Improving Delivery of Psychiatric Care in Rural Minnesota

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This session will review the need for innovation in the delivery of psychiatric mental health care in rural Minnesota as well as discuss pioneering strategies for provision of state of the art psychiatric care.

Integration of behavioral health in primary care settings as well as providing primary care in behavioral health settings and allowing psychiatric/mental health Registered Nurses to function at the top of their scope of practice are all vital components to improving access and utilization of psychiatric care to disenfranchised persons.

We will discuss "The Good Mood Protocol for the Screening, Referral and Management of Major Depression", a creative evidence based tool to assist health care providers in improving depression outcomes. Each participant will receive a colored copy of the protocol.
Objectives

At the conclusion of this 60 minute session, the participant should be able to:

1) Describe ideas for innovations in the provision of mental health care in rural Minnesota.
2) Identify three strategies for integration of behavioral health into primary care and other settings.
3) Recognize and diagnose depression in the context of co-morbid medical illness and co-morbid psychiatric illness.
4) Learn importance of screening for depression in primary care with use of an evidence based screening, referral and management tools.
5) Identify several ways that Registered Nurses can be utilized at the top of their scope of practice in the provision of psychiatric mental health care to improve access and utilization of care.
Region 7East

Counties:
Kanabec
Pine
Chisago
Isanti
Mille Lacs
Ideas for Innovation in Provision of Psychiatric Services

- Integration of Psychiatric care in primary care settings
- Integration of Medical care in behavioral health settings
- RN Care Management
- Easy to follow evidence based protocols/clinical care pathways in primary care practice
- Psychiatric consultation to Primary Care Providers
- Tele-medicine/phone apps to contact psychiatry during ARMHS appointments
- Mental Health Courts
- Certified Peer Specialists
Mental & Behavioral Health: Options and Opportunities for Minnesota White Paper, December 2015

- The “state of the union”
  http://www.aha.org/content/15/minnmentalhealthwhiteppr.pdf
“Minnesota embraces a vision of a comprehensive mental health system that is accessible and responsive to consumers, guided by clear goals and outcomes and grounded in public/private partnerships.”

(Mental & Behavioral Health: Options and Opportunities for Minnesota White Paper, December 2015, page 5).
“Outside of the Twin Cities, ZIP codes in the following regions are in the top 10 percent for utilization of mental health services:
- Northwestern Minnesota and along the Canadian border,
- Far western Minnesota
- West central Minnesota in the Willmar area
- Central Minnesota around St. Cloud and Little Falls, Winona
- Parts of the Iron Range
- Grand Portage.”

**See the map on page 59 that shows the zip codes of the highest utilizers of mental health care.**
Adult rehabilitative mental health services

Mobile crisis response teams

Adult assertive community treatment (Adult ACT)

Adult residential crisis services

Adult intensive residential treatment services (IRTS)

Adult permanent supportive housing

Access that meets demand as defined by MN DHS
Below state average availability
Above state average availability
No services of this type

Data source: MN Department of Human Services. 2015
Prevention
Mother and baby health; Early childhood care and screenings

Early Intervention
Screening as part of annual physical; School programs

Treatment
Outpatient, in-home, inpatient and crisis treatment

Recovery
Supportive services for housing, employment, ongoing therapy

Adapted from “Building on What Works,” MN Dept. of Human Services, 2015, p. 3.
Core of the problem of providing psychiatric services in Greater MN

- Sparse populations (including providers),
- Stigma of mental illness,
- Long distances between communities and the resulting transportation difficulties in rural areas all contribute to fewer people seeking treatment.
- Fewer patients mean fewer services provided and therefore fewer reimbursements from insurance companies and Medicaid, leading to less revenue overall and less money to provide a full array of services.
In 2014, Riverwood Centers, which operated five clinics in five east central Minnesota counties, closed abruptly after one of the counties opted not to renew its contract. While the area had private mental health clinics, “Riverwood was more accessible, used sliding-scale fees and served the uninsured,” Minnesota Public Radio reported at the time. Counties had to scramble to find services for Riverwood’s 3,000 clients.
1) See the big picture: Understanding the big picture is important and will help in understanding how potential solutions fit into the larger picture—and what impacts they may have in both rural and urban areas.

2) Workforce is a top priority:
   - Lack of psychiatrists
   - Lack of APRNs
Recommendations (continued):

- 3) Dedicate funds: Counties—and county taxpayers—are required to pay for the medically unnecessary days people spend at AMRTC because of a lack of community services in their county, but these funds go into the general fund. It is important that they be dedicated to some purpose that improves community services.

- [https://www.ruralmn.org/mental-health-services-in-greater-minnesota/](https://www.ruralmn.org/mental-health-services-in-greater-minnesota/)
Recommendations (continued):

4) Build trust I: The mental health system involves many separate groups with different levels of knowledge, interest and trust, and some are only beginning to talk to each other. Be cautious of assuming everyone is in the same place, which will help with keeping the paths of communication open and constructive.

https://www.ruralmn.org/mental-health-services-in-greater-minnesota/
5) Build trust II: In particular, while it was difficult to track officially, there was a perceptible level of friction between law enforcement and the mental health community, brought on by conflicting interests and regulations as the two groups tried to go about doing their jobs.

Given the current state of the system, these two groups will continue to be thrown together. Some care can be taken to make their jobs easier by helping them work together.

- https://www.ruralmn.org/mental-health-services-in-greater-minnesota/
6) Diversity: Immigrants and refugees are a growing part of Greater Minnesota’s population. Long-term planning should include addressing their mental health issues, too, especially since many of them went through traumatic experiences to get here.

https://www.ruralmn.org/mental-health-services-in-greater-minnesota/
Working on Solutions
Identify three strategies for integration of behavioral health into primary care and other settings
Integration of Behavioral Health into Primary Care
RN Care Management

*Nurses should practice at the full scope of their education and training.*

- Triage
- Follow-up visits in between psychiatry visits,
- Development and compiling of behavioral health handouts & resources for primary care providers
- Behavioral health consultation to primary care providers.
- Integration of evidence based protocols for screening, referral and management of chronic mental health conditions

*(IOM, The Future of Nursing, 2010)*
Use of billing codes
H0023  Behavioral health outreach
   (planned approach to reach a targeted population)
H0031  MH assessment, non-physician
H0032  MH service plan development by non-physician
H0033  Oral medication administration, direct observation
H0034  Medication training and support, per 15”
RN Care Management

- Expand opportunities for nurses to lead and diffuse collaborative improvement efforts.
- Expand opportunities for nurses to lead and manage collaborative efforts with physicians and other members of the health care team.
- Health care organizations should support and help nurses in taking the lead in developing and adopting innovative, patient-centered care models.

*(Institute of Medicine, The Future of Nursing, 2010)*
RN Care Management

- Health care organizations should engage nurses and other front-line staff to work with developers and manufacturers in the design, development, purchase, implementation, and evaluation of medical and health devices and health information technology products.

(Institute of Medicine, The Future of Nursing, 2010)
Recognize and diagnose depression in the context of co-morbid health conditions and co-morbid psychiatric illness.
Recovering Hope Treatment Center, Mora, MN
• 80 bed Residential treatment center located 70 miles north of Minneapolis, MN
• Housing for 50 women/30 children under the age of 5
• Recovering Hope Treatment Center’s services are recognized and accepted by most insurance companies or state funded programs.
• Recovering Hope is a Rule 31 residential treatment center for women and mothers with children.

Our Story/Our Program
Co-Occurring programming incorporates recovery based education with science based research (Good Mood Protocol) for treatment of chemical dependency and mental illness.

- Most common diagnosis:
  - Anxiety, depression, (chemically induced) mood disorder; PTSD
- Alpha-Stim
  - Psychological benefits; reduction of chronic pain (alternative options for pain management)
- Essential oils
MAT Programs incorporating use of RN Care Management Model

- Vivitrol (Extended release Naltrexone) Program offered on site (relapse prevention) with assistance and oversight of RN for management
Learn importance of screening for depression in primary care with use of an evidence based screening, referral and management tool.
The Good Mood Protocol for
the Screening, Referral and Management
of Major Depression
Why Screen for Depression?

- In 2030, depression will be leading cause of disease burden, according to World Health Organization
- MN Community Measures
- Depression is often co-morbid with many chronic health diseases and results in a 20-fold greater risk for suicide than in the general population.
- Improvement in mood helps with improvement of chronic illness/disease
**PATIENT HEALTH QUESTIONNAIRE (PHQ-9)**

<table>
<thead>
<tr>
<th>Question</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Little interest or pleasure in doing things</td>
<td>0</td>
</tr>
<tr>
<td>2. Feeling down, depressed, or hopeless</td>
<td>1</td>
</tr>
<tr>
<td>3. Trouble falling or staying asleep, or sleeping too much</td>
<td>0</td>
</tr>
<tr>
<td>4. Feeling tired or having little energy</td>
<td>1</td>
</tr>
<tr>
<td>5. Poor appetite or overeating</td>
<td>1</td>
</tr>
<tr>
<td>6. Feeling sad about yourself—or that you are a failure or have let yourself or your family down</td>
<td>1</td>
</tr>
<tr>
<td>7. Trouble concentrating on things, such as reading the newspaper or watching television</td>
<td>1</td>
</tr>
<tr>
<td>8. Moving or speaking so slowly that other people could have nodded. Or the opposite—being so fidgety or restless that you have been moving around a lot more than usual</td>
<td>1</td>
</tr>
<tr>
<td>9. Thoughts that you would be better off dead, or of hurting yourself in some way</td>
<td>1</td>
</tr>
</tbody>
</table>

**Total:** 15

10. 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

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Scoring:
1-4 minimal depression
5-9 mild depression
10-14 moderate depression
15-19 moderately severe depression
20+ severe depression
Psychiatry “Survivor” Island

- Depression
- ADHD
- Bipolar
- Thought Disorder
- Anxiety
**Sequenced Treatment Alternatives to Relieve Depression (STAR*D)**

★ Overall Aims:

★ Define preferred treatments for treatment-resistant depression.

★ Designed to address the question of what is the most effective “treatment of next choice” in patients with MDD who fail to achieve remission on initial antidepressant therapy.
STAR*D: Multiple Outcomes

★ Improvement of symptoms
★ Improvement of function
★ Improved side effect burden
★ Improved patient and provider satisfaction
★ Improved utilization and costs of health care services in protocol vs. treatment as usual
Objectives of STAR*D

- Determine best “next-step” treatments for depressions not responding satisfactorily to one or more prior treatment attempts
- Compare relative efficacy of different treatment strategies
- Compare side effect burden and economic costs of different treatments
- Describe longer term benefits of successful strategies
The aim of treatment for depression is full symptom remission, not just response.

Less than half of depressions remit with a single antidepressant.

Randomized comparisons of various treatment options will define the next best step following previous treatment failure(s).
PHQ-9 Critical Decision Points

PHQ-9

Week 0
Week 2
PHQ-9
*Citalopram 20mg

Level 1

Week 4
PHQ-9
Citalopram 40mg

Week 6
PHQ-9
Switch

PHQ-9 Critical Decision Points
assessed at each visit:
PHQ-9 is ≥9, either increase dose, or if dose is already maximized, or side effects intolerable, go to next level
PHQ-9 is 6-8 (other than week 2), continue current dose, increase dose if not done so already, or go to next level
PHQ-9 is ≤5, continue current dose

Level 2 Switch Options
If patient prefers therapy over meds:
Cognitive Behavioral Therapy

If more anxious than tired:
Sertraline (Zoloft)
• 50mg po qday x 2 weeks, then 100mg po qday*
• 150mg po qday for 2 weeks
• 200mg po qday thereafter

If more anxious than tired:
Bupropion SR
• 150mg x 7 days, then 200mg po qam*
• 300mg po qam x 2 weeks
• 400mg po qam thereafter

If anxious AND tired:
Venlafaxine (Effexor)
• 37.5mg po qam x 7 days then 75mg qam x 7 days, then 150mg qam*
• 225mg po qam x 2 weeks
• 300mg po qam x 2 weeks
• 375mg po qam x 2 weeks

Augmentation Options
*Stay at this dosage x 4 weeks

Refer to CNS/Psychiatrist if: PHQ-9 ≥9 after these strategies have been implemented or if patient irritable, agitated after a med. change, or psychiatric comorbidities, complexity.
LEVEL 1

PHQ-9 Critical Decision Points assessed at each visit:
- PHQ-9 is ≥9, either increase dose, or if dose is already maximized, or side effects intolerable, go to next level
- PHQ-9 is 6-8 (other than week 2), continue current dose, increase dose if not done so already, or go to next level
- PHQ-9 ≤5, continue current dose

Improved, but side effects are intolerable:
- Continue current dose and address side effects, or decrease to tolerated dose or go to next level

Level 2 Switch Options
- If patient prefers therapy over meds:
  - Cognitive Behavioral Therapy
- If more anxious than tired:
  - Sertraline (Zoloft)
    - 50mg po qday x 2 weeks, then 100mg po qday*
    - 150mg po qday for 2 weeks
    - 200mg po qday thereafter
- If more tired than anxious:
  - Bupropion SR
    - 150mg x 7days, then 200mg po qam*
    - 300mg po qam x 2 weeks
    - 400mg po qam thereafter
- If anxious AND tired:
  - Venlafaxine (Effexor)
    - 37.5mg po qam x 7days then 75mg qam x 7days, then 150mg qam*
    - 225mg po qam x 2 weeks,
    - 300mg po qam x 2 weeks,
    - 375mg po qam x 2 weeks

Augmentation Options
- Citalopram 60mg +
  - Bupropion SR 200mg po qam x 4 weeks*
  - Bupropion SR 300mg po qam
  - Bupropion SR 400mg po qam
- Citalopram 60mg +
  - Buspirone 15mg qday x 1 week, then 30mg po qday*
  - Buspirone 45mg po qday
  - Buspirone 60mg po qday

*Stay at this dosage x 4 weeks

Refer to CNS/Psychiatrist if: PHQ-9 is ≥9 after these strategies have been implemented or if patient irritable, agitated after a med. change, or psychiatric comorbidities, complexity.
LEVEL 2a
Only if on Citalopram 40mg
Augmentation Options
LEVEL 2
Switch Options
Referral

**Referral**

Refer to CNS/Psychiatrist if: PHQ-9 is ≥9 after these strategies have been implemented or if patient is irritable, agitated after a med. change, or psychiatric comorbidities, complexity.
**IMPACT** Improving Mood: Promoting Access to Collaborative Treatment

- **RN Care Management**
- **Patients will be seen at weeks 0, 2, 4, 6, 9, and 12**
- **Good Mood Toolkit**
- **Patients will:**
  1. Learn medication & non-medication skills to manage and improve mood,
  2. Learn problem solving strategies to help manage stress,
  3. Develop a relapse prevention plan and
  4. Receive one on one emotional support to help encourage them during the early part of recovery.
**IMPACT**

- Benefits extend beyond improving depression.
- Improvements in general health, pain, functioning, & overall quality of life.
- Works in diverse practice settings.
- Doubles the effectiveness of usual care.
The Good Mood Protocol
for the Screening, Referral and Management of Major Depression

Effective Collaboration

Prepared, Pro-active Practice Team

Practice Support

Informed, Activated Patient

RN Good Mood Care Management

1 on 1 clinic visits with Registered Nurse for six visits over a period of 12 weeks
Investing in Behavioral Health for Better Outcomes

References


- Mental & Behavioral Health: Options and Opportunities for Minnesota White Paper, December 2015, page 5.

- Mental health services in Greater Minnesota:
  - Limited resources are putting growing pressure on rural communities, retrieved May 27, 2018 at https://www.ruralmn.org/mental-health-services-in-greater-minnesota/
References


References


Thank you