The Evolution of Integrated Mental Health, Addictions and Primary Healthcare Initiatives at NEOMED

March 25, 2017
10:45 AM to 12:15 PM
Disclosure/Acknowledgement

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The work of the Department of Psychiatry and Best Practices in Schizophrenia Treatment (BeST) Center is also supported by The Margaret Clark Morgan Foundation.
The Evolution of Integrated Mental Health, Addictions and Primary Healthcare Initiatives at NEOMED - PART 1
Part 1:
TACT and the Fellowship

Presented by:
– Nichole E. Ammon, M.S.Ed., PCC-S
  • Manager for Integrated Healthcare Initiatives, Dept. of Psychiatry
– Sara Dugan, Pharm.D
  • Associate Professor, Dept. of Psychiatry and Dept. of Pharmacy Practice
– Douglas Smith, M.D., DFAPA
  • Director of public and community psychiatry; Co-director of the Integrated Community Psychiatry and Primary Care Fellowship
– Jody M. Bell, PS-MH
  • Certified Peer Recovery Supporter
– Ron Rett
  • Co-executive Director, NAMI Summit County

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Learning Objectives

(At the end of this presentation, learners will be able to…)

• Identify the major initiatives NEOMED’s Dept. of Psychiatry has implemented in integrating mental health, addictions and primary healthcare

• Describe the overlap between initiatives and how some projects evolved out of the work of earlier work

• Discuss the opportunities for ongoing work and collaboration (both internally and with external partners)

• Identify some potential barriers, challenges and considerations for those looking to create practice and academic-level integrated care
Evolution of Integration Initiatives: Mark Munetz, M.D. (NEOMED Dept of Psychiatry Chair)

1981
- Munetz and Wimberly article in Journal of Ambulatory Care Management

2006-2007
- Visiting professor (David Pollack, M.D.)
- The Margaret Clark Morgan Integrated Care Clinic at CSS

2009
- Creation of the BeST Center

2011
- CSS awarded PBHCI grant
- BeST Center publications on Integrated Care

2012-2013
- Integrated Care Forum Held
- MEDTAPP-HCA awarded
- Creation of TACT

2013 to Present
- Integrated Care Fellowship
  - ...

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# Integrated Care Technical Assistance and Consultation Team (TACT)

<table>
<thead>
<tr>
<th>ROLE</th>
<th>NAME</th>
</tr>
</thead>
<tbody>
<tr>
<td>Team lead; Clinical Counselor</td>
<td>Nichole E. Ammon, M.S.Ed., PCC-S</td>
</tr>
<tr>
<td>Community Psychiatrist</td>
<td>Douglas Smith, M.D., DFAPA</td>
</tr>
<tr>
<td>Primary Care Physician</td>
<td>Janice Spalding, M.D., FAAFP</td>
</tr>
<tr>
<td>Clinical Pharmacist</td>
<td>Sara E. Dugan, Pharm.D., BCPP</td>
</tr>
<tr>
<td>Certified Peer Recovery Supporter</td>
<td>Jody M. Bell, CPS, APP</td>
</tr>
<tr>
<td>Family Advocate</td>
<td>Ron Rett, B.S.</td>
</tr>
<tr>
<td>Counseling Psychologist</td>
<td>Russell Spieth, Ph.D.</td>
</tr>
<tr>
<td>Psychiatric Nurse Practitioner</td>
<td>Andrea Warner Stidham, Ph.D., RN</td>
</tr>
<tr>
<td>Consultant; Chair of Dept. Psychiatry</td>
<td>Mark R. Munetz, M.D.</td>
</tr>
<tr>
<td>Consultant; Director of the BeST Center</td>
<td>Patrice (Patti) Fetzer, LISW-S</td>
</tr>
<tr>
<td>Intermittent Collaborator: John M. Ellis</td>
<td>LISW-S, LICDC-CS, ICCS (University of Akron, School of Social Work)</td>
</tr>
</tbody>
</table>

*Promoting Innovation. Restoring Lives.*

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Effective teamwork is a practical response to the recognition that each of us is imperfect and "no matter who you are, how experienced or smart, you will fail." (Atul Gawande, 2011)
Critical Lessons

• There are various avenues to integrating health care

• Communication, collaboration and flexibility are critical for success

• Community partnerships work
  – Co-location in both directions/settings is ideal
Integrated Community Psychiatry and Primary Care Fellowship

- One-year, post-residency non-ACGME accredited fellowship program
  - Modeled after CWRU Public Psychiatry Fellowship (thanks to support from Patrick Runnels, M.D.)
- Only known Fellowship Program in the country to pair a practicing psychiatrist and practicing PCP to learn as a team, while advancing integration in their practices

“One of the most rewarding aspects of the Integrated Care Fellowship is utilizing the knowledge gained through didactics and discussions with the faculty at NEOMED to be able to be leaders in our respective workplaces. It has helped me to understand the importance of team-based care and how effective collaboration with psychiatry can result in an enhanced level of care for our patients. The skills and techniques that this fellowship so efficiently enforced have proven to be crucial for effective integration of care between primary care and mental health providers.”

— Vikil Girdhar, M.D., family medicine physician, AxessPointe Community Health Center, and NEOMED Integrated Community Psychiatry and Primary Care Fellow

“The integrated care fellowship appealed to me because its mission is in-line with the future of psychiatry and primary care. It was a great opportunity to strengthen my leadership skills and to learn more about effective team-based care.”

— Crystal Rozee-Thomas, M.D., child and adolescent psychiatrist, Children’s Advantage Family Behavioral Health and NEOMED Integrated Community Psychiatry and Primary Care Fellow
Expansion of Integrated Care Training Initiatives since MEDTAPP-HCA

• Interdisciplinary Case Conference focused on Integrated Care of Patients with Severe and Persistent Mental Illness
• Integrated Care Technical Assistance and Consultation Team (TACT)
• Integrated Community Psychiatry and Primary Care Fellowship
  – Ongoing support and mentorship of fellowship graduates
The Evolution of Integrated Mental Health, Addictions and Primary Healthcare Initiatives at NEOMED - PART 2
Part 2: Expansion through Project ECHO® NEOMED Ohio Alliance

Presented by:

– Nichole E. Ammon, M.S.Ed., PCC-S
  • Manager for Integrated Healthcare Initiatives, Dept. of Psychiatry

– Russell Spieth, Ph.D., CRC
  • Senior Consultant and Trainer, Motivational Interviewing, Dept. of Psychiatry
Learning Objectives

(At the end of this presentation, learners will be able to…)

• Describe how NEOMED plans to utilize Project ECHO® as a methodology to expand consultation and training efforts related to integrated care
• Identify major topic areas that will be covered and that should be built upon in the proposed ECHO® clinics
• Describe the benefits of participation in ECHO® clinics
• Identify how to access more information, become a “spoke” location, and/or serve as a topic expert
Lessons Learned from TACT

• Maintaining engagement with practice/implementation teams is a challenge

• Practices face competing demands

• Each organization and team is unique

• Training needs are highly variable and will change over time
Proposed Next Step: Project ECHO®

Expanding the reach and impact of TACT to advance integrated care in both practice and education.
Project ECHO® is...

- A distance health education model
- A movement to de-monopolize/democratize knowledge and amplify the capacity to provide best practice care in underserved communities
- ECHO connects providers with specialists through ongoing, interactive, tele-mentoring sessions to create and support professional communities of learning and practice

- essentially Virtual Grand Rounds
How does Project ECHO® work?

• Hub-and-spoke knowledge-sharing networks

• ECHO clinics are led by expert interprofessional teams (the “hubs”) who use multi-point videoconferencing technology (i.e. Zoom) to conduct interactive learning/consultation sessions with community providers (the “spokes”)

• Experts mentor their colleagues to manage complex cases
  – Expertise is shared via case-based learning, guidance, feedback and didactic education to promote use of best practices and monitor outcomes

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ECHO Clinic
(the series of calls specific to a topic and/or audience)

- **Hub** – the host (team of experts)
- **Spoke** – the community providers / sites joining video- (tele-)conference

General agenda:
- Introductions
- 1st Case presentation
  - Clarifying Questions, Recommendations
- Didactic presentation (10-15 min)
- 2nd Case presentation
  - Clarifying Questions, Recommendations
- Announcements
Potential Spokes

- Healthcare Providers
  - practitioners
  - preceptors and
  - residents/interns

- Residency Programs
  - Interdisciplinary journal club

- Clerkship sites
- Health coach program(s)*

*You will learn more about this in part 3

- Healthcare Organizations
  - Primary care practices (FQHCs, look-alikes, pediatric clinics)
  - Community Mental Health Centers (CMHCs)
  - Hospital systems serving the community
Integrated Care ECHO Clinic Topics

- Bi-directional integration
- Person-centered collaborative documentation
- Skill-building
  - SBIRT, MI, trauma informed care, Zero Suicide, TeamSTEPPS
- Pharmacotherapy for schizophrenia
- Incorporating peers, community health workers and families into the team
- Interactive complexity
  - billing to accurately reflect your patient population
- Family-based service modalities
# Sample ECHO Clinic Agenda

## Project ECHO®: NEOMED Ohio Alliance
Name of Clinic: Motivational Interviewing Strategies for Evoking Change

**Facilitator(s):** Russell Spieth, PhD  
**ECHO Specialist(s):** Christina Delos-Reyes, MD  
**Target Audience:** Primary Care Practitioners, Physicians, Mid-Level Providers, Pharmacists, RNs, Medical Assistants, other Healthcare Professionals  
**Clinic Objective(s):**  
1. Educate community healthcare providers in motivational interviewing strategies  
2. Enhance skills of primary care practitioners in managing patients with opiate use disorder  

<table>
<thead>
<tr>
<th>Time</th>
<th>Presentation Type (didactic, case, etc.)</th>
<th>Presenter(s)</th>
<th>Connection Type (audio, video, in-person)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Introductions</td>
<td>announcements of interest, local training opportunities, new programs/services</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
|               | 1st Case Presentation  
- a participant submits a de-identified case involving a patient who is ambivalent about their opioid use  
- clarifying questions are evoked from spoke-participants and then from hub-participants  
- recommendations and suggestions are generated from spoke-participants and hub-participants |              |                                         |
|               | Didactic Presentation (10-15 minutes)  
- facilitators/specialists lead a didactic presentation on using MI strategies to evoke change from patients with opioid misuse disorders |              |                                         |
|               | 2nd Case Presentation  
- a participant submits a de-identified case involving a patient who is ambivalent about their opioid use  
- clarifying questions are evoked from spoke-participants and then from hub-participants  
- recommendations and suggestions are generated from spoke-participants and hub-participants |              |                                         |
|               | Announcements and Post-evaluation                                                                      |              |                                         |
Why participate?

For the healthcare system:
- Better access for rural and underserved patients
- Reduced disparities
- Better quality and safety
- Rapid dissemination of best practices
- Reduced variations in care
- Greater efficiency
- Reduced wait times

Providers:
- Engage in a community with like-minded fellow providers and specialists from academic centers
- Develop specialized knowledge
- Acquire new skills and competencies, expanding access to care
- Become part of a community of learners, increasing professional satisfaction while reducing feelings of professional isolation

Practices:
- Have a way to expand access to care for complex chronic conditions and serve more patients, while keeping treatment dollars in the community
- They also acquire a new tool for recruiting and retaining providers

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How to get involved:

Reach out to us!

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Northeast Ohio Medical University
4209 St. Rt. 44 | PO Box 95 | Rootstown, Ohio 44272
nammon@neomed.edu
The Evolution of Integrated Mental Health, Addictions and Primary Healthcare Initiatives at NEOMED - PART 3
Part 3: Embedding Integrated Care into Undergraduate Medical Education Curriculum

**Presented by:**

- Nichole E. Ammon, M.S.Ed., PCC-S
  - Manager for Integrated Healthcare Initiatives, Dept. of Psychiatry
- Michael J. Appleman, M.A.Ed.
  - Curricular & Instructional Specialist; Dept. of Family and Community Medicine
Learning Objectives

(At the end of this presentation, learners will be able to…)

• Discuss rationale for adding curriculum specific to the integration of primary and mental healthcare to undergraduate medical education

• Describe the process used to develop a plan and several contingencies to achieve the broader vision for curriculum

• Identify some realistic starting points for embedding content on the integration of mental health and primary care into undergraduate medical education

• Identify and discuss challenges, potential barriers and needs related to making integrated care curriculum a reality
Practice to Pipeline: Reach Earlier

- Majority of integrated care efforts have focused on end-of-pipeline and early practice
- Inspiration needs to occur earlier in professional development

**New endeavor:**

- Develop curriculum for undergraduate medical education that better highlights the integration of primary and mental healthcare
A Starting Point: Align with Existing Curriculum

1. Find alignment with current curriculum

2. Identify realistic starting points

3. Construct a spectrum of contingencies
   - Elective for Clinical Epilogue and Capstone (CEC)
Rural Medicine Pathway: Enhancement of Current Curriculum

College of Medicine 2016-2017

M1: Basic Courses Essential to the Understanding of the Science of Medicine

M2: Transitional Courses Essential to the Understanding of the Science and Practice of Medicine

M3: Core Clerkships Essential to the Practice of Medicine

M4: Advanced Clerkships and Courses Essential for the Practice of Medicine

Professional Foundations

Human Development & Structure

Physiological Basis of Medicine

Molecules to Cells

Medical Neuroscience

Infection and Immunity

General Pathology

Introduction to Principles of Medical Science

Pulmonary, Allergy, Nephrology

O. Hematology, Oncology

Neurology, Psychiary

Endocrinology, Reproduction, Rheumatology

Dermatology, Infectious Disease

Six Required Advanced Electives

Applications of Clinical Medicine

HVM 5

USMLE Step 2

Clinical Skills Assessment IV

Community Experience

Professional Foundations II

Comprehensive Review Course

Human Values in Medicine I and II

Foundations of Clinical Med. I and II

Principles of Clinical Med. I and II

Family Medicine

Internal Medicine

Obstetrics/Gynecology

Pediatrics

Psychiatry

Surgery

Emergency Medicine

Clinical Epilogue & Capstone

MEDICAL UNIVERSITY
Opportunities to Align with Current Curriculum
Realistic Starting Points

- Develop new elective clerkship opportunities (M4)
  - through collaboration with graduates of the Integrated Community Psychiatry and Primary Care Fellowship

- Incorporate topics and embedding content slowly

- Build upon other initiatives
  - MI, SBIRT, social disparities curriculum

- Connect to Student Interest Groups
Realistic Starting Points

• Bolster existing Rural Medicine Pathway and Health Coach program

  • Health Coach programs
    • Community Experience required in yr-1
    • Ideal if connected to PDL
    • Engage pharmacy students (P1, P3)
## Using the Rural Pathway as a Model

<table>
<thead>
<tr>
<th>M1</th>
<th>Rising M2</th>
<th>M2</th>
<th>M3</th>
<th>M4</th>
</tr>
</thead>
<tbody>
<tr>
<td>FCM 1 &amp; 2: Seminars, PACE and PDL</td>
<td>Paid Summer Preceptorship</td>
<td>PCM 1 &amp; 2: Seminars, PACE, and PDL</td>
<td>HVM 5: Reflective Practice</td>
<td>Outpatient Elective</td>
</tr>
<tr>
<td>HVM 1 &amp; 2: Reflective Practice</td>
<td></td>
<td>HVM 3 &amp; 4: Reflective Practice</td>
<td>FM Clerkship</td>
<td></td>
</tr>
<tr>
<td>Community Experience 1 &amp; 2: Health Coach</td>
<td></td>
<td></td>
<td>Service Learning &amp; Mentorship activities</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Rural Capstone 1</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Rural Capstone 2</td>
<td>Rural Capstone 3</td>
<td>Rural Capstone 4 / Elective</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Rural seminars, workshops, and lunch meetings</td>
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</tbody>
</table>

### Service Learning & Mentorship activities

- FCM = Foundations in Clinical Medicine course
- PACE = Primary Ambulatory Care Experience
- PDL = Physical Diagnosis Laboratory
- HVM = Human values in Medicine course
- PCM = Principles of Clinical Medicine course

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### Potential for Integrated Mental Health and Primary Care PATHWAY

#### BLOCK SCHEDULE

<table>
<thead>
<tr>
<th>M1</th>
<th>Rising M2</th>
<th>M2</th>
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<tr>
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<td></td>
<td>HVM 3 &amp; 4: Reflective Practice</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Community Experience 1 &amp; 2: Health Coach on an Integrated Care Team</td>
<td>Volunteer: Health Coach</td>
<td></td>
<td>FM Clerkship</td>
<td></td>
</tr>
<tr>
<td>Integrated Care Capstone 1</td>
<td>Integrated Care Capstone 2</td>
<td>Integrated Care Capstone 3</td>
<td>Integrated Care Capstone 4 / Elective</td>
<td></td>
</tr>
<tr>
<td>Integrated Care seminars, workshops, and lunch meetings</td>
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### Spectrum of Contingencies

**Creating a culture ready for integrated care**

- TACT
- Fellowship
- Teaching opportunities
- Inter-departmental Collaboration
  - Family and Community Medicine
  - Internal Medicine
  - Diversity, Equity and Inclusion

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Think Big: Long-term Ambitions

• Replicate the Health Coach program with new clinical and academic partners
  • Enhance integration of primary and mental healthcare on the clinical teams
  • Expand to urban underserved populations
  • Potential to connect with Community Health Workers
Think Bigger: A Parallel Curriculum Track

- Primary and Mental Health Care Leadership Track
  - Rural Track
  - Dual Degree (M.D./M.S.)
  - Longitudinal Integrated Clerkship (LIC)
**Proposed/Draft Parallel Curriculum**

<table>
<thead>
<tr>
<th>Year</th>
<th>Integrated Primary and Mental Health Care Option</th>
<th>Rural Medicine Option</th>
<th>Dual Degree Option</th>
</tr>
</thead>
<tbody>
<tr>
<td>M1</td>
<td>Longitudinal course - with enhanced content</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Health Coach: Team IPE, Population health, Mental health</td>
<td>Rural FM Preceptorship</td>
<td>3 courses toward MA/MS degree</td>
</tr>
<tr>
<td>Summer</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>M2</td>
<td>Longitudinal course - with enhanced content</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Health Coach: Team IPE, Population health, Mental health</td>
<td></td>
<td></td>
</tr>
<tr>
<td>M3</td>
<td>Longitudinal Integrated Clerkship**</td>
<td></td>
<td></td>
</tr>
<tr>
<td>M4</td>
<td>Capstone Project</td>
<td>Rural Capstone Project</td>
<td>Capstone Project</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Electives</td>
</tr>
</tbody>
</table>

**Students will complete two clerkships before entering a 9-month integrated clerkship where they will be paired with a FM preceptor, and follow patients across specialties (should include segment covering HVM 5)**
Challenges, Barriers & Needs

• Curriculum change is hard and slow
  – Development
  – Accreditation
  – Clinical partners
• Fiscal and environmental constraints
• Time intensive (while all other efforts persist)
• Champions are critical!
QUESTIONS?

THANK YOU!