National VA Mental Health Wellness & Recovery Webinar Series:
Evaluation of Recovery-Oriented Acute INpatient Mental Healthcare (RAIN-MH)

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Ralf Schneider: Great, so we saw that someone couldn't hear, um we can just write a note for him that perhaps he needs to turn his speaker on his computer up since he is seeing everything. Um, but in the interests of time, I'd like to get started and welcome everyone. This is the Mental Health Recovery and Wellness Webinar Series. This series is made possible by the VA Office of Mental Health and Suicide Prevention, Psychosocial Rehabilitation and Recovery Section, and the VISN 5 Mental Illness Research Education and Clinical Center, or MIRECC in partnership with Employee Education System, planning committee members for this Webinar series include Dan Bradford, Valerie Fox, Spencer Glipa, Catherine Lewis, Marty Oexner, Kathryn Peacock-Dutt, Donna Russo, Tim Smith, and Samantha Hack. Today's Webinar is entitled *Evaluation of Recovery-oriented Acute Inpatient Mental Healthcare*. In other words, RAIN-MH. Our presenter for today's Webinar is Dr. Alan McGuire. Dr. Alan McGuire is a clinical research psychologist, who serves as a core investigator at the HSR&D Center for Health Information and Communication and an Associate Research Professor at Indiana University, Purdue University, Indianapolis. Dr. McGuire's research focuses on the dissemination and implementation of evidenced based psychosocial interventions for people with chronic conditions such as severe mental illness, chronic pain, and substance use disorders. He has received funding from the National Institute of Health, VA Rehab Research and Development, VA Health Services Research and Development, and VA Query to support his work. So, at this time, we are happy to turn over the Webinar to our presenter, and we will be keeping track of comments that you make in chat and addressing those at the end of the session. Thank you Alan, why don't you take it away.

Dr. Alan McGuire: Well thank you Ralf and thank you to the whole team that puts this series together. It's such a great resource and a lot of work that goes into it, so thank you guys very much for that. Um, I'm excited today to present on our ongoing research focused on recovery-oriented inpatient services, the RAIN-MH project. First of course, I want to just note that these views that I am talking about today are mine, and that the VA and everybody else will just completely deny they even know me if you say it's their views, and also I have no financial conflicts to disclose. I do want to take a moment to acknowledge the whole team here, including my co-investigators, our great operational partners from the Office of Mental Health and Suicide Prevention including Gayle Iwamasa and Marcia Hunt, as well as the funding that we receive from Health Services Research and Development through the form of an IAR. So we're going to take a moment here to have some polling questions. I've told you who I am and Spencer will bring up some questions that we will get at, who all you are. So Spencer if you can go ahead and bring up the first poll question. All right, so, the first question is I'd like you to tell me what is your involvement in acute inpatient services and we will check all that apply. So, have you regularly provided clinical or administrative services on the inpatient unit? Have you occasionally provided services on a unit? Have you conducted research involving inpatient? Have you been a patient or a family member yourself, or have you never formally been involved with inpatient services? I'm seeing results are trickling in here and, still getting a few… All right, it looks like that we've gotten most people in so let's take a look at our…our results here. So it looks like that the vast majority of you, so 70% of you have regularly provided services, so that's great. A lot of people who are really down, down in the front line there, so that's great. Some other of you who are, like me, on the occasionally provided services, a solid quarter. A few fellow researchers out

there, that's fantastic. And also a solid representation of patients and family members, that's great. And, then a few of you that have no involvement, so that's fine, welcome. All right, and I believe that we have a second poll question that we can bring up at this time. All right, and so, similar question, I'd like to know just kind of what is your primary role, check all that apply. Are you a mental health provider or some other type of provider? Are you primarily a researcher? Primarily administrator? Primarily a Veteran or family member – obviously many of our VA employees are Veterans or family members themselves, and that's great. Or do you describe yourself as some other sort of, some other sort of animal? All right, it looks like those results have come in pretty quickly. All right. Great. So, again, we have a strong representation from providers here on this call – that's great, as well as definitely a strong administrator representation, and just a few of us researchers, definitely solid Veteran presence. Okay, great. Thank you very much Spencer. Okay, so a little bit of background and rational for what we've done. So, there have been numerous efforts to define, measure, and support the implementation of recovery-oriented care in the outpatient setting, starting with seminal work by Bill Anthony and Pat Deagan that many, if not all of us, are familiar with, um as well as numerous people in recovery themselves. However, this focus on recovery-oriented inpatient care has received relatively less attention, but this, it's still important, because we know that inpatient care is an important part of the recovery journey for many people in recovery. Relapse is recognized as a part of recovery for many people and with relapse often times comes acute hospitalization. So it's really an important place to focus our attention. And consistent with that, the VA has made some very important strides. Back in 2013, just a little over seven years ago now, the VHA distributed it's inpatient mental health services handbook, that really was set out in detailed the services that should be

provided in the inpatient setting, and in conjunction with that, they issued their recovery services toolkit, which was meant to be a guide for the field on how to implement recovery principals and practices within inpatient settings. One of the tools in that toolkit that has received a fair amount of attention is the Inpatient Recovery Checklist. This was developed as a guide for the systematic implementation of recovery-based services. It is a self-assessment that people in the field could use to see, where are we on this. Despite these great efforts though, there has not been a systemic assessment of recovery-oriented inpatient care within VA and really, at the time, there really hadn't been any large-scale systematic assessment. So, that is what we, the gap that we were trying to address. So, we proposed a study with three aims. The first aim, to assess the penetration of recovery-oriented inpatient care across VHA, and the second aim was to describe the implementation process and what challenges that people in the field faced in implementing recovery-oriented inpatient services, as well as what strategies they used to overcome these barriers. And finally, we wanted to look at the relationship between recovery-oriented inpatient care and Veteran outcomes. So, just briefly here is an overview. So, we have used a mixed qualitative and quantitative design. So this is a strategy in which both quantitative and qualitative data are collected and are integrated in a meaningful sort of way. And as we got involved in this work, we realized that there was kind of a preliminary step that was necessary, which is to really define and operationalize what does recovery-oriented inpatient care look like so that we can then measure it. [laughter] Um, and then after that step, we went to measure it at a selection of VA sites – understand that implementation process, and then test the association with Veteran outcomes, and we are still in the data analysis phase, so my presentation today is going to focus primarily our efforts to define and operationalize recovery-oriented inpatient care, as

well as our results from measuring it at our sample of sites. I'll go into just a little bit of understanding the implementation process, but those will be preliminary. So first the operationalization of recovery-oriented inpatient care, or the development of what we call the RAIN scale. So, the first question that we really faced is where to start. At the time, there were numerous definitions existed for recovery-oriented care broadly and how that might apply to inpatient care. We found that often times those were general or abstract they weren't operationalized in the way that we needed them to be for a research study, and we weren't quite sure how to choose the best. But, we did have the VA checklist that I mentioned before, it had certain advantages, including that it is meant for VA, it's tied directly to VA policy, and this was and is a VA study; however, the checklist was intended for self-assessment and quality assurance purposes, making it not an ideal fit for a research study. So we made some modifications. Some of the types of modifications that we made from the beginning were that one wording was sometimes not clear, to us, at least, as a research team. So, for instance, one of the items made reference to appear "a reality check" and we felt like, well we can't reliably know what that means, so, we kind of tried to work those into things that were a little more clear and straightforward. Um, multiple aspects of care were rated in a single item – in research terms we call that a double-barreled item, so we just split those out into their own separate items. Um, the checklist includes 3-point anchors, not implemented all, progressing and fully implemented, or something along that line. We felt like we needed more precision for our purpose and, very importantly, we needed some objective criteria for how we would assess whether an element and how strongly an element was implemented. So, it's also important to note that after we developed this initial scale, based on the checklist, that we took the opportunity of this study that I'm going to describe, to make continuous

improvements to the scale. Um, site scoring meetings occurred after each study visit, that I will describe a little bit more in detail later, but suffice to say that after each scoring meeting we collected notes, we really reflected on the process, not only how well did the site do, but also how well did our scale do. And then we would take these, we would also pair them with periodic reviews of the literature, and also check in with our operational partners, as well as our own practice partners at the local level. And so, what came out of this process is a 23-item scale with a 5-point ratings for each element, each of these 23 items represents one element of recovery-oriented inpatient care and they're rated from 0, .5, 1, 1.5 and 2 with 0 indicating pretty much a complete absence of that element. So here is the first item as goal setting, recovery-oriented goal setting, and so a 0 is really no process at all for collecting Veteran recovery goals, all the way up to a 2, which would be excellent quality and consistency. Inherent in this rating scale is that we are taking into account both the quality of the process that is in place, but also how consistently that process is implemented across Veterans who are admitted to that unit. And also we developed some scoring criteria, how it is that we would go about, and this was grounded in not only theoretically what we thought or seemed like would be very high versus very low, but also using our sites experience and when we saw it, we were sure to try to capture that in our scale. The scale is organized into four subscales. This is based on a series of confirmatory factor analyses that we conducted and that are still ongoing. It's a good start and it makes a lot of sense, but it's, um, the fit indices are not quite where we would like them to be, so we're still working on that. But, in general, the four subscales that we found were inpatient treatment planning, outpatient treatment planning, the group programming and the unit milieu. So let me walk through the elements falling under each of these subscales. So the inpatient treatment planning – this is the process

by which the plan starts with the Veteran's recovery goals, and seeking out and understanding what are the Veteran's goals for their own recovery. These are recorded in a written treatment plan and are used as the starting point for shared decision making for medication management and shared decision making for inpatient treatment. And by inpatient treatment, I'm talking about the care that happens while the Veteran is still on the unit. This takes place in the context of an interdisciplinary treatment team that the Veteran is considered at the center of, and also involves significant others and family members in this planning process. The outpatient treatment planning also starts with the Veteran's recovery goals and uses those to engage in a shared decision-making process to plan for outpatient treatment, or the care that the Veteran will receive after they are discharged from the unit. This outpatient care is coordinated between the inpatient and outpatient teams and that there is a philosophy towards the least restrictive discharge possible for each Veteran. So there isn't a assumption that all Veterans coming off of an inpatient unit will have to go to some sort of stepdown unit or residential or nursing home sort of setting, but that we want to get Veterans to the closest they can as living in the community with the appropriate supports. And finally, this is in reach, or the notion that outpatient treatment programs will provide services on the inpatient unit so that Veterans can experience firsthand the types of services that those outpatient programs provide, and can make a better and more informed decision regarding whether that is an appropriate fit for them. The group programming includes both if there is a sufficient volume of groups available on the unit, as well as a sufficient variety to meet the needs of the most diverse presenting concerns and needs of Veterans served by the unit, and that this programming is supported by the staff so that Veterans are encouraged to participate maximally in group programming with minimal disruptions or competing interests for that. So that

groups are happening in a quiet space where Veterans can concentrate and there isn't a constant revolving door of nurses coming in, puling Veterans out for vitals and things like that. And then finally, that this programming is of high quality, so that it is of therapeutic value basically. And finally, the milieu. That the milieu is a warm and inviting home-like unit that is an autonomy promoting environment in which that to the most can be done while maintaining safety that Veterans are able to, you know, maintain their rights as humans and some sense of normality. That there is respectful and therapeutic interactions between staff and patients. Nurses and other staff are out and about in the milieu on a regular basis interacting in a respectful and supportive way with the Veterans, and that behavior is managed through the least restrictive means. So this is looking at minimizing the use of seclusion and restraint and things of that nature, even chemical restraint and using our verbal deescalation techniques and things of that nature, and ideally, preventing escalation before it even happens. There are a few other items that are included in the scale that didn't fall neatly into one of our other subscales, but are nonetheless, I think are important, one of which is there is integrated care for comorbid visible health needs. Also the availability and use of individual evidence-based psychotherapies. Suicide prevention, so the linkage with suicide prevention coordinators, as well as filling out and maintaining safety plans for Veterans for whom that's appropriate. Also, that this is a multidisciplinary treatment team with representation from all relevant disciplines. And finally, the inclusion of peer support services. So, how did we go about assessing recovery-oriented care within the VA? Well, we sought out to recruit a sample of 34 acute inpatient units across the VA. I have to tell you that this was driven by what a statistician told us we needed to have power to reach our aims – I put it down in the proposal thinking there is no way I'm actually going to be able to recruit all these, but we

will do the best we can. And low and behold, the field responded with great generosity in offering up their time to participate in our research and we actually made our goal and I'm very excited that we have a diverse sample. These units represent every major region of the country, so 16 different VISN are represented in this sample. And although it says only three of these sites were rural, I will say that that is just based on VA Medical Center classification – many of these sites are serving a very large proportion of Veterans that are coming from rural areas. Some Veterans of course coming hundreds of miles to the closest inpatient unit. So lets talk a little bit about the data sources that we used to assess recovery-oriented care. We used several. So first, there were observations, well not first, but um, there are observations from two-day site visits conducted by the team. Additionally, we conducted key informant interviews with staff, Veteran interviews with Veterans who had been recently discharged from that unit, administrative data that was collected from the corporate data warehouse that included things like the number of individual psychotherapy encounters for Veterans during the past six months, the number of group psychotherapy encounters, or group therapy encounters and things of that nature. And then, finally, we conducted at least five chart reviews for each site. The key informant interviews, so we targeted, for each unit, interviews with the Unit Nurse Manager, the Medical Director or lead Psychiatrist, the Inpatient Program Coordinator, a Social Worker and the Local Recovery Coordinator, and we were able to get an average of a little over four interviews per site, ranged from 3 to 7. These were one-hour telephone interviews. They were semi-structured and they focused primarily on the implementation of these inpatient elements, but also tried to get at the implementation process, or as I call it, the implementation story. How is it that things came, the elements that you have in place came to be in place at your site, and what barriers did you face and why the

things that you don't have, do you not have? For our Veteran interviews, we were able to recruit an average of almost six Veterans per site, and as you will see here, the demographics, despite the fact that we did over-sample for non-white Veterans, and for Hispanic Veterans, as well as for women Veterans, the breakdown roughly does represent the VA Veteran sample. So let me talk a little bit about how it is that we went about scoring sights. So, first of all, there was a group of raters that are members of the study team. I myself was one of them as well as four or five of my colleagues. I will say that we were very fortunate our team included decades of experience, as mental health providers, consultants, researchers, and family members. So, these, for each site, there would be a primary rater assigned, as well as secondary and tertiary raters were assigned as necessary based on the size and the complexity of the unit. The primary rater coordinated data collection for that site. They would lead the site visit and after all data collection was done, they would draft a preliminary site summary. We would convene a site scoring meeting, in which at least four members of the rater team, including the primary and any secondary or tertiary raters were presented. They would present all the data that we had collected, and we would attempt to come to consensus, 0.5, 1.5 what have you, for a rating for each of these elements. In the case in which we really just could not come to consensus, it felt like we didn't have enough information, then we would go back to the sites with any clarifying questions that we would have. I would also say that data triangulation was very important to us throughout this process. So for each of the sites we would offer a wrap up meeting at the end of the site visit, in which we would say to our primary point of contact, you know, whoever, or whomever would like to come, whoever would like to come, let's come, we can share our initial thoughts, what we've seen, what are your relative strengths and weaknesses. But as part of that process, we really

want to say that if we say this is what we saw and you like, oh, no, no, no, you missed this, please tell us so that we can kind of verify with you that we are actually capturing a fair representation of your unit. So, what did we find? So here, in this box, we see, I have broken down the elements based on whether they were very commonly implemented, uncommon to see them, or very uncommon. And in order to categorize them with that I used a kind of top box approach but sort of, of how many sites scored a 1.5 or 2. So that would land you in the range of that it was both a high quality and high consistency for that particular element. And to be rated as very common, those are elements in which 75% of those 34 units that we visited had a 1.5 or a 2 on that particular element. The very uncommon would be 25% or less of sites. And then the common versus uncommon is at the 50% breakpoint. So, I'll give you a moment to kind of scan through that, but I'll be walking through some more specific examples next. So, here is a table, it's a little bit busy, but this is for the inpatient treatment planning elements. And, what you will see here is a lot of red. So, far and away, the inpatient treatment planning elements were the least frequently implemented elements as a whole. Some of the lowest scoring elements in general were located here. As you can see, goal setting, written treatment plan, shared decision making for medication management, decision making for inpatient treatment are all in that red column with very, very few sites scoring 1.5 or 2. In contrast, outpatient treatment planning items are all in the yellow where we see kind of a range, where there are some sites that are doing it fairly well and there are also plenty of sites that aren't doing particularly well with some kind of clustering in the middle. The same is true for group programming. Some are doing it well, some are not doing it so well, a lot of them clustered in the middle. And finally, milieu, a similar sort of, similar sort of process there. The one exception being behavior managed through least restrictive

means, which I will talk a little bit more about later, but it was in the green with a lot of sites doing a very nice job on this. Then these non-item factors are as, one would guess, a hodgepodge. [laughter] So, with two of the highest scoring items, located here, integrated care for comorbid physical needs and suicide prevention, but then also one of the lowest scoring with individual evidence-based psychotherapy showing up here. So, let's unpack this just a little bit. So, first of all, I want to pause and just note that I feel as though that the development of this scale is a big step forward in terms of conceptualizing and operationalizing recovery-oriented care in the context of acute mental health care – kind of that last frontier in mental health recovery. I feel as though that we a case for some pretty strong content validity in that the elements that we included in this that arose from our process are very consistent with numerous perspectives, including literature on the patient perspective of what they, what patients want out of inpatient care, and view as high quality and recovery-oriented. Same for staff and provider perspectives, and also consistent with other efforts in which people have attempted to implement recovery-oriented care in their own settings. So in other words, nothing really popped out up here that was strange or foreign. But we're definitely not done yet, so, the psychometrics for this scale definitely have some issues. There are some item level issues that need some tweaking and, as I mentioned before the factor analysis, the fit is still not strong. And so definitely we have a some more scale development to do. We also really need feedback from the field – that starts today. These are the first time that have presented these results and I'm really excited to hear what feedback I get from you all, and of course the peer review process as we submit this to journal publication and then whatnot. And then of course we really want those outcomes, the association with Veteran outcomes. I was hoping to have those to share with you today, but alas, it just wasn't,

wasn't ready yet. Let's talk about some VA successes. So, of those elements that were very commonly implemented two of them, suicide prevention and behavior management really shouldn't come as a surprise. So suicide prevention is, of course, the number one priority for VA mental health and I think that that has definitely shown some um, shown some uh, some, borne some fruit here. Similarly, there are definitely metrics that look at how often units are using these more restrictive and aggressive behavior management techniques, such as seclusion restraint, and we found that by and large that there really was an emphasis on attempting to manage behavior through these less restrictive means. Some other feathers in our cap, if you will, so, the integration of physical health, I think that the VA is really capitalizing on itself as a full service integrated healthcare system. So, in contrast to a standalone mental health unit, the units in our sample were making use of the availability of physical health. And this is, they should be commended for this. I should note that many of the people I talk to across VA say that many of the Veterans that they serve, they're coming in after being largely absent from the healthcare setting for a large period of time. So there is a lot of what we call deferred maintenance – Veterans coming in that haven't been receiving dental care, that haven't been receiving adequate primary care coverage and things like that. And so, at the same time that they're trying to do all of this important work regarding getting their mental healthcare up and running, they're also trying to get them caught up on all of these things and that's a lot of work, and it's really important. And finally, the quality of the programming is a pretty high quality of group programming out there that is going on currently. Now, on the other side of things, urgent attention needed. So, this inpatient treatment planning cascade, as I'm kind of calling it right now, was where a lot, a lot of work still needs to be done. This notion of starting with the goals, Veterans' own goals, recording

those in a written treatment plan and have that drive shared decision making regarding medication and inpatient treatment, and supporting individual therapy. That just, it seems like that is really a struggle in the field at this point in time. So that, I think, jumped out at me as the kind of the number one need for where we need more support. So, let me talk a little bit about the implementation data and some preliminary thoughts. As I said before, data analysis is ongoing, so what I'm sharing here is really more kind of what is starting to emerge and kind of my thoughts rather than being the product of rigorous qualitative analysis, so, I reserve the right to change my mind later. I would say that the biggest headline from these data, was how sparse they were. So, really, it felt like it was hard to get much information about how did things get to be the way that they are now. Why is that? Well, one thing that is of note, is that it was hard to get to a common understanding of the comments, of the elements that we were talking about. So, we would say, "well, you know, shared decision making," and then they would say, "oh yes, we do share decision making for all of our Veterans, for all of their medications." And then we would dig into that a little bit more and say, "well what do you mean by that," and like, "well, you know, the doctor will provide them with his recommendation and, you know, they can say no if they want to and we'll take that into consideration." Say, "well, you know, that's not quite what we meant by shared decision making." So, we spent so much time really kind of digging in to what is actually going on at this site because there wasn't this lingua franca that often times we didn't get to those implementation questions, or didn't have, we had limited bandwidth for it I would say. Also, there was an institutional amnesia. Many of these sites have experienced lots and lots of staff turnover, and so you would ask, "Hey how did this get to be the way it is now?" and the staff would say, "Well, you know, I've been here for two years and it's always been that way."

And finally, there was no singular launch of recovery-oriented inpatient care. Yes, there was this 2013 toolkit launch, but most of the sites that we saw had already been doing some of these things, or at least attempting to do some of these things before the launch of that toolkit and then even afterwards it varied in terms of what pieces of the toolkit they were using. So it wasn't like many places where you say, Hey, this is when VA launched its training in consultation for cognitive behavioral therapy for chronic pain, and it was a singular thing. So it just made it harder to talk about in that way. Model specificity I would say is a barrier and a facilitator. Everybody can talk to me about their 40 hours of programming, because there's a number to it, you just count up the number of groups that you have, and you either have 40 or you don't. Versus, as I said before, shared decision making or even goal setting, where they may say, "Oh yes, we asked the Veteran about their goals," but then we ask them more about that and they say, "Well yeah, you know, when the nurse does the intake she says, you know, what's your goal and they say uh, well, you know, I wanna get into the DOM and that's where they leave it." Well, that's kind of not what we were talking about, and so that uh, the more kind of, um, easy to count it is, the easier it is to talk about it, and the easier it is to implement. Also, it will come as no surprise to many of you, that there is a big focus on safety and acute stabilization within inpatient units. There has to be, because keeping our Veterans safe has to be number one priority and keeping our staff safe as well. And then also there are, of course, are many people who are still rooted in the medical model and I point at prescribers here, not because I am suggesting that prescribers are further behind non-prescribers, but yet their role is so central, particularly on an acute inpatient unit that there is some sense that if the prescriber is actively against this notion of recovery-oriented care, there's, that's kind of the end of the game. Versus other, other

disciplines you might be able to work around for some elements. So I just included a sample quote here that really demonstrated this. This is from a psychologist, a treatment coordinator at one of our sites, and he said, "Yeah, it's basically I find that the treatment team meetings are, I guess, like 90% about discussions about medications, and there is very little room for any psychosocial type issues. I believe that our psychiatrist is totally grounded in the biological processes and totally believes in those, and therefore, theirs psychosocial issues are either discounted or they're farmed out to the social workers." So, I thought that this was really emblematic of a place were there were people who were trying to do this. They had set up this interdisciplinary treatment team meeting, um, where the Veteran was hypothetically brought in to be part of this discussion, but you had one, this psychiatrist, who was just saying like, "Yeah, no, we're just gonna talk about which medication and we've already made these decisions". And so, kind of nothing else could happen with that in any sort of a reasonable sense. Um, I will just say briefly, regarding facilitators, that there was no one thing that if sites did this thing, or had this thing, then they were good. Um, staffing is really helpful. If you don't have the overall staffing it makes it harder, but there were sites that were really well staffed that didn't implement very well, and there were sites that were really struggling with staffing, but yet still pulled it off. There's some examples; like, if you don't have a psychologist or a therapist, then you're probably not gonna have individual therapy. Some sites try to have outpatient providers come on the unit and provide it, but it just really, it was very sparse. Also, having a champion for recovery-oriented care can really help, but it also depends on who that person is, how much clout they have, can they get trumped, do they have buy in, things like that. So, future directions for our team – we're gonna continue our work analyzing relationships to outcomes, and analyzing our implementation data. I will

say, that there are some real needs. For instance, I mentioned inpatient programming and the types of group and individual therapy. There is not really a research base for this. We talk a lot about providing evidenced-based psychotherapy. So for instance, CBT-D, in the settings, but those models were designed for outpatient settings. Nobody has 12 weeks, well, I won't say that, but it's very, very rare that a Veteran has 12 weeks on inpatient, and we hope that they don't. So what does it look like? What are the effective practices and what should be the target of those practices? I would say two other things, so specific models for goal setting and for shared decision making, I know there are some, um, but really understanding how those could be used to support those processes on the inpatient unit I think is definitely a very important question for the field. So, I'm gonna stop there with my thoughts, I'm really interested in your questions and I just want to thank you for tuning in today and so I'll turn it over now to the moderators to see what questions we have.

Ralf Schneider: Sure, uh, so, uh, this is Ralf, we have Alyssa Rippy who got in the first question, and she started out by asking, "Were the treatment plans being completed in MHS" and, you know, what was behind that, was her thought, if you had a sense of "why the inpatient treatment planning was so low? Did it have to do with um, the templates not being in, um, and then providing recovery-oriented planning that wasn't documented?" I think that was the gist of it.

Dr. Alan McGuire: Uh huh. Yeah, so that's a, that's a great question. Thank you very much. So, almost all, with the exception of maybe one unit, and I will point out that that unit was one of the highest scorers, used Mental Health Suite, um, I have done some previous work regarding mental health treatment planning and I will say it is very, very hard, and we are talking about, when we talk about it in these items, we're not talking about is there a treatment plan with the required elements in, in CPRS.

So, Mental Health Suite gets you there but what it doesn't get you is the more soft skill stuff. Are you gathering a real goal from the Veteran and documenting that, and is that real goal and plan being used to drive the care that is actually taking place on the unit? In some cases, there is that really seductive drop down menu that provides you those pre-populated goals and we would sniff those out and recognize that they were being used, in some cases for convenience sake and not really matching what the Veteran said. My personal pet peeve is when a goal is put in with quotation marks around it that it clearly comes from a pre-populated goal and isn't actually a quote from the Veteran. That's not what we're looking for. But, Mental Health Suite aside, there is, regarding the inpatient treatment with some units, because their focus was very much we are about acute stabilization, we are about adjusting their medications and then getting them out as fast as they can that the kind of esprit de corps was we don't really provide treatment on the unit, so there is not a reason to spend a whole lot of time thinking about which groups that they might go to, or what they might need from therapy, or how the medications that we might, medication adjustments that we might make on the unit might tie into their life outside of the unit, because that's just not what they were focused on. So, there's a whole lot of issues there that go into that.

Ralf Schneider: Thank you. Um, Alicia Lucksted had a question, "How do your psychometric concerns that you mention impact your interpretation of the results?"

Dr. Alan McGuire: Yeah, that's a fantastic question, thank you Alicia. Um, so, in a number of ways. So, some of the issues where we were able to address kind of uh, so we made some scoring rules. For instance, regarding the group variety item that we have reversed based on the distributions that we were seeing and, so there were a whole lot of clustering in the initial item at .5

because we said that there were these four types of groups that were critical for inpatient programming, and if they didn't have it then we automatically drop them down to a .5. We relaxed that because we felt like we didn't have sufficient justification to really make that call. So some of those we were able to adjust them that way. Then there were others that are just going to have to be focus of future work. We might have to drop certain items from our outcome analysis to adjust for those issues. So that's the…, unfortunately when you're talking about site level assessment it's not like, you know, my statistician is like, hey, you know, could you maybe get 10 more sites, I think that would help with the… and like, no we can't just go to 10 more sites, especially during COVID. So, um, that's the long and the short of that.

Ralf Schneider: Thank you. Um, next question was from Richard Keeney. "Would you weigh any of the areas you were measuring as more important than others in regard to implementing a recovery model?" And I think you said something about what you thought was central, but maybe you could speak more to that one.

Dr. Alan McGuire: Yeah, absolutely. So I personally have a hard time wrapping my mind around how you do true recovery-oriented programming if it's not being driven by a nuanced understanding of the Veteran's recovery goals. That to me is just the starting point of recovery-oriented care – is understanding what does this Veteran want for his or her recovery, and starting there. So, I feel like that this inpatient treatment planning cascade, starting with a goal plan, the goal setting is, is really, I would put it as the most important piece. But that's, of course, just my opinion.

Ralf Schneider: All right. Fair enough. Anne Canastra asked, “Could sites request a coach to review some of your scores and implement action plans to address gaps in some of their areas. In other words, were you aware of follow-up that they could implement based on you coming back to them?”

Dr. Alan McGuire: Yeah. So um, that’s a great question, and so, we have had a couple of sites that have reached back out to us and um, have asked for, you know “we want to use this to grow, what can we do, are there people who are farther along than us that we can talk to” and there has. So far, we’ve gotten a site that scored very well who was graciously agreed to speak with those sites, so we’ve been able to do some matchmaking there. Um, and, you know, I wish that, I wish that the Office of Mental Health and Suicide Prevention had a team of external facilitators who could, you know, [laugher] who could parachute in and provide support. I’ve talked with Gayle Iwamasa just the other day and we were in initial conversations about what we could do, what sort of resources that we could develop for the field, um, and uh, and that’s still in development. You know, we, our team is research funded and so it’s, it’s not like we have somebody supporting us to be able to provide that. But, I’m, the, I guess the short answer is that I’m more than happy to try to facilitate a Community of Practice for sites that want to continue and improve on this, and talk about, do follow-up conversations with scores, and learn more about the scale and our process through those conversations.

Ralf Schneider: Great, thanks. And then, Rob Ansen, um, prefaced it by saying, “Not sure if this is a fair question, but you may have noticed, or did you see in inpatient settings that might have been shifting toward a more a PSR-oriented care, was there a shift

in the dynamics of how the units functioned? For instance, with Peer Support staff given a larger role or included in treatment team decisions?"

Dr. Alan McGuire: Okay, so Rob I'll try to unpack your question here. Um, so see inpatient settings shift toward a more psychosocial rehab orientation. Was there is a shift in the dynamics of how the unit functioned? Wow. What a sophisticated question. I think if I was answering it, I would kind of be speculating because I haven't looked at it from that lens. So I'm gonna hesitate to answer that question. Sorry Rob, I don't mean to cop out because it's really sophisticated, but I don't want to just make things up on the spot. [laughter]

Ralf Schneider: All right. I think that's about all the questions we had, although we have someone typing in. Let's just see… oh, you have a comment from Christina that you can see.

Dr. Alan McGuire: Mm hm. Yeah so, she has mentioned that "some goals are at odds with a lengthy stay of four days and inpatient by utilization management." Yeah. "…may be helpful for RAIN-MH programming to meet with UM teams." Oh yeah, yeah. Um, so, thank you very much for that thought. Utilization management is an interesting player in this. I do just anecdotally have memory of a site that I went to where utilization management sat on the treatment team and I will say that I could see that being a nightmare scenario for some places. For this particular unit, I thought that the utilization management people asked very good questions regarding why does this Veteran need to continue to be on the acute unit, and was willing to have a conversation with the rest of the treatment team regarding that. Um, I think what Dr. Hines points towards here too is this interplay between what are we going to get done, what's reasonable to get done while the Veteran is on the acute unit, versus what needs to be

held off until they get established in outpatient, and I would encourage us as a field to think very carefully regarding how do we make that transition to be as seamless as possible? The Veteran is still the Veteran before they're admitted, while they're admitted and after they're admitted, but yet it seems as though in many places there is a completely different view of the Veteran, a completely different set of goals and objectives for that Veteran, and the more that we can make that a seamless transition I think the better that we will serve our Veterans.

Ralf Schneider: Thank you so much. This is our last question that if you just have a quick thought on this, um, and then we'll wrap up. "What's your thoughts on the importance, or lack of importance of Peer Support Specialists on inpatient units?"

Dr. Alan McGuire: Uh huh. Yeah, um, I think, I'm a big proponent of Peer Support Specialists in all aspects of care. We saw, so I would say that it's not just about having the Peer Support Specialists on the unit, but what did they do, how did they fit within the interdisciplinary team? One unit that really struggled with recovery range of care, it was the recovery Peer Support Specialist who said, "No, we don't do recovery here, we're acute stabilization." That was a quote. So, it's very easy for, it's definitely possible to include them and still minimize their role, not use them appropriately, or have them be overwhelmed by the culture. However, if you have a good culture or have a good role for them, they can be a tremendous asset.

Ralf Schneider: Thank you. So to wrap things up, just to remind everyone to please go to TMS and complete the 10-item test and the Webinar evaluation within the next 30 days so you can receive your CE credit. And as most of you know, this is a monthly presentation that we provide. Our next presentation will be on Tuesday, December 8th at noon eastern. Drs. Lauren Lovato

Jackson and Meredith Sears will be presenting on Targeting Firearms in Dialectical Behavior Therapy. We will see you then, and Dr. McGuire thank you again for a very interesting presentation. Great work.