Evaluation of Recovery-oriented Acute INpatient Mental Healthcare

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Disclosures

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- **Study Team**
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  - Nancy Henry, Research Assistant
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Polling Questions
There have been numerous efforts to define, measure, and support the implementation of recovery-oriented care in outpatient settings.


However, recovery-oriented inpatient care has received relatively less attention.

Nonetheless, inpatient care is an important part of the recovery journey for many persons with mental illness.
Background

- 9/18/2013 - VHA-wide distribution of the new Inpatient Mental Health Services Handbook (VHA Handbook 1160.06)

  **Recovery Services Toolkit:** “a Toolkit and related guidance for use of the Toolkit for the implementation of recovery principles and practices for VHA inpatient units”

  As part of the Toolkit, the **Inpatient Recovery Checklist** was developed as a guide for “systematic implementation of recovery-based services”.

- Despite these great efforts, there had not been any systematic assessment of recovery-oriented inpatient care w/in VA
Study Aims

- **Aim 1**: Assess the penetration of recovery-oriented inpatient care across the VHA.

- **Aim 2**: Describe the implementation process, including challenges and strategies to overcome them, used by sites to implement elements of recovery-oriented care.

- **Aim 3**: Examine the relationship between recovery-oriented inpatient care and Veteran outcomes.
Overview: Mixed Qual/Quant

- Define Recovery-Oriented Inpatient Care
- Measure ROC at Sites
- Understand Implementation
- Test Association: ROC & Outcomes
Operationalizing Recovery-Oriented Inpatient Care

THE RAIN SCALE
Where to start?

- Numerous definitions exist
  - Often general or abstract - not operationalized
  - How do you choose the best?

- VA Checklist
  - Meant for VA
  - Tied to policy
  - However, Checklist intended for self-assessment & QA
Checklist Modification

- Wording sometimes not clear to research team
  - E.g., periodic “reality check”
- Multiple aspects of care rated in an item
  - I.e., “double-barreled”
- Anchors not precise enough
  - 3-pt. scale
- Needed more objective criteria
Continuous Development

- Initial Scale
- Site scoring meetings after each visit
- Notes from meetings collated and reviewed by the full team
- Periodic reviews of the literature
- Review by partners at the VA Office of Mental Health and Suicide Prevention and inpatient program coordinator
RAIN Scale

- 23 items
- 5-Point Rating Scale
  - 2.0 Excellent quality and consistency (deviations or deficits rare)
  - 1.5 Good quality and consistency (some deviations or minor deficits)
  - 1.0 Regular deficits in consistency OR quality
  - 0.5 Regular deficits in consistency AND quality
  - 0.0 Little or no goal setting

- Scoring Criteria
Scale Organization

4 subscales based on CFA (still ongoing)

- Inpatient Treatment Planning
- Outpatient Treatment Planning
- Group Programming
- Milieu
Inpatient Treatment Planning

- Recovery-oriented Goal Setting
- Written Treatment Plan
- SDM for Medication Management
- SDM for Inpatient Treatment
- Interdisciplinary Treatment Team
- Family/Significant Other Involvement
Outpatient Treatment Planning

- SDM for Outpatient Treatment
- Outpatient Care Coordination
- Least Restrictive Discharge
- In-Reach
Group Programming

- Sufficient Volume of Group Programming
- Sufficient Group Variety
- Support for Programming
- High Quality Programming
Milieu

- Warm & Inviting Unit
- Autonomy Promoting Environment
- Respectful Therapeutic Interactions
- Behavior Managed Through Least Restrictive Means
Other (Non-factor Items)

- Integrated Care for Comorbid Physical Health
- Individual Evidence-Based Psychotherapy
- Suicide Prevention
- Multiple Disciplines Represented
- Peer Support
Assessing ROC Within VA
Sample Sites

- Acute inpatient mental health units at 34 VAMCs:
  - Representing every major region of the country
  - 16 different VISNs
  - Rural (n=3, 9%) and urban (n=31; 91%) setting
Data Sources

- Data collection included several sources:
  - Observations from 2-day site visits
  - Key informant (staff) interviews
  - Veteran interviews
  - Administrative data
  - Chart reviews
**Staff Key Informants**

- Average of 4.4 key informant interviews were conducted for each site (range 3 to 7)
- Targeted:
  - Unit Nurse Manager
  - Medical Director/Lead Psychiatrist
  - Program Coordinator
  - Social Worker
  - Local Recovery Coordinator
- 1 hour
- Semi-structured (phone)
- Implementation of elements
- Implementation process
Sample

Veteran interviews

- Average of 5.7 veteran interviews were conducted for each site (range 4 to 9)
- Over half of Veterans interviewed were White (56%)
- One-third were Black or African American (33%)
- Small number were Hispanic or Latino (9%)
- Majority of participating Veterans were male (79%)
Scoring

- Raters
  - Members of Study Team
  - Decades experience as providers, consultants, researchers, and family members
- Primary rater (secondary and tertiary raters when necessary)
  - Coordinated data collection
  - Led site visit
  - Drafted a preliminary site summary
- A site scoring meeting
  - ≥4 raters
  - consensus.
Results
Levels of Implementation

**Common**
- Sufficient Volume of Group Programming
- Respectful Therapeutic Interactions
- Autonomy Promoting Environment
- Outpatient Care Coordination

**Very Common**
- Integrated Care for Comorbid Physical Health
- Suicide Prevention
- High Quality Programming
- Behavior Managed Through Least Restrictive Means

**Uncommon**
- SDM for Outpatient Treatment
- Least Restrictive Discharge
- In-Reach
- Support for Programming
- Warm & Inviting Unit
- Peer Support
- Interdisciplinary Treatment Team
- Family/Significant Other Involvement

**Very Uncommon**
- Written Treatment Plan
- Recovery-Oriented Goal Setting
- SDM for Medication Management
- SDM for Inpatient Treatment
- Individual Evidence-Based Psychotherapy
Inpatient Treatment Planning

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Discussion

- Development of this scale is a big gain toward conceptualizing and operationalizing recovery-oriented care in the context of acute inpatient mental health care.

- Content validity is strong
  - Consistent with extant literature
    - Patient perspectives
    - Staff/provider perspectives
    - Other implementation efforts
Not done yet

- Psychometrics
  - Item level issues
  - Factor analysis not strong fit
- Feedback
  - Field
  - Peer review
- Outcomes
VA Successes

- Suicide Prevention
- Behavior Management
- Integration of Physical Health
- Quality Programming
Implementation Data (Preliminary Thoughts)

- Data analysis on-going
- Data is sparse - Why?
  - Common understanding of concepts took a long time
  - Institutional amnesia
  - No singular “launch” at sites
- Model specificity a barrier or facilitator, depending on the item
  - 40 HOURS OF PROGRAMMING!!!!
  - VS. SDM or Goal-setting
Other Barriers

- Focus on Safety and Acute Stabilization
- Medical Model Focused Prescribers

“Yes. 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 psychosocial type issues. I believe that our psychiatrist is totally grounded in biological processes and totally believes in those and therefore there’s- psychosocial issues are either discounted or they’re farmed out to the social workers.”

– Psychologist/Treatment Coordinator
Facilitators

- Not necessarily sufficient (or necessary)

- Staffing
  - E.g., No psychologist = no therapy

- Champion
  - Helpful (but can be trumped)
Future Directions

- For our team
  - Assess relationship with Veteran outcomes
  - Analyze implementation data

- Need evidence-base for
  - Inpatient programming (individual & group)
  - Specific models of goal-setting
  - Specific models of shared decision-making
Thank you!

QUESTIONS & DISCUSSION