needs
3. Create a Customized Integrated Behavioral Health Care Workflow for your Practice
4. Generate an Implementation Plan and Timeline Tailored to Your Practice
5. Track Program Outcomes and Adjust as Necessary

There are 3 worksheets to support this team building process:

1. Team Member Self Assessment
2. Task Summary by Team Member
3. Summary & Change Plan

Facilitation of Integrated Care Team Building Process

First, 1 or 2 team member(s) should be identified to facilitate the team building process:

1. Tailor worksheets based on relevant collaborative care tasks
2. Distribute and collect completed Step 1 Worksheets for each team member*
3. Tabulate all team member responses by completing the Task Summary by Staff Worksheet
4. Facilitate a follow-up meeting after Team Building Worksheets are completed and tabulated, and document—during or after the meeting—the current status and change plans in the Summary & Change Plan Worksheet
5. Create an implementation plan and timeline
6. Regularly revisit the Summary & Change Plan with the team to review progress and adjust roles as necessary

Appendix D

MENTAL HEALTH REFERRAL FORM

Patient Name _____ DOB: _____
ID # _____
Group # _____

Insurance Company/Information

Referring Clinician
☐ Name, MD
☐ Name, DO
☐ Name, ARNP
☐ Name, PA

Address
Practice Name
Street
City, State Zip

Telephone: xxx-xxx-xxxx
FAX: xxx-xxx-xxxx

Mental Health Professional Providing Services
Name: _____
Phone: _____ Town: _____

Reason for Referral

_____
_____

Management Options
❑Evaluation & Recommendation Only
❑Co-Management of Patient
❑Assume Primary Management
❑Psychopharmacologic Management

Services Required
❑Diagnostic Assessment
❑Psychotherapy Treatment
❑Psychopharmacologic Recommendations
❑Other:

❑Please call me when you have seen the patient.
❑Please send a written report when the consultation is complete.
❑I would like to receive periodic status reports on this patient. (see attached communication form)

Patient History /Current Medications
Working Psychiatric Diagnosis:

_____
_____

Medical Problems:

_____
_____

Medication: _____ Dose: _____mg Frequency _____
Medication: _____ Dose: _____mg Frequency _____
Medication: _____ Dose: _____mg Frequency _____
Medication: _____ Dose: _____mg Frequency _____

Clinician Signature: _____ Date: _____

I authorize my clinician, care manager, and the mental health professional to discuss my *diagnosis, and treatment as it relates to my medical condition.* May discuss drug/alcohol issues. ❑ Yes ❑ No

Signature: _____ Date: _____

Appendix E

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(Use "✔" to indicate your answer)*	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

FOR OFFICE CODING 0 + _____ + _____ + _____

=Total Score: _____

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
☐	☐	☐	☐

Developed by Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke and colleagues, with an educational grant from Pfizer Inc. No permission required to reproduce, translate, display or distribute.

Appendix F: Clinical Tracking Chart

Interventionist ID_____ **Clinical Tracking Chart** Patient ID_____

Patient Information	Chronic Medical Conditions
Name_____ Age_____ Gender: M F Ethnicity_____ Doctor_____ Dr. of_____	MMSE_____
Medication Information (name, dose, start date, adherence, changes)	Psychosocial Notes (social support, stressors, living conditions, finances, spiritual)

Baseline Information	Behavioral Plan	Medication	Depression PHQ Score	Anxiety Outs Score	MH/Other Consults	Notes
Date_____ Tel/In-P_____ Next Visit Date_____						

Visit Information	Behavioral Plan	Medication	Depression PHQ Score	Anxiety Outs Score	MH/Other Consults	Notes
Date_____ Tel/In-P_____ Next Visit Date_____			≥ 50% Change? ☐Yes ☐ No	≥ 50% Change? ☐Yes ☐No		

Visit Information	Behavioral Plan	Medication	Depression PHQ Score	Anxiety Outs Score	MH/Other Consults	Notes
Date_____ Tel/In-P_____ Next Visit Date_____			≥ 50% Change? ☐Yes ☐ No	≥ 50% Change? ☐Yes ☐No		

Appendix G: Perceived Continuity of Care Survey

Susquehanna Health Behavioral Health

Perceived Continuity of Care Survey[1]

We would like to know how you feel about the services we provide so we can make sure we are meeting your needs. Please answer each question as it relates to the behavioral health treatment you have received at Susquehanna Health Behavioral Health. Your responses are directly responsible for improving these services. All responses will be kept confidential and anonymous. Thank you for your time.

Date:

Please circle how much you agree with the following statements:	Completely agree	Strongly Agree	Somewhat agree	Agree Very little	Do not agree
Service Delivery					
1. I am not treated like an individual in mental health services.	5	4	3	2	1
2. I would not be able to change providers if things did not go well.	5	4	3	2	1
3. I have had to repeat my history every time I need help.	5	4	3	2	1
4. My family or significant other and I have been confused about what is happening with my care.	5	4	3	2	1

5. I cannot seem to move easily between services.	5	4	3	2	1
6. I have a treatment plan that goes where I go.	1	2	3	4	5
7. My records never seem to be available to new providers I see.	5	4	3	2	1
8. There is no single place to find out about all services available.	5	4	3	2	1
9. There does not seem to be a link from one service to the next.	5	4	3	2	1
10. I have been unable to pay for my medications when out of the hospital.	5	4	3	2	1
11. After discharge, I have felt that I had no care outside of the hospital.	5	4	3	2	1
12. Those involved in my care do not seem to talk with each other.	5	4	3	2	1
13. I have felt "lost in the system."	5	4	3	2	1
14. Hospital and community staff work together to make sure that I have choices in my care.	1	2	3	4	5
15. My mental health provider is in touch with my medical provider.	1	2	3	4	5
16. I do not understand why I have to deal with so many different agencies and programs.	5	4	3	2	1
17. I have been refused admission to certain programs and was unable to understand why.	5	4	3	2	1

18. Some services I need are just not out there.	5	4	3	2	1
Accessibility					
19. I do not know where I would go if I needed help.	5	4	3	2	1
20. I can easily get to the services I need.	1	2	3	4	5
21. I have been able to get services in my own community.	1	2	3	4	5
22. My primary caregiver kept in contact, even when I went into the hospital.	1	2	3	4	5
23. Hospital staff made sure I had somewhere to go when I left.	1	2	3	4	5
24. My hospital psychiatrist did everything possible to make sure that I was linked to continuing treatment after discharge.	1	2	3	4	5
25. I am not able to see my primary caregiver quickly when I need to.	5	4	3	2	1
26. After discharge, I had to wait a long time before I was seen in a community program.	5	4	3	2	1
Relationship base					
27. My primary caregiver has called to check in on me.	1	2	3	4	5

28. I can turn to my primary caregiver whether I am sick or doing well.	1	2	3	4	5
29. My primary caregiver asks me about more than just my symptoms.	1	2	3	4	5
30. I have been treated with dignity and respect.	1	2	3	4	5
31. I believe that my primary caregiver cares about what happens to me.	1	2	3	4	5
32. My care team includes people with different skills.	1	2	3	4	5
33. I can count on my primary caregiver to help me when I am in need.	1	2	3	4	5
34. My team has encouraged me to take responsibility for my own care.	1	2	3	4	5
Individualized Care					
35. I was asked what I wanted out of my treatment.	1	2	3	4	5
36. My team included my family or significant other when planning my treatment.	1	2	3	4	5
37. I do not feel involved in decisions about my care.	5	4	3	2	1
38. My treatment fits my needs.	1	2	3	4	5
39. My care does not change when my needs change.	5	4	3	2	1

40. My care is checked regularly to see if it is working.	1	2	3	4	5
41. My appointments can be more often if I am not doing well.	1	2	3	4	5
42. If I run into problems, I can get services the same or the next business day.	1	2	3	4	5
43. I am reminded of appointments or called if I miss appointments.	1	2	3	4	5
44. I am confident that my psychiatrist or nurse practitioner can admit me whenever I need to be in the hospital.	1	2	3	4	5
45. As my time in services has increased, my life has become more satisfying.	1	2	3	4	5
46. Everyone seems to work together for me.	1	2	3	4	5
47. My provider knows about all the different services available.	1	2	3	4	5

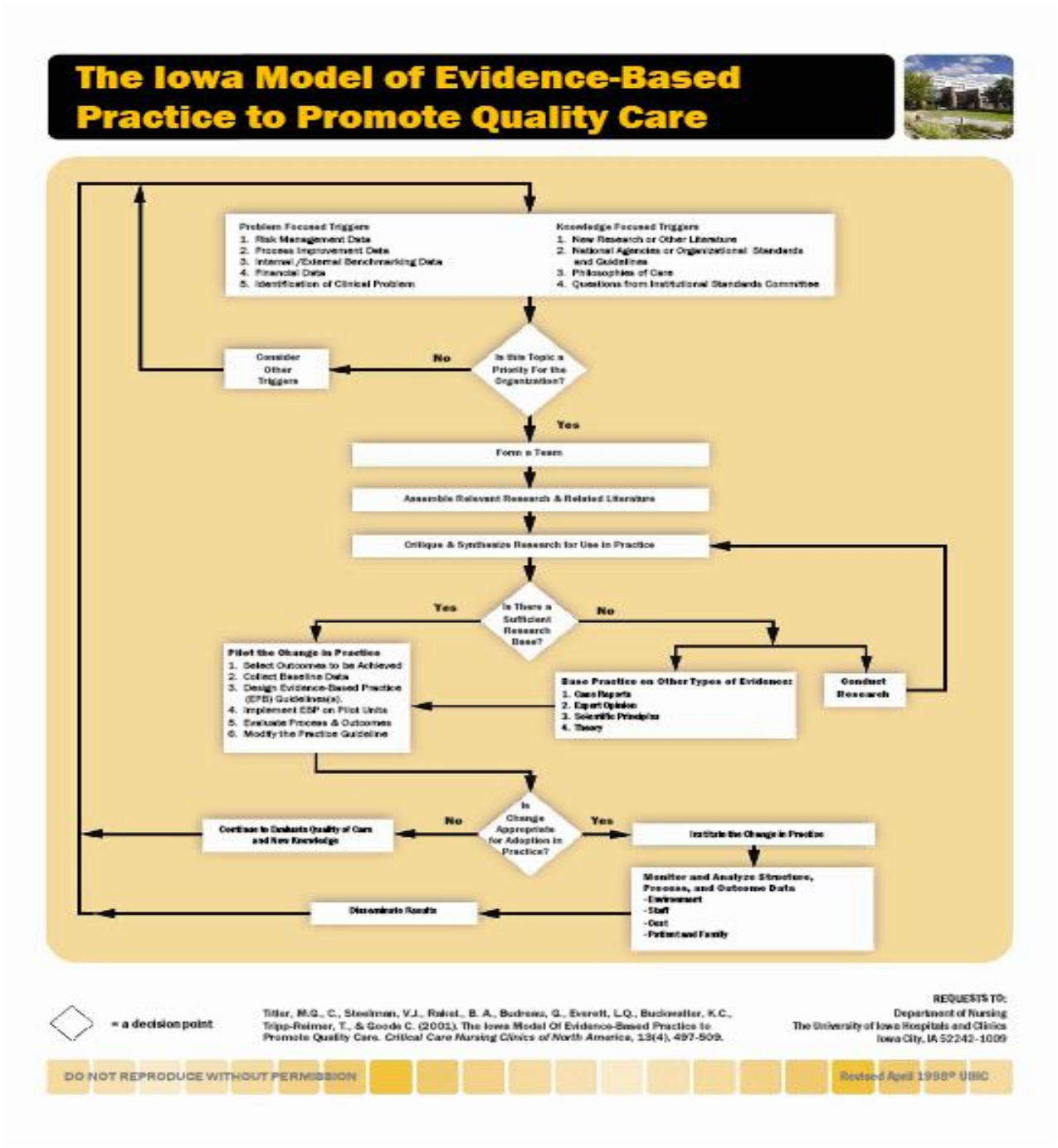
***Total possible of 235 points=poor continuity **Totals** _____ _____ _____ _____ _____

***Least score of 47=best continuity

Overall Score (all columns)=_____

[1] Note. Adapted from Alberta Continuity of Services Scale-Mental Health (ACSS-MH). Adair, C. E., McDougall, G. M., Mitton, C. R., Joyce, A. S., Wild, T. C., Gordon, A.,... Beckie, A. (2005). Continuity of care and health outcomes among persons with severe mental illness. *Psychiatric Services 56*(9), 1061–9. doi:10.1176/appi.ps.56.9.1061

Appendix H



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Appendix I

MENTAL HEALTH COMMUNICATION TO PRIMARY CARE CLINICIAN

Patient Name _____ DOB:_____ ID#:_____

Please provide an update about the patient by: (Date) _____

Provider Name:_____ Phone: _____

Street Address:_____ Fax #:_____

City, State ZIP:_____

Patient Progress:
Dates of Treatment From _____ to _____

a) Did the patient come for an evaluation? ❑ Yes ❑ No

b) Is the patient engaged in treatment? ❑ Yes ❑ No

c) What are the psychotropic drugs either recommended or prescribed?
Medication: _____ Dose: _____mg. Frequency: _____
Medication: _____ Dose: _____mg. Frequency: _____
Medication: _____ Dose: _____mg. Frequency: _____
Medication: _____ Dose: _____mg. Frequency: _____

d) What type of psychotherapy is the patient receiving? _____
How Often? _____

Patient Response to Treatment (Symptoms & Function) _____
_____
_____
Plans to Alter Treatment _____
_____
_____

Recommendations to the Primary Care Clinician _____
_____
_____
_____

Mental Health Professional Signature:_____Date:_____

Please FAX completed form to:
❑ Name, MD ❑ Name, DO ❑ Name, ARNP ❑ Name, PA
@ 1-555-555-5555

Appendix J: Cover Letter

Susquehanna Health
The art of caring. The science of healing.

Dear Participant,

Hello! As you know, I am a psychiatric and mental health nurse practitioner here at Susquehanna Health Behavioral Health. You may also know that I am finishing my Doctor of Nursing Practice Degree at Chatham University, in Pittsburgh, Pennsylvania. You are being invited to participate in an evidence-based project to improve continuity of care and collaboration in the outpatient mental health department. As part of the program, you will be asked to participate in a weekly life skills and psycho-education group to decrease symptoms of depression and help you develop improved self-care skills. The group will last for eight weeks and each group session will last approximately 75 minutes. All materials will be provided to you free of charge. Each group participant will receive a copy of the Life Goals Workbook, a copy of the Group Therapy Manual for Cognitive Behavioral Treatment of Depression, and the project IMPACT patient manual. These will be yours to keep at the end of the intervention. In addition to the life skills group, there will be other interventions aimed at improving your care in the outpatient behavioral health department. All interventions are aimed at improving your health, decreasing symptoms of depression, and improving collaboration between your mental health and primary care providers. This program poses no risk to you. All information and data will be confidential and securely stored. No personal information about you will ever be shared. Your time commitment is approximately 10 hours for the group sessions. Additionally, we will be implementing several changes to the way you receive care during this intervention period, including same day telephone response and next business day appointments for any problems you may experience. We will also be communicating with your primary care providers about your care, and providing them with tools to help you treat your depression and provide better coordinated care.

I am asking you to consider participating in this evidence-based project. Please read the attached form and sign if you agree to participate. If you have any questions or concerns, please feel to call my office at 570-320-7525. Thank you for your time and consideration.

Project Coordinator

Faculty Advisor

Corporate Office
700 High Street | Williamsport, PA 17701 | Phone: 570-321-1000 | Fax: 570-321-3199 | SusquehannaHealth.org

Appendix K: Permission to Use Iowa Model