Behavioral Health Collaborations with the Interdisciplinary Team Toward Improving Participant Health Outcomes

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Behavioral Health
Rocky Mountain PACE
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Behavioral Health Product Lines on the PACE team

- Participant Care and consultation
- IDT Support
- Program Development and Clinical Outcome Tracking
- Education, Training, Supervision

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Mental Health and Older Adults

• Poor physical health is an important risk factor to development of psychological distress (Kramer et al., 1992).

• Mental health disorders are often undetected by health professionals.

• Depression is *not* a part of normal aging
  – Can increase risk of developing a disability
  – Disability can increase the risk of depression
Prevalence Rates of Mental Health Disorders at Rocky Mountain PACE

<table>
<thead>
<tr>
<th>Diagnoses</th>
<th>2012</th>
<th>2013</th>
<th>2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dementia/Cognitive Impairment</td>
<td>29%</td>
<td>31%</td>
<td>35%</td>
</tr>
<tr>
<td>Depr, Anx, Bipolar, Schizoaffec (4 most prevalent diagnoses)</td>
<td>66%</td>
<td>64%</td>
<td>71%</td>
</tr>
<tr>
<td>More than 1 MH Diagnosis</td>
<td>Not measured</td>
<td>39%</td>
<td>42%</td>
</tr>
<tr>
<td>Both Dementia &amp; MH/BH Dx</td>
<td>22%</td>
<td>25%</td>
<td>23%</td>
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Percentage of Total Enrollees
PACE Philosophy

• Keep participants independent and living in their own home as long as possible;
• Complete continuum of care is necessary to address all participant needs to maintain independence;
• Health issues are frequently not solely in the domain of medical or mental health, but overlap and require a team effort for treatment.
“Alone we can do so little; together we can do so much.” - Helen Keller

• Evidence-based practice is here to stay.
• Clinician expertise and flexibility are vital.
• Tailoring interventions and programs to client characteristics can lead to better outcomes.
• Concerns that arise during program development and implementation:
  – Participant variables
  – Staff variables
Collaborative Programming at Rocky Mountain PACE

1. Participants-At-Risk (PART)

2. Bariatric Assessment and Lifestyle Change Program

3. Wellness Class
Participants-At-Risk Team (PART)

• Antecedents:
  – Time spent in IDT discussions;
  – Participant’s non-engagement in PACE model of care;
  – Staff frustration;
  – Participant frustration.
PART, cont.

• Every Wednesday, 2:30-3:30.
• Participant is identified by discipline who requests input from other disciplines.
• Team meeting addresses specific concerns regarding complexity of participant’s situation.
• Summary of PART meeting provided at the IDT meeting the day following.
PART Structured Form

Date:
Attending Disciplines:
   Medical:
   Case Management:
   Behavioral:
   Therapy Staff:
   Nursing:
   Others:
Participant Under Discussion:
   Issues:
   Implications:
   Interventions Tried:
Recommended Interventions:
   Responsible for Team Communications:
*OUTCOME SUMMARY:
Participant Engagement Model

1: Triggers for Investigation:
- Appt cancellations
- Treatment refusal

2: Contributing factors:
- Medical
- CM/environmental
- BH consult (preference/values assessment)
- SC (religious/spiritual beliefs, values)
- Transportation
- PT/OT Mobility & Functional limitations

Pt non-engagement¹:

Investigation²: contributing fx

Pt Capacity/Competence?

Need decisional capacity indicator in EHR

MOCA/FXL
Review cognitive data hx; re-assess case by case

Pursue Surrogate

Conference:
- Adjust Care Plan Goals, Interventions
- Complete med/tx contracts PRN

Capacity NOT Indicated

Not sure/No

Capacity Indicated

Conference:
- Adjust Care Plan Goals, Interventions
- Complete med/tx contracts PRN
Qualitative Themes

• Utility and Effectiveness
  – “[It] absolutely decreased co-worker tension and anxiety around how to help participants who present with complex challenges. The PART meeting facilitates collaborative goal-setting, a primary component of the PACE model.” –NP
  – “[It] allows the disciplines to be more productive and focused, simply by the fact that individual parties know the participant and can edit and critique the snapshot that is typically presented in IDT.” -Dietician
Qualitative Themes

• Documentation and process
  – “[it] is a wonderful concept, although most people hesitate to put a participant on the PART board for discussion because they don’t want to be responsible for documentation and follow-through.” – PT
  – “We are not consistent on documentation and tracking of outcomes. However, the discussions have been helpful in developing strategies and interventions across disciplines.” – CM
Bariatric Assessment and Lifestyle Change Program

• Antecedents
  – Participants with morbid obesity and associated medical co-morbidities;
  – Medically necessary to improve health and physical functioning;
  – Participant interest in pursuing bypass surgery to assist with weight loss.
Request for Surgery goes to Dietitian to assess if criteria is met (degree of obesity)

INITIAL DIETITIAN CONSULTATION

INITIAL BEHAVIORAL HEALTH EVALUATION

High Readiness Level?

NOT A CANDIDATE FOR SURGERY:
Referral to dietitian, therapy, and counseling to develop a Lifestyle Change Program. Reassess readiness for surgery at next 6 month assessment.

Review Assessment Questionnaire; Overview of pre-surgical process, surgery, and post surgery processes; Review nutrition guidelines for success; Start **Lifestyle Change Program**

Review PACE Medical Evaluation: Labs, EKG, Medical History Review, Surgical Risks with Surgery

PT/OT EXERCISE PLAN

LIFESTYLE CHANGE PROGRAM

Commitment to Ongoing **Lifestyle Change** appointments:
- Dietitian
- Behavioral Health
- Exercise Plan

SURGICAL CONSULT

SURGEON’S MANDATORY PRE-OP CLASS

Referral to dietitian, rehab therapy and/or behavioral health to develop a **Lifestyle Change Program** – Not a candidate for bariatric surgery.
Process and Outcome

• IDT Collaboration
  – Common language and goals established by the participant and supported by the team;
  – Sensitivity to participant’s challenges influencing lifestyle change:
    • Psychosocial complexities
    • Medical co-morbidities
    • Mobility limitations
Process and Outcome, cont.

• Weight loss is variable and slower for PACE participants;
• Participants’ and staff’s expectations need to be continuously revisited and calibrated in the context of multifactorial influences;
• Continued coordination of services and ongoing education from dietician and behavioral health to help maximize ppt’s strengths and provide support are critical.
Case Example: Ms. H

- 62-yr old White, widowed woman with nine adult children. Retired RN.
- Resides in 1-bedroom apartment with a grandson and two young great-grandchildren.
- Lifelong weight problems triggered by a failed marriage at 30 years of age.
  - Multiple unsuccessful attempts at weight loss
Ms. H

• Medical Dx
  – Anemia, CDK II, diabetes, arthritis, chronic pain, mobility impairment, a-fib, hyperlipidemia, vit D & B12 deficiencies, HTN, morbid obesity, CHF, and COPD.

• Mental Health Dx
  – Depression and anxiety
Bariatric Psychiatric Evaluation

- **Cognitive functioning**
  - Montreal Cognitive Assessment (MoCA)
    - MoCA score = 25/30 (normal cutoff ≤26)

- **Mood functioning**
  - Geriatric Depression Scale (GDS-15)
    - GDS = 2/15 within normal limits
  - Short Anxiety Screening Test (SAST)
    - SAST = 21/40 within normal limits
Bariatric Psychiatric Evaluation

• Personality Data
  – Personality Assessment Inventory (344-item)
    • Elevated score on the Somatic scale (T score=81) and moderate elevations on the Depression scale (T = 65) and Drug Use scale (T = 66).
    • Self-concept and Interpersonal Relationships
      – Strong and stable; balanced and assertive; denies aggression and no suicidal/homicidal ideations. Positive attitude toward the possibility of life improvement and acceptance of personal responsibility.
Bariatric Psychiatric Evaluation

• Internal vs. External Control of Weight (IECW)
  – A 5-item measure to assess the degree to which a person considers goal achievement as contingent or non-contingent on her own behavior.
    • Score suggested ppt has an internal local of control pertaining to weight loss.

  – Process: Dietician, Medical, and BH weigh ppt’s readiness and likelihood for success. Biopsychosocial framework for ppt’s strengths and challenges are discussed.
Green Light!

• Ms. H. was deemed a good candidate for bariatric surgery.
• She participated in weekly counseling sessions focused on behavioral interventions to enhance her ability to benefit from surgery.
• Interventions included:
  – Relapse prevention and management for depression and anxiety disorders.
  – Use of visual aids to enhance memory function.
  – Provision of support and assistance with problem-solving around psychosocial stressors and barriers to lifestyle change.
BH, Nutrition, and Physical Therapy

• Weekly food diary to track intake and identify eating patterns and emotional triggers.
• Weekly Bariatric support group co-facilitated by dietitian and Ph.D.
• PT and Recreation Services
  – Strengthening class, Movin’ To the Music, Tai Chi, and recumbent bike in PT gym.
Tracking Progress

• Ms. H. lost 30 lbs. prior to surgery on the Lifestyle Change Program.
• Since surgery, Ms. H. has lost an additional 70 lbs.
• Ppt attends bariatric support group; BH and Dietician monitors ppt’s adjustment to new dietary challenges and ongoing psychosocial stressors.
Ms. H’s goals

• “I want to walk more and play with my grandchildren.”
• “I want to live longer to enjoy my family.”

• Important learning moments for IDT:
  – Programming needs to be tailored to the individual’s strengths and real/perceived barriers.
  – Early understanding of ppt’s goal-setting
    • Moving away from “diet talk” to “change talk”
    • Using ppt’s language to anchor discussions and enhance ppt engagement
Wellness Class

I just want to learn something new!!!
Antecedents

• Participants expressed interest in continued learning.
• Lifelong learning started as trend in 1973
  – France: University of the Third Age (U3A) courses for older adults.
    • Courses ranged from humanities, social sciences, and technology.
• Research on older adults attending the University Program for Older Adults (PUMA)
  – Findings: Pre-post comparisons showed increased overall level of activity and improved memory functioning over time; university students showed improved performance on tests of information-seeking and general health awareness.
Development and Implementation

• Curriculum development guided by BH for first 8 weeks; intended to extend to other disciplines of the IDT.
• Initial group consisted of 8-11 participants ranging in cognitive abilities and age.
• Eight-week class held Thursdays, 2:00-3:00PM
Wellness Class Syllabus

1. Class Goals and Guidelines
   1. Self-care, Values, and Goals Towards a Balanced Life
2. Introduction to Mindfulness
3. How to Recognize and Manage Anxiety
4. Increasing Positive Emotions through Pleasant Activities
5. Effective Thinking: Shifting and Expanding Our Interpretations of Events
6. Mindfulness of Emotion: Safe Coping Skills
7. Effective Communication: The Art of Mindful Listening
8. Assertiveness Training; Wrap-up and Review
Observations and Feedback

• Group was highly cohesive which aided ppt’s learning and enthusiasm for the content.
• Participants assisted each other with assignments and offered peer support.
• Facilitator and student co-facilitator developed strong rapport with class members.
• Learning was bi-directional given ppt’s life experiences and strengths.
Challenges and Opportunities

• Cognitive impairment impacted learning, however, social connection was beneficial.
• Facilitator’s flexibility is key: Allowing the class to develop on its own. Pushing our agenda/syllabus was not helpful.
• Time and scheduling
  – Competing with other programming and activities
• Participation from other disciplines.
Feedback

• Benefits from a participant’s perspective:

“I don’t need counseling, but those classes you teach are pretty good.”
Collaboration is Essential
AND...it’s not easy!

“Sometimes I think the collaborative process would work better without you.”
Pre-development stages

• Knowing what our participants want/need;
• Appreciating the gaps in services and close consideration of the cost-benefit aspect of programming:
  – Potentially fewer hospital admissions?
  – Improved communication between ppts and providers?
  – Decreased inpatient psych admissions?
  – Group vs. individual service delivery – pros and cons?
Real Challenges

- Staff buy-in in the context of an imbalanced resources/demand work environment;
- Competition for time and space with existing programs;
- Continuity and sustainability as ppt’s needs change and staff’s availability/interest changes;
- Outcome tracking and documentation.
Opportunities

• Student intern training – filling the pipeline of professionals in interdisciplinary geriatric care.
• Multiple-discipline coordination that enhances collaboration and offers additional oppty for cross-professional training.
• Improvement in participant engagement and overall well-being.
Discussion

• Is BH on your team?
  – If so, do you utilize the service for programming?
• What programs have you tried?
• What are the barriers to developing and implementing programs?
• What is your success story?
Thank You.