INTERPROFESSIONAL PRIMARY CARE OUTREACH FOR THE MENTALLY ILL (IPCOM)

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IPCOM Is A Unique Nurse-managed Model Of Primary Care Delivery

An NP led primary care outreach/UCSF partnership with Progress Foundation (since 1994) for medically complex clients with mental illness.

Expanded interprofessional teams with new communication and infrastructure systems. Students engaged in interprofessional teams delivering primary care. QI projects nested in a behavioral health model.

Heightened collaboration and communication across team members and clinical sites with improved client outcomes. Increased student exposure to interprofessional model of care.
IPCOM Interprofessional Team

- Nurse practitioner faculty
- Psychiatrist or Psychiatric Nurse Practitioner
- Pharmacist
- Mental health staff
- Interprofessional students
- In year 3, Dentist
Key To The Project Is The Strategic Partnership Between The UCSF School Of Nursing And The Progress Foundation

Progress Foundation
• Founded in 1969.
• Non-profit organization providing community-based residential treatment and supported housing programs for individuals with psychiatric disabilities.
• Specializes in care for those with dual diagnosis.
• Social rehabilitation model.
• Culturally and diagnostically diverse client population.
• Services provided to over 3000 individuals per year.
Progress Foundation (continued)

- Continuum of residential treatment programs (RTFs)
  - Four acute diversion units (ADUs) (10-12 bed two-week programs)
  - Six Transitional programs (three to twelve month programs which include programs for older adults and mentally ill women with children - 4 in San Francisco)
  - Five supported living programs (3 in San Francisco)
  - One psychiatric crisis clinic
- Each site provides 24 hour professional and non-professional staff including services provided by NPs, psychiatrists, psychiatric nurse practitioners, and pharmacists.
Diverse Population Demographics

• Data were extracted from “Clinical Logs” maintained by NPs from 2006 to 2012.
• They include all utilization information for cases with valid demographic allowing identification of unduplicated cases.
• Data from 8,235 units of service (contacts with NPs) were merged to provide information on 1,999 unique individuals.
# Demographic Characteristics

<table>
<thead>
<tr>
<th>Variable</th>
<th>%, M (S.D.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>63</td>
</tr>
<tr>
<td>Age</td>
<td>41.3 (11.3)</td>
</tr>
<tr>
<td>Race/ethnicity</td>
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<tr>
<td>African American</td>
<td>29</td>
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<tr>
<td>Hispanic/Latino</td>
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<tr>
<td>Caucasian American</td>
<td>47</td>
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<tr>
<td>Asian/Pacific Islander</td>
<td>7</td>
</tr>
<tr>
<td>Others</td>
<td>7</td>
</tr>
<tr>
<td>Homeless</td>
<td>54</td>
</tr>
<tr>
<td>Occupation in the past 6 months</td>
<td>5</td>
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<tr>
<td>Insured</td>
<td>65</td>
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<tr>
<td>Smoker</td>
<td>79</td>
</tr>
<tr>
<td>Physical trauma/Abuse during lifetime</td>
<td>79</td>
</tr>
</tbody>
</table>

All cases, duplicated (N=8,235)
All cases, duplicated (N=8,235)

Percentage Of Medical Diagnosis

- HIV/AIDS
- Endocrine
- Circulatory
- Respiratory
- Digestive
- Muscular/skeletal
- 2 or more dx

bar chart with percentages for each category
All cases, duplicated (N=8,235)

Percentage Of Substance Use

- Alcohol: 60%
- Stimulant: 50%
- Opiate: 10%
- Marijuana: 30%
- 2 or more use: 30%
UCSF/Progress Foundation Partnership

• Began in 1994 and currently provides primary care services to those with complicated medical, psychiatric, and substance abuse issues in 10 San Francisco-based RTFs.
  • 5 NPs
  • 60 hours of service provision
  • 200-250 monthly visits
  • 20 NP Student clinical placements annually
• Increasing medical complexity among patients with serious mental illness in community-based treatment programs
NP services include:
• Health screening
• Physical examinations
• Urgent care
• Chronic disease management
• Health promotion and education
• Staff education targeted to the risk profile of people with mental illness.
• Referrals for ongoing primary care within the community
Why Is IPCOM Important In This Setting?

• Psychiatrists, Psychiatric NPs, and staff counselors maintain paper charts for each client as well as enter information into the county’s electronic behavioral health record.
• NPs document primary care notes in paper format and not electronically.
• Clients move from program to program and between many county and community clinics without their treatment information going with them.
• Many providers acting in parallel which creates inefficiencies, unnecessary costs, and reduced quality of care.

Goal: to improve communication within this framework of providers and clinical sites, to improve outcomes and patient safety, reduce duplication of efforts and costs, and create and interprofessional collaborative model that can be replicated elsewhere.
IPCOM Grant Objectives

1) Expand IP activities by formalizing collaborative relationships and by incorporating team based strategies using IP collaborative practice core competencies.

2) Improve safety and continuity of care across service providers by use of team-based decision support for guideline specific care, effective communication and collaboration with patients and the health care team, throughout and after care in residential treatment.

3) Increase numbers of emerging nurse practitioners and leaders skilled in IPCP by providing opportunities to learn core competencies in this collaborative setting to prepare the future healthcare workforce.

4) Enhance the existing technology system to improve continuity of care and select quality improvement outcomes by leveraging the existing EHR and evaluating options for linking patients to a web-based portal.
Initial Project Strategies
Our first steps toward achieving grant objectives

• Formalizing team membership
  – Quarterly meetings of System Level Team (SLT)
  – Weekly team huddles at the four SF ADU sites which include members of the different disciplines.
  – Assess attitudes/beliefs about interprofessional teams across the different professions/team members
• Leveraging online, HIPPA compliant “message boards” to enhance communication among providers
• Standardize and expand the existing electronic health record
  – INCREASE ACCESS TO THE EHR
  – Provide space in the EHR to enter primary care notes
  – Decision support and monitoring of metabolic parameters for those on antipsychotics,
  – Treatment compliance for chronic medical conditions such as diabetes, hypertension, and HIV
  – Smoking cessation strategies
How are we doing so far?
A few examples...

• Attitudes about interprofessional care among the stake-holders
• Formalizing team membership and communication strategies
• Adding primary care notes to the existing mental health electronic record
Attitudes about the Interprofessional Core Competencies
Initial Team Membership
Communication Outcomes

• Good attendance at System Level Meetings with enthusiastic stakeholder support.
  – Regular meetings incorporating all the different team members had never happened before and have been well received.

• Team huddles are becoming part of the culture at the ADUs.
  – Development of a standardized huddle format with NPs acting as coaches.
  – Providers had been acting in parallel rather than in concert with duplication of some duties.
  – Great learning opportunities for providers and students with the different professions providing input.
Team Membership/Communication Outcomes (continued)

- Educational sessions for Program Staff on topics of interest to them.
  - Have conducted sessions on HTN, DM, Pain Control, etc for ADU staff at their request.

- **Workflow analysis is showing us all how to function more efficiently as a team.**
  - Still in progress, but has already revealed several areas where improvements can easily be made such as standardization of forms across location, avoidance of multiple communications regarding the same issues, standardization of equipment at clinical sites, etc.
Team Membership/Communication Challenges

• Fears of increased time demands among colleagues who are already too busy.
• A single provider might work at several locations making schedule coordination very difficult.
• Selecting an appropriate online message board that provides the tools we want in an economical and HIPPA compliant format.
Initial Outcomes: Standardizing And Expanding The Existing EMR

- Slowly obtaining access from CBHS for all of our providers.
- Discussions with County EMR team about adding areas for primary care data entry.
- Purchase of laptops and tablets to allow providers to enter and access existing EMR data.
Challenges To Leveraging The Existing EMR

• Computer access at the ADUs was limited requiring the purchase of portable devices for use by some team members.
• The huge bureaucracy of the Department of Public Health has made it surprisingly difficult to obtain access to the EMR for our providers.
• The existing county EMR has very specific operating system requirements that made it difficult to purchase new laptops and tablets that were compatible and still met UCSF security specifications.
• Some resistance to adding primary care notes.
• WiFi access was very limited at some locations necessitating broadband access.
As We Move Forward...

• Expand from the ADUs to Transitional Care sites.
• Addition of standardized primary care information into the existing EMR to reduce duplication of efforts and provide improved care as patients move between providers and locations.
• Better leverage other existing technologies such as online message boards to improve IP communication.
• Expanding QI efforts throughout the project.
• Addition of dentist to IP care teams in year 3.
• Continue to train students from the different disciplines in the IP core competencies.
• Evaluate patient portal options for this unique population.
For More Information

• UCSF Nursing Faculty Practice at the Progress Foundation: [http://nursing.ucsf.edu/nursing-faculty-practice-progress-foundation](http://nursing.ucsf.edu/nursing-faculty-practice-progress-foundation)

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