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**Improving Access and Delivery of Mental Health Care to Veterans  
Through a Care Coordination Pilot at a Texas Department of  
Veterans Affairs Hospital**

Jacqueline Buval  
*Boise State University*

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Improving Access and Delivery of Mental Health Care to Veterans Through a Care Coordination  
Pilot at a Texas Department of Veterans Affairs Hospital

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Boise State University

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By

Jacqueline Buval

Committee Chair (Faculty Mentor): Teresa Serratt, PhD, RN

Committee Member (Second Reader): Leslie Falk, DNP, RN

## Table of Contents

Abstract .....	7
Problem Description .....	9
Introduction.....	9
Problem Background .....	11
Local Problem.....	13
Available Knowledge.....	14
Literature Review.....	14
Synthesis of the Evidence .....	16
Rationale .....	21
Theoretical Models .....	21
Project Framework.....	22
Specific Aims.....	23
Context.....	24
Population .....	24
Setting and Resources .....	24
Congruence of Project with Organizational Mission, Values, Strategies, and Needs	
Assessment.....	27
Evaluating change and readiness for change .....	28
Strengths and Weaknesses .....	28
Scholarly Project Agreement .....	29

Interventions .....	29
Logic Model.....	31
Correlation of interventions with the Theoretical Model .....	34
Timeline .....	35
Measures .....	35
Analysis.....	36
Ethical Considerations .....	37
Ethical considerations and protection of participants .....	37
Conflicts of Interest.....	38
Biases .....	38
Threats to Quality .....	38
IRB application and project determination .....	39
Project Budget.....	39
Sustainability.....	40
Results.....	40
Steps of the intervention .....	40
Process measures and outcomes .....	42
Outcome analysis .....	44
Contextual elements that interacted with the intervention(s) and associations between the outcomes, intervention(s), and contextual elements .....	49
Unintended consequences .....	51

Actual project revenues/expenses .....	51
Summary .....	52
Interpretation.....	54
Association Between Interventions and Outcomes.....	54
Comparison of Results with Previous Findings.....	55
Impact of Project on People and Systems.....	55
Costs and Strategic Trade-Offs.....	55
Policy Implications .....	56
Limitations .....	58
Conclusion .....	58
Usefulness of the Work.....	59
Sustainability.....	59
Potential for Spread to Other Contexts .....	60
Implications for Practice and Further Study .....	60
Next Steps and Dissemination .....	61
References.....	63
Appendices.....	74
Appendix A: Literature Review Summary Table .....	74
Appendix B: Logic Model Table .....	91
Appendix C: SWOT Analysis Table.....	98
Appendix D: Scholarly Project Agreement .....	99
Appendix E: Care Transition Workflow .....	102

Appendix F: Project Timeline.....	103
Appendix G: Outcome Evaluation Table.....	107
Appendix H: Collaborative Institutional Training Initiative .....	112
Appendix I: Recruitment Script .....	113
Appendix J: Project Flyer .....	114
Appendix K: Employee Survey Question Notification Memorandum.....	115
Appendix L: Letter of Determination .....	116
Appendix M: Expense Reports .....	117
Appendix N: 2 to 3-year Budget.....	129
Appendix O: Statement of Operations .....	130
Appendix P: Communication to Mental Health providers .....	131
Appendix Q: Communication to Primary Care providers .....	132
Appendix R: Communication to Nursing Staff .....	133
Appendix S: Care Transition Inclusion/Exclusion Criteria .....	134
Appendix T: Telephone Script.....	135
Appendix U: MH Discharge Packet .....	137
Appendix V: Coping skills Resource.....	145
Appendix W: My HealthVet Flyer.....	146
Appendix X: Electronic Documentation Template.....	148
Appendix Y: Handoff to Primary Care Nurse .....	150
Appendix Z: Mental Health Provider Pre and Post Assessment Scores .....	151
Appendix AA: Primary Care Provider Pre and Post Assessment Scores .....	152
Appendix AB: Outcome 1 Mental Health Provider Responses .....	153

Appendix AC: Outcome 2 Primary Care Provider Responses .....	154
Appendix AD: Participant Gender .....	155
Appendix AE: Participant Age Group .....	156
Appendix AF: Participant Diagnoses.....	157
Appendix AG: Participant Military Service Period .....	158
Appendix AH: Participant Conflict Involvement .....	159
Appendix AI: Primary Care provider panel receiving MH patients .....	160
Appendix AJ: Mental Health provider panel discharges .....	161
Appendix AK: Veteran Satisfaction Questionnaire Results .....	162
Appendix AL: Staff Satisfaction Questionnaire Results .....	163
Appendix AM: Actual Expense Report .....	164
Figures.....	167
Figure 1 .....	167
Figure 2 .....	168

## Abstract

**Background:** Mental health (MH) disorders are among the leading cause of disabilities in adults, with an even greater prevalence among Veterans who served in combat. Forty percent of troops returning from combat zones report suffering from post-traumatic stress disorder (PTSD) or depression and 33% report trouble accessing MH care. Access to care is directly influenced by care coordination procedures in health care systems. If care coordination is poor or lacking, patients remain in settings that are inappropriate for their level of care. Implementing a care coordination program can improve care transitions, provide the necessary support for patients to successfully transition, and improve access to specialty MH for patients who need a higher level of care.

**Project Design:** The purpose of this project was to 1) review the literature to determine best practices for health care transitions, 2) develop a pilot quality improvement program based on the best evidence, 3) implement the pilot, and 4) obtain feedback from facilitators and participants to enhance care transitions and sustain project interventions. The intervention was to implement a nurse-led standardized care coordination pilot program in the MH department to facilitate effective care transitions from MH to Primary Care (PC), specifically aiming to improve the process and patient experience.

**Results:** Results demonstrated that the interventions improved Veterans' experience of care, provided them with the necessary education and support, and facilitated the continuation of care in a setting appropriate to meet their needs. Further inquiry is needed to identify best practices in translating the term "care coordination" into the providers' standard medical language to improve their awareness and understanding of this model of care.



**Recommendations:** The results of the project demonstrated that care coordination programs can be useful in MH and PC and can be adopted in other health care settings where care transitions occur. It is essential to develop partnerships with organizational leaders and staff to design a multidisciplinary approach for care transitions to be effective. Care coordination activities that focus on timely communication and shared decision-making will ensure the continuation of care across settings and promote positive patient outcomes.

**Conclusion:** Effective care transitions require collaboration among health care professionals. A care coordination model can improve patient outcomes. The care coordination pilot established guidance related to care coordination activities needed for successful care transitions to occur, improved care transitions between MH and PC, supported patients in managing their health care during care transitions, and provided a framework for future improvement work.

**Keywords:** Veteran, Mental Health, PTSD, Depression, Primary Care, Care Coordination, Care Transitions.

Improving Access and Delivery of Mental Health Care to Veterans Through a Care Coordination  
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## **Problem Description**

### **Introduction**

Mental health (MH) disorders are among the leading causes of disabilities in adults, with an even greater prevalence among Veterans who served in combat (National Institute for Mental Health, 2017; World Health Organization, 2018; Tanielian et al., 2008). Conflicts in Afghanistan and Iraq have been the longest-ever sustained United States (U.S.) military operations in history; and returning Veterans are increasingly diagnosed with post-traumatic stress disorder (PTSD) and depression than other combat-era Veterans (Seal et al., 2007). Combat Veterans are exposed to traumatic events, involved in high-stress and dangerous situations, and are subjected to a rigorous active-duty lifestyle. They are at an increased likelihood of being diagnosed with MH disorders as opposed to Veterans who have not served in combat. Because of this, the MH prevalence rates have increased from 18% in 2008 to close to 30% in 2019 (Riley et al., 2019), and are predicted to continue to rise as conflicts overseas continue.

The escalation in MH disorders has led to an influx of Veterans seeking care at their local Department of Veterans Affairs (VA) hospital. The organization has been challenged in meeting the demand. Access to care, whether privately or within the VA, is one of the most significant concerns discussed in the literature and is directly influenced by poor communication among health care providers and suboptimal care coordination procedures spanning across the health care system (Dusek et al., 2015). The increased demand for MH care has prompted organizational leaders to review current care delivery, ensuring that care is delivered in the most appropriate care setting and that care transitions are made when patients are clinically stable.

Ideally, patients expect to receive care in the most appropriate care setting to meet their health care needs and for MH patients, “receiving care in the least-restrictive care setting” is an important contributor to transitioning individuals out of the sick role and into recovery (Smith et al., 2019, p. 2). Due to the complexity of the health care system, patients often remain in settings that are inappropriate for their level of care. Care is often fragmented and poorly coordinated, leading to a lack of care transition, which impedes access to care (Hudson et al., 2019). Transitioning patients back to a lower level of care when they are stable and/or recovered aligns with the MH recovery model and supports continuum of care. Individuals can improve and recover from their illness, do not require indefinite specialty-MH treatment, and can be managed by Primary Care (PC) providers (Fletcher et al., 2019).

Transition of care refers to the movement from one health care setting to another and relies heavily on effective coordination of care to ensure continuum of care. For example, patients discharged from acute care to home depend on the health care staff to educate, follow-up, and provide them with the necessary equipment and resources to succeed at home. This activity is referred to as care coordination. Care coordination involves deliberate actions to organize care activities and communication of information among the health care team involved in patient care to achieve safer and more effective care (Choi, 2017). Coordination failures such as untimely follow-up care, delayed access to care, and difficulty navigating the health care system can contribute to poor patient outcomes and possibly rehospitalization (Dusek et al., 2015). Care coordination activities must engage the patient and family/caregiver to ensure they actively participate and collaborate with their health care team for ongoing health care needs; this process is often referred to as the continuum of care (American Academy of Family Physicians, 2015).

When organizational care transitions are poor or absent, patients' sustained recovery and/or stability is negatively impacted, and relapse may occur. However, when care transitions are effectively coordinated while ensuring a continuum of care, it can reduce non-optimal utilization of care resources across care settings and increase access to care throughout the health care system (Smith et al., 2019).

### **Problem Background**

As of June 2015, approximately 2.7 million troops have served in Iraq and/or Afghanistan. Over 1.9 million have become eligible for VA health care since 2002. Nearly 1.2 million have subsequently obtained VA care (Epidemiology Program, Post-Deployment Health Group, Office of Patient Care Services, Veterans Health Administration, Department of Veterans Affairs, 2017). Mental Health disorders were among the top three diagnoses of Veterans obtaining VA care between 2002 and 2015 (Epidemiology Program et al., 2017), with approximately 57.6% having at least *one* mental health diagnosis (Brancu et al., 2017). The most prevalent MH diagnoses were PTSD (55%), depressive disorders (45%), anxiety (43%), and alcohol dependence (Brancu et al., 2017). Veterans often delay seeking care due to the stigma surrounding MH and report experiencing trouble accessing care (Morissette et al., 2018; Seal et al., 2009).

Individuals with PTSD and depression are at increased risk of unhealthy behaviors and fall into the cycle of poor health. According to the Office of Disease Prevention and Health Promotion (2019), there is strong evidence that links MH disorders to serious chronic diseases. The cycle of poor health exacerbates chronic conditions, which intensifies symptoms of mental disease, decreasing the person's ability to actively participate in treatment and recovery from their MH disorder(s). This is a major concern because early detection and adequate treatment can

prevent the development of more chronic physical and behavioral health problems (True et al., 2015).

Meeting the needs of returning troops suffering from MH disorders is a prioritized health issue of health care systems. Organizations must deploy strategic plans to meet the demand. Access to care is a complex issue, requiring an adequate number of providers. Over the last 15 years, the number of MH providers in the U.S. per 100,000 patients has steadily declined by 10%, compounding the access to care issue (Bishop et al., 2016; Smith et al., 2019). The VA, which operates the largest integrated health care system in the U.S., faces similar challenges of MH provider shortages, contributing to reduced access for Veterans seeking MH care (Smith et al., 2019).

The VA MH care department is one of the largest segments within the organization. As a result, it experiences many referrals and issues with transitioning care back to PC providers once Veterans are stable or recovered (Smith et al., 2019, Seal et al., 2009). Recovery is a process where individuals change and accept to live a self-directed life. It does not mean they will be symptom free. In essence, it means they will be able to live without their MH disorder(s) interfering with activities of daily living or exacerbating or contributing to a chronic disease. The VA supports this recovery model and uses it as a guiding principle for its entire MH delivery service line (Benzer et al., 2015; Smith et al., 2019).

Primary Care is the first point of entry into the health care system. Mental Health disorders are typically diagnosed there and referred onward to specialty-MH clinics for further evaluation, initial treatment, and development of a sustainable care plan (Seal et al., 2007). Many patients may not require long-term treatment in specialty-MH as PC providers can manage the maintenance of uncomplicated MH medications and monitor for symptoms of relapse. Veterans

often remain in specialty-MH even though their care can be effectively transitioned to PC. A review of the literature reveals that major barriers to effective care transitions are a lack of standardized care coordination and referral process, electronic health record impediments, and clinic access (Benzer et al., 2015). The lack of a standardized care transition process between departments negatively impacts Veterans who have achieved recovery or are stable and reduces access for Veterans who need a higher level of specialty-MH care (Seal et al., 2009).

### **Local Problem**

Texas is the second largest state in the U.S., with a population of 1.6 million Veterans (Texas Department of State Health Services, 2019). Approximately 50 thousand Veterans reside in the [REDACTED] County area. Sixty percent of these Veterans were involved in Iraqi and /or Afghanistan conflicts, and 40% have a PTSD and/or depression diagnosis (Morissette et al., 2018; World Population Review, 2019). Despite the documented need, Veterans hesitate to seek care for multiple reasons (stigma, shame, insecurities), and those that do seek care experience trouble navigating their care (True et al., 2015). In [REDACTED] County, the Community Health Needs Assessment (CHA) reported that patients' perception of MH care access is limited, even though, statistically the number of MH providers in the county is double that of the state average and deemed adequate by professional standards (Bilton, 2019). Focus group participants expressed concern over fragmented care and lack of coordination among health care providers (Bilton, 2019).

Suboptimal care coordination across health care settings directly influences overall access to care and becomes a barrier for Veterans to receive care in settings that are appropriate for stabilization and recovery (Dusek et al., 2015; National Academies of Sciences, Engineering, and Medicine, 2018). The lack of care coordination may help explain why [REDACTED] County residents

perceive inequitable health care access, despite having an ample supply of health care providers and facilities in the region. As a result, the CHA denoted access to MH care and effective care coordination as a prioritized health care need for █████ County residents. With the growing number of Veterans diagnosed with MH disorders seeking care in █████ County, meeting the demand and providing access to MH services in appropriate care settings has been challenging (Riley et al., 2019; Seat et al., 2007) for the local VA.

### **Available Knowledge**

#### **Literature Review**

The VA is highly scrutinized by the public and other health care systems regarding access to care, evidence-based treatment options, and resource utilization (Arya, 2020; Seal et al., 2009). As the demand for MH services increases, ensuring care delivery in appropriate care settings has become important to improve overall access to care. Concentrating on care coordination activities to ensure effective care transitions from MH back to PC is one strategy to improve Veteran recovery and stability while increasing access to care (Benzer et al., 2015). Care coordination can be an effective strategy for MH patients to feel a sense of security during care transitions, emphasizing their strengths and accomplishments as they progress toward recovery (Fletcher et al., 2019; Nembhard et al., 2020). Identifying evidence-based care coordination activities that support these optimal care transitions would be necessary for developing a pilot project.

A literature review was conducted to identify evidence to support continuum of care during transitions of care. The purpose was to determine if utilizing an integrated technology-based care coordination framework effectively supports patients as they transition from one setting to the next. The searchable question was: For individuals with stable mental health

disorders who are transferring from specialty-MH back to PC setting, can the use of an electronic communication tool provide an effective mechanism or process to improve coordination along the care continuum?

A systematic database search was completed in PubMed, PsycINFO, CINAHL, and Computer Source (via EBSCOhost) using the terms: primary care, mental health, integration, health information exchange, communication, and transitions of care. Inclusion criteria were English language, published in a health care peer-reviewed journal within the last five years for the adult patient population (>18 years of age) who received MH care in an outpatient setting with outcomes pertaining to improved communication and coordination of care during care transitions. Initial results yielded 65 eligible articles, which resulted in 50 articles that met inclusion criteria after being reviewed for relevance. Of these, article abstracts were further screened to identify those that specifically discussed care coordination, integration, transitions of care, technology, and communication. Pediatric, adolescence, inpatient settings, mobile technology, telehealth modalities of care, dissertations/theses, and interventions targeting *treatment* of specific MH or other illnesses were excluded. As a result, 38 of the initial 50 articles were excluded. Major exclusionary reasons were: duplicates, supplemental materials, pediatric and youth populations, high-need/complex patient population, disease-specific intervention focus, telemedicine treatment, and outside of the scope of aim statement or had mental health as a secondary focus.

Twelve peer-reviewed articles were included and provided strong evidence that care coordination, integrated care, and health information technology (IT) support patients during care transitions but did not identify interventions. A subsequent literature review was conducted to find new evidence regarding nursing interventions that support safe care transitions. The



subsequent searchable question was: For individuals with stable mental health disorders who are transferring from specialty-MH back to PC setting, what is the best evidence to coordinate care along the care continuum? The search was completed in the aforementioned databases using the terms: *nurse*, *transitions of care*, and *care transitions*. Initial results yielded 38 articles.

However, once reviewed with the same inclusion and exclusionary list described prior, three were included as new evidence that contributed interventions towards safe care transitions. These 18 articles were examined and appraised for their level of evidence and quality using the John Hopkins research and non-research evidence appraisal tools. The appraisal identified one level I, five level II, eight level III, and four level V articles, of which 14 were A (high-quality) and four were B (good quality) (Appendix A).

### **Synthesis of the Evidence**

There was strong evidence to support the three emerging concepts to benefit care transitions: integrated care, care coordination, and health IT solutions through the selected articles.

### **Integrated Care**

Changing care delivery is the foundation of improvement work, and moving to an integrated model of care supports care coordination, and transitions can meet organizational quality of care goals and enhance patient-centered care (Benzer et al., 2012; Benzer et al., 2015; Sandoval et al., 2018; Sullivan & Whaler, 2017). Integrated care includes strategies that can be deployed through population health strategies and health IT solutions to improve the current system of care, collaboration, and communication for the betterment of health outcomes (Sullivan & Whaler, 2017). Benzer et al. (2012) adds to these findings through a grounded theory study design in which they sought to understand potential barriers to implementing an integrated

collaborative model of care. Study findings revealed that successful implementation of integrated care coordination considers preexisting collaborative relationships, emphasizing the importance of organizational leadership support to influence collaboration between PC and MH coordination practices (Benzer et al., 2012). Various barriers to implementation included lack of leadership support, education, time, and physical space (Benzer et al., 2012 & Benzer et al., 2015). In addition, electronic workflow impediments (such as inconsistencies in documentation) impaired communication between PC and MH (Benzer et al., 2012 & Benzer et al., 2015). Implementing a standardized coordination process when discharging patients from one setting to another can address these barriers as it improves collaboration and communication among providers and departments, and improves overall access to care (Benzer et al., 2015). Evidence-based components of care coordination include care plan development, support of patients during health care transitions, arrangement of services, self-management goal setting, and chronic disease management (Benzer et al., 2015). Organizational leadership support and provider experience were noted as key influences in overcoming barriers and successfully implementing MH coordination practices (Benzer et al., 2012).

Fletcher et al. (2019) reported that providers and patients were most concerned about getting lost in the shuffle during transitions and potential inconsistencies in care. Leung et al. (2019) provided a perspective on possible disparate treatment options between PC and MH. The study found no appreciated difference between the quality of care, treatment guidelines, and follow-up adherence between specialty-MH and PC-MH integration. Their study found that Veterans who were deemed stable receiving MH care in PC received the same (and sometimes even higher) level of care than those who remained in specialty-MH (Leung et al., 2019). Vulnerable populations, such as homeless Veterans, were found to have received higher quality

of care. They cited that the improvement could be due to MH service being available in the same PC setting, as opposed to potentially losing the opportunity to care for Veterans when care is postponed (referred) to a specialty area (Leung et al., 2019). Integrating care overcomes barriers and fragmentation of care by linking and coordinating services to improve health outcomes. In essence, it creates a safety net – especially for vulnerable periods, such as change of care setting (Leung et al., 2019)

### **Care Coordination**

Nurses play a central role and are key communicators and collaborators in the coordination of patient care, and there is a great need for them to take an active role in care transitions (Duske et al., 2015; Jeffs et al., 2017). Successful nurse-led interventions included education and coaching patients about self-management skills, ensuring patients are aware of follow-up appointments and post-discharge plans through the use of standardized electronic documentation tools, and bidirectional communication techniques (Jeffs et al., 2017). Case management, use of care plans or pathways, and standardized handoff information through the electronic health record (EHR) were cited as additional successful nurse-led strategies (Duske et al., 2015). A systematic review (Falconer et al., 2018) reported that multiple studies found the use of the EHR and web-based care for coordinating care as beneficial, mentioning specifically that using technology aids in collaborative decision-making, improves care coordination, and proved to be effective for the Veteran population.

Roulea et al. (2017) examined the impact of nurses using technology to improve communication and care delivery. Morton et al. (2015) explored user perspectives of using an EHR to support care coordination. Both studies found that the use of technology reduced time devoted to the verbal transmission of information, supported translating research into practice,

improved care coordination and collaboration among health care staff. Smith et al. (2019) developed an electronic report for the VA that contained patient information, visit patterns, and follow-up appointments that could be used to initiate care coordination procedures and facilitate transitions more readily.

The literature demonstrated that the use of technology improved coordination of patient care, integrated care teams and enhanced timely communication between sending and receiving teams during care transitions. Furthermore, the implementation of an integrated care coordination model increased surveillance of patients, improved coordination of care, documentation, effectiveness of care, and teamwork (Jones et al., 2018). Tomlinson et al. (2020) supports this strategy, offering that follow-up models such as bridging outreach and liaison services help bolster integration and post-transition support for patients. Nurses as the point of contact for patients during care transitions (through a bridging or liaison role) can be instrumental to patients during their care transition. Although coordinating care is part of the nurses' traditional role, strong organizational leadership is required to optimize the scope and responsibility of the nurse to ensure nursing interventions can cross care transition points (Jeffs et al., 2017). Care coordination is the vehicle that links patients to services within the organization and is linked directly to promoting recovery for MH patients (Hannigan et al., 2018).

### **Health IT solutions**

Care coordination activities reflected in the EHR can promote transparency and easy access to patient treatment goals and care plan. Still, they cannot be fully appreciated unless health care staff are educated on its use and purpose. De Angelis et al. (2016) conducted a systematic review to examine health professionals' perceived usability of information and

communication technologies for the dissemination of clinical practice guidelines. The authors concluded that the use of web-based workshops, email, and electronic educational games were the most useful in knowledge transfer and skill enhancement (De Angelis et al., 2016). While clinical practice guidelines were not the focus of the literature search, the study conclusions can be generalized for information on dissemination and teaching in process improvement projects that seek to implement health IT solutions.

Jones and Wittie (2015) found that safety, quality improvement, and cost reduction were positively correlated to care coordination activities conducted through the EHR, but pointed out that electronic documentation must be customized to departments' specific needs to be deemed "useful" in their daily practice. Cifuentes et al. (2016) and Woodson et al. (2018) also found that customizing EHR templates improved integration and coordination of care while improving care provider communication. They surmise that EHRs need to automate and support data exchange of screenings, behavioral health history, patients' social and medical history, and care goals to provide a summary of information to share between health care teams during and after transitions of care (Cifuentes et al., 2016; Woodson et al., 2018). Robke (2015) further expounded on this concept through storytelling of a patient who expired due to untimely transfer of medical information causing a delay in treatment. Robke's case study illustrates the importance of data exchange for effective care delivery, coordination of care, and health outcomes.

A variety of high evidence, good to high-quality research exists in the literature to support evidence-based interventions during transitions of care. While one can analyze these concepts separately and form an opinion that one may be stronger than another, the evidence consistently incorporated all three concepts in their discussions and findings, citing them inclusively as the most advantageous way to meet the care needs of patients and health care staff

during transitions of care. This literature review offers convincing evidence that an integrated, standardized care coordination process between PC and MH may improve care transitions. Implementing a nurse-led standardized process can meet organizational quality of care goals, improve access to proper care, and enhance patient-centered care (Sandavol et al., 2018; Sullivan & Whaler, 2017; Falconer et al., 2018). A standardized care coordination model combines the physical and MH care needs through the lens of holistic care and reduces fragmentation between providers and services. This model of care has shown to be clinically effective, cost-effective, and improves collaboration among care providers to effectively manage and coordinate patient care (Benzer et al., 2015). These are key concepts in line with the VAs strategic plan and vision.

## **Rationale**

### **Theoretical Models**

Meleis' Transitions Theory (MTT) was chosen to guide the development of this project as it provides context and understanding of the complexity and multidimensional nature of care transitions (Figure 1). The VA's Quality Enhancement Research Initiative (QUERI) model will be used to operationalize interventions (Figure 2).

The essential properties of MTT include awareness, engagement, change and difference, time span, critical points, and events (Meleis, 2010). The theory describes transitions as a process that occurs over time, including factors relating to change in identity, role, relationships, abilities, and behaviors. MTT provides a holistic framework for care transition instead of focusing on just the physical movement alone. Meleis (2010) believes that nurses are instrumental in coordinating care transitions and that nursing interventions, such as readiness assessment, education, preparation, transitional planning, patient engagement, and multidisciplinary collaboration, support patients to achieve successful transitions. As transitions are often a vulnerable period for

patients, the MTT was chosen because it provides a framework to facilitate effective care transitions, an important consideration for the MH population. When there is no mechanism or process in place to support safe care transitions from one care setting to another, the underlying assumption is that the lack of coordinated care contributes to poor transitions and delays access to care. Using MTT to guide nursing therapeutics and interventions will reduce siloed care and support successful care transitions. Interventions will aim to reduce fragmentation of care by efficiently coordinating care needs and bridging the communication gap between the MH and PC.

The QUERI model's mission is to improve the health outcomes of Veterans by providing a quality improvement and systems redesign framework to accelerate evidence-based practices adoption into routine health care settings (Kilbourne et al., 2019). Six main steps are included in the model: 1) identification of problem per patient population, 2) identification of best practices, evidence-based guidelines, and recommendation, 3) review of existing practice patterns and outcomes across the VA and current variation from best practices, 4) implementation of interventions or programs to promote best practice, 5) validation that best practices improve outcome, and 6) documentation that outcomes are associated with improved health-related quality of life (Kilbourne et al., 2019). The QUERI model, known throughout the VA and its culture, aligns organizational priorities with front line staff engagement and supports VA's transformation to a Learning Health System and High-Reliability Organization (HRO). These two initiatives are a top priority for VA's Medical Centers.

### **Project Framework**

The Kellogg Logic Model (W.K. Kellogg Foundation, 2004) was used to organize the project elements. The logic model is a systematic approach that facilitates clear thinking and

planning, generates ideas, and communicates program objectives and outcomes to stakeholders. The model is a structured roadmap to achieve the intended project impact, linking activities with outputs, correlating those outputs to short and long-term goals, and continually evaluating organizational resources. The Kellogg's Logic Model (2004) provides a visual for stakeholders to understand how human and financial investments contribute to the process improvement project and how that connects to improved health care outcomes (Appendix B).

### **Specific Aims**

The purpose of this Doctor of Nursing Practice (DNP) project is to implement a nurse-led standardized care coordination pilot program in the MH department to facilitate effective care transitions between MH and PC, specifically aiming to improve the process and patient experience. The Veteran MH population is the largest population within the organization, access to care is problematic, and perception of care and care coordination is poor. The scope and process of the project will be defined by the date the patient discharges from MH to the completion of hand-off between nurse care coordinator and clinic nurse, or when the Veteran has completed their first PC appointment after the transition (whichever occurs first). It will include evidence-based interventions that support coordination of care needs between the time the patient discharges from MH to the completed transfer back to PC. The nurse care coordinator will be the point of contact for Veterans, supporting them with the transition process and navigating their health care. The nurse will educate patients on what to expect after discharge from MH, assess and assist with any intermittent care needs, support self-management of health care needs, and organize their care (e.g., developing a plan of care that includes education, follow-up appointments, and organizational resources, etc.) so that they can successfully transition between health care settings. They will act as the liaison between MH and PC for follow-up and ongoing



care needs, improving integration and communication among health care teams. The scholarly project will focus on seven elements identified by the Joint Commission (JC) (n.d.) for safe transitions to occur: leadership support, multidisciplinary collaboration, early identification of patients at risk, transitional planning, medication management, patient and family engagement, and timely transfer of information. If the pilot program functions as intended, patient experience of care, support for self-management of health care needs, and access to care should improve.

## **Context**

### **Population**

The Veterans Health Administration is the largest integrated health care system in the U.S., serving over nine million Veterans in over a thousand VAs nationwide. It is a federal organization funded by Congress with a hierarchical and bureaucratic structure. With the growing number of Veterans diagnosed with MH disorders and seeking care in rural [REDACTED] County, meeting the demand and providing access to MH services in appropriate care settings has been challenging. The local VA, [REDACTED], is a medium sized JC accredited 1-A complexity level facility serving more than 252,000 Veterans in 11 congressional districts in 39 counties, spanning over 35,243 square miles in [REDACTED] Texas [REDACTED], 2015). In the fiscal year 2019, the medical center treated 110,237 unique Veterans, recorded 6,660 inpatient admissions, and totaled 1.3 million outpatient visits [REDACTED], 2020).

### **Setting and Resources**

The executive leadership team consists of the Director, three Associate Directors, Chief of Staff, and an Associate Director for Patient Care Services. [REDACTED] employs approximately 4,200 staff committed to VA's ICARE values of integrity, commitment, advocacy, respect, and

excellence. They are dedicated to upholding the mission and vision of honoring Veterans by promoting individual well-being and providing exceptional health care, characterized by compassionate care and trust. Many strides have been made towards shared governance, achieving Pathways to Excellence, and becoming an HRO. The strategic plan envisions: (1) improvements in Veteran experience and employee engagement, (2) commitment to HRO principles, (3) improvements in communication to staff, (4) achieving a higher level of analytic maturity, and (5) embodying a Whole Health vision where we change the conversation from “What’s the matter with you” to “What matters to you, and how can we help you live your best life?”

Primary Care and MH are the largest departments within the organization consisting of 90.77 full-time equivalent (FTE) PC providers and 137.92 FTE MH providers (Mental Health workforce report, 2020; Primary Care Leadership report, 2020). In the fiscal year 2019, MH and PC provided care to 109,365 and 110,223 thousand Veterans, respectively (Mental Health workforce report, 2020; Primary Care Leadership report, 2020). The MH department struggled to meet organizational performance metrics such as access to care and patient satisfaction (Mental Health workforce report, 2020; Primary Care Leadership report, 2020). The VA uses the Strategic Analysis for Improvement and Learning (SAIL) value model to measure, evaluate, and benchmark quality and efficiency of care. According to the 2019 SAIL report, [REDACTED] is not meeting its goal of being among the top 10% best place for MH care. The SAIL report composite score of 0.004 (goal 1.6) reflects inadequate access to care, poor Veteran experience of care, and suboptimal continuation of care procedures (VA Mental Health Management System, 2019). The composite score is made up of four domains, rated from 1 (best) to 5 (worst), and [REDACTED] received the following scores: care coordination (5), appropriate treatment options (2), timely

follow-up (2), and Veteran and provider experience of care delivery (5) (VA Mental Health Management System, 2019). The organization is also rated on a Star metric scale that measures access to care, quality of care, employee perception about the organization, nursing turnover rates, efficiency and capacity. On a rating scale of five being the best and one being the worst, [REDACTED] star rating was a two in 2019 (VA Mental Health Management System, 2019).

While [REDACTED] does a good job in providing appropriate MH treatment options and timely follow-up appointments for established patients during potentially risky periods, there is room for improvement in coordinating Veteran care, especially for stable patients who can transition to a lower acuity care setting such as PC. Poor or absent care coordination practices places additional strain on providers' workload and access to care. This issue is further compounded by a 20% vacancy for MH providers, high Veteran no-show rate, and low PC-MH engagement (9%) (VA Mental Health Management System, 2019). The higher the PC-MH engagement score, the more opportunity to treat Veterans during identification of need (usually in PC) instead of referring them to specialty-MH and possibly missing or losing the chance to address Veteran care needs. Furthermore, the specialty-MH saturation rate (Octane Ratio) for the fiscal year 2019 was 14% higher than the acceptable rate of 5% (VA Mental Health Management System, 2019). The Octane Ratio is the ratio of established patient appointments to new patient appointments. A high-octane ratio indicates the departments need to review their current patient panel to see if patients are appropriate to refer back to PC. Assisting patients in reaching desired goals and returning to PC, when appropriate, allows specialty care resources to be directed to other patients waiting for specialty care. These challenges highlight the importance of maximizing existing resources efficiently and ensuring Veterans receive care in settings that are

appropriate to improve health, function, and well-being (Gulliford et al., 2002; Smith et al., 2019).

### **Congruence of Project with Organizational Mission, Values, Strategies, and Needs Assessment**

To meet demand and improve MH access to care, ██████ received additional government funding in FY20 to fill vacancies and expand services. Addressing staffing challenges is essential; however, improving current support structures and processes is equally important in improving care delivery and patient perception of care. An organizational questionnaire and strengths, weaknesses, opportunities, and threat (SWOT) analysis was completed in collaboration with the Associated Chief of Staff Mental Health and facility Flow Champion (Appendix C). The results were incorporated in the logic model to identify the best strategies to improve processes, while being flexible and in tune with organizational resources and needs.

The VA recognizes these challenges at the national level and has introduced several initiatives to improve care delivery in appropriate care settings. One such initiative is the Flow Initiative. It uses a clinical decision support (CDS) tool to identify Veterans in specialty-MH who may be appropriate to transition their care back to PC. The initiative was piloted in a ██████ ██████ Health Care System, and early results proved favorable to the initiative's goal of discharging patients back to PC (Smith et al., 2019). A total of 1,566 patients were studied over a 12-month period, assessing the effectiveness of the CDS tool's effectiveness, and 424 patients were transferred back to PC, with only nine returning to the specialty-MH clinic during the study period. Study results also indicated that Veteran were apprehensive to transition, citing that it was easier to accept when their MH provider discussed the idea over several sessions, allowing

Veterans to think it through and reach acceptance, without feeling abandoned or pressured to transition to another care setting (Smith et al., 2019).

### **Evaluating change and readiness for change**

The transition from specialty-MH back to PC is often a vulnerable period for patients and can cause risk to their MH and well-being if not coordinated properly (Slade, 2017). Transitions of care requires robust collaboration among health care professionals with effective transfer of information to safeguard continuation of care. While the Flow initiative laid the groundwork for identifying appropriate patients to discharge back to PC via the CDS tool, it came up short in addressing care coordination strategies to support Veterans to ensure a safe continuum of care once discharged back to PC. It did, however, provide the impetus for local VAs to find and implement strategies to support care transitions, placing it as a performance indicator on the [REDACTED] leadership Executive Career Field Performance plan. This will bring a greater emphasis to this critical problem and prompt leadership commitment and support. According to [REDACTED] subject matter experts, the local VA does have the capacity and support structure to address care coordination inefficiencies and support improvement initiatives. This aligns with improving SAIL metrics and moving [REDACTED] towards its goal of becoming part of the top 10% of best VAs for care delivery.

### **Strengths and Weaknesses**

Successful implementation of the improvement project poses several barriers and potential threats. The 2019 [REDACTED] Patient Experience Consultation visit and All Employee Survey results indicated poor staff engagement, poor communication among health care staff, and overall organizational change fatigue (Gabris, 2019; VA All Employee Survey, 2019). These elements are important contributors to the success or failure of process improvement initiatives.

The proposed nurse care coordination pilot heavily relies on the success of the overarching Flow Initiative. A version of the Flow Initiative had been semi-implemented in the past and failed due to PC and MH reluctance to accept the implementation. Primary Care providers voiced concerns that Veterans were being “dumped” on them, and MH complained that even stable patients who were transitioned ended up back in specialty-MH inappropriately. Because of this, staff may be resistant to engage in the Flow Initiative and hesitate to participate in the pilot project, posing a threat to implementation. A major difference between the prior Flow Initiative and current efforts is recognizing that there is no standardized transition process between the two departments. It is proposed that implementing a nurse-led care coordination program may bridge this gap.

Concerted attention will be required to engage all stakeholders, educate and coach them, build and leverage connections to solve problems, improve communication, define clear roles and expectations, and embrace a shared decision-making concept model of care. The benefits of implementing this change project outweigh the weaknesses and threats. Changing the optics from “dumping” Veterans to delivering care in the most appropriate care setting to support Veteran recovery will help improve access and perception of care delivery. Project design and implementation strategies will involve collaborating with the staff involved in the patients’ care and transition (admin. staff, MH providers, nurses, PC providers, etc.).

### **Scholarly Project Agreement**

A scholarly project agreement was developed and presented to key stakeholders and organizational leadership for concurrence and signature (Appendix D).

### **Interventions**

Fragmented health care is a systemic crisis that requires an urgent culture change, where holism, coordination, and collaboration are embraced and part of daily practice patterns (Storjell

et al., 2017). Based on the examination of best evidence and the coordination gap identified within the MH and PC departments, a nurse-led care coordination project is proposed to facilitate effective care transitions. The nurse care coordinator will be the primary resource for Veterans during their transition and act as an integral team member liaising between MH and PC departments. This type of collaboration encourages bidirectional communication between departments to ensure compassionate, quality, and patient-centered care (Curley & Vitale, 2016). Having a standardized care coordination practice is especially important to achieve quality outcomes in the ever-changing health care environment. A workflow was created with input from organization stakeholders correlating interventions to the interrelationships described by Meleis' care transition theory (Appendix E). The pilot project will be implemented on the [REDACTED] main campus in the MH and PC departments only during May-August 2021.

The first step of the process is for MH providers to review the VA's electronic report provided to them electronically biweekly by administrative staff. The report identifies Veterans who may be appropriate to transition, mainly those who have completed MH treatment and are not taking psychotropic medications and/or who are stable on pharmacotherapy regimen (Smith et al., 2019). Once Veterans are reviewed, MH providers will discuss transition their care back to PC at the next scheduled visit or via telephone call/visit (step 2). At this juncture, the Veteran will be offered the opportunity to participate in the nurse care coordination program. If the Veteran is agreeable, the MH provider will utilize a standardized electronic "MH discharge back to PC" note title. The note will have standardized verbiage embedded to clearly communicate the impending care transition. Standardizing this process will aid in achieving consistent communication between MH and PC. The MH provider will add the nurse care coordination as an additional signer to the discharge note (step 3). The additional signer mechanism acts as an

electronic alert for the nurse care coordinator to review the record to assess for project inclusion. The nurse care coordinator will contact the Veteran within 14 calendar days of the notification (step 4) and engage patients in care coordination activities such as (Lamb et al., 2018):

- a) assess needs and goals to develop a proactive care plan
- b) provide education on how to access care and navigating the health care system,
- c) monitor, follow-up, and respond to change,
- d) support self-management goals,
- e) discuss organizational and community resources,
- f) review scheduled follow-up appointments,
- g) and address any questions or concerns.

The nurse care coordinator will follow the patient's episode of care for 30 days, or up until the patient has completed their first PC appointment (whichever comes first). The nurse care coordinator will document hand-off communication via a standardized discharge note for the PC nurse, and add them as an additional signer (the additional signer mechanism acts as an electronic alert for the nurse), concluding the transition (step 6). If the Veteran is not ready to accept transitioning their care back to PC, they will remain in MH for ongoing care and support. Care transitions will be discussed as part of their care and goals at subsequent visits.

### **Logic Model**

The logic model framework was used to assimilate the following short-term outcomes to help guide the project:

1. By August 2021, MH providers demonstrated a 25% increase in awareness that specialty MH-care is generally time-limited, and once Veterans are stabilized and/or recovered, their care will be transitioned back to PC.



2. By August 2021, PC providers demonstrated a 25% increase in awareness that specialty MH-care is generally time-limited, and once Veterans are stabilized and/or recovered, their care will be transitioned back to PC.
3. By August 2021, 25% of eligible MH Veterans transitioning back to PC agreed to have their care coordinated by the new nurse-led care coordination program.
4. During May-July 2021, the nurse care coordinator contacted 85% of MH Veterans (who were discharged from MH back to PC and agreed to participate in the pilot program) within 2 weeks of discharge; and coordinated their care back to PC via the standardized electronic coordination and handoff bundle.
5. By August 2021, more than 50% of MH staff reported utilizing the VA electronic report (emailed to them biweekly by administrative staff) as a guide to assist them in identifying appropriate Veterans to transition back to PC.
6. By August 2021, more than 50% of Veterans who responded to the questionnaire “agreed” or “strongly agreed” that the new care coordination program supported Veterans care as measured by the questionnaire.
7. By August 2021, more than 50% of MH providers, PC providers and nurses who responded to the questionnaire “agreed” or “strongly agreed” that the new care coordination program supported Veterans care as measured by the questionnaire.  
  
Intermediate outcomes have been developed, but will not be measured as part of the DNP project as they fall outside the project timeline:
8. By August 2022, MH and PC demonstrated a 75% increase in awareness that specialty MH-care is generally time-limited, and once Veterans are stabilized and/or recovered, their care will be transitioned back to PC.

9. By August 2022, PC demonstrated a 75% increase in awareness that specialty MH-care is generally time-limited, and once Veterans are stabilized and/or recovered, their care will be transitioned back to PC.
10. By May 2022, 50% of Veterans participated in the RN care coordination program when transitioning care from MH back to PC.
11. By May 2022, RN coordination program was expanded to include MH and PC at facility community-based outreach clinics.
12. By January 2022, MH providers utilized the VA electronic report routinely and reviewed at least 50% of their patient panel monthly to initiate transitions back to PC.
13. By May 2022, a 75% improvement in Veteran perception of care transitions was measured by the questionnaire.
14. By May 2022, 75% of PC and MH providers and nurses reported the transition of care process useful to help support Veterans' care transition.

If the project is successful and sustained the following long-term outcomes will be achieved:

15. Mental Health providers incorporated their knowledge that appropriate care settings for MH patients supports patient recovery and support care delivery in settings that is most appropriate for patient care into their day-to-day practice.
16. Primary Care providers incorporated their knowledge that appropriate care settings for MH patients supports patient recovery and support care delivery in settings that is most appropriate for patient care into their day-to-day practice.
17. Care coordination is routinely provided to Veterans who are deemed stable or have recovered and transitioned back to PC.

18. Veterans who are deemed stable and or who have recovered are identified and transitioned back to PC via the nurse-led coordination program.
19. Mental Health providers incorporated data into their daily practice to identify appropriate care transitions and support patient care delivery in settings that is most appropriate for the patient level of care.
20. Local VA MH service met 'Best place for care' goal based on VA's Strategic Analytics for Improvement and Learning metrics: MH experience of care and Coordination of care.
21. An RN care coordination program provided the necessary framework to support Veterans during transitions of care.

### **Correlation of interventions with the Theoretical Model**

Meleis' Transitions Theory acknowledges that care transitions are complex, and people who experience ineffective care transitions can experience adverse health effects that can be attributed to a lack of care coordination (Meleis, 2010). Storfjell et al. (2017) supports this position citing that the nurse coordination model is one of the most effective strategies for reducing costs and improving outcomes for at-risk populations. Interventions in this project were developed to reduce fragmentation of care, improve care transitions, and support patient's well-being.

The QUERI model is a quality improvement framework to assist evidence-based practice adoption into the health care setting. The model is well known throughout the VA and focuses on teamwork to translate data to knowledge (pre-implementation), knowledge to performance (implementation), and performance to data (sustainment) (Kilbourne et al., 2019). This project will use both the Meleis Transitions theory and the QUERI model to efficiently coordinate care

via a multidisciplinary approach focusing on high quality evidence-based care, patient engagement and self-efficacy, and optimizes internal and external resources.

### **Timeline**

Key milestone and projected time of completion is outlined in Appendix F. Pre-implementation will include finalizing the proposal, obtaining Institutional Review Board (IRB) review, and forming an interdisciplinary project team with a project charter to guide the project. Education and training will be completed prior to the implementation phase. May 1, 2021, is the proposed start of the implementation phase and will consist of pre-implementation questionnaires, initiation of evidence-based interventions, data collection and compiling, and monitoring project progress. Data will be reviewed on an ongoing basis and the final analysis completed by September 2021. Dissemination of project results and transition of process ownership within the organization will occur October/November 2021, with the final academic project presentation planned for May 2022.

### **Measures**

A data collection and outcome evaluation table has been created that identifies specific measures associated with each outcome to evaluate the success of the pilot project (Appendix G). A 10-question pre-implementation / post-implementation questionnaire will be used for outcomes 1 and 2 to assess MH and PC provider's awareness of appropriate care transitions and gauge their level of engagement in participating in care transitions before and after pilot program implementation. Outcome 3 and 4 will use an excel audit sheet to gauge the level of participation, assess the impact and timeliness of program interventions, and measure documentation compliance. Outcome 5 will use a multiple-choice questionnaire (yes, no, other) to assess if MH providers are using the electronic report, emailed to them biweekly, to assist

them in identifying eligible patients who may be appropriate to transition back to PC. Outcomes 6 and 7 focus on patients and staff who participated in the program. Outcome 6 and 7 will use questionnaires consisting of 6 questions for patients and 5 questions for staff. Feedback received will be evaluated to determine the pilot programs impact and their satisfaction.

### **Analysis**

Quantitative and qualitative analysis is planned to evaluate outcomes 1 and 2. Responses obtained will be displayed graphically by modes, medians, and frequency of each item choice. There will be open-ended questions with each of the outcomes to garner insight into any barriers of resources needed for them to be successful in care transitions. Responses will be aggregated and categorized by item. Depending on the responses received, data could be categorized by magnitude, frequency, and/or topic. Outcomes 3 will use descriptive statistics to analyze the number of Veterans who 1) agreed to participate in the pilot compared to those that did not, 2) were discharged per provider panel, and 3) were contacted timely by the nurse care coordinator. Outcome 4 data will assess the standardized electronic care coordination and discharge bundle compliance rates. Data retrieved from outcomes 3 and 4 will be displayed graphically by percentages, mean, median, and trend. Outcome 5 will assess the impact of providing providers with an electronic report to assist in the identification of eligible patients to transition back to PC. Data received will be used to quantify the percent of responses with the frequency of each choice, and qualitative data will be used to gain feedback. Feedback will be categorized by responses received. Outcomes 6 and 7 will use a post-implementation satisfaction questionnaire to assess program impact and participants' (patient and staff) satisfaction. Close-ended responses will be displayed graphically by modes, medians, and frequency of each item choice. Open-ended responses will be aggregated and categorized by responses received.

## **Ethical Considerations**

### **Ethical considerations and protection of participants**

Health care environments are complex, and success depends on the contribution from multiple professions, emphasizing the need for interprofessional communication and partnership. Provision six of the American Nurses Association (ANA) code of ethics, Interprofessional Collaboration for Improving Patient and Population Health Outcomes, outlines the importance for nurses to engage health care professionals in promoting health literacy, improving health outcomes, and protecting human rights (American Nurses Association (ANA), 2015). This project aims to promote values that are essential for collaboration and integration for personnel to function as highly collaborative teams (ANA, 2015), reducing siloes and improving the delivery of comprehensive, holistic care.

In preparation for the project proposal and implementation, the project leader completed the Collaborative Institutional Training Initiative (CITI) Human Research, Social & Behavioral research program (Appendix H). Upon faculty project approval, the proposal was sent to the project site IRB to ensure that the rights and welfare of human subjects participating in the practice project are protected (Reavy, 2016). The project was reviewed by the organizations Associate Chief of Research and deemed non-research. A recruitment script (Appendix I) and project flyer (Appendix J) will be utilized to garner participants for the project. Participation in the program will be voluntary, and selection will target Veterans who are transitioning their care from MH back to PC at the VA's main location only. To ensure that staff participating in the program have their rights and welfare protected, the organizations union was notified about the intent to survey and provided an opportunity to review and bargain (Appendix K). The union did not request to negotiate, and approval was received to implement the questionnaires. Data

collection activities will abide by the Health Insurance Portability and Accountability Act and the VA's rules and regulations to protect health information, ensuring that it remains confidential and that it cannot be linked to the participants.

### **Conflicts of Interest**

The project leader is an employee with the project site, however in a different department and affiliations should not interfere with project results. The project leader will be acting in her role as a DNP student during the project implementation rather than an employee.

### **Biases**

The project leader, acting in the role of project nurse care coordinator, can easily influence the results of their own work to get the outcome they desire (Reavy, 2016; Wa-Mbaleka, 2020). Standardizing the project leader interaction with participants can help reduce this bias (Pannucci & Wilkins, 2010). Recognizing that personal bias might exist and potentially influence results, the DNP student will attempt to neutralize this by partnering with their organizational mentor and DNP supervisory committee to discuss and review ongoing project efforts. Data collection of pre- and post-questionnaires is another concern as the participants, both patients, and providers, may feel pressured to respond positively. Using a standardized anonymous electronic tool, such as Survey Monkey®, can minimize bias and encourage participants to respond honestly. Lastly, performance bias of MH providers can occur as their participation in transitioning Veterans back to PC is tied to their performance appraisal. The project site Association Chief of MH has reassured all MH providers that their performance appraisal will not be affected based solely on the number of transitions, instead they will be evaluated to ensure that transitions were initiated and completed when appropriate.

### **Threats to Quality**

By incorporating interdisciplinary collaboration among departments, the poor quality of their communication and interactions could pose a threat to the value of the project itself. In order to mitigate this, leaders will be part of monitoring project implementation and outcomes, ensuring that quality controls are met throughout the project's development, implementation, and analysis phases (George et al., 2005).

### **IRB application and project determination**

The project was reviewed by the organizations Associate Chief of Research and deemed non-research. A letter of determination was received (Appendix L).

### **Project Budget**

A financial analysis was conducted to project expenses associated with project development, implementation, expansion, and sustainment. Three separate expense reports (pilot, year 2, year 3, and statement of operations) were developed itemizing expenses by personnel, material and supplies, space, equipment, and IT requirements (Appendix M). A 2 to 3-year budget was developed to forecast expenses incurred, including associated revenue earned over time (Appendix N). In year one (pilot phase), \$1,926,867 was calculated based on part-time staffing of 1 RN coordinator, 32 PC providers, 138 MH providers, 32 RNs, 101 admin staff, and associated categorized expenses to support personnel and project. In year 2, the project plan is to move personnel and activities to full-time status, increasing expenses by \$3,960,576 (year total of \$5,887,443). In year three, the plan is to continue project operation on a full-time basis and expand to a sister facility, including 10 additional PC providers, 10 additional RNs, and 20 additional admin staff. Expansion and project sustainability are projected to total \$6,551,228 for year three. Each year, an annual 1% salary and 3% in supplies and general expense increase were included based on organization standard calculations. Total pilot project expenses and revenue



balanced the operating income to zero (Appendix O). All organizational expenses and DNP student time are projected to be absorbed by the organization as in-kind donations. No additional out-of-pocket expenses are anticipated, and no supplementary revenue will be generated.

### **Sustainability**

Since this project is working alongside the Flow initiative there are plans to expand to other locations within the organization. This expansion could provide the opportunity for scholarly project sustainment. Local and national calls provide an opportunity to discuss project results and the opportunity for replication at other VA sites. In discussion are plans to transition ownership of the new care coordination process to the Flow champion. She plans to continue using the process and will incorporate it into the Flow initiative when it expands. In support of this, it will be important to develop a transition plan that includes all applicable resources (tools, resources, etc.). Feedback from facilitators and participants of the project will be presented to organizational leadership to discuss how results improve care transitions and how sustainment will benefit the organization and patients.

### **Results**

#### **Steps of the intervention**

Final project planning was completed in March 2021, and approval was obtained from Boise State University on April 2, 2021. Prior to project implementation, 85 MH and 49 PC providers and 72 nurses were solicited to participate in the project. Their agreement to participate was achieved through project promotion and collaboration with their service line supervisors. On April 15, 2021, the PC and MH providers were emailed the project pre-implementation questionnaire. The purpose was to assess their knowledge regarding concepts surrounding care delivery and transitions for MH patients returning to PC. It was important to assess the providers

knowledge before implementation to gauge their understanding because they were the ones that would initiate and accept the transfers. After pre-implementation data gathering was completed, care transition education was provided to the providers via virtual meetings. A follow-up email containing the post-education questionnaire was sent afterward (Appendices P and Q).

The nursing staff education was completed in May 2021 (Appendix R). Their role in the project was planned for after the Veteran was already discharged from MH. Because of this, no pre-implementation questionnaire was utilized for the nursing staff.

The project officially began on May 1, 2021. To begin, the MH providers were provided an electronic report to assist them in identifying Veterans that may be appropriate to transition back to PC. Weekly beginning May 5, 2021, the nurse care coordinator started gathering the names of Veterans discharged by MH and reviewed their chart for possible project recruitment. The MH provider's documentation in the Veteran chart was assessed to see if they were discharged based on the Flow and project principles. Veterans who met inclusion criteria (Appendix S) were contacted by telephone to recruit for project intervention. Outreach attempts followed the organization's Communication and Contact policy with one modification. The policy stipulates that at least two phone calls are made in an effort to reach the patient. If phone calls were unsuccessful, then an "unable to contact letter" was sent. Due to the project duration, timing, and the nature of the pilot, the project team agreed that a third phone call would substitute for the outreach letter. Appropriate organizational approvals were obtained for this exception to the policy.

Upon successfully contacting the Veteran, the nurse care coordinator used a standardized script to ensure that interactions and care coordination elements were consistent, yet flexible enough to meet the Veterans' care needs (Appendix T). The care coordinator reviewed follow-up

appointments, care coordination needs, and organization contact information with every participant. During the discussion, care coordination activities were further tailored to meet the Veterans unique plan of care. For instance, if the Veteran was discharged from psychiatry with a MH prescription, the nurse care coordinator would review the medication(s) list, confirming that the Veteran understood how to obtain refills and that the PC provider would manage the medication(s) moving forward. This education component was vital in ensuring that Veterans did not return to MH clinic unnecessarily (i.e., for medication refills exemplified in this scenario).

After the telephone conversation, follow-up emails were sent to each participant (with their permission) highlighting important concepts discussed. The email included additional educational attachments such as the MH discharge packet, coping skills resource, and My HealthVet pamphlet (Appendices U, V, and W). These resources were provided to support the Veteran with accessible and easy-to-read reference materials to aid in their recovery. The nurse care coordinator also provided her contact information in case the Veteran had any further care needs during their transition back to PC. The telephone conversation was documented in the electronic medical record, and the PC nurse was added electronically for informational purposes and handoff (Appendices X and Y). At the conclusion of the intervention, Veterans were emailed the satisfaction questionnaire link.

### **Process measures and outcomes**

Outcome 1 – did not meet goal of 25%. MH providers demonstrated an average 9% increase in awareness that specialty MH-care is generally time-limited, and once Veterans are stabilized and/or recovered, their care can be transitioned back to PC. Twelve (14%) MH providers responded to the pre-, and 31 (36%) responded to the post-implementation questionnaire.

Outcome 2 – did not meet goal of 25%. Primary Care providers demonstrated an average 8% increase in awareness that specialty MH-care is generally time-limited, and once Veterans are stabilized and/or recovered, their care will be transitioned back to PC. Thirteen (27%) PC providers responded to the pre and 15 (31%) responded to the post-implementation questionnaire.

Outcome 3 – met goal of 25%. Forty-eight Veterans were identified to participate in the pilot project, and 100% agreed to have their care coordinated by the new nurse-led care coordination program.

Outcome 4 – met goal of 85%. The nurse care coordinator contacted 100% of MH Veterans (who were discharged from MH back to PC and agreed to participate in the pilot program) within two weeks of discharge and coordinated their care back to PC via the standardized electronic coordination and handoff bundle.

Outcome 5 – met goal of >50%. Forty-six MH providers were available to query and 16 responses were received. Fifty-six percent (n=9) of the respondents reported utilizing the VA electronic report to assist them in identifying appropriate Veterans to transition back to PC, while 47% (n=7) reported not using the report. When asked why not, the consensus was they were not using it due to workload demands, time constraints, and feeling like “it was one more thing to do.”

Outcome 6 – met goal of >50%. Ninety-eight percent of Veterans responded to the questionnaire with “agreed” or “strongly agreed” that the new care coordination program supported them during their care transition.

Outcome 7 – met goal of >50%. Fifty-eight percent (n=40) MH and PC providers and nurses who responded to the questionnaire “agreed” or “strongly agreed” that the new care coordination program supported Veterans during their transition.

### **Outcome analysis**

Quantitative data for short term outcomes were analyzed by comparing the pre- and post-implementation questionnaires (Appendices Z & AA). Outcomes one and two demonstrated an 8.5% improvement in provider understanding of appropriate care transitions. While this did not meet the stated goal of 25%, the data provided a contextual baseline for future project improvement work to support the larger VA Flow initiative. In addition, the qualitative data that accompanied outcomes one and two revealed several complexities that exist between PC and MH providers. Mental Health providers reported feeling resistance from PC providers to accept the transfer. Primary Care providers reported not feeling comfortable caring for MH patients. Veterans reported confusion as to who was managing their care. These elements contributed to the lack of provider knowledge when initiating and accepting care transitions.

For outcome one, there was a gross difference in the number of responses to the pre- and post-questionnaire, making it difficult to compare the quantitative questions (1-8). For instance, pre-implementation results demonstrated a combined 41% (n=12) response of “strongly agreed”; however, post data revealed a 16% (n=31) reduction in that same category. The difference in the number of respondents before implementation compared to after could be a contributing factor to this discrepancy. Organizational contextual elements may also be a contributing factor in the difference of the number of respondents. The pre-implementation questionnaire was initiated during other mandatory organizational training priorities creating competing priorities for staff.

Outcome one did provide valuable insight through its qualitative questions. Question nine was a hybrid quantitative and qualitative question. For the quantitative portion, there was a 14% improvement in MH providers responding that they were given the necessary tools to transition patients back to PC, when compared to the pre-implementation questionnaire. As a follow-up to this question, providers were asked: “please explain what resources you need to be successful,” and eight providers responded. Seven requested additional training and support to be successful. One respondent reported a difference in the specialty-MH process when discharging patients back to PC compared to other specialty clinics. The respondent reported an underlying assumption that all specialty clinics operate similarly (i.e., they are consulted to take care of a patient for a specific problem, and once treated and deemed stable, the patient is discharged back to PC without any stipulations). However, for specialty-MH there is a requirement that MH providers obtain the Veteran and PC provider consent before transitioning the care back. This is different from the standard specialty care process and places additional strain and stress in an already complex situation. The respondent cited it as a barrier to successful care transitions.

Question ten was the last qualitative question and asked, “What would improve the likelihood of you transitioning eligible Veterans back to Primary Care?” Twenty-seven providers responded. Two responses were not analyzed because the response was “none” or “N/A.” The remaining 25 responses were categorized as: more education and training (n=8), less resistance from PC (n=6), improved communication between PC and MH (n=4), a standardized discharge process (n=3), leadership support (n=2), and reassurance that PC was capable of caring for MH patients (n=2). Results were discussed with organizational leadership and they are working to create more educational opportunities and finalize a standardized referral process where roles and responsibilities are clearly defined.

Outcome two. Although the number of responses was more comparable between pre- (n=13) and post- (n=15) questionnaires the results varied, making interpretation inconclusive. For instance, there was a 12% decrease in “strongly agree”, an 11% increase in “agree”, a 5% increase in “neither agree or disagree”, a 3% decrease in “disagree”, and a 1% decrease in “strongly disagree”. No consistent positive or negative trend or pattern was discerned.

In comparing outcome two to outcome one, which asked similar quantitative questions (1-6) of the PC providers, there was only a 6% increase in PC agreement that they were given the tools to successfully care for Veterans in PC once discharged from MH clinic. As a follow-up, providers were asked: “please explain what resources you need to be successful,” and eight responded. The responses were categorized as: more education and training (n=3), belief that MH patients are best served in MH clinic (n=3), and increased clinic time to care for patients in PC successfully (n=2). Results were discussed with organizational leadership, and further education, training, and resources are being deployed to support PC providers to lessen their apprehension in taking care of MH patients.

For outcome three, 48 Veterans agreed to participate in the pilot project. The participant population data determined that 90% (n=43) of the participant were male and 10% (n=5) were female (Appendix AD). Thirty-five percent (n=17) of the participants were between the age of 48-62, 27% (n=13) were between 63-77, 25% (n=12) were between 33-47, 8% (n=4) were between 18-32, and 2% (n=2) were >78 years of age (Appendix AE). Their top two diagnoses were PTSD (46%, n=22) and Major Depressive Disorder (15%, n=7) (Appendix AF). Seventy-one percent (n=33) service period fell during the Persian Gulf war, 19% (n=9) served during Vietnam, and 10% (n=5) served post-Vietnam (Appendix AG). Forty-six (n=22) participants did

not participate in a conflict, while 54% (n=26) did, mainly OIF and OEF (Appendix AH). Ten percent (n=5) served in Vietnam, and 6% (n=3) served in the Gulf war.

For outcome four, the chart audit indicated 100% (n=48) compliance in obtaining the Veterans consent to participate, documentation of care coordination, and handoff elements. The average length of time between discharge and follow-up contact was less than seven days. Data demonstrated that PC received on average 3% (n=48) Veterans discharged per individual provider panel, equating to about 1.5 Veterans per provider (Appendix AI). Similarly, MH providers discharged patients at a comparable rate of 4% (n=48), averaging 2 Veterans discharged per provider panel (Appendix AJ). There was, however, one outlier. A provider who retired discharged 12 (27%) patients back to PC. Aside from that, there was an equal distribution of patients per provider panel which helped reduce the provider's feeling of being overwhelmed.

Outcome five was evaluated through an online poll. Fifty-six percent (n=9) of the MH providers reported using the VA electronic report to identify Veterans to transition back to PC, and 47% (n=7) reported they were not. When questioned further, several cited time constraints and competing work priorities. Mental Health leadership was made aware, and they are working to provide further education and support to their staff. Actively discharging eligible patients lessens the provider's overall workload and improves clinic access. This is needed to redistribute the provider's workload to support them in managing their priorities more effectively.

Forty-eight Veterans agreed to participate in the care coordination program (outcome six). A total of ten Veterans responded to the satisfaction questionnaire and 98% "agreed" or "strongly agreed" that the new care coordination program supported them during their care transition (Appendix AK). Nine Veterans responded to the qualitative question, "What can we do to improve this program?" Each respondent reported that the care coordination pilot did not need



any improvement and appreciated the additional support and follow-up. One respondent, however, did report that although the care coordination program helped and did not think any improvements were needed, it would have been more helpful to have prior notice from his/her MH provider about what to expect. This information was reviewed with the project team. Further education and training were provided to MH staff so that care transitions are properly discussed to improve the patient's level of understanding.

Additionally, it is noted that the Veteran response rates to the satisfaction questionnaire were lower than desired. While Veterans appreciated the initial outreach attempt, a continued support system helps to reinforce recovery and stability. To address this feedback and to provide this level of support, the nurse care coordinator performed a secondary outreach (2 weeks from initial contact) through email inquiring about any additional care needs, questions, or concerns the Veteran may have. With this communication, the online questionnaire link was included encouraging Veterans to respond, explaining that every response helps in the improvement work to support patient care.

Forty staff members responded to outcome seven quantitative questions. Fifty-eight percent agreed or strongly agreed that the project was helpful, while 36% neither agreed or disagreed and 6% disagreed or strongly disagreed (Appendix AL). Twenty-two responded to the qualitative question, "What can we do to improve this program?" Nine responses were not analyzed as the answer was "not sure" or "the program is great and doesn't need any improvement." The remaining responses were categorized as more education (n=6) and needed improvement in provider engagement and communication (n=7). This feedback was shared with PC and MH leaders and further work is being done to enhance service agreements between both services.

### **Contextual elements that interacted with the intervention(s) and associations between the outcomes, intervention(s), and contextual elements**

Due to the COVID-19 global pandemic, education modules for outcomes one and two were completed online, and therefore the convenience of doing immediate pre- and post-knowledge checks was lost. The pre-implementation questionnaire response rate was lower than expected, and the lack of face-to-face interaction may have been a contributing factor. During this time, the organization was also undergoing an unannounced JC survey, and the staff's attention was focused on ensuring a successful survey outcome. Additionally, at the end of the JC survey the organization implemented mandatory HRO training for all staff which further diverted their attention. These contextual elements may explain the low engagement and response rates received from the pre-implementation questionnaire for outcomes one and two. Refresher training was completed in June 2021 to improve post-implementation response rates.

For outcome three, although 100% of eligible Veterans agreed to participate in the pilot project, the recruitment did not go as planned. The plan was for MH providers to discuss care transitions with Veterans, offer them the recruitment script, and add the nurse care coordinator to the discharge note in the EHR. Attaining the MH providers' agreement and willingness to provide the Veteran with the recruitment script was not achieved. The project team did not feel confident that MH providers would remember to add the nurse care coordinator to the discharge note. To overcome this barrier, the nurse care coordinator electronically queried data from the EHR weekly to gather every Veteran's chart where the MH provider used the standardized note title in their documentation. This report was compared to the national Flow report to ensure that all eligible Veterans were identified. The nurse care coordinator reviewed each chart to

determine if the Veteran met the inclusion criteria. When met, the intervention was carried out as planned.

There was one unanticipated factor that was uncovered during data cleansing. Not all MH providers used the Flow health factors (HF) in their documentation, which led to a discrepancy between local and national data reports. There were eligible Veterans identified through the local data query that were not on the national Flow report. Once identified, the nurse care coordinator and facility leadership agreed that when this discrepancy was found in the EHR, the nurse care coordinator would add the HF and an addendum to the electronic note indicating that the HF was missed on initial documentation and thus added. The HF and addendum were added on the same day that the nurse care coordinator made telephone contact with the Veteran.

Outcome four primarily moved forward as planned but had one minor issue. Several Veterans who were identified as eligible through the data query were, in fact, not appropriate for discharge and subsequently not recruited to participate in the pilot project. After review with the project team, it was determined that one particular psychiatrist was discharging patients from care due to his impending retirement. Some of these Veterans were still engaged in therapy and not appropriate to discharge back to PC. This discrepancy was discussed with MH leadership, and Veterans who were still engaged in therapy continued to remain in the MH clinic and were not discharged back to PC.

Outcome five was not implemented as planned. Due to the low questionnaire response rates for outcomes one and two, the project team felt another online questionnaire was not the best course of action to gather the necessary information. In addition, during June (the timeframe the questionnaire was to be implemented) there were several competing organizational priorities. The organization rolled out its annual All-Employee survey and two other mandatory initiatives

(Safety Standdown and the Outpatient Patient Experience project). With staff concentrating on the organizations' priority items, the plan for outcome three changed. Instead of doing an online questionnaire through a link, a virtual question and answer session was held, and an online poll was taken during the session.

Outcome six and seven were implemented as planned.

### **Unintended consequences**

Poor response rates to the project questionnaires posed challenges for the project. To improve engagement and communicate the importance of the participants' involvement, the nurse care coordinator relayed any positive feedback from Veterans during the outreach call. Veterans readily praised their MH and PC providers, and the feedback was shared with the applicable provider and their supervisor. The intent of this communication was to highlight that their work mattered and that Veterans appreciate them.

Another unintended consequence was the reluctance of Veterans to answer their phone from an unrecognizable phone number. The nurse care coordinator used her government issued cell phone to make calls that did not have the organization's main number displayed during outbound calls. To overcome this issue, the nurse care coordinator started using the Doximity® application which allowed outgoing calls to display the organization's main telephone number. This greatly improved Veterans answering their phones during the first outreach attempt.

### **Actual project revenues/expenses**

Originally, the pilot project expenses were estimated to be \$1,926,867. The actual cost of the project was \$827,080 (Appendix AM). The cost difference was attributed to changes in personnel, hours of participation, supplies and materials, space, and equipment. The decrease in personnel cost was due to the number of project participants. It was projected that 56

psychiatrists, 82 psychologists, 26 PC physicians, and 6 PC Nurse Practitioners (NPs) would participate. The actual number of participants were 50 psychiatrists, 35 psychologists, 36 PC physicians, and 13 PC NPs. Their hours of participation and associated costs were adjusted based on the number of Veterans they discharged or received during the transition. Project lead, clinical champion, and administrative staff hours were also reduced based on their involvement and the number of Veteran participants.

There was a noticeable reduction in supply, material, space, and equipment costs. This was because education and training were moved from in-person to a virtual platform. Expenses that were projected for training, such as a classroom and printed materials, were not needed. Outreach materials were shared with Veterans electronically, and therefore envelopes, stamps, printing, etc. expenses were avoided. The difference of 36 staff members, their associating salaries, hours of participation, and cost avoidance associated with supplies, materials, and equipment resulted in a net savings of \$1,099,787.

### **Summary**

Due to the complexity of the health care system, patients frequently remain in settings that are inappropriate for their level of care. Care is often fragmented and poorly coordinated, leading to a lack of care transition that impedes access to care (Hudson et al., 2019). An intensive literature review demonstrated that a nurse care coordination model is an effective strategy to improve access to care (Appendix A). It promotes effective care transitions, streamlines communication, and assists patients in maintaining MH recovery congruent with their level of care needs. The care coordination pilot project measured outcomes related to (1) providers understanding and awareness of proper care transitions, (2) the use of tools available in identifying Veterans who may be appropriate to transition, (3) recruitment of participants, (4)

timeliness of the care coordination intervention, and (5) Veteran and staff satisfaction related to the usefulness of the pilot project. Outcomes one and two were not met, because PC and MH providers did not demonstrate a 25% increased awareness. However, the qualitative data accompanying these outcomes provided valuable insights such as providers needing more education, the organization needing improvement in support structures, and barriers that contributed to uncoordinated care. Moreover, although 56% of MH providers reported using the electronic report available to identify Veterans appropriate for transition (outcome five), post-implementation qualitative results (outcome one) demonstrated that organizational tools would be most useful when integrated into their daily practice opposed to an add-on to their workflow.

Outcomes three, four, and six directly impacted the Veteran. The nurse care coordinator contacted every Veteran within two weeks of discharge from MH to recruit for project participation, and every Veteran agreed to participate (outcomes three and four). The Veterans who responded to the satisfaction questionnaire all agreed or strongly agreed that the project helped them during their transition (outcome six). They expressed their appreciation and gratitude for the follow-up. The qualitative responses demonstrated that Veterans appreciated the follow-up care provided by the care coordinator. They expressed the additional support helped them know what to expect and where to turn if questions arose. The care coordinator used a structured approach in coordinating each Veteran's care but personalized it based on the participant's unique care need.

Fifty-eight percent of staff who responded to the satisfaction questionnaire agreed or strongly agreed that the care transition pilot was useful and supportive of care transitions (outcome seven). Qualitative responses continued to demonstrate similar sentiments for outcomes one and two, mainly the need for more education and improvements in MH and PC

engagement and communication. As a result of the pilot, these elements are being discussed by staff and leadership to improve and support one another.

The pilot project results contribute to the literature by validating the assumption that adding care coordination activities to the care transition process can help organizations achieve seamless care transitions. The outcomes emphasized that assessing, aligning, and integrating guidance for continued PC involvement during and following specialty care is a key component to ensure care is delivered in the most appropriate setting for the patient's level of care. The project facilitated communication and collaboration among providers to improve shared decision making in developing and meeting patient care goals. Lastly, it provided the necessary support and follow-up Veterans needed to successfully maintain recovery and stability during their care transition.

## **Interpretation**

### **Association Between Interventions and Outcomes**

The aim of the nurse care coordination pilot was to provide support for MH and PC providers and Veterans transitioning from one service to another. The project demonstrated success in meeting five out of the seven planned outcomes. Outcomes one and two were not met and can be attributed to the literature lacking proper guidance regarding adequate coordination needs to achieve successful care transitions (Smith et al., 2019). Despite sufficient evidence that care coordination interventions improve safe care transitions (Lamb et al., 2018); providers were not current on the literature that supported the change initiative or were too comfortable in their current practice beliefs to consider the change. Another confounding factor was that the term "care coordination" is typically not part of the providers' standard medical language, as it is

mostly associated with the nursing profession. This could have contributed to their lack of awareness related to outcomes one and two.

### **Comparison of Results with Previous Findings**

The success achieved in outcomes three through seven mirror what was reported in the literature. Mainly that integrating a care coordination model improves patient-centered care, access to care, care transitions, and care delivered in the most appropriate care setting (Hannigen et al., 2018, Jeffs et al., 2017; Jones et al., 2018; Tomlisen et al., 2020). This care coordination project helped set care coordination activity standards to meet patients' needs for successful care transition, elements that the literature mentioned was lacking between MH and PC settings (Smith et al., 2019).

### **Impact of Project on People and Systems**

Overall, the project adds value to the organization's effort in facilitating the transition of stabilized and recovered MH patients back to PC. Several contextual elements impacted the project implementation; however, the purpose and content remained consistent, which resulted in meeting many of the projected outcomes. The qualitative responses were consistent with the existing grounded theory literature, which aims to help leaders better understand (and develop strategies to overcome) the barriers faced when implementing an integrated collaborative model of care. The quantitative responses provide leaders insight in what to consider when broaching process improvement work. Aside from the measured outcomes, the project's development, implementation, and promotion provided the needed catalyst to impact people's interest and create deeper discussion regarding care transitions.

### **Costs and Strategic Trade-Offs**



The cost of this project was significantly lower than budgeted because of the level of provider engagement, participation, and the number of Veterans who transitioned from MH to PC. The majority of the actual cost was attributed to salaries, but there was unaccounted cost avoidance that was not demonstrated in this project due to the short duration. Nurse care coordination models have been shown to reduce costs by reducing the use of unnecessary resources, such as remaining or returning to care settings incongruent with their care needs (Lamb et al., 2018; Smith et al., 2019). While this was not measured during the pilot, it is important to note as it directly impacts organizational costs and access to care. Future process improvement work will be needed in this area to quantify costs associated with these avoidable events. In addition, reimbursement for care coordination activities could not be accounted for. While the organization does reimburse for care provided via telephone when evaluation and management is demonstrated, care coordination activities can only be reimbursed if the patient is enrolled in a care coordination model. This is another area that could benefit from future process improvement work.

### **Policy Implications**

As the demand for health care changes and patient care needs evolve, health care systems must adapt. They must consider implementing strategies that meet the Institute for Health Care Improvement (IHI) Quadruple Aim for Health Care Initiative. The IHI quadruple aim strives to enhance the patient's experience of care, improve population health, reduce costs, and improve the work environment of health care providers (Bachynsky, 2019; Haverfield, 2020). One strategy is to develop and implement policies to support these efforts. Health care policies are designed to describe the decisions, goals, and actions needed to deliver care (Loversidge &

Zurmehly, 2019). The expectation is that people will abide by it so that organizations can achieve their objectives.

Locally, the organization has developed a service agreement between MH and PC outlining roles and responsibilities in caring for Veterans, but service agreements are not policy. Service agreements adherence is strongly recommended but not mandatory. This increases the rate of noncompliance and further compounds an already complex situation (care transitions). The service agreement also does not account for the care coordination activities needed to ensure successful care transitions and a positive patient experience. An organizational care transition policy is one solution to address the discrepancy in the current health care environment. A care transition policy is important to establish roles, responsibilities, procedures, and support structures (such as a care coordination program) to benefit patient care and enhance standardization in daily practice. A policy can also improve collaboration among service as roles and expectations are clearly defined. This can prevent unnecessary utilization of resources and improve communication among health care providers.

Nationally, there are ongoing efforts that support policy development for nurse-led care coordination models. Nurses are advocating to implement new policies based on their knowledge of evidence-based practice. Knowledge and experience are the vehicles to translation. From the bedside to the executive suite, these skills can influence policy. DNPs, specifically, have the essential competencies and policy literacy to collaborate with others when health care issues are being discussed. They are key players in evaluating current policies (or lack thereof) that addresses access to care and safe practice environments (Sherrod & Goda, 2016). They can influence policies associated with health care practice changes, such as a care coordination

model, and its return on investment to ensure organizations keep up with the latest practice standards (Sherrod & Goda, 2016).

Implementing a policy that focuses on integrating care coordination activities during care transitions will promote the quadruple aim of health care and enhance the clinical environment. Standardizing care coordination activities within the clinical realm is important to ensure the work is reimbursable and organizations can maximize their revenue potential. Efforts such as this may help establish clear guidelines for organizations to review when considering implementing a care coordination model.

### **Limitations**

There were several limitations to this project. First, results cannot be considered generalizable because the pilot was implemented at a single site with unique characteristics. Second, due to the variation in the questionnaire response rates compared to the number of participants, the pre- and post-changes should be interpreted with caution. Both quantitative and qualitative responses suggested strong opinions on both ends of the spectrum, positively and negatively. In contrast, a third of the responses lingered somewhere in the middle with “neither agree or disagree”. Data suggests that opinions and viewpoints regarding the benefits of the project evolved over the project’s lifespan. In contrast, those who focused on the drawbacks were less likely to believe otherwise. Efforts were made to address the need for continual education, it was difficult to engage providers to participate in educational opportunities due to the project timeline. Finally, due to the pandemic the implementation project team could not deliver and reinforce education in-person. This could be why the theme of needing additional education was consistent throughout the project.

### **Conclusion**

## **Usefulness of the Work**

Meeting the needs of returning troops suffering from PTSD and/or depression is a prioritized health issue identified nationally and locally. Prevalence of these conditions will continue to manifest as conflicts overseas continue, and organization mental and behavioral health departments must be accessible. Access to care is prominent in the literature and identified as the top barrier for Veterans when seeking care. The pilot project implemented an integrated care coordination program to assist transitioning stable, non-complex, Veterans back to PC. In doing this, clinic access was improved for Veterans who needed specialized MH care. Care coordination interventions improved the Veterans' experience of care and facilitated the continuation of care in settings appropriate to meet their needs. The work completed helped translate evidence into practice and demonstrated that using a care coordination model supports patients in managing their health during care transitions. It contributes to the existing body of knowledge regarding the benefits of care coordination. Moreover, it provides a framework for further improvement work in establishing guidance on what constitutes adequate coordination and appropriate transitions, specific to MH and PC.

## **Sustainability**

For the project to be sustainable, leadership will need to provide human (dedicated nurse care coordinator) and financial capital. The project lead was the nurse care coordinator, and currently, there is no FTE assigned to this role. To encourage leaders to consider allocation of resources for sustainment, the project outcomes and results can be used to demonstrate that implementing a consistent care coordination practice during times of constant change can effectively achieve organizational goals, especially when leaders are contemplating less expensive ways to achieve quality outcomes. It will be important to provide evidence to

demonstrate that this model of care is cost-effective and improves the quality of care (Benzer et al., 2015).

Moreover, the benefits of care coordination programs are centered around improving the patient's experience of care. Activities are designed to integrate deliberate actions, such as continuous patient education, assessment, monitoring, and counseling when managing and organizing the patients' health care. It also ensures that patients are cared for in settings congruent to their needs, which reduces the use of higher cost resources and yields a positive return on investment for the organization (Lamb et al., 2018; Smith et al., 2019).

The proposed sustainment plan also included expanding to other sites within the organization alongside the Flow initiative. Currently, expansion has been delayed by the pandemic and is still in the infancy stage. The next step is to present outcomes to organizational leaders focusing on outcomes achieved and resources needed for sustainment.

### **Potential for Spread to Other Contexts**

The pilot project represented a small test of change that has the potential to expand and replicate to other sites. The project team has already presented project aims, interventions, and early results on national organizational calls, and other sites are eager to learn more about possible replication. Final report findings and recommendations will continue to be shared as opportunities arise.

### **Implications for Practice and Further Study**

The work represented by this pilot project lays foundational building blocks for future work within MH and PC departments and can be replicated in other settings. Care coordination programs have implications for practice as this model of care can be useful in any care setting where patients transition from one setting to another. Care coordination activities promote team

cohesion, clear communication, and shared decision-making to improve care delivery and patient outcomes (Bachynsky, 2019). For others who wish to replicate this project, it is essential to develop partnerships with organizational leaders and staff. Doing so will enhance early adoption and increase the likelihood of achieving program goals. As pilot project outcomes three through seven demonstrated, continuous communication and education are important for staff to adopt new processes or programs.

Not meeting outcomes one and two require further inquiry. As learned with this project, medical providers may not understand nursing jargon, creating a gap in evidence translation. Further research and education would help determine effective strategies to use when translating peer-reviewed research into existing practice.

### **Next Steps and Dissemination**

Project results and lessons learned will be shared with organizational and national leaders in hopes that it will influence the necessary support structures and financial expenditures in the upcoming budget. This will be crucial in project sustainment. For other sites considering replicating this project, project summary and results can be used as a guide to help in their development and implementation of a care coordination program. Publishing findings in an academic journal can reach audiences outside of the organization. Journals for consideration are the Journal of Multidisciplinary Healthcare, the International Journal of Care Coordination, Psychological Services Journal, and the Journal of Nursing Care Quality. Publishing can impact current practices, leading to process improvement efforts to improve patient outcomes.

In conclusion, meeting the needs of Veterans suffering from MH disorders is a prioritized health issue identified nationally and locally. Organizations must find ways to be accessible to Veterans. Care coordination models have been shown to be clinically-effective in supporting

patients as they transition from one care setting to another. The care coordination pilot implemented is one strategy to help organizations improve access to care. This project assisted in transitioning stable patients from specialty-MH back to PC. Patients reported improvement in their experience of care, and access to specialty-MH was more accessible for patients who needed higher levels of care. The project demonstrated that clinical scholarship, collaboration, and process improvement activities are critical in expediting the integration of evidence-based care into practice and transforming health care organizations.

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## Appendices

### Appendix A: Literature Review Summary Table

**Search Statement:** The PICOT format (P = Veterans with mental health disorders; I = technology-based instruments and nursing interventions; C = care as usual (N/A); O = care transitions) was used to develop the following question, “For individuals with stable mental health disorders who are transferring from specialty-mental health back to primary care, can the use of an electronic communication tool provide an effective mechanism/process to coordinate care along the care continuum?” A systematic search was conducted in PubMed, PsycINFO, CINAHL, and Computer Source (via EBSCOhost) databases for evidence (2015 to present, adult population) relating to the following keywords: *primary care, mental health, integration, health information technology, health information exchange, integrated care, care coordination, transitions of care*. Initial database results yielded 65 eligible articles; 12 met inclusion criteria and relevance to identified problem, but did not identify interventions. A subsequent literature search was completed. The searchable question was “For individuals with stable mental health disorders who are transferring from specialty-mental health to primary care, what is the best evidence to coordinate care along the care continuum?” Results yielded 38 articles and after review with same inclusion and exclusionary lists, three were included as new evidence that contributed interventions to support safe care transitions. Eighteen articles were examined and then appraised using the John Hopkins appraisal tools. The appraisal identified: one level I, five level IIs, eight level IIIs, and four level V articles of which 14 were A (high-quality) and four were B (good quality).

TITLE OF ARTICLE	AUTHORS	RESEARCH QUESTION OR AIM OF THE ARTICLE	TYPE OF STUDY (DESIGN)	LEVEL / QUALITY OF EVIDENCE	DESCRIPTION OF SAMPLE (IF APPLICABLE)	OUTCOME MEASURES	RESULTS/KEY FINDINGS
<b>Background/Significance</b>							
Invisible Wounds: Mental Health and Cognitive Care Needs of America’s Returning Veterans	Tanielian, T., Jaycox, L. H., Schell, T. L., Marshall, G. N., Burnam, M. A., Eibner, C., Karney, B. R., Meredith, L. S., Ringel, J.	Discuss/review gaps in understanding of the Mental Health (MH) and cognitive needs of U.S. servicemembers returning from Afghanistan and Iraq, the costs of	Quantitative Population-based survey via a structured computer-assisted telephone interview system.	III / A	1,965 Veterans who recently returned from Operation Iraqi Freedom and/or Operation Enduring Freedom (OEF/OIF) deployments.	-Survey focused on three major conditions: post-traumatic stress disorder (PTSD), major depression, and traumatic brain injury (TBI).  -Approximately 18.5% reported PTDS or depression; and 19.5%	-Improving access to high-quality care (treatment supported by scientific evidence) can be cost-effective and improve recovery rates.  -Recommended four areas to improve understanding and treatment of PTSD,

	S., & Vaiana, M. (2018)	MH and cognitive conditions, and the care systems available to deliver treatment.				<p>reported TBI during deployment.</p> <p>-Roughly half of those who need treatment for these conditions seek it, but only slightly more than half who receive treatment get minimally adequate care.</p>	<p>depression, and TBI:</p> <ol style="list-style-type: none"> <li>1. Increase/improve capacity to deliver evidence-based care</li> <li>2. Change policies to encourage and promote service members to seek care</li> <li>3. Deliver evidence-based care in all settings</li> <li>4. Invest in further research to enhance understanding of MH disorders, war, treatment, and outcomes.</li> </ol>
Trends and Risk Factors for Mental Health Diagnoses Among Iraq and Afghanistan Veterans Using Department of Veterans Affairs (VA) Health Care, 2002–2008	Seal, K. H., Metzler, T. J., Gima, K. S., Bertenthal, D., Maguen, S., & Marmar, C. R. (2009)	Investigate longitudinal trends and risk factors for MH diagnoses among Iraq and Afghanistan veterans.	Descriptive quantitative Study	II / A	289, 328 OIF/OEF Veterans identified through the VA OEF/OIF Roster who were first-time users of VA health care after their military service.	<p>-One-third Veterans were diagnosed with a MH disorder and over 40% had combination of MH disorder and psychosocial/behavioral problems, which is an increase prevalence than other war-era Veterans.</p> <p>-Factors related to Veterans delay in seeking care included stigma associated with mental illness, reluctant to disclose illness due to various reasons, and delayed recognition / acknowledgement of</p>	<p>-There is a problem with Veterans seeking care that can be attributed to either access to care or stigma surrounding mental illness.</p> <p>-Seeking care is often delayed until it interferes with activity of daily living or exacerbates/contributes to chronic disease.</p> <p>-Implementation of evidence-based screen and interventions, focusing on war-era Veterans may improve</p>

						MH symptoms.	recovery of chronic MH, social, and occupational problems.
█ County Community Health Assessment	Bilton, M. (2019)	Health determinants in █ County to review and identify needs of low-income populations, minorities, the medically underserved and populations with chronic diseases.	Community Health Assessment	V / A	15 participating organizations: health agency administrators, faith-based service organizations, governmental agency representatives, and participants from various community organizations in █ County.	-Identified 4 main categories impacting █ county residents' health care: 1. Inequitable health care access 2. Coordination of care 3. MH care 4. Chronic diseases management	-Access to care for poor and vulnerable groups is inadequate.  -Lack of care coordination contributes to poor health outcomes.  -Access to MH is poor, especially for poor and vulnerable populations. -Suicide rates increased in last 20 years.  -Increase prevalence of chronic disease, especially onset of newly diagnosed diabetes.
Bringing the War Back Home Mental Health Disorders among 103,788 U.S. Veterans returning from Iraq and Afghanistan seen at Department of	Seal K.H., Bertenthal D, Miner, C.R., Sen, S, & Marmar, C. (2007)	What is the prevalence of single and co-occurring MH diagnoses and psychosocial problems among OEF/OIF Veterans seen at VA facilities after returning from Iraq and Afghanistan?	Descriptive quantitative Study	II / A	103,788 Veterans identified through the VA OEF/OIF Roster.	-The most common military service-related MH diagnosis was PTSD.  -25% diagnosed with single MH disorder.  -56% had 2 or more MH diagnoses.  -60% of MH diagnosis was made in nonmental	-Early and accurate detection of illness is central to early intervention.  -Large number of initial diagnosis made in PC and were validated to be accurate 90% of the time when Veterans were referred to specialty-MH.

Veteran Affairs facilities						health clinics.	
Prevalence, Comorbidity, and Prognosis of Mental Health Among U.S. Veterans	Trivedi, R. B., Post, E. P., Sun, H., Pomerantz, A., Saxon, A. J., Piette, J. D., Maynard, C., Arnow, B., Curtis, I., Fihn, S. D., & Nelson, K. (2015)	To evaluate the association of mental illnesses with clinical outcomes among U.S. Veterans and evaluate the effects of Primary Care–Mental Health (PC-MH) Integration.	Time series cohort study	II / A	4,461 208 veterans who were seen in PC in the first year following the Patient Aligned Care Team concept rollout.	-A quarter of all patients reported 1 or more mental illnesses: -Depression 13.5% - PTSD 9.3% -Substance abuse 8.3% -Anxiety disorder 4.8% -Serious MH 3.7%	- Coordinated care between MH and PC was associated with better health outcomes.
Mental Health Service Use in Depressed Military Personnel: A Systematic Review	Thériault, F. L., Gardner, W., Momoli, F., Garber, B. G., Kingsbury, M., Clayborne, Z., Cousineau-Short, D.Y., Sampasa-Kanyinga, H., Landry, H., & Colman, I. (2020)	Systematic review of military personnel with major depression and treatment gaps.	Mixed Methods Systematic Review	II / B	28 studies mixed study design review articles of people who served in Australia, Canada, New Zealand, the United Kingdom, or the U.S. armed forces.	- 47.6% were diagnosed with Depression  -36% had Depression and other psychiatric diagnoses.	-There is a treatment gap in identifying MH disorders, namely major depression.  -The prevalence rate is documented, but treatment gaps prevail.
The Post-Deployment Mental Health study and	Brancu, M., Wagner, H. R., Morey, R. A.,	The study had two primary goals. First, it was to serve as a baseline	Quantitative Population-based survey with	III/A	3600 Veterans participated and were reviewed for comprehensive	-MH disorders were among the top three diagnoses of Veterans obtaining VA care	-High level of resilience acts as a protective mechanism to prohibit or lessen severity of

<p>repository: A multi-site study of U.S. Afghanistan and Iraq era veterans</p>	<p>Beckham, J. C., Calhoun, P. S., Tupler, L. A., Marx, C. E., Taber, K. H., Hurley, R. A., Rowland, J., McDonald, S. D., Hoerle, J. M., Moore, S. D., Kudler, H. S., Weiner, R. D., VA Mid-Atlantic MIRECC Workgroup, &amp; Fairbank, J. A. (2017)</p>	<p>study to characterize MH risk and resiliency factors in these veterans. The second goal was to create a data repository to serve as (a) a central “subject registry” or re-contact database and (b) a “data warehouse”.</p>	<p>standardized instruments to collect demographics, blood samples, imaging, and questionnaires .</p>		<p>behavioral health (BH) characterization.</p>	<p>-57.6% had at least one MH diagnosis.</p> <p>-The most prevalent MH diagnoses were PTSD (55%), depressive disorders (45%), anxiety (43%), and alcohol dependence.</p>	<p>PTSD, suicide, substance abuse, and depression.</p> <p>-Data repository offered information for:</p> <ol style="list-style-type: none"> <li>1. Longitudinal studies to better understand what behavioral, biological, medical, and other MH-related factors predict the development of post-deployment mental illness.</li> <li>2. Determination of which interventions are effective in preventing the development or decreasing the severity of post-deployment mental illness.</li> </ol>
<p>Lack of access to mental health services contributing to the high suicide rates among Veterans</p>	<p>Hester R. D. (2017).</p>	<p>Described the prevalence of MH care needs and disparities in providing access to MH care within the VA and local community.</p>	<p>Literature Review</p>	<p>V / A</p>	<p>U.S. Veterans</p>	<p>-The changing nature of warfare increases injuries that affect MH.</p> <p>-More than 1.5 million of the 5.5 million veterans seen in VA hospitals had a MH diagnosis in 2016, a 31% increase since 2004.</p>	<p>-Veteran efforts to gain access to quality psychological health services after multiple deployments are often met with significant obstacles.</p> <p>-Personal obstacles such as acceptance of disorder, needing help, and stigma.</p>

							-System obstacles such as access to care and eligibility of VA care.
<b>Health Information Technology (HIT)</b>							
Electronic Health Record Challenges, Workarounds, and Solutions Observed in Practices Integrating Behavioral Health and Primary Care	Cifuentes, M., Davis, M., Fernald, D., Gunn, R., Dickinson, P., & Cohen, D. J. (2016)	Described electronic health record (EHR) experience for practice sites striving to integrate BH and PC.	Mixed methodology – descriptive quantitative and observational, cross-case qualitative study design	III / B	11 diverse practice settings in the U.S.; 8 PC clinics and 3 community BH practices.	-Challenges noted with EHR use and integration: 1. Separate software programs for BH and PC leading to duplicate data entry. 2. Communication and coordination of care problematic due to lack of interface exchange between software systems and interoperability, resulted in workarounds.	-Emerging solutions to assist with integration: 1. Customize EHR templates to improve integration and coordination. 2. EHR upgrades to improve interfacing and interoperability. 3. Unify EHR so that all are working with same technological platform.
Information and communication technologies for the dissemination of Clinical Practice Guidelines to health professionals:	De Angelis, G., Davies, B., King, J., McEwan, J., Cavallo, S., Loew, L., Wells, G. A., & Brosseau, L. (2016)	Identified research about health professionals' perceived usability and practice behavior change of information and communication technologies for the dissemination of clinical practice guidelines.	Systematic Review	II / A	21 RCT and 1 controlled study reviews in variety of care settings around the world.	-Evaluation of dissemination of evidence via various HIT solution that included at least one information and one communication technology component.	-Best ways to disseminate information was through a combination of web-based workshops, email, and electronic educational games. -Improved knowledge transfer, usefulness, and skill



a systematic review							enhancement/retention.
Accelerated adoption of advanced health information technology in Beacon community health centers	Jones, E., & Wittie, M. (2015)	Exploratory research to understand the interaction between community-based transformation efforts and federal/state initiatives to support HIT adoption.	Original research; descriptive quantitative study design	II / A	85 health centers participating in 17 Beacon Community Program initiatives.  (The Beacon Community program is a Health and Human services collaboration with National Coordinator for Health Information technology program wherein \$250 million dollars was given to 17 selected communities in the U.S.)	-Explored rate and patterns of adoption, use, and quality of EHR in Beacon health program communities compared with non-Beacon centers.  -Communities that were part of the Beacon program adopted EHR at faster rate than other organizations not part of the program. This can be a result of financial incentives.	- Safety, quality improvement, and cost reduction were positively correlated to advanced EHR adoption.  -Advanced functionalities improved care coordination.  -Health information exchange (HIE) and interoperability were key to share information among all care providers, to include community partners.
Connecting what matters	Robke, B. (2015)	Patient-centered interoperability leads to better care.	Case Study – non research	V / A	N/A	-Interoperability is the availability of the right information to make accurate treatment decisions, regardless of where or what software program the	-HIE is important for safe care delivery and needs implementation nation-wide.  -Improvements in data exchange is essential

						information derived from.  -It saves patients from unnecessary and costly medical procedures/interventions, in turn also improving organizational financial outcomes.	for effective care delivery, coordination of care, and health outcomes.
Designing health information technology tools for behavioral health clinicians integrated within a primary care team	Woodson, T. T., Gunn, R., Clark, K. D., Balasubramanian, B. A., Jetelina, K. K., Muller, B., Miller, B. F., Burdick, T. E., & Cohen, D. J. (2018)	Describe workflows and tasks of integrating BH information technology needs and develop IT solutions to address them.	Mixed method observational, comparative-case study.	III / B	Six federally qualified health centers in Oregon.	-Workflows were broken down into 3 steps: a) identification of patients in need of BH services b) connecting patient to BH services c) follow- up for patients that have a series of BH appointments.	-EHR that lack functionality to fully support integrated care is primary reason for lack of full integration.  -EHR that support integration minimally need to automate and track screenings, document BH history, access patient social and medical history, and rapidly document and track treatment goals.
<b>Care Coordination</b>							
Use of technology for care coordination	Falconer, E., Kho, D., & Docherty, J. P. (2018)	Investigates the use of technology for the coordination and	Mixed Methods Systematic Review	III / A	21 mixed method study designs in PC and MH	-Multiple studies report the use of EHR and web-based care for	-Benefits of technology-based care was evident across many areas to include screening,

<p>initiatives for patients with mental health issues: a systematic literature review</p>		<p>management of MH care with an emphasis on outcomes.</p>			<p>practices in the US.</p>	<p>coordinating care as beneficial.</p> <p>-HIT communication tools aid in collaborative decision-making amongst professionals and patients.</p> <p>-Barriers and challenges in HIT for care coordination included lack of financial resources to upgrade technology, poor HIE for shared care plans between PC and MH, and poor EHR templates.</p>	<p>scheduling, assessments, facilitating communication, and improving treatment compliance.</p> <p>-Integrated MH care with PC using technology for care coordination was effective for Veteran population as evidenced by reduced appointment wait times, improved adherence to evidence based treatment, and increased patient satisfaction.</p>
<p>Traditions of research in community mental health care planning and care coordination: A systematic meta-narrative review of the literature</p>	<p>Jones, A., Hannigan, B., Coffey, M., &amp; Simpson, A. (2018)</p>	<p>What interventions have proved more or less effective in promoting personalized, recovery-oriented care planning and coordination for community MH service users?</p>	<p>Systematic meta-narrative review</p>	<p>III / A</p>	<p>50 study review articles in outpatient population in the U.S., UK, and Australia.</p>	<p>-Research traditions evaluated:</p> <p>a) government policies for healthcare organization management and delivery of services.</p> <p>b) organizational and service delivery efficiency.</p> <p>c) user experience of community health care coordination.</p>	<p>-Integrated care coordination model implementation increased surveillance of patients, improved care coordination, enhanced teamwork, improved documentation, and improved effectiveness of care.</p>

<p>Health IT-enabled care coordination: A national survey of patient-centered medical home clinicians</p>	<p>Morton, S., Shih, S. C., Winther, C. H., Tinoco, A., Kessler, R. S., &amp; Scholle, S. H. (2015)</p>	<p>1. How frequently are EHR used for proposed meaningful use stage 3 care coordination objective? 2. What is the clinicians perspective of the use of EHR to support care coordination 3. What organizational and contextual factors are associated with greater use of HIT for care coordination</p>	<p>Quantitative observational study</p>	<p>II / B</p>	<p>997 practices recognized under the National Committee for Quality Assurance 2011 Patient-Centered Medical Home program.</p> <p>-275 were community health centers -284 health system-owned practices -247 small physician-owned practices -191 large physician-owned practices in the U.S.</p>	<p>-Fewer than half of practices continue to rely on non-HIT care coordination; however, results from this study indicated a higher use of HIT for care coordination than previous studies.</p> <p>-Clinicians routinely used HIT -Referral tracking (51.7% compared to 28.6%) -Provide clinical summaries (76.6% vs 33.3%).</p>	<p>-Findings were consistent with previous research in that greater team cohesion support improves the use of an integrated EHR for care coordination.</p> <p>-Study participants initially reported low value of care coordination activities, but with the assistance of technical support to help redesign workflows and technology capabilities, value increased.</p>
<p>Impact of Information and Communication Technologies on Nursing Care: Results of an Overview of Systematic Reviews</p>	<p>Rouleau, G., Gagnon, M. P., Côté, J., Payne-Gagnon, J., Hudson, E., &amp; Dubois, C. A. (2017)</p>	<p>To explore how information and communication technologies (ICT) support health care delivery.</p>	<p>Mixed Methods Systematic Review</p>	<p>II / B</p>	<p>22 articles were included: 12 used mixed-method, nine used quantitative, and one used qualitative approach.</p> <p>Registered Nurses, nursing students, and/or patients receiving care</p>	<p>-Four topics emerged that supported the use of ICT for care delivery. Improved:</p> <ol style="list-style-type: none"> <li>1. Time and efficiency</li> <li>2. Nursing processes</li> <li>3. Professional satisfaction</li> <li>4. Nursing sensitive outcomes</li> </ol>	<p>-Use of EHR reduced:</p> <ol style="list-style-type: none"> <li>a) time devoted to verbal transmission of information</li> <li>b) time spent documenting (but did not improve quality of documentation)</li> </ol> <p>-Clinical data support systems improved:</p> <ol style="list-style-type: none"> <li>a) knowledge and translating research</li> </ol>

					from qualified Registered Nurse through the means of ICT were focus of interest.		into practice b) intra- and interprofessional collaboration c) care coordination
Flow: Early Results from a Clinical Demonstration Project to Improve the Transition of Patients with Mental Health Disorders Back to Primary Care	Smith, T. L., Kim, B., Benzer, J. K., Yusuf, Z. F., Terri L., & Walder, A. M. (2019)	Devise and implement strategies to coordination transitioning stable MH patients back to PC.	Mixed methodology – quantitative observational study and qualitative case study designs	III / A	1,566 Veterans over 12-month study period in the VA.	-Implementation of clinical decision support (CDS) tool that identifies patients who may be candidates to transition care to PC.  -Over the 12-month period 424 MH patients transitioned back to PC.  -Only 9 MH patients who transitioned from MH to PC returned to MH during study period.	-Leadership and designated facilitator were key in project success.  -CDS tool deemed to be accurate and useful in identifying patients who were candidates for transitioning back to PC.  -Transitions were reported to be easier and more effective for patients when MH providers broached the subject over several session, giving Veterans the time to think it through and accept it.
Care transitions: a systematic review of best practices.	Dusek, B., Pearce, N.J., Harripaul, A., & Lloyd, M. (2015)	Identify best practice guidelines to assist nurses in understanding their roles and responsibilities in promoting safe	Systematic Review	II / A	127 studies were included to appraise for themes correlating to the research questions related to the following	-Early and ongoing assessment was identified as essential to support patients before, during, and after transition.	- Several studies identified the following as critical to successful care transitions: 1. medication reconciliation

		and effective coordination and continuity of care during patient care transitions.			during care transitions: a) assessment and management strategies b) specific safety and monitoring strategies, c) education support, d) organizational characteristics	- Early assessment includes assessing psychological readiness, improve patient engagement and decision-making. -Poor communication and coordination lead to adverse outcomes. -Use multiple strategies to enhance communication to coordinate care and transfer information. - Case management, especially those led by nurses, improves successful transitions and flow of information.	2. education and teaching for self-management 3. timely flow of patient information with a summarized care plan 4. post-transition support with effective handoff  - Nurses are key communicators and collaborators in the coordination of patient care and there is a great need for them to take an active role in care transitions.
Successful care transitions for older people: a systematic review and meta-analysis of the effects of interventions that support medication continuity.	Tomlinson, J., Cheong, V.-L., Fylan, B., Silcock, J., Smith, H., Karban, K., & Blenkinsopp, A. (2020).	Systematic review evaluated interventions that supported successful transitions of care through enhanced medication continuity.	Systematic Review with Meta-analysis	I / A	24 RCT studies included divided by themes: Interventions commenced post-discharge, interventions commenced during hospital admission that transferred to post-discharge, and interventions during hospital admission only.	- Successful transitions occurred when patients were supported up to 90 days through a bridge program. - Interventions that best supported patients were a) self-management education and teaching b) telephone follow-up and medication reconciliation c) patient-centered discharge summary	- Patient education, self-management techniques, and communication among health care providers were useful in ensuring safe care transitions. -Supporting patient post-transition for a period of time reduces adverse outcomes.

						<p>d) collaboration within care team</p> <p>e) timely cross-sector communication</p> <p>f) patient hotline</p>	
Identifying Effective Nurse-Led Care Transition Interventions for Older Adults with Complex Needs Using a Structured Expert Panel	<p>Jeffs, L., Kuluski, K., Law, M., Saragosa, M., Espin, S., Ferris, E., Merkley, J., Dusek, B., Kaster, M., &amp; Bell, C. M. (2017)</p>	<p>A structured expert panel was established to identify effective nurse-led care transition interventions.</p>	Expert opinion	V / A	<p>23 panelists were asked to rate, rank, and revise the components of nurse-led care transitions.</p>	<p>The 5 highest ranked interventions for successful care transitions were:</p> <ol style="list-style-type: none"> <li>1. education and coaching patients about self-management skills</li> <li>2. ensuring patients are aware of follow-up appointments and post-discharge plans</li> <li>3. use of standardized documentation tools and comprehensive communication techniques</li> <li>4. optimize the nurses' role and scope of practice across the health care system</li> <li>5. having strong leadership, strategic alignment and accountability</li> </ol>	<p>-Optimizing nurses' role and scope during care transitions is key.</p> <p>-Useful interventions include nurses providing "warm hand-off" and serve as the point of contact for patients when there is a need.</p>
Care Coordination as Imagined, Care Coordination	<p>Hannigan, B., Simpson, A., Coffey, M., Barlow, S., &amp; Jones, A. (2018)</p>	<p>Aim to investigate care planning and coordination in the context of</p>	Qualitative comparative case study	III / B	<p>28 care coordinators from ix sites (four NHS trusts in England and two local</p>	<p>The relationship aspect of care coordination depended on engaging patients, attending to their need, and</p>	<p>Care coordination requires knowledgeable and skilled persons.</p> <p>-When well done, care coordination crosses</p>

as Done: Findings from a Cross- national Mental Health Systems Study		community mental health care.			health boards in Wales) were interviewed.	supporting their recovery. Care coordinators were responsible for connecting patients to the systems and bring services to them when able.	multiple service lines; all for the benefit of the patient. -Care coordinators must hone their craft of collaboration to be successful.
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### Integrated Care

High quality of care persists with shifting Depression services from VA Specialty to Integrated Primary Care	Leung, L. B., Escarce, J. J., Yoon, J., Sugar, C. A., Wells, K. B., Young, A. S., & Rubenstein, L. V. (2019)	Longitudinal study to: a) describes depression diagnosis and care quality over time for newly diagnosed PC patients b) to examine if increased PC engagement in integrated PC-MH services was associated with difference in the quality of depression care	Quantitative correlational longitudinal cohort research design	I / A	80,136 Veterans seen in 26 Southern California VA outpatient settings.	-No difference appreciated between the quality of care, treatment guidelines, and follow-up adherence between specialty-MH and PC- MH integration.  -PC-MH integration engagement rates did not correlate to significant difference in diagnosis of Depression. Veterans continued to receive the same level of care.	-Veterans treated in PC- MH receive same level of high-quality of care compared to specialty- MH; vulnerable populations such as homelessness received even <i>higher</i> quality of care. This could be due to MH service being available in the same PC setting, as opposed to referring patient to specialty clinic.  -Referrals can be cumbersome and potentially lose the opportunity to care for Veterans when care is postponed (referred) to another area.  -Decreasing referrals to specialty clinic for
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							stable MH patients also improve access for patients who need a more intensive specialty care setting.
Toward a unified integration approach: uniting diverse Primary Care strategies under the Primary Care Behavioral Health (PCBH) Model	Sandoval, B.E., Bell, J., Khatri, P. Robinson, P.J. (2018)	Recommendation for development of clinical pathways for PC-BH model service delivery.	Literature review	V / A	PC setting	-PC settings that integrated BH are able to better manage the needs of its population with more comprehensive preventative care, early intervention, and treatment.	-Integrating care can meet organizational quality of care goals, and enhance patient-centered holistic, accessible, and affordable care. -PC-BH model of care helps with Depression, Opioid epidemic and management of persistent pain, alcohol misuse, obesity, and insomnia.
Chronic care, integrated care, and mental health: Moving the needle now	Sullivan, W. P., & Wahler, E. A. (2017)	Highlights multiple changes that can be incorporated into MH care now, including population health, technology, and multidisciplinary teams.	Literature review	V / A	PC setting	-Barriers in care is no longer a knowledge gap, instead it is an integration gap.  -Integrating PC and MH within the same setting improves identification of MH disorders and offering of early treatment options.  -Integration reduces stigma of MH by	-Applying elements of the Chronic Care model and incorporating partnerships among MH and PC can improve current system of care and health outcomes.  -Holistic care approaches with the utilization of case management, care coordination, and community resources

						<p>incorporating it with the normality of medical illnesses.</p> <p>-HIT interventions assists with screening, management, and shared-decision making of mental and medical disorders.</p>	<p>can improve health outcomes.</p> <p>-Collaboration through effective communication techniques has proven to meet patient mental and physical care needs.</p>
<p>Grounded Theory of Barriers and Facilitators to Mandated Implementation of Mental Health Care in the Primary Care Setting</p>	<p>Benzer, J. K., Beehler, S., Miller, C., Burgess, J. F., Sullivan, J. L., Mohr, D. C., Meterko, M., &amp; Cramer, I. E. (2012)</p>	<p>Framework to understand the potential barriers in implementing MH in PC setting.</p>	<p>Qualitative grounded theory research design</p>	<p>III / A</p>	<p>30 clinicals leaders from 16 PC-MH integration clinics in 8 VA medical centers in the U.S: 12 PC physicians; 10 psychologists; 5 psychiatrists; 4 nurses; 3 social workers; 1 physician assistant.</p>	<p>-Barriers that emerged:</p> <ul style="list-style-type: none"> <li>a) Leadership does not provide direction</li> <li>b) Lack of space for staff</li> <li>c) Lack of staff, time pressure</li> <li>d) Lack of knowledge / training plan</li> <li>e) Design/ workflow, staff participation</li> <li>f) Perceived boundaries between professional groups</li> <li>g) EHR referral system</li> <li>h) Interpersonal communication between PC and MH</li> <li>i) Patient complexity</li> </ul>	<p>-Organizational leadership support and provider experience were key influences to successful implementation of MH coordination practices.</p> <p>-Successful implementation of care coordination took into account preexisting collaborative relationships or utilized highly engaged key individuals to reduce boundaries between services and increase staff participation.</p> <p>-HIT solutions can assist with communication, proper referrals and transitions, and identification of patient</p>

							complexity/readiness for transition.
How personal and standardized coordination impact implementation of integrated care	Benzer, J. K., Cramer, I. E., Burgess, J. F., Mohr, D. C., Sullivan, J. L., Charns, M. P. (2015)	Identify how organizational factors impacted coordination, and how to facilitate implementation of integrated care.	Qualitative evaluation research design	III / A	30 clinic leaders and 35 front line staff from 16 PC and MH clinics across 8 VA medical centers in the U.S.	-Potential factors that impacted integrated care: a) Distance between PC and MH b) Interaction history – the degree of collaborative relationship between PC and MH c) Electronic health impediments d) Lack of standardized referral process e) Clinic access	-Study indicates barriers can be addressed with standardized approach to care coordination.  -Patients with multiple chronic conditions require care across multiple health care professionals and settings.  -Collaborative approach between PC and MH can improve care coordination and access to care.

## Appendix B: Logic Model Table

Project date: May 2021 – August 2021

Resources/Inputs	Activities	Outputs Are what you do as a direct result of activities		Outcomes: Short term	Outcomes: Intermediate	Outcomes: Long term
<p><b>Personnel:</b> Mental Health (MH) psychiatrist and psychologists, MH clerical staff, Clinical Education subject matter expert (SME), Informatic clinical application coordination and information technology SME, Finance SME, MH leadership and DNP student. Time to train and for staff to attend training.</p> <p><b>Materials/Supplies:</b> Paper, ink &amp; ink cartridges, and handouts.</p> <p><b>Space:</b> meeting space</p> <p><b>Equipment:</b> Computers, screen projector, printer</p> <p><b>Information technology:</b> online learning system, Microsoft Office software.</p>	<ul style="list-style-type: none"> <li>-Develop training budget.</li> <li>-Develop training materials: overview of recovery model, identification of patients who may be appropriately transitioned back to PC, roles and responsibilities, collaboration among PC and MH.</li> <li>-Assess best method to disseminate information.</li> <li>-Garner leadership support to allocate staff time to attend training</li> <li>-Secure educators for training.</li> <li>-Schedule training dates, times, and location for in-person training.</li> <li>-Create education module for upload to organization learning management system for online training.</li> <li>-Develop pre and posttest to assess understanding.</li> <li>-Collaborate with Service Chiefs to allocate care transition as monthly staff meeting agenda item.</li> </ul>	<ul style="list-style-type: none"> <li>-Training budget approved.</li> <li>-Training materials approved by leadership.</li> <li>-Educational module completed for in-person training on care transitions.</li> <li>-In-person and online trainings are scheduled.</li> <li>- Leadership approved staff time for training.</li> <li>- Training provided at monthly staff meetings.</li> <li>- Educational handouts for training session created.</li> <li>- Training module approved, uploaded, and assigned staff.</li> <li>-Analyze test results for continued education plan.</li> </ul>	<ul style="list-style-type: none"> <li>-Mental Health care staff</li> <li>-Nursing staff</li> <li>-Clerical staff</li> </ul>	<p><b>1)</b> By August 2021, MH providers demonstrated a 25% increase in awareness that specialty MH-care is generally time-limited, and once Veterans are stabilized and/or recovered, their care will be transitioned back to PC. (CO)</p>	<p><b>8)</b> By August 2022, MH demonstrated a 75% increase in awareness that specialty MH-care is generally time-limited, and once Veterans are stabilized and/or recovered, their care will be transitioned back to PC. (CO)</p>	<p><b>15)</b> MH providers incorporated their knowledge that appropriate care settings for MH patients supports patient recovery and support care delivery in settings that is most appropriate for patient care into their day-to-day practice.</p>

<b>Resources/Inputs</b>	<b>Activities</b>	<b>Outputs Are what you do as a direct result of activities</b>		<b>Outcomes: Short term</b>	<b>Outcomes: Intermediate</b>	<b>Outcomes: Long term</b>
<p><b>Personnel:</b> Primary Care (PC) providers, PC Nurses, PC clerical staff, Clinical Education subject matter expert (SME), Informatic clinical application coordination and information technology SME, Finance SME, and PC leadership. and DNP student. Time to train and for staff to attend training.</p> <p><b>Materials/Supplies:</b> Paper, ink &amp; ink cartridges, and handouts.</p> <p><b>Space:</b> meeting space</p> <p><b>Equipment:</b> Computers, screen projector, printer</p> <p><b>Information technology:</b> online learning system, Microsoft Office software.</p>	<p>-Develop training budget.</p> <p>-Develop training materials: overview of recovery model, identification of patients who may be appropriately transitioned back to PC, roles and responsibilities, collaboration among PC and MH.</p> <p>-Assess best method to disseminate information.</p> <p>-Garner leadership support to allocate staff time to attend training</p> <p>-Secure educators for training.</p> <p>-Schedule training dates, times, and location for in-person training.</p> <p>-Create education module for upload to organization learning management system for online training.</p> <p>-Develop pre and posttest to assess understanding.</p> <p>-Collaborate with Service Chiefs to allocate care transition as monthly staff meeting agenda item.</p>	<p>-Training budget approved.</p> <p>-Training materials approved by leadership.</p> <p>-Educational module completed for in-person training on care transitions.</p> <p>-In-person and online trainings are scheduled.</p> <p>- Leadership approved staff time for training.</p> <p>- Training provided at monthly staff meetings.</p> <p>- Educational handouts for training session created.</p> <p>- Training module approved, uploaded, and assigned staff.</p> <p>-Analyze test results for continued education plan.</p>	<p>-Primary Care staff</p> <p>-Nursing staff</p> <p>-Clerical staff</p>	<p>2) By August 2021, PC providers demonstrated a 25% increase in awareness that specialty MH-care is generally time-limited, and once Veterans are stabilized and/or recovered, their care will be transitioned back to PC. (CO)</p>	<p>9) By August 2022, PC demonstrated a 75% increase in awareness that specialty MH-care is generally time-limited, and once Veterans are stabilized and/or recovered, their care will be transitioned back to PC. (CO)</p>	<p>16) PC providers incorporated their knowledge that appropriate care settings for MH patients supports patient recovery and support care delivery in settings that is most appropriate for patient care into their day-to-day practice.</p>
<b>Resources/Inputs</b>	<b>Activities</b>	<b>Outputs Are what you do as a direct result of activities</b>		<b>Outcomes: Short term</b>	<b>Outcomes: Intermediate</b>	<b>Outcomes: Long term</b>

<p><b>Personnel:</b> Primary Care (PC) and Mental Health (MH) providers, PC Nurses, PC &amp;MH clerical staff, Informatic clinical application coordination and information technology SME, Finance SME, PC and MH leadership, and IRB.</p> <p><b>Materials /Supplies:</b> Paper, ink &amp; ink cartridges, handouts, and incentive to participate.</p> <p><b>Space:</b> RN staff office, training space</p> <p><b>Equipment:</b> Computers, screen projector, printer, telephones</p> <p><b>Information technology:</b> Microsoft Office software.</p> <p><b>Incentives:</b> incentive to participate</p>	<p>-Develop nurse-led care coordination process: standardize MH provider discharge (DC) note, once Veteran is discharge RN coordinator is added to the DC note. RN coordinator will contact Veteran to assist with any coordination needs, discuss follow-up appointments, and act as liaison between MH and PC.</p> <p>- Develop care coordination tools/interventions</p> <p>-Garner IRB approval for Veteran participation</p> <p>-Develop training budget.</p> <p>-Develop training and education materials of new nurse-led care coordination program.</p> <p>-Identify RN point of contact for pilot.</p> <p>-Market new program to MH service and Veterans.</p> <p>-Educate Veteran/family of new RN care coordination program.</p> <p>- Collaborate with MH providers to disseminate information.</p>	<p>-Tools and interventions vetted through evidence-based literature and approved by organizational leadership.</p> <p>-IRB approval attained.</p> <p>-Budget approved.</p> <p>-Training materials/flyers approved.</p> <p>-Training provided at monthly staff meetings (May 2021).</p> <p>-RN for pilot confirmed.</p> <p>-Improved awareness of program by key stakeholders.</p> <p>- MH providers educated Veterans/family and offered the program to 100% of Veterans who were ready to transition</p>	<p>-Veterans / families</p> <p>-Primary Care staff</p> <p>-Mental Health care staff</p> <p>-Nursing staff</p> <p>-Clerical staff</p>	<p><b>3)</b> By August 2021, 25% of eligible MH Veterans transitioning back to PC agreed to have their care coordinated by the new nurse-led care coordination program. (PO)</p>	<p><b>10)</b> By May 2022, 50% of Veterans participated in the RN care coordination program when transitioning care from MH back to PC. (PO)</p>	<p><b>17)</b> Care coordination is routinely provided to Veterans who are deemed stable and or/recovered transitioned back to PC.</p>
<p><b>Resources/Inputs</b></p>	<p><b>Activities</b></p>	<p><b>Outputs</b> Are what you do as a direct result of activities</p>	<p><b>Outcomes: Short term</b></p>	<p><b>Outcomes: Intermediate</b></p>	<p><b>Outcomes: Long term</b></p>	

<p><b>Personnel:</b> Primary Care (PC) and Mental Health (MH) providers, PC Nurses, PC &amp; MH clerical staff, Informatic clinical application coordination and information technology SME, Finance SME, PC and MH leadership.</p> <p>DNP student. Time to train and for staff to attend training.</p> <p><b>Materials &amp; Supplies</b> Paper, ink &amp; ink cartridges, handouts, and flyers.</p> <p><b>Space:</b> meeting space</p> <p><b>Equipment:</b> Computers, printer, screen projector</p> <p><b>Information technology:</b> Microsoft Office software.</p>	<p>-Create nurse workflow process (contact versus unable to reach)</p> <p>-Develop standardized electronic and handoff bundle for: MH discharge and care coordination notes (with specific elements; education, follow-up appointments, resources, etc.), and handoff between nurse care coordinator and PC nurse.</p> <p>-Develop training and education materials of electronic templates.</p> <p>-Obtain Veteran participation agreement.</p> <p>-Develop standardize audit tool to capture compliance.</p>	<p>-Approved process integrated into daily workflow.</p> <p>- Templates approved and deployed May 1, 2021.</p> <p>-Training materials approved</p> <p>-Training provided at monthly staff meetings (May 2021).</p> <p>-Veteran were offered program during their MH visit where transition back to PC was discussed.</p> <p>-Audit compliance monthly via standardized audit tool.</p>	<p>-Veterans / families</p> <p>-Primary Care staff</p> <p>-Mental Health care staff</p> <p>-Nursing staff</p> <p>-Clerical staff</p>	<p>4) During May-July 2021, the nurse care coordinator contacted 85% of MH Veterans (who were discharged from MH back to PC and agreed to participate in the pilot program) within 2 weeks of discharge; and coordinated their care back to PC utilizing the standardized electronic coordination and handoff bundle. (PO)</p>	<p>11) By May 2022, RN coordination program was expanded to include MH and PC at facility community-based outreach clinics. (CO)</p>	<p>18) Veterans who are deemed stable and or/recovered are identified and transitioned back to PC via the nurse-led coordination program.</p>
Resources/Inputs	Activities	Outputs Are what you do as a direct result of activities		Outcomes: Short term	Outcomes: Intermediate	Outcomes: Long term
<p><b>Personnel:</b> Primary Care (PC) and, Mental Health (MH) providers, PC &amp; MH clerical staff, Informatic clinical application coordination and</p>	<p>-Educate MH providers of VA-developed criteria, resources, and electronic tools (already established) used to identify Veterans who may be appropriate to transition back to PC.</p>	<p>-Training provided at monthly staff meetings (May 2021).</p> <p>-Point of contact established.</p>	<p>-Veterans / families</p> <p>-Primary Care staff</p> <p>-Mental Health care staff</p> <p>-Nursing staff</p> <p>-Clerical staff</p>	<p>5) By August 2021, more than 50% of MH staff reported utilizing the VA electronic report (emailed to them biweekly by administrative staff) as a guide to assist them in</p>	<p>12) By January 2022, MH providers utilized the VA electronic report routinely and reviewed at least 50% of their patient panel monthly to initiate transitions back to PC.</p>	<p>19) MH providers incorporated data into their daily practice to identify appropriate care transitions and support patient care delivery in settings that</p>

<p>information technology SME, Finance SME, PC and MH leadership.</p> <p>DNP student. Time to train and for staff to attend training.</p> <p><b>Materials &amp; Supplies:</b> Paper, ink &amp; ink cartridges, and handouts.</p> <p><b>Space:</b> meeting room</p> <p><b>Equipment:</b> Computers, printer</p> <p><b>Information technology:</b> Microsoft Office software.</p>	<p>-Identify point of contact to disseminate VA electronic report of Veterans who may be appropriate to transition</p> <p>-Identify best method to disseminate transition reports</p> <p>-Develop standardize audit tool to capture the number of Veterans on the report appropriate to transition versus the number who actually transitioned</p> <p>-Meet monthly with stakeholders to discuss care transitions and any barriers.</p>	<p>-POC emailed transition report every 2 weeks to MH providers.</p> <p>- Audit results monthly via standardized audit tool.</p> <p>-Discuss results biweekly with stakeholders</p>		<p>identifying appropriate Veterans to transition back to PC.</p> <p>(Report identified Veterans who:</p> <ul style="list-style-type: none"> <li>- Have completed MH treatment and are not taking psychotropic medications</li> <li>- Stable on pharmacotherapy regimen)</li> </ul> <p>(PO)</p>	<p>(CO)</p>	<p>is most appropriate for patient level of care.</p>
Resources/Inputs	Activities	Outputs Are what you do as a direct result of activities		Outcomes: Short term	Outcomes: Intermediate	Outcomes: Long term
<p><b>Personnel:</b> MH providers, nurse care coordinator, MH and PC clerical staff, education SME, Informatic and information technology SME, mailroom, IRB, and PC and MH leadership.</p> <p>DNP student. Time to train and for staff to attend training.</p>	<p>-Review and select an appropriate (pre and post) questionnaire.</p> <p>-Garner IRB approval for questionnaire dissemination</p> <p>-Collaboration with nurse care coordinator to discuss upcoming anonymous questionnaire with Veterans during initial contact.</p> <p>-Development of database to track questionnaire results.</p>	<p>- Questionnaire created and approved by IRB.</p> <p>- Questionnaire disseminated (mail/electronically) to Veterans pre- and post-participation in the program.</p> <p>-Excel and Minitab identified as two software programs to maintain, track, trend, and analyze data.</p>	<p>-Veterans</p>	<p>6) By August 2021, more than 50% of Veterans who responded to the questionnaire “agreed” or “strongly agreed” that the new care coordination program supported Veterans care. (CO)</p>	<p>13) By May 2022, a 75% improvement in Veteran perception of care transitions was measured by the questionnaire. (CO)</p>	<p>20) Local VA MH service met ‘Best place for care’ goal based on VA’s Strategic Analytics for Improvement and Learning metrics: MH experience of care and Coordination of care.</p>



<p><b>Materials &amp; Supplies:</b> Paper, ink &amp; ink cartridges, questionnaire, stamps, envelopes.</p> <p><b>Space:</b> meeting room</p> <p><b>Equipment:</b> Computers, printer</p> <p><b>Information technology:</b> Microsoft Office software.</p>						
Resources/Inputs	Activities	Outputs Are what you do as a direct result of activities		Outcomes: Short term	Outcomes: Intermediate	Outcomes: Long term
<p><b>Personnel:</b> MH and PC providers, nurse care coordinator, MH and PC clerical staff, education SME, Informatic and information technology SME, mailroom, IRB, and PC and MH leadership. DNP student.</p> <p><b>Materials &amp; Supplies:</b> Paper, ink &amp; ink cartridges, questionnaire, stamps, envelopes.</p> <p><b>Space:</b> meeting room</p> <p><b>Equipment:</b> Computers, printer</p>	<p>-Review and select an appropriate usability questionnaire</p> <p>-Collaborate with Service chiefs and supervisors for questionnaire dissemination</p> <p>-Development of database to track questionnaire results</p>	<p>-Usability questionnaire created.</p> <p>-Support received from Chiefs and supervisors for disseminated to staff</p> <p>- Questionnaire emailed to staff post implementation</p> <p>-Excel and Minitab identified as two software programs to maintain, track, trend, and analyze data</p>	<p>-Primary Care staff</p> <p>-Mental Health care staff</p> <p>-Nursing staff</p> <p>-Clerical staff</p>	<p>7) By August 2021, more than 50% of Mental Health and Primary Care providers, and nurses who responded to the questionnaire “agreed” or “strongly agreed” that the new care coordination program supported Veterans’ care. (CO)</p>	<p>14) By May 2022, 75% of staff reported the transition of care process useful to help support Veteran’s care transition. (CO)</p>	<p>21) A nurse care coordination program provided the necessary framework to support Veterans during transitions of care.</p>

**Information****technology:**

Microsoft Office and  
Minitab software.

Information technology: Microsoft Office and Minitab software.						
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### Appendix C: SWOT Analysis Table

<b>Strengths</b>	<b>Weaknesses</b>
<ol style="list-style-type: none"> <li>1. National initiative with evidence showing it is effective</li> <li>2. Part of Executive Career Field Performance plan</li> <li>3. Leadership commitment</li> <li>4. Tools and framework for implementation available</li> <li>5. Robust systems redesign program</li> <li>6. Dedicated to continuous learning, inquiry, and improvement</li> </ol>	<ol style="list-style-type: none"> <li>1. Large organizational change with various obstacles from each respective service/stakeholder</li> <li>2. Poor communication</li> <li>3. Increased demand and workload</li> <li>4. Has been semi-tried and failed; lost momentum</li> <li>5. PC perception of “dumping”</li> <li>6. MH perception of failure as patients tend to be referred back to MH</li> <li>7. Veterans may not welcome change without clear reason for the change and time allowed for shared-decision making</li> </ol>
<b>Opportunities</b>	<b>Threats</b>
<ol style="list-style-type: none"> <li>1. Engage all stakeholders</li> <li>2. Build and leverage connections to solve problems</li> <li>3. Bounce back from mistakes</li> <li>4. Empower expertise and knowledge regardless of education level</li> <li>5. Education, coaching, and evaluation</li> <li>6. Shared-decision making</li> <li>7. Improve patient and provider satisfaction</li> <li>8. Improve health literacy and care coordination</li> <li>9. Promote integrated care</li> <li>10. Aligns with VA EHR modernization</li> </ol>	<ol style="list-style-type: none"> <li>1. Buy in from Primary care</li> <li>2. Buy in from specialty mental health</li> <li>3. Functionality and interoperability for health IT solutions</li> <li>4. Legislative issue</li> <li>5. Organizational culture</li> <li>6. Change fatigue</li> </ol>

## Appendix D: Scholarly Project Agreement

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### Scholarly Project Agreement

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Scholarly Project Agreement

Between

Jacqueline Buval, Doctor of Nursing Practice (DNP) student

Boise State University

and

[REDACTED] Department of Veterans Affairs

This Scholarly Project Agreement outlines the terms and understanding between Jacqueline Buval, a DNP student at Boise State University, and [REDACTED] Department of Veterans Affairs, to pilot a nurse-led care coordination program that aims to promote healthy care transitions for Veterans who are discharged from Mental Health (MH) back to Primary Care (PC).

#### Background

The prevalence of MH disorders, particularly post-traumatic stress disorder and or depression, among combat Veterans has doubled in the last ten years. The escalation in MH disorders has led to an influx of Veterans seeking care at their local Department of Veterans Affairs (VA) hospital, and the organization has been challenged in meeting the demand. Ideally, patients expect to receive care in the most appropriate care setting to meet their health care needs and for MH patients, "receiving care in the least-restrictive care setting" is an important contributor to transitioning individuals out of the sick role and into recovery (Smith et al., 2019, p. 2). Oftentimes, PC is the first point of entry into the health care system and MH disorders are typically diagnosed there. Once diagnosed, veterans are referred onward to specialty-MH for further evaluation and development of a care plan. When stable and/or recovered, veterans remain in specialty-MH even though their needs can be effectively transitioned back to PC. Poor care transitions impact veteran sustainment of recovery and reduces access to care for other veterans who require higher level of MH service(s). Access to care, whether privately or within the VA, is one of the most significant concerns discussed in the literature and is directly influenced by poor communication among health care providers and suboptimal care coordination procedures spanning across the health care system (Dusek et al., 2015). An intensive literature review demonstrates that a nurse care coordination model is an effective strategy to improve access to care by promoting effective care transitions, streamlining

communication, and assisting veterans in maintaining MH recovery congruent with their level of care needs.

#### **Purpose**

The aim of the pilot project is to implement strategies to support effective care coordination for stable MH veterans transitioning back to PC. The pilot project will use a nurse care coordinator as a liaison between MH and PC departments, and be the primary resource for veterans during their care transition. The nurse care coordinator will follow a standardized care coordination process providing care through care coordination activities such as: a) development of a proactive care plan, b) provide patient education for accessing and navigating the health care system, c) support patient self-management goals, d) relay organizational and community resources, e) review scheduled follow-up appointments, and f) address questions and concerns (Lamb et al., 2018). If the pilot program functions as intended, patient experience of care, support for self-management of health care needs, and access to care should improve.

#### **Intended Project Outcomes**

- Improve MH and PC awareness that specialty MH-care is generally time-limited and once veterans are stabilized and/or recovered, their care will be transitioned back to PC.
- MH and PC providers incorporate the knowledge that appropriate care settings for MH patients is vital in maintaining patient's recovery into their daily practice.
- MH providers use the VA electronic report in their daily practice to identify appropriate patients to transition and support patient care delivery in settings that is most appropriate for the patient's level of care.
- Care coordination is routinely provided to veterans who are transitioned back to PC.
- Improve veteran and staff perception of care transitions.

#### **Duration**

The scholarly project will work alongside the organization's Flow initiative; a national quality improvement project to facilitate care transitions of stabilized MH patients back to PC, which began January 2020. The student secured a facility mentor and project discussion started February 2020. Implementation of the project is forecasted to begin May 2021 and end August 2021. The project will be completed by December 2021. During February 2020 and December 2021 timeframe the student will engage stakeholders for the planning, development, intervention, and evaluation of the nurse care coordination pilot.

#### **Reporting**

The DNP Scholarly Project will include a final report, an abstract, an oral presentation of the report and potential publication. The DNP student will submit a Final Project Report for publication in ScholarWorks. ScholarWorks is a collection of services designed to capture and showcase all scholarly output by the Boise State University community, including doctoral dissertations and doctoral project reports. The nurse care coordination pilot project results will be presented to stakeholders October 2021 with final project report presentation to Boise State University May 2022.

No personal identifiers will be included and all data will be reported in aggregate form. Analysis of data will be used to satisfy the DNP student's degree requirement. The author welcomes any comments or suggestions from the [REDACTED] Department of

Veterans Affairs but reserves the right to publish findings and analysis according to professional standards and principles of academic freedom. For any work of a scholarly nature, the author agrees to follow the organization(s) preferences in how it is to be named (or not) in the work. For the final report, abstract, publication and presentation purposes the agency will be referenced in the DNP Scholarly Project as [REDACTED] Department of Veterans Affairs.

**Contact Information:**

**Student**

Jacqueline Buval

Phone: [REDACTED]

Email: [REDACTED]

[REDACTED] Date: 1/10/21

*(DNP Student signature)*

Jacqueline Buval, Boise State University DNP student

**Scholarly Project Faculty Mentor**

Dr. Teresa Serratt PhD, RN

Phone: [REDACTED]

Email: [REDACTED]

[REDACTED] Date: 1/14/21

*(Scholarly Project Faculty Mentor)*

Teresa Serratt, Boise State University Associate Professor, DNP Program

**Scholarly Project Organizational Mentor**

Dr. Carla Hitchcock-Robinson PhD, Clinical Psychologist

Phone: [REDACTED]

Email: [REDACTED]

[REDACTED]

**Organizational Leader**

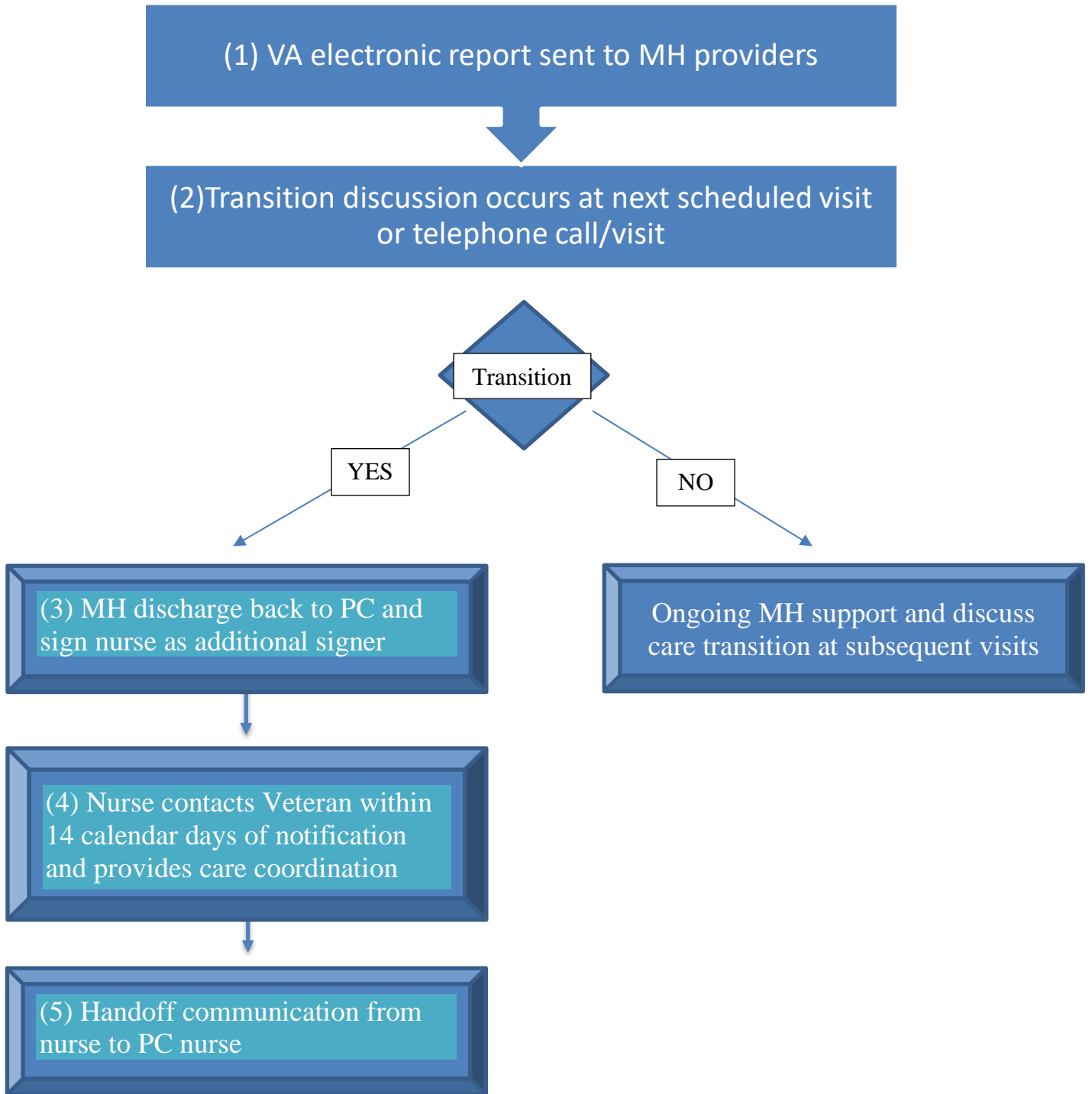
Dr. Stacy Ritz PhD, Associated Chief Mental and Behavioral Health Services

Phone: [REDACTED]

Email: [REDACTED]

[REDACTED]

**Appendix E: Care Transition Workflow**













**Appendix G: Outcome Evaluation Table**

Outcome	Data Collection Instrument / Data	Analysis Goal	Analytic Technique
<p><b>#1</b> By August 2021, MH providers demonstrated a 25% increase in awareness that specialty MH-care is generally time-limited, and once Veterans are stabilized and/or recovered, their care will be transitioned back to PC.</p>	<p><b>Instrument:</b> A pre-implementation / post-implementation questionnaire will be used to compare provider awareness of appropriate care transitions.</p> <p><b>Questionnaire instructions:</b> In thinking about your current experience in Mental Health clinic and transitioning patients back to Primary Care, how would you rate the following:</p> <ol style="list-style-type: none"> <li>1. I have a good understanding of Flow program criteria.</li> <li>2. Specialty Mental Health care is generally referred to as an episode of care that is time-limited.</li> <li>3. Caring for Veterans in the most appropriate care setting (level of care) is important to maintain recovery and stability. Example: PC vs. specialty-MH</li> <li>4. Shared-decision making is used between provider and Veterans when discussing care transitions.</li> <li>5. A Veteran who has completed and/or sustained remission of substance dependence disorder for one year is appropriate to transition back to Primary Care.</li> <li>6. A Veteran who has had no change in medication during the past six months is appropriate to transition back to Primary Care.</li> <li>7. Once Veterans become psychiatrically stable and have completed counseling, they can be referred back to their primary care provider for continued medication management.</li> <li>8. Veterans are given tools (self-care management, web-based courses, mobile applications, etc.) to support their recovery.</li> <li>9. I have been given the tools to successfully transition eligible patients back to Primary Care.               <ol style="list-style-type: none"> <li>a. If not, please explain what resources you need to be successful?</li> </ol> </li> <li>10. What would improve the likelihood of you transitioning eligible Veterans back to Primary Care?</li> </ol>	<p>Assess MH providers awareness of appropriate care transitions before pilot program implementation and after.</p> <p>Gauge their level of engagement in transitioning eligible patients.</p> <p>Gauge level of experience with care transitions versus knowledge.</p> <p>Use of open-ended questions will give insight to any barriers or resources needed to be successful in care transitions.</p> <p>Feedback received will be used to showcase improvement in awareness and commitment to care delivery in appropriate settings and/or provide information as to how to assist providers in being more successful in care transitions.</p>	<p><b>Mixed analysis methods</b></p> <p><b>Quantitative</b> – Ordinal data represented by a bar chart to visualize modes, medians, and frequency of each item choice.</p> <p><b>Qualitative</b> responses will be aggregated and categorized by item. Depending on the responses received, data could be categorized by magnitude, frequency, and/or topic. Data can be reported as recommendations for project sustainment.</p>

	<p><b>Data:</b> Pre and post implementation design using 5-point Likert Scale ((1) Strongly disagree; (2) Disagree; (3) Neither agree nor disagree; (4) Agree; (5) Strongly agree) and two open-ended questions.</p> <p>Questionnaire: <a href="https://www.surveymonkey.com/r/████████">https://www.surveymonkey.com/r/████████</a></p>		
<p><b>#2</b> By August 2021, PC providers demonstrated a 25% increase in awareness that specialty MH-care is generally time-limited, and once Veterans are stabilized and/or recovered, their care will be transitioned back to PC.</p>	<p><b>Instrument:</b> A pre-implementation / post-implementation questionnaire will be used to compare provider awareness of appropriate care transitions.</p> <p><b>Questionnaire instructions:</b> In thinking about your current experience in Primary Care clinic and caring for patients who have been discharged back to Primary Care from Specialty-Mental Health clinic, how would you rate the following:</p> <ol style="list-style-type: none"> <li>1. I have a good understanding of Flow program criteria.</li> <li>2. Specialty Mental Health care is time-limited and once Veterans are stable their care can be effectively handled in Primary Care (i.e., Veterans with uncomplicated depression or anxiety).</li> <li>3. Caring for Veterans in the most appropriate care setting (level of care) is important to maintain recovery and stability. Example: PC vs. specialty-MH</li> <li>4. A Veteran who has completed and/or sustained remission of substance dependence disorder for one year is appropriate to transition back to Primary Care.</li> <li>5. A Veteran who has had no change in medication during the past six months is appropriate to transition back to Primary Care based (i.e., Veterans with uncomplicated depression or anxiety).</li> <li>6. Once Veterans become psychiatrically stable and has completed counseling, their care can effectively be managed by primary care provider for continued medication management (i.e., Veterans with uncomplicated depression or anxiety).</li> <li>7. I have been given the tools to successfully care for Veterans' mental health in Primary Care.             <ol style="list-style-type: none"> <li>a. If not, please explain what resources you need to be successful?</li> </ol> </li> </ol> <p><b>Data:</b> Pre and post implementation design using 5-point Likert Scale ((1) Strongly disagree; (2) Disagree; (3) Neither agree nor disagree; (4) Agree; (5) Strongly agree) and one open-ended questions.</p>	<p>Assess PC providers awareness before pilot program implementation and after to assess level of change.</p> <p>Gauge their level of engagement in accepting and managing stable MH conditions.</p> <p>Use of open-ended questions will give insight to any barriers or resources needed to be successful in managing stable MH patients.</p> <p>Feedback received will be used to showcase improvement in awareness and commitment to care delivery in appropriate settings and/or provide information as to how to assist providers in being more successful in care transitions.</p>	<p><b>Mixed analysis methods</b></p> <p><b>Quantitative</b> – Ordinal data represented by a bar chart to visualize modes, medians, and frequency of each item choice.</p> <p><b>Qualitative</b> responses will be aggregated and categorized by item. Depending on the responses received, data could be categorized by magnitude, frequency, and/or topic. Data can be reported as recommendations for project sustainment.</p>

	Questionnaire: <a href="https://www.surveymonkey.com/r/██████████">https://www.surveymonkey.com/r/██████████</a>		
<p><b>#3</b> By August 2021, 25% of eligible MH Veterans transitioning back to PC agreed to have their care coordinated by the new nurse-led care coordination program.</p>	<p><b>Instrument:</b> An audit sheet will be created in Excel to capture the following data points from the EHR:</p> <ul style="list-style-type: none"> <li>• MH Provider clinic panel designation</li> <li>• Patient name</li> <li>• Date discharged from MH</li> <li>• Patient agreed to participate</li> </ul> <p>(Data points are readily available in the EHR)</p> <p><b>Data:</b> Data will be retrieved by either health factors through National VA report (Flow report) or note title through Vista software program. <i>Numerator:</i> Number of identified eligible Veterans who participated in the new nurse-led care coordination program. <i>Denominator:</i> Number of eligible Veterans who did not agree to participate.</p>	<p>Assess impact of pilot program for Veterans transitioning back to PC.</p> <p>To quantify the number of patients who agreed to participate in the pilot versus those who did not agree to participate.</p>	<p><b>Quantitative</b> Descriptive statistics - Nominal count, percentage, and trend of patients who agreed to participate. Data will be displayed using a bar graph, including the mean, median and forecast.</p> <p>Data will be collected and shared with core team members monthly.</p>
<p><b>#4</b> During May-July 2021, nurse care coordinator contacted 85% of MH veterans (who were discharged from MH back to PC and agreed to participate in the pilot program) within 2 weeks of discharge; and coordinated their care back to PC via the standardized electronic coordination and handoff bundle.</p>	<p><b>Instrument:</b> An audit sheet will be created in Excel to capture the following data points from the EHR:</p> <ol style="list-style-type: none"> <li>1. Provider clinic panel designation</li> <li>2. Patient name</li> <li>3. Patient age (18-35, 36-55, &gt;56)</li> <li>4. Patient service period / conflict location</li> <li>5. Date discharged from MH</li> <li>6. Date contacted by nurse care coordinator</li> <li>7. Elements of coordination bundle documented</li> <li>8. Handoff completed</li> </ol> <p><b>Data:</b> Chart audit review purpose is to gather the identified variables and not intended to evaluate patient medical care. Data will be retrieved by either health factors or note title. <i>Numerator:</i> Number of identified eligible veterans on VA electronic report wherein chart review indicates initiation/discussion to transition care back to PC. <i>Denominator:</i> Number of identified eligible Veterans on VA electronic report.</p> <p>Data points 1-7 are readily available in the EHR; the last 3 data points will be added fields in the EHR prior to project implementation.</p>	<p>To assess impact and timeliness of program intervention.</p> <p>To quantify the number of patients who a) agreed to participate in the pilot, b) discharged per provider panel, and c) contacted timely.</p> <p>To quantify the compliance rate of using the standardized electronic coordination and handoff documentation bundle.</p>	<p><b>Quantitative</b> Descriptive statistics - Nominal count and percentage of program variables to track and trend compliance. Data will be displayed using a bar or pie graph, including the mean and median.</p> <p>Data will be collected and shared with core team members monthly.</p>
<p><b>#5</b> By August 2021, more than 50% of MH staff</p>	<p><b>Instrument:</b> Multiple choice questionnaire; Yes, No</p>	<p>Assess impact of providing providers with an electronic</p>	<p><b>Mixed analysis methods</b></p>

<p>reported utilizing the VA electronic report (emailed to them biweekly by administrative staff) as a guide to assist them in identifying appropriate Veterans to transition back to PC</p>	<p>1. Are you using the FLOW report that is provided to you biweekly to assist in identifying Veterans who are appropriate to transition back to PC?                  Yes / No                  If no, why not? (Free text)</p> <p><b>Data:</b> Electronic questionnaire email  <i>Numerator:</i> Number of "Yes", "No" and free text responses to questionnaire. <i>Denominator:</i> Number of MH staff who responded to the questionnaire.</p> <p>Questionnaire: <a href="https://www.surveymonkey.com/r/██████████">https://www.surveymonkey.com/r/██████████</a></p>	<p>report to assist in identification of eligible patients to transition back to PC.</p> <p>Data will be reviewed monthly for project improvement.</p>	<p><b>Quantitative</b> – Descriptive statistics - Nominal data represented by percent of responses and frequency of each item choice.</p> <p><b>Qualitative</b> responses will be aggregated and categorized by item.</p>
<p><b>#6</b> By August 2021, more than 50% of Veterans who responded to the questionnaire “agreed” or “strongly agreed” that the new care coordination program supported Veteran’s care.</p>	<p><b>Instrument:</b> A post-implementation Veteran satisfaction questionnaire.</p> <p><b>Questionnaire instructions:</b> In thinking about your recent transition from Mental Health clinic back to Primary Care, how would you rate experience:</p> <ol style="list-style-type: none"> <li>The care coordination program helped me clearly understand what to expect during the transition.</li> <li>The care coordination program helped me understand how to access the health care system for questions and/or follow-up care.</li> <li>The care coordination program provided me with the support I needed to feel confident in transitioning my care back to Primary Care.</li> <li>I found the care coordination program helpful for my care transition.</li> <li>I think the care coordination program would be helpful for other Veterans transitioning their care back to Primary care.</li> <li>What can we do to improve this program?</li> </ol> <p><b>Data:</b> Satisfaction questionnaire using Likert Scale ((1) Strongly disagree; (2) Disagree; (3) Neither agree nor disagree; (4) Agree; (5) Strongly agree) and one open-ended question.  <i>Numerator:</i> Number of Veterans participating in the pilot program who responded "Agreed" or "Strongly agreed."  <i>Denominator:</i> Number of Veterans in the pilot program who responded to the questionnaire.</p> <p>Questionnaire: <a href="https://www.surveymonkey.com/r/██████████">https://www.surveymonkey.com/r/██████████</a></p>	<p>Assess program impact and Veteran satisfaction.</p>	<p><b>Mixed analysis methods</b></p> <p><b>Quantitative</b> – Ordinal data represented by a bar chart to visualize modes, medians, and frequency of each item choice.</p> <p><b>Qualitative</b> responses will be aggregated and categorized by item. Depending on the responses received, data could be categorized by magnitude, frequency, and/or topic. Data can be reported as recommendations for project sustainment.</p>

<p>#7 By August 2021, more than 50% of Mental Health and Primary Care providers and nurses who responded to the questionnaire “agreed” or “strongly agreed” that the new care coordination program supported Veteran’s care.</p>	<p><b>Instrument:</b> A post-implementation staff satisfaction questionnaire will include the following:</p> <p><b>Questionnaire instructions:</b> Questionnaire: In thinking about your experience in caring for patients who have transitioned from Mental Health clinic back to Primary Care, how would you rate the following:</p> <ol style="list-style-type: none"> <li>1. I found the care coordination program helpful in transitioning patients from Mental Health to Primary Care.</li> <li>2. I found that the care coordination program provided the needed support to Veterans transitioning care back to Primary Care.</li> <li>3. I found the care coordination program improved communication among the Veterans care team.</li> <li>4. I think this program would be beneficial for continued use after the pilot period.</li> <li>5. What can we do to improve this program?</li> </ol> <p><b>Data:</b> Satisfaction questionnaire using Likert Scale ((1) Strongly disagree; (2) Disagree; (3) Neither agree nor disagree; (4) Agree; (5) Strongly agree) and one open-ended question.  <i>Numerator:</i> Number of staff participating in the pilot program who responded "agree" or "strongly agree." <i>Denominator:</i> Number of staff who responded to the questionnaire.</p> <p><b>Questionnaire:</b> <a href="https://www.surveymonkey.com/r/██████████">https://www.surveymonkey.com/r/██████████</a></p>	<p>Assess program impact and staff satisfaction.</p>	<p><b>Mixed analysis methods</b></p> <p><b>Quantitative</b> – Ordinal data represented by a bar chart to visualize modes, medians, and frequency of each item choice.</p> <p><b>Qualitative</b> responses will be aggregated and categorized by item. Depending on the responses received, data could be categorized by magnitude, frequency, and/or topic. Data can be reported as recommendations for project sustainment.</p>
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**Appendix H: Collaborative Institutional Training Initiative**



Completion Date 07-Jul-2020  
Expiration Date 07-Jul-2023  
Record ID 37151159

This is to certify that:

**Jacqueline Buval**

Has completed the following CITI Program course:

**Human Research** (Curriculum Group)  
**Social & Behavioral Researchers** (Course Learner Group)  
**1 - Basic Course** (Stage)

Not valid for renewal of certification through CME. Do not use for TransCelerate mutual recognition (see Completion Report).

Under requirements set by:

**Boise State University**



Verify at [www.citiprogram.org/verify/?wf653042c-e5c1-4c19-9beb-09747f03ca99-37151159](http://www.citiprogram.org/verify/?wf653042c-e5c1-4c19-9beb-09747f03ca99-37151159)

**Appendix I: Recruitment Script**

Hello (patient name),

My name is (nurse or provider). I am reaching out to ask if you would be interested in participating in a 90-day project at the VA related to transitioning your mental health care back to primary care. The project consists of a telephone call with a registered nurse within 2 weeks of when your mental health provider and you decided that your care can be transitioned back to primary care. The nurse will go over any questions or concerns you have about returning your care back to primary care, as well as provide education on how to access care and navigate the VA health care system.

Participation is strictly voluntary, and choosing not to participate will not impact the care you receive at the VA in any way. If you choose to participate a nurse will contact you to review what you can expect during the project, as well as review and obtain your consent to participate in the project.

Thank you for your time!

Appendix J: Project Flyer

# FLOW Program and an RN Care coordination Pilot Program

## What is the FLOW program?

FLOW is a quality improvement project to facilitate the transition of stabilized and recovered Mental Health patients back to Primary Care.

## What is the RN care coordination pilot program?

The aim of the program is to implement strategies to support effective care coordination for stable Veterans transitioning their care back to Primary Care.

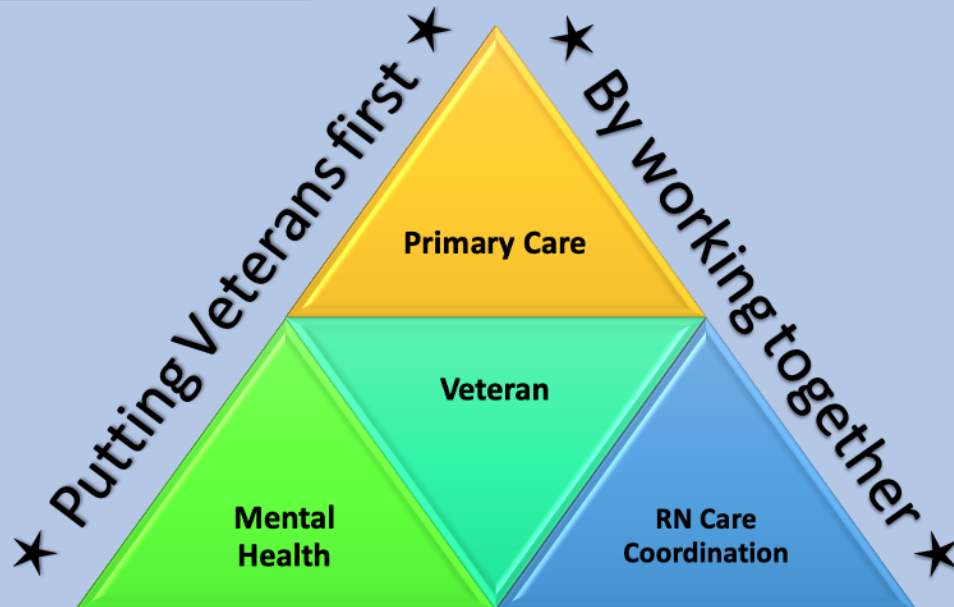
## Why is this important?

Specialty-Mental Health is generally time-limited and once Veterans are stable research shows that in order to sustain recovery care can be effectively delivered in Primary Care.

## What can Veteran expect?

The pilot project will use a nurse care coordinator as a liaison between Mental Health and Primary Care departments, and be the primary resource for veterans during their care transition. The nurse care coordinator will follow a standardized care coordination process providing care through care coordination activities such as:

- Development of a proactive care plan
- Review scheduled follow-up appointments
- Address questions and concerns
- Support patient self-management goals
- Patient education for accessing and navigating the health care system
- Patient education of organizational and Community resources



## Appendix K: Employee Survey Question Notification Memorandum

Employee Survey for Quality Improvement Project

### Department of Veterans Affairs

### Memorandum

**Date:** February 1, 2021

**From:** Jacqueline Buval, RN MSN; [REDACTED]

**Subject:** Employee Survey for Quality Improvement Project

**To:** President AFGE [REDACTED]

**Thru:** Human Resource Labor Relations

1. This memorandum is to inform you that I will be conducting a quality improvement project for Veterans who are transferring care from the Mental Health clinic back to Primary Care.
2. The aim of the program is to implement strategies to support effective care coordination for stable Veterans transitioning their care back to Primary Care. As part of the project, I plan to disseminate pre, mid, and post implementation surveys to staff participating in the project, mainly Primary Care and Mental health clinic providers and nurses who provide direct care to these Veterans.
3. Project and survey participation is completely voluntary. Recruitment for this project is anticipated to begin late April 2021 and conclude August 2021. Project implementation timeframe is planned to begin 5/1/21 and conclude August 31, 2021, pending local Institution Review Board (IRB) letter of determination.
4. Employees who wish to participate in the survey will be sent a link electronically. The survey will be conducted through SurveyMonkey®, will take approximately less than 5 minutes to complete, and are as follows:
  - a. Mental Health provider pre and post survey (identical):  
[https://www.surveymonkey.com/tr/\[REDACTED\]](https://www.surveymonkey.com/tr/[REDACTED])
  - b. Primary Care provider pre and post survey (identical):  
[https://www.surveymonkey.com/tr/\[REDACTED\]](https://www.surveymonkey.com/tr/[REDACTED])
  - c. Mental Health provider intermittent (pre, mid, and post) survey:  
[https://www.surveymonkey.com/tr/\[REDACTED\]](https://www.surveymonkey.com/tr/[REDACTED])
  - d. Primary Care and Mental Health provider, and nursing staff post satisfaction survey: [https://www.surveymonkey.com/tr/\[REDACTED\]](https://www.surveymonkey.com/tr/[REDACTED])
5. The purpose of the surveys is to assess Mental Health and Primary Care providers' awareness of appropriate care transitions and gauge their level of engagement in participating in healthy care transitions. Participants will be asked to rate questions on a 5-point Likert scale with 1 being "strongly agree to 5 "strongly disagree." Responses will be categorized by frequency of item response. The use of open-ended questions will be used to garner insight to any barriers of resources needed for them to be successful in care transitions.
6. Only the project lead, Jacqueline Buval, will have access to project participant names, email address, and password protected SurveyMonkey® account. Participant names and email address will be used for the sole purpose of survey distribution only. Completed surveys will be distributed and collect through project lead SurveyMonkey® account. Participation is voluntary. Responses will remain confidential and cannot be linked to the participant. Participants will remain anonymous.
7. If you have any questions, please contact the undersigned at [REDACTED]

Attachments:  
Copy of Survey Questions

**Appendix L: Letter of Determination**



**DEPARTMENT OF VETERANS AFFAIRS**

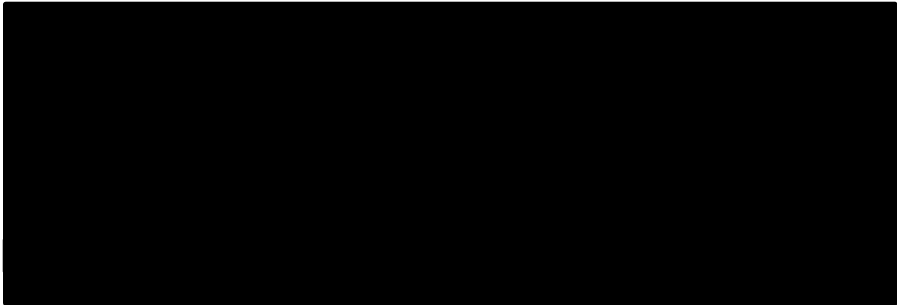


Subject: DNP Scholarly Project  
Date: 03042021

Dear Ms. Buval:

Under VHA regulations and guidelines, your proposal entitled "Improving access and delivery of Mental Health care to Veterans through a care coordination pilot program" has been reviewed and does not meet Veterans Health Administration (VHA) or other federal guidelines for human subject research. You may proceed with your project.

Sincerely,



## Appendix M: Expense Reports

PILOT					Grand Total	\$ 1,926,867.35
Expense Category	Expense Description	Explanation of Expense	Type of Cost	Volume	Cost per Unit	Total
Personnel	Psychiatrist wages	Psychiatrists participating in program. Hourly rate is an average based on organizational HR data.	Variable	10 hrs. a week x program length (3 months) = 120 hrs. X 56 Psychiatrist	\$75/hr.	\$ 504,000.00
Personnel	Psychologist wages	Psychologists participating in program. Hourly rate is an average based on organizational HR data.	Variable	10 hrs. a week x program length (3 months) = 120 hrs. X 82 Psychologist	\$44/hr.	\$ 432,960.00
Personnel	Clinical champion staff wage	A Psychologist has been appointed as clinical champion participating in the program	Variable	20 hrs. a week x program length (3 months) = 240 hrs.	\$44/hr.	\$ 10,560.00
Personnel	Primary Care Physician wages	Primary Care providers participating in program. Hourly rate is an average based on organizational HR data.	Variable	10 hrs. a week x program length (3 months) = 120 hrs. X 26 PC providers	\$106/hr.	\$ 330,720.00
Personnel	Primary Care Nurse Practitioner wages	Primary Care NP's participating in program. Hourly rate is an average based on organizational HR data.	Variable	10 hrs. a week x program length (3 months) = 120 hrs. X 6 NP providers	44/hr.	\$ 31,680.00
Personnel	RN staff wages	Primary Care RN's participating in program. Hourly rate is an average based on organizational HR data.	Variable	10 hrs. a week x program length (3 months) = 120 hrs. x 32 RNs	31/hr.	\$ 119,040.00

Personnel	Clerical staff wages	Administrative staff participating in program. Hourly rate is an average based on organizational HR data.	Variable	5 hrs. a week x program length (3 months) = 60 hrs. X 101 admin staff	\$20/hr.	\$	121,200.00
Personnel	Clinical education wages	RN educator participating in program. Hourly rate is an average based on organizational HR data.	Variable	1 hr. a week x program length (3 months) = 12 hrs. x 1 RN	\$31/hr.	\$	372.00
Personnel	Informatics clinical application coordinator wages	Clinical application coordinator participating in program. Hourly rate is an average based on organizational HR data.	Variable	0.5 hrs. a week x program length (3 months) = 6 hrs. x 1 staff member	\$27/hr.	\$	162.00
Personnel	Financial advisor wages	Finance staff participating in program. Hourly rate is an average based on organizational HR data.	Variable	0.5 hrs. a week x program length (3 months) = 6 hrs. x 1 staff member	\$29/hr.	\$	174.00
Personnel	Mail room staff wages	Mailroom staff participating in program. Hourly rate is an average based on organizational HR data.	Variable	3 hrs. a week x program length minus 1 month to allow for mail turn-around time (2 months) = 36 hrs. x 1 staff member	\$12/hr.	\$	432.00
Personnel	Executive leadership wages	Leadership participating in project review, procedures, education, and status. Hourly rate is an average based on organizational HR data.	Variable	Bimonthly 1-hour meeting with leadership = 6 hrs. x 3 staff members	\$110/hr.	\$	1,320.00

Personnel	IRB personnel wages	IRB staff reviewing and approving project proposal. Hourly rate is an average based on organizational HR data.	Variable	1-hour x 2 members	\$110/hr.	\$	220.00
Personnel	Information technology staff wages	IT support for program implementation and evaluation. Hourly rate is an average based on organizational HR data.	Variable	0.5 hrs. a week x program length (3 months) = 6 hrs. x 1 staff member	\$26/hr.	\$	156.00
Personnel	DNP student	Project lead in program development, implementation (RN care coordinator), and evaluation. Hourly rate is an average based on organizational HR data.	Variable	25 hrs. a week x program length (3 months) = 300 hrs.	\$45/hr.	\$	13,500.00
Material & Supplies	Paper	307 educational packets, 170 pre & post questionnaires, 15-unit flyers	Fixed	1 ream of paper (500 pages)	\$15/ream	\$	15.00
Material & Supplies	Ink	Ink cartridge	Fixed	1	\$129.96	\$	129.96
Material & Supplies	Internet	Monthly high speed internet fee	Fixed	3 months	\$89.99/month	\$	269.97
Material & Supplies	General office supplies	Pens, paper clips, sticky notes, etc.	Fixed	3 months	\$50.00	\$	1,500.00
Material & Supplies	Stamps	Stamps to mail patient questionnaires	Fixed	1 coil of forever stamps / 100 stamps	\$55	\$	55.00
Material & Supplies	Envelopes	Envelopes to mail questionnaires	Fixed	100 envelopes per box	\$8.59	\$	8.59



Space	Meeting/training room	Meet with respective teams to discuss project	Fixed	Meet 3 times x.2 hours per meeting = 6 hours	160/hr.	\$	480.00
Space	RN office including utilities	Office for RN care coordinator wherein no current office/position exists	Fixed	25 hrs. a week x program length (3 months) = 300 hrs.	160/hr.	\$	48,000.00
Equipment	Printer	Xerox WorkCentre Wireless printer	Fixed	1 printer	\$359.59	\$	359.59
Equipment	Computer	Computer	Fixed	308 staff participating in program	\$899/staff	\$	276,892.00
Equipment	Screen projector	Portable screen projector for education meetings	Fixed	1 screen projector	\$66.30	\$	66.30
IT	Microsoft Office	Microsoft professional bundle	Fixed	1 unit	\$39.97	\$	39.97
IT	Adobe Pro	1-year subscription	Fixed	1 unit	\$179.99	\$	179.99
IT	Electronic education app	1-time fee	Fixed	1 unit	\$19.99	\$	19.99
IT	Online learning platform	1-time fee	Fixed	1 unit	\$59.99	\$	59.99
IT	Statistical software (Minitab)	1-year subscription	Fixed	1 unit	\$1,495.00	\$	1,495.00
IT	Telephone and service	3-month phone rental and use	Fixed	308 units	\$100	\$	30,800.00

<b>YEAR 2</b>										<b>Grand Total</b>	<b>\$ 5,887,443.63</b>
Expense Category	Expense Description	Explanation of Expense	Type of Cost (variable /fixed)	Volume explanation	Hrs. a week	Length	Total hrs.	Quantity	Cost per Unit (personnel = hourly)	Total	
Personnel	Psychiatrist wages	Psychiatrists participating in program. Hourly rate is an average based on	Variable	8 hrs. a week x 52 weeks = 416 hrs. X 56 Psychiatrist	8	52	416	56	\$75	\$ 1,747,200.00	

organizational HR data.

Psychologists participating in program. Hourly rate is an average based on organizational HR data.

A Psychologist has been appointed as clinical champion participating in the program

Primary Care providers participating in program. Hourly rate is an average based on organizational HR data.

Primary Care NP's participating in program. Hourly rate is an average based on organizational HR data.

Personnel	Psychologist wages	Variable	8 hrs. a week x 52 weeks= 416 hrs. X 82 Psychologist	8	52	416	82	\$44	\$	1,500,928.00
Personnel	Clinical champion staff wage	Variable	4 hrs. a week x 52 weeks = 208 hrs.	4	52	208	1	\$44	\$	9,152.00
Personnel	Primary Care Physician wages	Variable	8 hrs. a week x 52 weeks = 416 hrs. X 26 PC providers	8	52	416	26	\$106	\$	1,146,496.00
Personnel	Primary Care Nurse Practitioner wages	Variable	8 hrs. a week x 52 weeks = 416 hrs. X 6 NP providers	8	52	416	6	\$44	\$	109,824.00

Personnel	RN staff wages	Primary Care RN's participating in program. Hourly rate is an average based on organizational HR data.	Variable	8 hrs. a week x 52 = 416 hrs. x 32 RNs	8	52	416	32	\$31	\$	412,672.00
Personnel	Clerical staff wages	Administrative staff participating in program. Hourly rate is an average based on organizational HR data.	Variable	5 hrs. a week x 52 week = 260 hrs. X 101 admin staff	5	52	260	101	\$20	\$	525,200.00
Personnel	Informatics clinical application coordinator wages	Clinical application coordinator participating in program. Hourly rate is an average based on organizational HR data.	Variable	0.25 hrs. a week x 52 = 13 hrs. x 1 staff member	0.25	52	13	1	\$27	\$	351.00
Personnel	Financial advisor wages	Finance staff participating in program. Hourly rate is an average based on organizational HR data.	Variable	0.25 hrs. a week x 52 = 13 hrs. x 1 staff member	0.25	52	13	1	\$29	\$	377.00
Personnel	Mail room staff wages	Mailroom staff participating in program. Hourly rate is an average based on organizational HR data.	Variable	3 hrs. a week x 52 weeks = 156 hrs. x 1 staff member	3	52	156	1	\$12	\$	1,872.00

Personnel	Information technology staff wages	IT support for program implementation and evaluation. Hourly rate is an average based on organizational HR data.	Variable	0.25 hrs. a week x 52 = 13 hours x 1 staff member	0.25	52	13	1	\$26	\$	338.00
Material & Supplies	Paper	pre & post questionnaires	Fixed	1 ream of paper (500 pages)	--	--	--	4	\$15	\$	60.00
Material & Supplies	Ink	Ink cartridge	Fixed	1	--	--	--	2	\$129.96	\$	259.92
Material & Supplies	Internet	Monthly high speed internet fee	Fixed	12 months	--	--	--	12	\$89.99	\$	1,079.88
Material & Supplies	General office supplies	Pens, paper clips, sticky notes, etc	Fixed	12 months	--	--	--	12	\$50.00	\$	600.00
Material & Supplies	Stamps	Stamps to mail patient questionnaires	Fixed	forever stamps / 100 stamps	--	--	--	3	\$55	\$	165.00
Material & Supplies	Envelopes	Envelopes to mail questionnaires	Fixed	100 envelopes per box	--	--	--	3	\$8.59	\$	25.77
Space	RN office including utilities	Office for RN care coordinator wherein no current office/position exists	Fixed	40 hrs. a week x 52 weeks = 2080 hrs.	40	52	2080	1	\$160	\$	332,800.00
Equipment	--	--	--	--	--	--	--	--	--	--	--
IT	Adobe Pro	1-year subscription	Fixed	1 unit	--	--	--	--	\$179.99	\$	179.99

IT	Statistical software (Minitab)	1-year subscription	Fixed	1 unit	--	--	--	--	\$1,495.00	\$	1,495.00
IT	Telephone and service	12-month phone rental and use	Fixed	1 unit	--	52		308	\$100	\$	30,800.00

**YEAR 3****Grand Total \$ 6,551,228.49**

<b>Expense Category</b>	<b>Expense Description</b>	<b>Explanation of Expense</b>	<b>Type of Cost (variable /fixed)</b>	<b>Volume explanation</b>	<b>Hrs. a week</b>	<b>Length</b>	<b>Total hrs.</b>	<b>Quantity</b>	<b>Cost per Unit (personnel = hourly)</b>	<b>Total</b>
Personnel	Psychiatrist wages	Psychiatrists participating in program. Hourly rate is an average based on organizational HR data.	Variable	8 hrs. a week x 52 weeks = 416 hrs. X 56 Psychiatrist	8	52	416	56	\$75	\$ 1,747,200.00
Personnel	Psychologist wages	Psychologists participating in program. Hourly rate is an average based on organizational HR data.	Variable	8 hrs. a week x 52 weeks= 416 hrs. X 82 Psychologist	8	52	416	82	\$44	\$ 1,500,928.00
Personnel	Clinical champion staff wage	A Psychologist has been appointed as clinical champion participating in the program	Variable	4 hrs. a week x 52 weeks = 208 hrs.	4	52	208	1	\$44	\$ 9,152.00

Personnel	Primary Care Physician wages	Primary Care providers participating in program. Hourly rate is an average based on organizational HR data. Primary Care NP's participating in program. Hourly rate is an average based on organizational HR data.	Variable	8 hrs. a week x 52 weeks = 416 hrs. X 31 PC providers	8	52	416	31	\$106	\$	1,366,976.00
Personnel	Primary Care Nurse Practitioner wages	Primary Care RN's participating in program. Hourly rate is an average based on organizational HR data.	Variable	8 hrs. a week x 52 weeks = 416 hrs. X 11 NP providers	8	52	416	11	\$44	\$	201,344.00
Personnel	RN staff wages	Administrative staff participating in program. Hourly rate is an average based on organizational HR data.	Variable	8 hrs. a week x 52 = 416 hrs. x 42 RNs	8	52	416	42	\$31	\$	541,632.00
Personnel	Clerical staff wages		Variable	5 hrs. a week x 52 week = 260 hrs. X 121 admin staff	5	52	260	121	\$20	\$	629,200.00

Personnel	Informatics clinical application coordinator wages	Clinical application coordinator participating in program. Hourly rate is an average based on organizational HR data.	Variable	0.25 hrs. a week x 52 = 13 hrs. x 1 staff member	0.25	52	13	1	\$27	\$	351.00
Personnel	Financial advisor wages	Finance staff participating in program. Hourly rate is an average based on organizational HR data.	Variable	0.25 hrs. a week x 52 = 13 hrs. x 1 staff member	0.25	52	13	1	\$29	\$	377.00
Personnel	Mail room staff wages	Mailroom staff participating in program. Hourly rate is an average based on organizational HR data.	Variable	3 hrs. a week x 52 weeks = 156 hrs. x 1 staff member	3	52	156	1	\$12	\$	1,872.00
Personnel	Information technology staff wages	IT support for program implementation and evaluation. Hourly rate is an average based on organizational HR data.	Variable	0.25 hrs. a week x 52 = 13 hrs. x 1 staff member	0.25	52	13	1	\$26	\$	338.00

Material & Supplies	Paper	pre & post questionnaires	Fixed	1 ream of paper (500 pages)	--	--	--	4	\$15	\$	60.00
Material & Supplies	Ink	Ink cartridge	Fixed	1	--	--	--	2	\$129.96	\$	259.92
Material & Supplies	Internet	Monthly high speed internet fee	Fixed	12 months	--	--	--	12	\$89.99	\$	1,079.88
Material & Supplies	General office supplies	Pens, paper clips, sticky notes, etc.	Fixed	12 months	--	--	--	12	\$50.00	\$	600.00
Material & Supplies	Stamps	Stamps to mail patient questionnaires	Fixed	3 coil of forever stamps / 100 stamps	--	--	--	3	\$55	\$	165.00
Material & Supplies	Envelopes	Envelopes to mail questionnaires	Fixed	100 envelopes per box	--	--	--	3	\$8.59	\$	25.77
Space	RN office including utilities	Office for RN care coordinator wherein no current office/position exists	Fixed	40 hrs. a week x 52 weeks = 2080 hrs.	40	52	2080	1	\$160	\$	332,800.00
Equipment	Computer	Computer	Fixed	40 additional staff participating in program	40	--	--	40	\$899.00	\$	35,960.00
IT	Adobe Pro Statistical software	1-year subscription	Fixed	1 unit	--	--	--	--	\$179.99	\$	179.99
IT	(Minitab)	1-year subscription	Fixed	1 unit	--	--	--	--	\$1,495.00	\$	1,495.00



IT	Telephone and service	12-month phone rental and use	Fixed	1 unit	--	52	348	\$100	\$	34,800.00
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**Appendix N: 2 to 3-year Budget**

<b>Yearly Totals:</b>				
	<b>\$ 1,926,867.35</b>	<b>\$5,887,443.63</b>	<b>\$ 6,551,230.47</b>	
<b>Expense Category</b>	<b>Year 1</b>	<b>Year 2</b>	<b>Year 3</b>	<b>Rationale</b>
Personnel	\$ 1,552,996.00	\$ 5,508,954.10	\$ 6,119,357.40	Pilot first year part-time basis with 1 RN coordinator, 32 PC providers, 138 MH providers, 32 RNs, and 101 admin staff. Year two move the program with same staff to full-time. Third year, continue as full-time basis and expand to sister facility and include 10 additional PC providers, 10 additional RNs, 20 additional admin staff. Annual 1% salary increase.
Material & Supplies	\$ 1,978.52	\$ 2,256.29	\$ 2,323.98	Material Sum with annual 3% increase
Space	\$ 48,480.00	\$ 342,784.00	\$ 352,768.00	Space Sum with annual 3% increase
Equipment	\$ 277,317.89	\$ -	\$ 38,117.60	Initial start-up cost and expansion in year 3.
IT	\$ 32,594.94	\$ 33,449.24	\$ 38,663.49	Initial start-up, annual software fees, and expansion in year 3.

**\*Annual increase of 1% in salaries based on standard calculation utilized by organization**

**\*Annual increase of 3% in supplies and general expenses based on organization standard calculations**

## Appendix O: Statement of Operations

<b>Operating Income</b>			<b>\$0.00</b>
<b>Revenue Total</b>		<b>\$</b>	<b>1,926,867.35</b>
<b>Source</b>	<b>Description</b>	<b>Amount</b>	
Salaries (in kind)	Hourly wages from staff participating in the project	\$	1,552,996.00
DNP student (in kind)	Hourly wage from DNP student designing, implementing, and evaluating project	\$	13,500.00
Organization provided supplies, space, IT and equipment (in kind)	space, equipment, materials & supplies, personnel	\$	360,371.35
<b>Expenses Total</b>		<b>\$</b>	<b>1,926,867.35</b>
<b>Expenses</b>	<b>Description</b>	<b>Amount</b>	
Personnel	Salaries of staff participating in the program	\$	1,552,996.00
DNP student	DNP student designing, implementing, and evaluating project.	\$	13,500.00
Material & Supplies	General office supplies (paper, ink, stamps, envelopes)	\$	1,978.52
Space	Training and office space	\$	48,480.00
Equipment	Printer, computers, screen projector	\$	277,317.89
IT	Software package, mobile service, online learning platform	\$	32,594.94

## Appendix P: Communication to Mental Health providers

Hello Mental Health providers,

As part of the VAs Flow initiative, we are implementing a care coordination pilot project to help support Veterans during their transition from Mental Health clinic back to Primary Care.

### What is the Flow initiative?

Flow is a quality improvement project to facilitate the transition of stabilized and recovered Mental Health patients back to Primary Care.

### Why is this important?

Specialty-Mental Health is generally time-limited and once Veterans are stable, research shows that sustained recovery can be effectively managed in Primary Care.

### What is the care coordination pilot program?

The aim of the program is to implement strategies to support effective care coordination for stable Veterans transitioning their care back to Primary Care. The timeframe of the project is May – August 2021 and will focus on [REDACTED] location only at this time.

### What can Veterans expect?

A phone call to Veterans from a clinical care coordinator to provide care coordination activities such as:

- One point of contact to address questions and concerns
- Support patient established discharge plan
- Coordinate follow-up appointments
- Support patient self-management goals
- Patient education for accessing and navigating the health care system
- Patient education of organizational and Community resources

### What are we asking of you?

We are seeking your participation in providing valuable feedback through a few brief questionnaires related to both Flow and the pilot project. The questionnaires are voluntary and completely anonymous. The initial pre-implementation questionnaire can be found here: [https://www.surveymonkey.com/r/\[REDACTED\]](https://www.surveymonkey.com/r/[REDACTED]) and will take less than 3 min. to complete. Subsequent questionnaires will be sent at a later date. Even if you have not yet discharged a patient back to Primary Care, we would still like to hear from you!

Your feedback is greatly appreciated and thank you in advance!

If you have any questions please reach out to:

Jackie Buval – project coordinator

[REDACTED]

Dr. Hitchcock-Robinson – Flow champion

[REDACTED]

## Appendix Q: Communication to Primary Care providers

Hello Primary Care providers,

As part of the VAs Flow initiative, we are implementing a nurse care coordination pilot study to help support Veterans during their transition from Mental Health clinic back to Primary Care.

### What is the Flow initiative?

Flow is a quality improvement program that facilitates the transition of stabilized and recovered Mental Health patients back to Primary Care.

### Why is this important?

Specialty-Mental Health is generally time-limited and once Veterans are stable, research shows that sustained recovery can be effectively managed in Primary Care.

### What is the care coordination pilot program?

The aim of the program is to implement strategies to support effective care coordination for stable Veterans transitioning their care back to Primary Care. The timeframe of the project is May – August 2021 and will focus on [REDACTED] location only at this time.

### What can Veterans expect?

A phone call to Veterans from a clinical care coordinator to provide care coordination activities such as:

- One point of contact to address questions and concerns
- Support patient discharge plan
- Coordination of follow-up appointments
- Support patient self-management goals
- Patient education for accessing and navigating the health care system
- Patient education of organizational and Community resources

### What are we asking of you?

We are seeking your participation in providing valuable feedback through a couple of brief questionnaires related to both Flow and the pilot study. The questionnaires are voluntary and completely anonymous. The first questionnaire can be found here: [https://www.surveymonkey.com/r/\[REDACTED\]](https://www.surveymonkey.com/r/[REDACTED]) and will take less than 3 min. to complete. A subsequent questionnaire will be sent at the conclusion of the project. Even if you have not yet received a discharged patient from Mental Health, we would still like to hear from you!

Your feedback is greatly appreciated and thank you in advance!

If you have any questions please reach out to:

Jackie Buval – project coordinator

[REDACTED]

Dr. Hitchcock-Robinson – Flow program champion

[REDACTED]

## **Appendix R: Communication to Nursing Staff**

Good afternoon Nursing staff,

As part of the VAs Flow initiative, we are implementing a nurse care coordination pilot study to help support Veterans during their transition from Mental Health clinic back to Primary Care.

### **What is Flow program?**

Flow is a quality improvement project to facilitate the transition of stabilized and recovered Mental Health patients back to Primary Care.

### **What is the RN care coordination pilot program?**

The aim of the program is to implement strategies to support effective care coordination for stable Veterans transitioning their care back to Primary Care. The timeframe of the project is May – August 2021 and will focus on [REDACTED] location only at this time.

### **What can Veterans expect?**

The pilot project will use a care coordinator as a liaison between Mental Health and Primary Care departments, and act as the primary resource for veterans during their care transition. The care coordinator will follow a standardized care coordination process providing care through care coordination activities such as:

- One point of contact to address questions and concerns
- Support patient discharge plan
- Coordination of follow-up appointments
- Support patient self-management goals
- Patient education for accessing and navigating the health care system
- Patient education of organizational and Community resources

The care coordinator will assist Veterans for up to 30 days, or until they have seen their PCP (whichever comes first) with any care coordination needs, questions or concerns. This does not mean the patient has to be seen by PCP within 30 days of discharge from MH.

### **What are we asking of you?**

Awareness.

We want you to be aware of these Veteran who are transitioning back to Primary Care. Once we have talked to the patient and offered supportive services during their transition, we will add you as an additional signer to our care coordination note. The note is informational only to increase your awareness that the Veteran is being transitioned back to Primary Care. We may also reach out to you in case of any Primary Care related questions the Veteran may have.

At the end of the summer, we would appreciate your participation in a quick questionnaire. The questionnaire is voluntary, completely anonymous, and will be email to you through a SurveyMonkey link.

If you have any questions please reach out to:

Jackie Buval – project coordinator  
[REDACTED]

Dr. Hitchcock-Robinson – Flow program champion  
[REDACTED]

## Appendix S: Care Transition Inclusion/Exclusion Criteria

Veteran who met the following were included in the project:

- Veteran has adhered to and benefited from pharmacotherapy regime and will be transferred to PC based on improvement and sustainability of the following:
  - Self-report mental health measures
  - Quality of life
  - Interpersonal functioning
  - Health behaviors
  - Occupational/Educational functioning
- All mental health goals have been sufficiently met:
  - Improvement in self-report mental health measures
  - Review of gains

Veteran who met the following were not included in the project:

- Veteran has consistently not engaged in treatment, as demonstrated by the following:
  - Nonadherence to pharmacotherapy despite repeated efforts to improve adherence
  - Had a long course of psychotherapy with little to no evidence of improvement
  - Inconsistent attendance
  - Repeated failure to complete assigned homework/practice exercises despite problem solving
  - Undersigned was unable to make contact with veteran despite three documented phone calls and one mailed notification
- Veteran preference
  - Veteran is not interested in MH services
  - Veteran prefers to end treatment despite recommendations to continue treatment
  - Veteran is moving out of our catchment area

## Appendix T: Telephone Script

Hi my name is \_\_\_\_\_ and I am calling from the [REDACTED] VA. I'm helping to coordinate care for Veterans transitioning from the Mental Health clinic back to Primary Care. I see you have recently discharged from the Mental Health clinic. Do you have a few minutes to discuss your discharge plan and potential additional resources available to support your transition back to Primary care?

**If, no:** Is there a better time to reach you in the next week?

**If, yes:**

1. I see that you were seeing Dr. \_\_\_\_\_ in the mental health clinic and according to our medical record system (CPRS) you belong to the [name of the PC team]. Dr. [name of provider] is your primary care provider and/or:
  - a. Your next scheduled appointment with him/her is on [date of next appointment].
  - b. I don't see that you have a scheduled appointment with them yet. The number to contact your health care team the main number is [REDACTED], option 2.
    - i. There is also the option of using MyHealthVet (confirm that they know about MyHealthVet /can use it. If not, go over how to sign up).
2. Let's review your current mental health medications. In the medical record system, I see that you are:
  - a. Taking the following \_\_\_\_\_.
  - b. Your PCP will be managing / refilling your prescription(s) moving forward.
  - c. For your prescription for \_\_\_\_\_ (MH meds), you have 2 refills in the system and you can call the pharmacy and a request refill when needed.
    - i. Pharmacy number: [REDACTED] Ext. [REDACTED] or [REDACTED] Ext. [REDACTED].
  - d. If there are no refills remaining, and you have not seen your PCP yet you can contact your Mental Health provider for an additional refill to assist until you see your PCP.
  - e. If your prescription will run out after you have seen your PCP, please contact your PCP to request additional refill.
  - f. It is best to request refills about a month or more prior to running out of medication, setting an alarm reminder on your calendar or phone may be helpful.

If no MH medication are prescribed remind patient:


- a. Should you have questions or require a prescription in the future, please speak to your primary care provider.
3. Next, I'd like to go over resources available to support you:
  - a. As part of your discharge from MH you *may* have received a congratulatory information packet to help you maintain the gains you have made as well as help you get back on track should you experience increase of symptoms. It also provides contact information in case you have additional questions/concerns. Did you happen to get the packet? (it's new therefore you may not have been offered it yet). If you are agreeable, I can send the packet to your email.
  - b. I'd like to highlight some of the things covered in the packet:
    - i. The Veteran crisis line 1-800-273-8255, press 1, or send a text to 838255
    - ii. We would like to encourage you to continue to use coping skills developed while in treatment.
    - iii. Should bumps occur think about the bumps the you've encountered in the past and what skills you used to help.



- iv. (If needed, or if it comes up the following # can be given):
  - 1. The VA Suicide Prevention Program 1-800-273-8255
  - 2. The VA Patient Advocate office [REDACTED]
- c. I can also send you additional coping skills information such as:
  - 1. VA Mobile Applications available to help navigate mental health
  - 2. Relaxation Fact sheet, exercises and techniques
  - 3. Behavior modification
  - 4. How to deal with Anxiety and Depression
  - 5. Problem solving techniques
  - 6. Reframing the way you think
  - 7. Anger coping strategies
  - 8. Effective communication
- 4. We are here to support you and your recovery journey and am available to help you with any further questions or concerns as you transition back to Primary Care. If you need anything between now and when you contact your PCP, I can be reached at \_\_\_\_\_. Do you have any questions or concerns that I can address?
- 5. Contacting Veterans and supporting them during their transition from MH back to PC is a new program and we value your feedback, would you be agreeable in filling out an anonymous survey? The survey is very brief and takes less than 5 minutes to complete. If you are interested, is there an email address (or secure message) I can send the survey link to?

Thank you for your time!

## Appendix U: MH Discharge Packet

***Congratulations on the successes you have made toward recovery and emotional well-being!  
Recovery is an ongoing journey that benefits from ongoing coping skill practices*** 



This guide aims to help you maintain the gains you have made as well as help you get back on track should you experience increase of symptoms. Lastly, it provides contact information in case you have additional questions/concerns.

### **Tips for Maintaining Your Gains**

- If on medication: Continue taking your medication as prescribed. Talk to your primary care provider (PCP) if you experience any side effects or want to make any medication changes.
- Continue using the healthy coping skills you have learned to maintain a good quality of life.
- Remain socially connected—be it in your faith community, social groups, the VA, or with friends and family.
- Tell someone close to you about the progress you have made and share any ongoing goals. That way, you have support and accountability.
- If you created a recovery plan, review that from time to time. Simple things like getting exercise, eating well, and getting enough sleep can make a big difference in how you feel.
- Monitor your emotional well-being and if you start to feel worse ask your PCP and/or emotional support system for help.

### **Bumps in the Road**

Despite our best intentions, things happen! We expect that people might hit bumps in the road. When you do, be kind to yourself and remember:

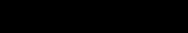
- Think about the bumps in the road you've encountered in the past—how did you get past them?
- What skills can you use to continue reaching your goals?
- Who can you reach out to for extra support or help?

### **Options for Seeking Additional Help**

In spite attempts to use healthy coping skills, you may need additional help. If you notice your symptoms are returning or worsening, contact your PCP to determine the best course of action.

Your primary care provider can help you get back into mental health care if needed.

My VA primary care provider is: \_\_\_\_\_

- Call center:  (option 2), they can send a note to your PCP regarding your needs.

- You can also contact your PCP provider on  secure message (see attached form for further information).

\*Please see Q/A section at the end for additional information\*

## Your Coping Skills “Toolbox”

“Although the world is full of suffering, it is full also of the overcoming of it.”

Helen Keller

### Self-Care Plan

- Utilization of **relaxation** techniques to decrease body tension and to manage stress:
  1. \_\_\_\_\_
  2. \_\_\_\_\_
  3. \_\_\_\_\_
 (e.g., breathing, body scans, listening to music, mindfulness, stretching/walking)
  
- What **social support** systems are available to you. If necessary, work at developing an adequate and appropriate support system. Utilizing your social supports can offer relief, distraction, and pleasure. Make a list of your supports:
  1. \_\_\_\_\_
  2. \_\_\_\_\_
  3. \_\_\_\_\_
 (e.g., in order to increase social support, it may take additional effort and time, maybe volunteering or reaching out to others more often)
  
- Initiate a **journal**. Instead of keeping thoughts and feelings inside where they build up and cause confusion and distress, get them down on paper. A journal is useful for venting thoughts and feelings, clarifying issues, and problem-solving. It can also be helpful in determining patterns, relationships, health, and emotional functioning. Keeping a journal will help you monitor progress in life goals. Remember to balance out your thoughts/concerns in your journal and challenge unhelpful thinking patterns.
  
- Get adequate **sleep and rest**. Sleep hygiene strategies to implement:
  1. \_\_\_\_\_
  2. \_\_\_\_\_
  3. \_\_\_\_\_
 (e.g., setting routine, setting up transition time prior to bed, no worrying/planning in bed)
  
- **Smile** and have laughter in your life. Be spontaneous at times and be playful.
  
- **Feed your body, mind, and spirit**. Eat meals regularly and nutritionally. Practice good hygiene and grooming. Participate in life for personal, spiritual, and professional growth.
  
- Approach each day with a **purpose**. Be productive by outlining daily structure. No task is too small to feel good about. Each step can be important to reach goals that you develop.
  
- **Avoid being self-critical**. Be as kind and understanding of yourself as you would be to another person. Use positive self-talk to reassure yourself, to cope effectively, and to allow yourself to see that there are always choices. Positive self-talk statements:
  1. \_\_\_\_\_
  2. \_\_\_\_\_
  
- Be sure to build in to your schedule time for **relationships** and **pleasurable activities**.

- Take **responsibility** for your own life. Life is about choices. Understand yourself, your behaviors, your thoughts/beliefs, and your motivations.

## Coping Skills Plan

Describe the warning signs that would tell you it is time to seek additional help to get back on track.

### **Step 1: Warning signs:**

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

### **Step 2: Internal coping strategies – Things I can do to take my mind off my problems without contacting another person:**

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

### **Step 3: People and social settings that provide distraction:**

- |               |             |
|---------------|-------------|
| 1. Name _____ | Phone _____ |
| 2. Name _____ | Phone _____ |
| 3. Name _____ | Phone _____ |

### **Step 4: People whom I can ask for help:**

- |               |             |
|---------------|-------------|
| 1. Name _____ | Phone _____ |
| 2. Name _____ | Phone _____ |
| 3. Name _____ | Phone _____ |

### **Step 5: Professionals or agencies I can contact during a crisis:**

1. Clinician Name \_\_\_\_\_ Phone \_\_\_\_\_
2. Clinician Name \_\_\_\_\_ Phone \_\_\_\_\_
3. Local Urgent Care Services local ER, 911
4. VA Suicide Prevention Hotline 1-800-273-TALK (8255) and press 1

### **Step 6: Making the environment safe:**

1. \_\_\_\_\_
2. \_\_\_\_\_

What are some of your red flags/warning signs and what is your action plan? (It may be helpful to look over the “Safe Coping Skills” list to get action plan ideas, modify the ideas and make them your own).

- 1) Physiological (e.g., heart racing, sweaty hands, tension).
- 2) Cognitive (e.g., problematic self-talk).
- 3) Emotional (e.g., prolonged sadness, anger).
- 4) Behavioral (e.g., starting to isolate).

<b>Red Flag</b>	<b>Action Plan</b>
<b>Mild Red Flag</b>	
<b>Moderate Red Flag</b>	
<b>Large Red Flag</b>	

**SAFE COPING SKILLS**  
**(PART 1)**

1. **Ask for help** – Reach out to someone safe.
2. **Inspire yourself** – Carry something positive (e.g., poem) or negative (photo of a friend who overdosed).
3. **Leave a bad scene** – When things go wrong, get out.
4. **Persist** – Never, never, never, never, never, never, never, never, never give up.
5. **Honesty** – Secrets and lying are at the core of PTSD and substance abuse; honesty heals them.
6. **Cry** – Let yourself cry; it will not last forever.
7. **Choose self-respect** – Choose whatever will make you like yourself tomorrow.
8. **Take good care of your body** – Eat right, exercise, sleep, safe sex.
9. **List your options** – In any situation, you have choices.
10. **Creating meaning** – Remind yourself what you are living for: your children? Love? Truth? Justice? God?
11. **Do the best you can with what you have** – Make the most of available opportunities.
12. **Set a boundary** – Say “no” to protect yourself.
13. **Compassion** – Listen to yourself with respect and care.
14. **When in doubt, do what is hardest** – The most difficult path is invariably the right one.
15. **Talk yourself through it** – Self-talk helps in difficult times.
16. **Imagine** – Create a mental picture that helps you feel different (e.g., remember a safe place).
17. **Notice the choice point** – In slow motion, notice the exact moment when you chose a substance.
18. **Pace yourself** – If overwhelmed, go slower; if stagnant, go faster.
19. **Stay safe** – Do whatever you need to put your safety above all.
20. **Seek understanding, not blame** – Listen to your behaviour; blaming prevents growth.
21. **If one way does not work, try another** – As if in a maze, turn a corner and try a new path.
22. **Link PTSD and substance abuse** – Recognize substances as an attempt to self-medicate.
23. **Alone is better than a bad relationship** – If only people who are receiving help are safe for now, that is okay.
24. **Create a new story** – You are the author of your life; be the hero who overcomes adversity.
25. **Avoid avoidable suffering** – Prevent bad situations in advance.
26. **Ask others** – Ask others if your belief is accurate.
27. **Get organized** – You will feel more in control with lists, “to do’s” and a clean house.
28. **Watch for danger signs** – Face a problem before it becomes huge; notice red flags.
29. **Healing above all** – Focus on what matters.

30. **Try something, anything** – A good plan today is better than a perfect one tomorrow.
31. **Discovery** – Find out whether your assumption is true rather than staying “in your head”.
32. **Attend treatment** – AA, self-help, therapy, medications, groups – anything that keeps you going.
33. **Create a buffer** – Put something between you and danger (e.g., time, distance).
34. **Say what you really think** – You will feel closer to others (but only do this with safe people).
35. **Listen to your needs** – No more neglect – really hear what you need.
36. **Move toward your opposite** – For example, if you are too dependent, try being more independent.
37. **Replay the scene** – Review a negative event; what can you do differently next time?
38. **Notice the cost** – What is the price of substance abuse in your life?
39. **Structure your day** – A productive schedule keeps you on track and connected to the world.
40. **Set an action plan** – Be specific, set a deadline, and let others know about it.
41. **Protect yourself** - Put up a shield against destructive people, bad environments, and substances.
42. **Soothing talk** – Talk to yourself very gently (as if to a friend or small child).


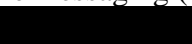
### SAFE COPING SKILLS (PART 2)

43. **Think of the consequences** – Really see the impact for tomorrow, next week, next year.
44. **Trust the process** – Just keep moving forward; the only way out is through.
45. **Work the material** – The more you practice and participate, the quicker the healing.
46. **Integrate the split self** – Accept all sides of yourself- they are there for a reason.
47. **Expect growth to feel uncomfortable** – If it feels awkward or difficult you’re doing it right.
48. **Replace destructive activities** – eat candy instead of getting high.
49. **Pretend you like yourself** – See how different the day feels.
50. **Focus on now** – Do what you can to make today better; do not get overwhelmed by the past or future.
51. **Praise yourself** – Notice what you did right; this is the most powerful method of growth.
52. **Observe repeating patterns** – Try to notice and understand your re-enactments.
53. **Self-nurture** – Do something that you enjoy (e.g., take a walk, see a movie).

54. **Practice delay** – If you cannot totally prevent a self-destructive act, at least delay it as long as possible.
55. **Let go of destructive relationships** – If it cannot be fixed, detach.
56. **Take responsibility** – Take an active, not a passive, approach.
57. **Set a deadline** – Make it happen by setting a date.
58. **Make a commitment** – Promise yourself to do what is right to help your recovery.
59. **Rethink** – Think in a way that helps you feel better.
60. **Detach from emotional pain (grounding)** – Distract, walk away, change the channel.
61. **Learn from experience** – Seek wisdom that can help you next time.
62. **Solve the problem** – Do not take it personally when things go wrong – try to just seek a solution.
63. **Use kinder language** – Make your language less harsh.
64. **Examine the evidence** – Evaluate both sides of the picture.
65. **Plan it out** – Take the time to think ahead – it is the opposite of impulsivity.
66. **Identify the belief** – For example, shoulds, deprivation reasoning.
67. **Reward yourself** – Find a healthy way to celebrate anything you do right.
68. **Create new “tapes”** – Literally! Take a tape recorder and record a new way of thinking to play back.
69. **Find rules to live by** – Remember a phrase that works for you (e.g., “Stay real”).
70. **Setbacks are not failures** – A setback is just a setback, nothing more.
71. **Tolerate the feeling** – “No feeling is final”, just get through it safely.
72. **Actions first and feelings will follow** – Do not wait until you feel motivated; just start now.
73. **Create positive addictions** – Sports, hobbies, AA...
74. **When in doubt, don’t** – If you suspect danger, stay away.
75. **Fight the trigger** – Take an active approach to protect yourself.
76. **Notice the source** – Before you accept criticism or advice, notice who is telling it to you.
77. **Make a decision** – If you are stuck, try choosing the best solution you can right now; do not wait.
78. **Do the right thing** – Do what you know will help you, even if you don’t feel like it.
79. **Go to a meeting** – Feet first; just get there and let the rest happen.
80. **Protect your body from HIV** – This is truly a life-or-death issue.
81. **Prioritize healing** – Make healing your most urgent and important goal, above all else.
82. **Reach for community resources** – Lean on them! They can be a source of great support.
83. **Get others to support your recovery** – Tell people what you need.
84. **Notice what you can control** – List the aspects of your life you do control (e.g., job, friends...)

***YOU CAN DO IT!***

**Question & Answers:**

- 1) **Who will manage my medication refills in the future?**
  - a. Your primary care provider (PCP) will be refilling your prescription(s) moving forward.
- 2) **What if I have questions about my medication?**
  - a. Please contact your PCP.
- 3) **How do I contact my PCP?**
  - a. Using  secure messaging (instructions attached).
  - b. Contacting the call center:  option 2 who can forward message to your PCP provider.
- 4) **When is my next PCP appointment?**
  - a. Your PCP appointments may vary depending on your medical needs. If you need to schedule an appointment with your PCP, please use one of the methods above to request an appointment, please do so a couple of months ahead of needed timeline, in case there is a delay. Your mental



health clinic (MHC) provider will be adding your PCP to the discharge note informing them of your MHC clinic discharge.

**5) I'm concerned I will not get my refills in time?**

- a. You should have at least 2 refills in the system upon MHC discharge where you can call into pharmacy and request refill (pharmacy number: [REDACTED] Ext. [REDACTED] or [REDACTED] Ext. [REDACTED]).
- b. You can contact your PCP with methods above for additional refill, please do so a month or more prior to running out of medication, setting an alarm reminder on your calendar or phone may be helpful.

**6) What if my symptoms increase?**

- a. Great question, due to life events/stressors etc., symptoms may increase and decrease over time. Continuing to practice skills on a daily/weekly basis is a good way to keep your skills sharp in the event that your symptoms increase.
- b. Should you need additional support, please contact your PCP with one of the methods above and they can help direct you to appropriate treatment sources.
- c. If you experience suicidal/homicidal ideation with plan or intent, please either contact the crisis line, call 911 or present to any emergency room.

**7) What if I need to return to MHC?**

- a. After practicing your skills on your own, should you feel that you need to re-engage with MHC, then please call [REDACTED] to schedule an appointment or talk to your PCP about other available treatment options. Based on your needs, your PCP may connect you with primary care mental health services for brief treatment options.

If things are getting to the point of a crisis and you need immediate help, contact the **Veterans Crisis Line which is available 24 hours a day, 7 days a week, 365 days a year Phone: 1-800-273-8255 (press 1) OR Send a text to 838255**

**Appendix V: Coping skills Resource**

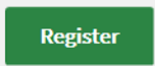
Available upon request. If interested, please contact Jacqueline Buval at [Jackiebuval@u.boisestate.edu](mailto:Jackiebuval@u.boisestate.edu)

## Appendix W: My HealthVet Flyer

### Create a My HealthVet Account

#### Today!

GO TO: [www.myhealth.va.gov](http://www.myhealth.va.gov) and click the green "Register" icon on the top right-hand corner



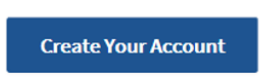
FILL in the blanks in sections 1-7, under your "relationship to VA," check the following:

- VA Patient
- Veteran

CHECK and ACCEPT the following:

- My HealthVet Terms and Conditions

FINISH up by clicking the "Create your account" icon



Visit the My HealthVet Coordinator or frontline staff at the nearest VA facility to complete an In-Person Authentication (IPA). Once your IPA is complete, you can **USE ALL** the features of your My HealthVet account.

To retrieve USER ID and Rest Password-

[Forgot User ID?](#)

[Forgot Password?](#)

Note: the hint questions are **CASE SENSITIVE**.

For user name and Password assistance, MHV Helpdesk- (877) 327-0022 7AM-7PM CT

### Additional Features

#### Appointments

My HealthVet is an online system that lets you view your VA Appointments 24 hours a day, 7 days a week. Summary and detailed information is given for each appointment.



The Labs + Tests feature gives you the ability to self-enter and keep track of laboratory tests and results done by your non-VA providers. Premium users are also able to view their VA lab results in this section.

#### Veterans Health Library

Your source for health information . . . . \*

My HealthVet provides two VA-generated online medical libraries:

- Veterans Health Library
- Medline Plus



My HealthVet Coordinator

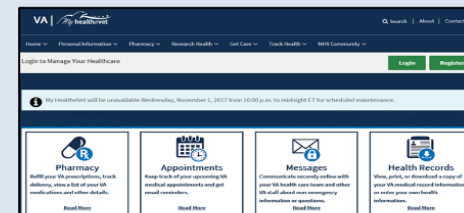
MHV Help Desk (Technical issues) 7AM-7PM CT

(877) 327-0022

User ID: \_\_\_\_\_

Password: \_\_\_\_\_

[WWW.MYHEALTH.VA.GOV](http://WWW.MYHEALTH.VA.GOV)



Popular Features include:

- View, print or download lab results, medical information and doctor notes
- Communicate with your healthcare team using Secure Messaging
- Refill prescriptions on line with the click of a button



### Access to Health Records



LOG into your *Premium* account

Under "Health Records" **CLICK** "Blue Button Medical Reports"

On the "Select Type of Report", **CLICK** "VA Blue Button Report". For VA Images- select VA Images and Reports.

On the "Download My Selected Data" page, **SELECT** the desired "Date Range" and "**Specific Types of Information**". Provider notes -select **VA NOTES**. Finally, scroll down and **CLICK** the blue "Submit" button.

At mid-page, select to view or download information in either PDF or Text format. If using a Smartphone, you will need to download. Some smartphones will download to a file on the phone.

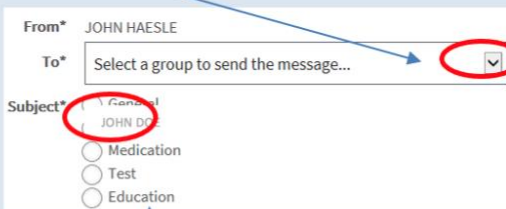
## SECURE MESSAGING

Secure Messaging (SM) is a web- based, encrypted communication between patients and health professionals. SM through My HealtheVet offers patients convenient access to healthcare team members for **non-urgent issues**.

LOG into your *Premium* account  
Under Messages, **SELECT** "Compose Message"



Use dropdown, **SELECT** group to receive Message



**CLICK** appropriate "Subject" **TYPE** message subject in the "Subject Line" box. **COMPOSE** message in open text box.

**NOTE:** You can attach file(s) if you would like as per instructions

**CLICK** "Send" to send your message  
**If your Health Care teams are not listed- contact Sonja Skinner- your My HealtheVet Coordinator**

**\*\*Secure Messages are typically answered within 3 business days\*\***



### Prescription Refills



LOG into your My HealtheVet *Advanced* or *Premium* account

Under "Pharmacy", **CLICK** "Refill VA Prescriptions"

**ENSURE** list of your VA prescriptions display

**NOTE:** an active prescription ready for refill will display a check box- only those available for refill will be refilled at that time.

Under the column "Select to Refill", **CLICK** the box by the medication you want to refill

Finally, **CLICK** "Submit Refills" at the bottom of the page

**NOTE:** If you have more than one page of VA prescriptions, select the Submit Refills button before going to the next page. Otherwise, your medication on that page may not be refilled.

## Appendix X: Electronic Documentation Template

### Care Coordination Telephone Contact

Date: \_\_\_\_\_

Time spent with Veteran: \_\_\_\_ min

Caller: \_\_\_\_\_

Veteran was contacted to assist in coordinating their care from Mental Health Clinic to Primary Care. Identified by full name and DOB.

### Discharged from Mental Health

Date discharged from Mental Health: \_\_\_\_\_

### Consent for Care Coordination services:

Veteran verbally educated on purpose of care coordination program to include: roles and responsibilities of patient and care coordinator.

Verbal consent obtained: Yes

### Education: Discussed and reviewed the following with Veteran

1. Mental Health Discharge Plan

2. PACT Team

Verified Veteran assigned PACT Team: \_\_\_\_\_

Follow-up appointments confirmed: \_\_\_\_\_

3. How to access care at [REDACTED] Health Care System

Main phone number [REDACTED], option 2

MyHealthvet

The Veteran crisis line: 1-800-273-8255, press 1, or send a text to 838255

Pharmacy number: [REDACTED] Ext. [REDACTED] or [REDACTED] Ext. [REDACTED]

4. Coping skills packet which includes:

VA Mobile Applications available to help navigate mental health

Relaxation Fact sheet, exercises and techniques

Behavior modification

How to deal with Anxiety and Depression

Problem solving techniques

Reframing the way you think

Anger coping strategies

Effective communication

### Veteran expressed verbal understanding of above:

Yes

### Medications

Reviewed and Veteran confirmed he/she has sufficient medications until next PACT appointment.

### Questions or concerns:

Veterans and /or family/caregiver questions/concerns addressed

Yes

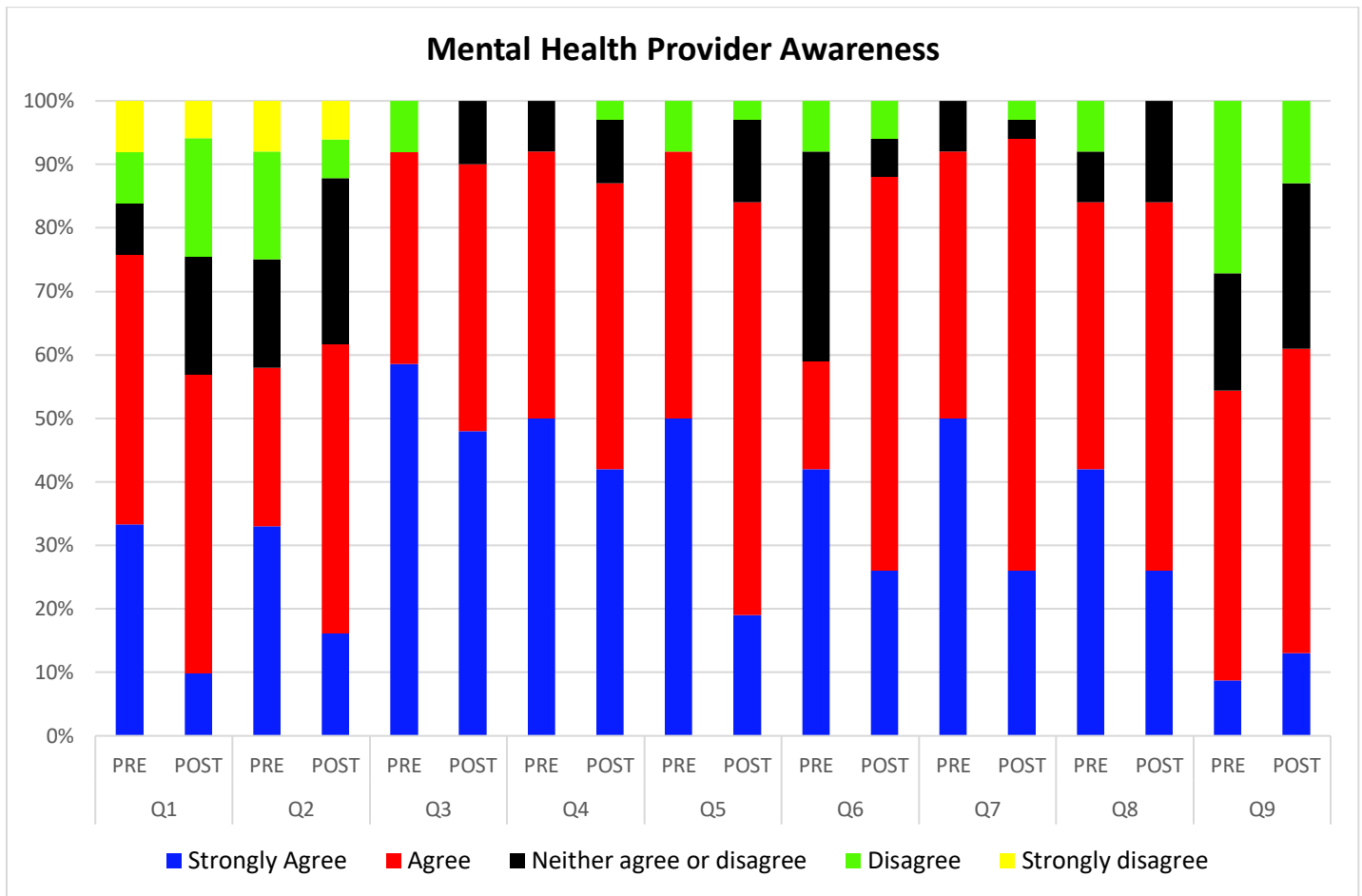
Follow-up:

No further follow-up, Veteran feels comfortable with current level of care and plan for follow-up with PACT.

**Appendix Y: Handoff to Primary Care Nurse**

Per MHC clinic provider, Veteran completed mental health episode of care and symptoms are considered stable. Veteran discharged from MHC to be managed by Primary Care. Primary care provider added to MHC discharge note by MHC. Primary Care RN signed to this note for informational purposes only.

## Appendix Z: Mental Health Provider Pre and Post Assessment Scores



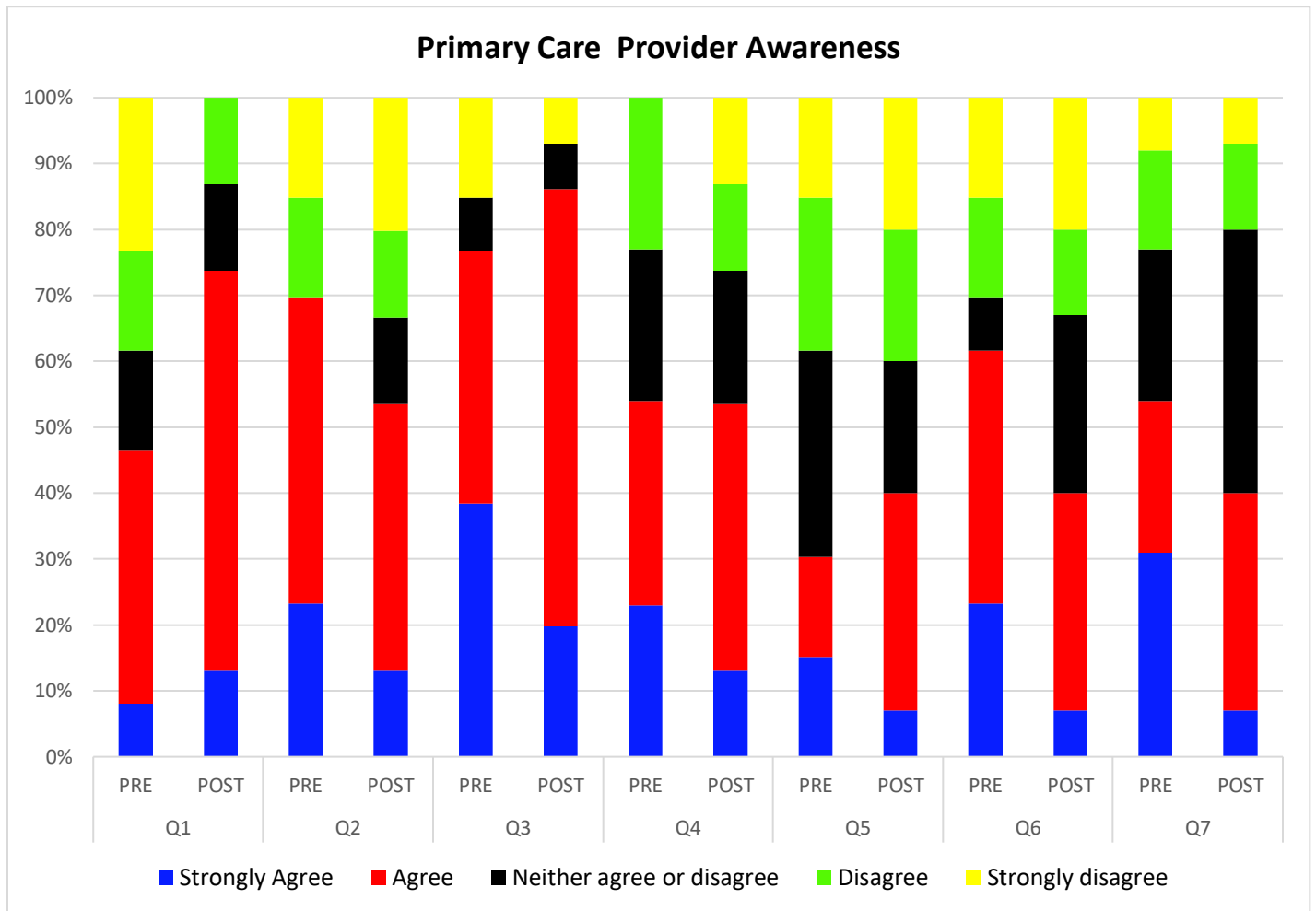
Questionnaire: In thinking about your current experience in Mental Health clinic and transitioning patients back to Primary Care, how would you rate the following:

1. I have a good understanding of Flow program criteria.
2. Specialty Mental Health care is generally referred to as an episode of care that is time-limited.
3. Caring for Veterans in the most appropriate care setting (level of care) is important to maintain recovery and stability. Example: PC vs. specialty-MH
4. Shared-decision making is used between provider and Veterans when discussing care transitions.
5. A Veteran who has completed and/or sustained remission of substance dependence disorder for one year is appropriate to transition back to Primary Care.
6. A Veteran who has had no change in medication during the past six months is appropriate to transition back to Primary Care.
7. Once Veterans become psychiatrically stable and have completed counseling, they can be referred back to their primary care provider for continued medication management.
8. Veterans are given tools (self-care management, web-based courses, mobile applications, etc.) to support their recovery.
9. I have been given the tools to successfully transition eligible patients back to Primary Care.

Data: Pre and post 5-point Likert Scale: (1) Strongly disagree; (2) Disagree; (3) Neither agree nor disagree; (4) Agree; (5) Strongly agree.



## Appendix AA: Primary Care Provider Pre and Post Assessment Scores

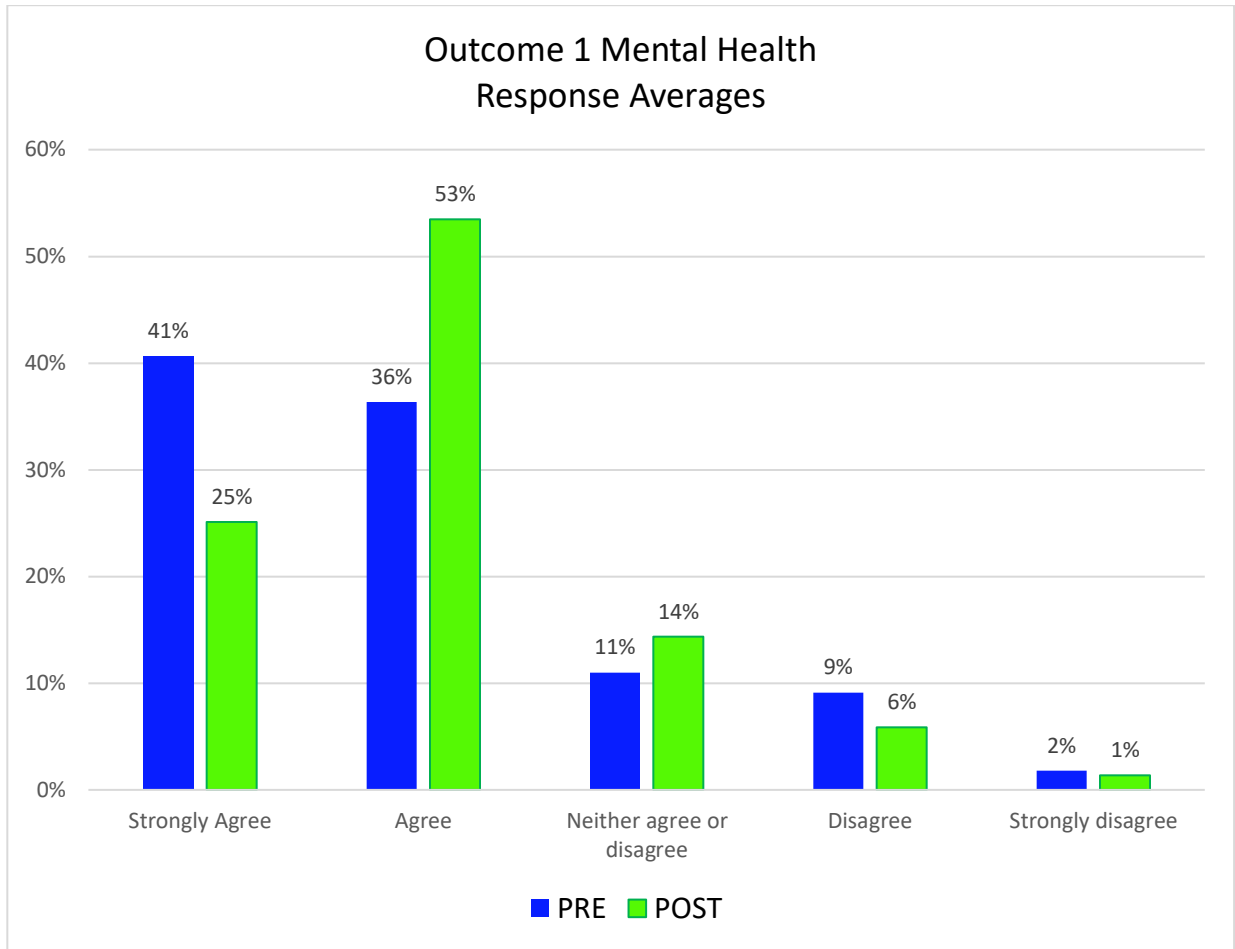


Questionnaire: In thinking about your current experience in Primary Care clinic and caring for patients who have been discharged back to Primary Care from Specialty-Mental Health clinic, how would you rate the following:

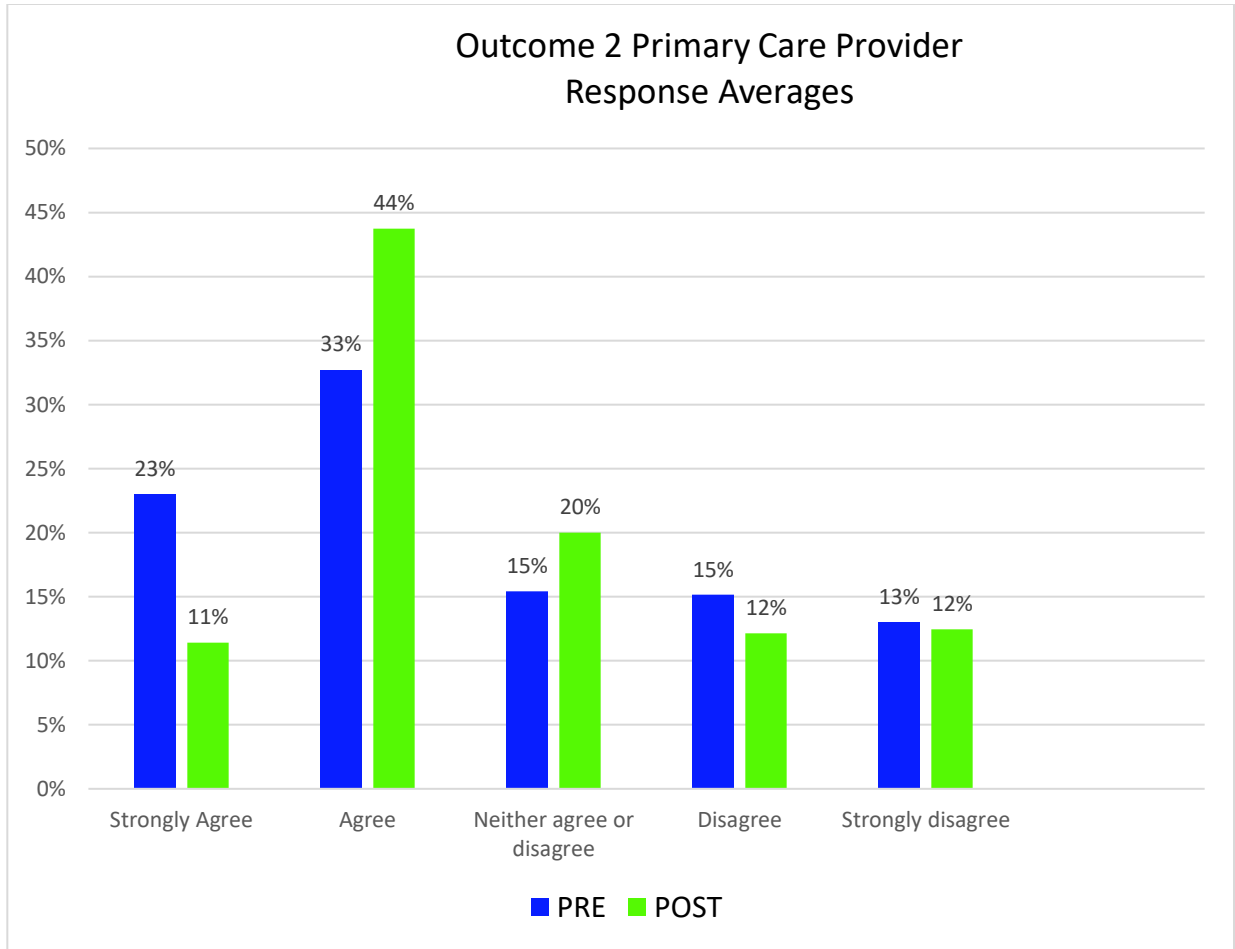
1. I have a good understanding of Flow program criteria.
2. Specialty Mental Health care is time-limited and once Veterans are stable their care can be effectively handled in Primary Care (i.e., Veterans with uncomplicated depression or anxiety).
3. Caring for Veterans in the most appropriate care setting (level of care) is important to maintain recovery and stability. Example: PC vs. specialty-MH
4. A Veteran who has completed and/or sustained remission of substance dependence disorder for one year is appropriate to transition back to Primary Care.
5. A Veteran who has had no change in medication during the past six months is appropriate to transition back to Primary Care based (i.e., Veterans with uncomplicated depression or anxiety).
6. Once Veterans become psychiatrically stable and has completed counseling, their care can effectively be managed by primary care provider for continued medication management (i.e., Veterans with uncomplicated depression or anxiety).
7. I have been given the tools to successfully care for Veterans' mental health in Primary Care.

Data: Pre and post 5-point Likert Scale: (1) Strongly disagree; (2) Disagree; (3) Neither agree nor disagree; (4) Agree; (5) Strongly agree.

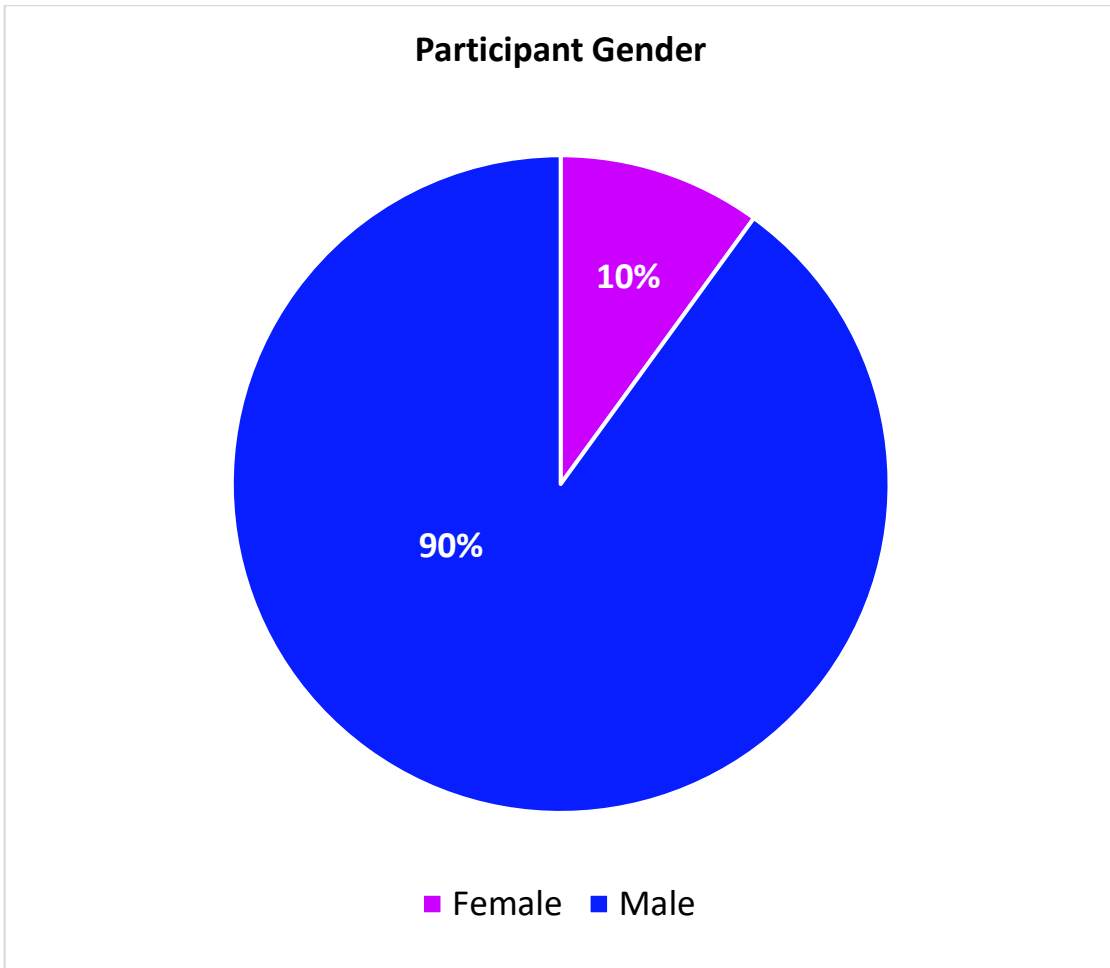
### Appendix AB: Outcome 1 Mental Health Provider Responses



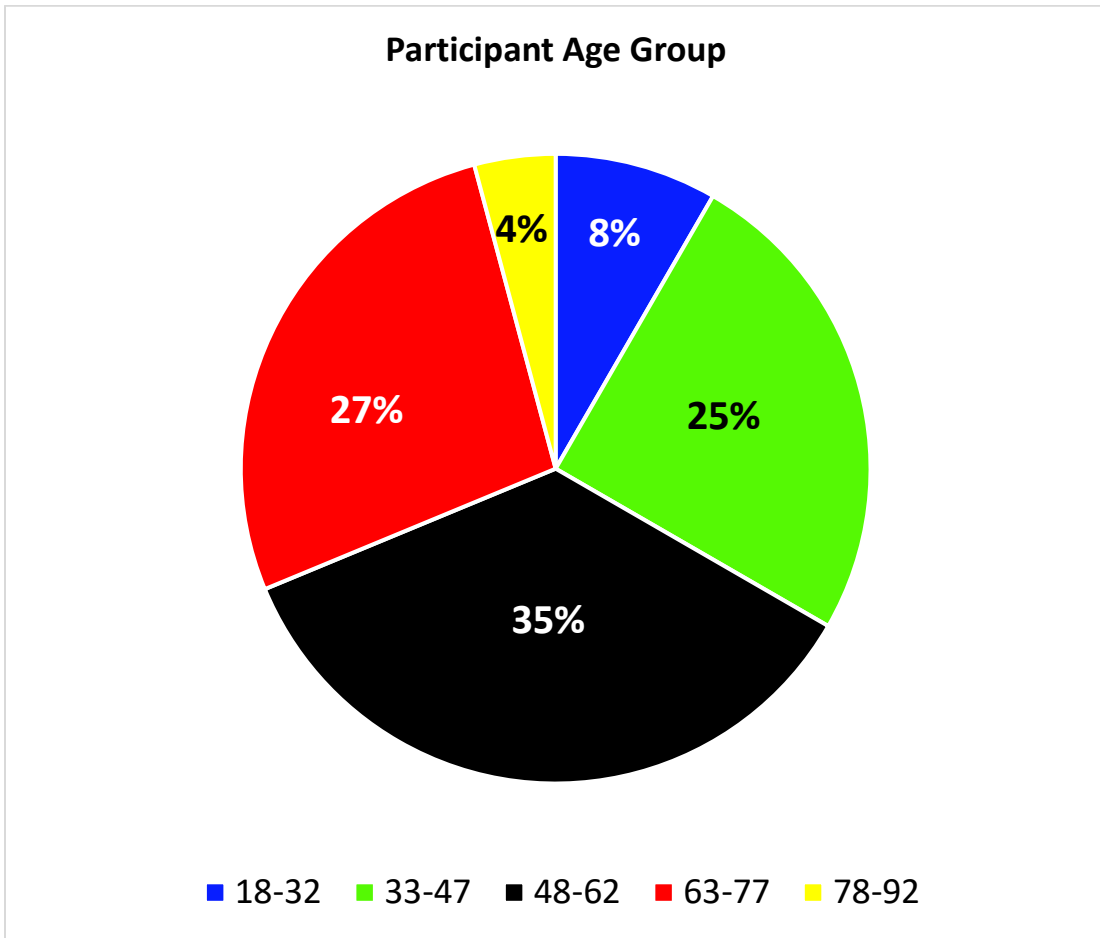
### Appendix AC: Outcome 2 Primary Care Provider Responses



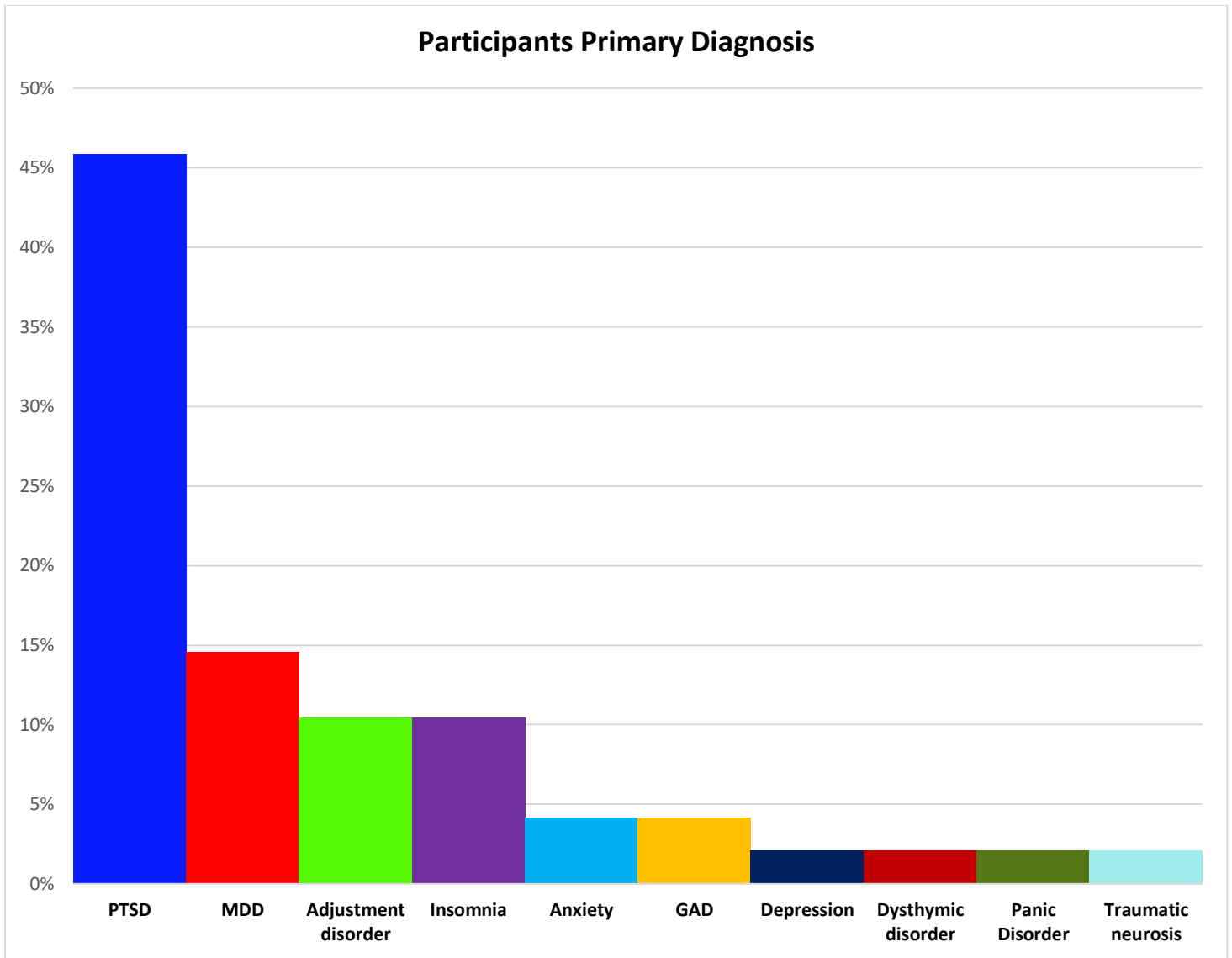
**Appendix AD: Participant Gender**



### Appendix AE: Participant Age Group



### Appendix AF: Participant Diagnoses



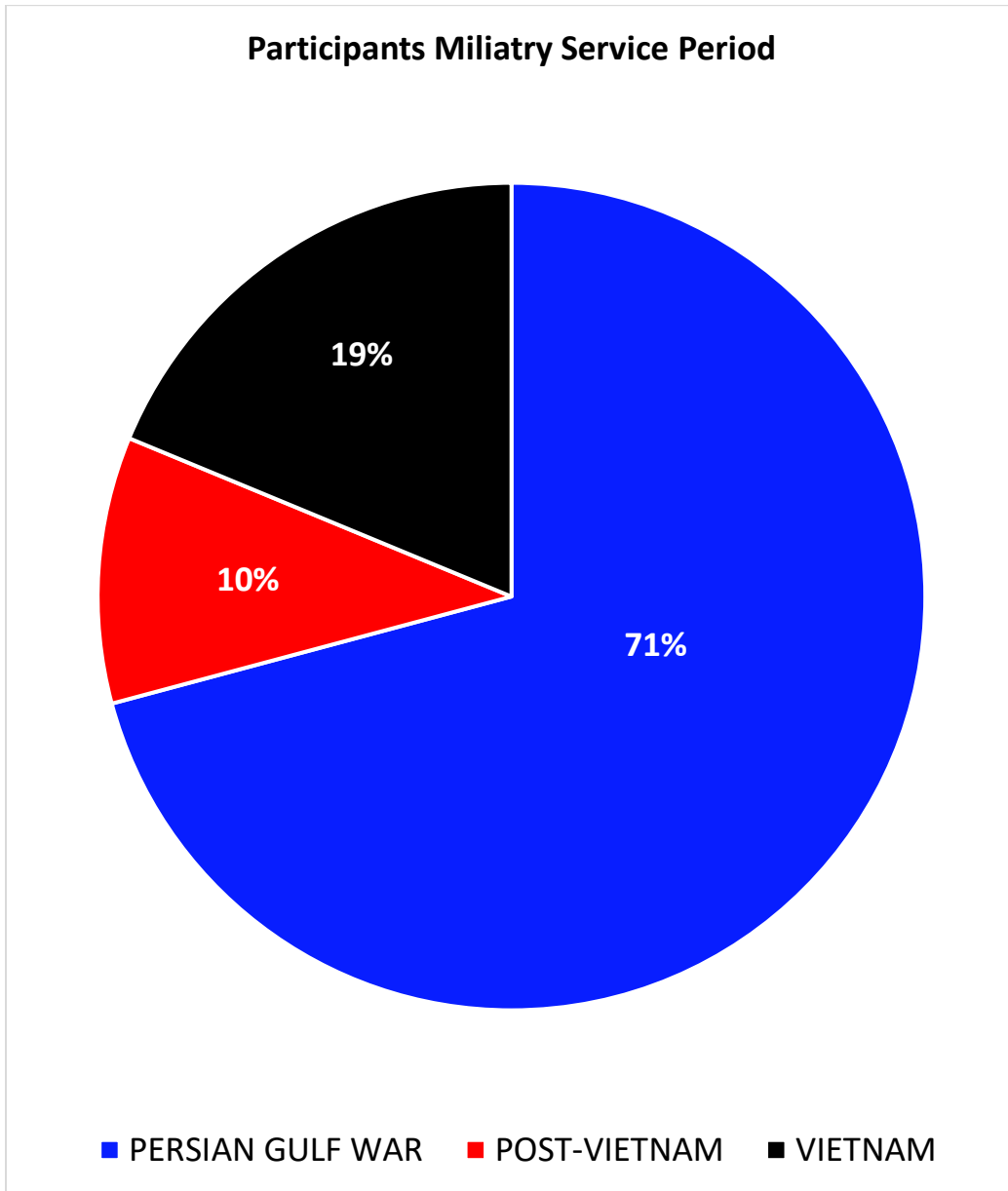
Key:

PTSD: Post-Traumatic Stress Disorder

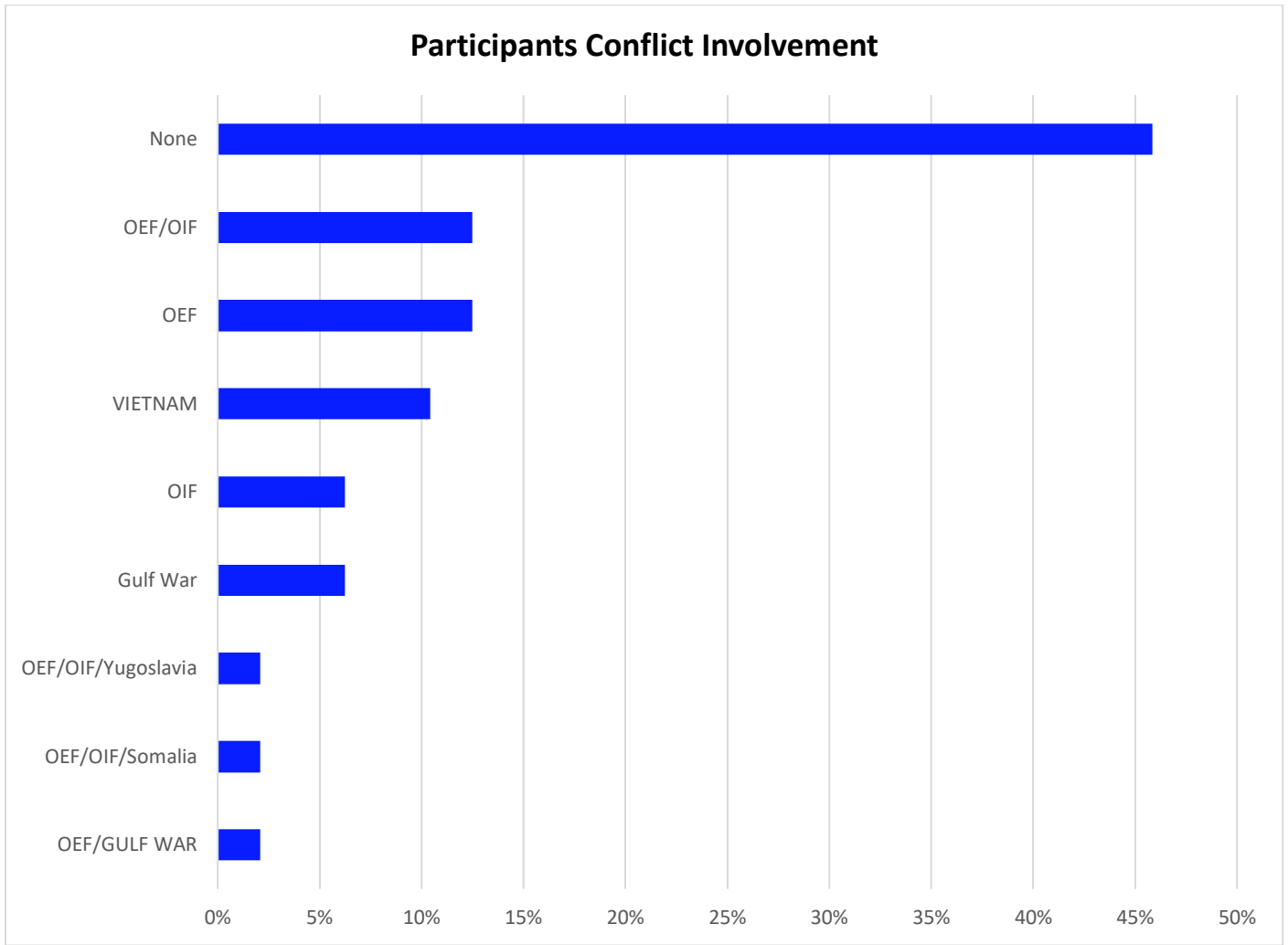
MDD: Major Depressive Disorder

GAD: Generalized Anxiety Disorder

**Appendix AG: Participant Military Service Period**



### Appendix AH: Participant Conflict Involvement



Key:

OEF = Operation Enduring Freedom

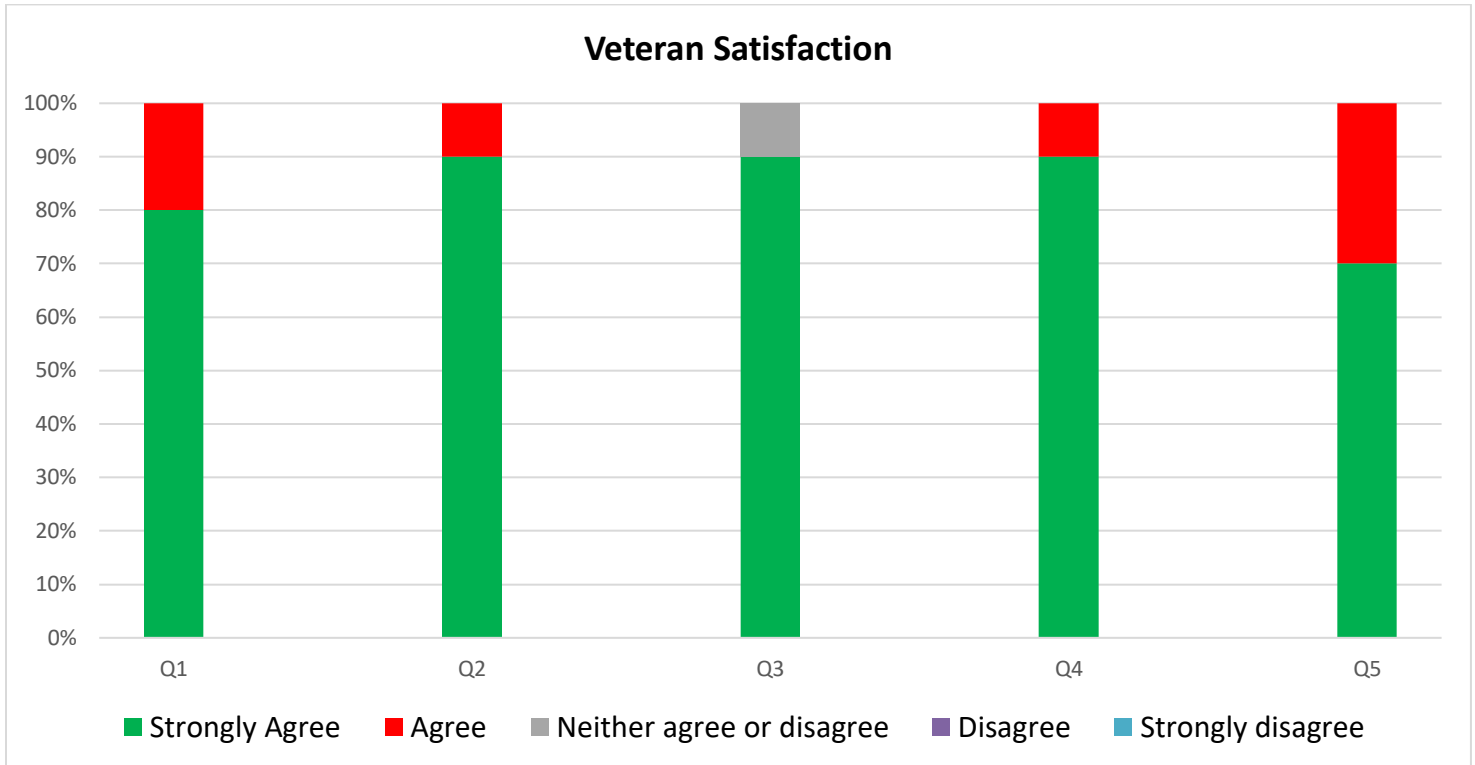
OIF = Operation Iraqi Freedom







## Appendix AK: Veteran Satisfaction Questionnaire Results

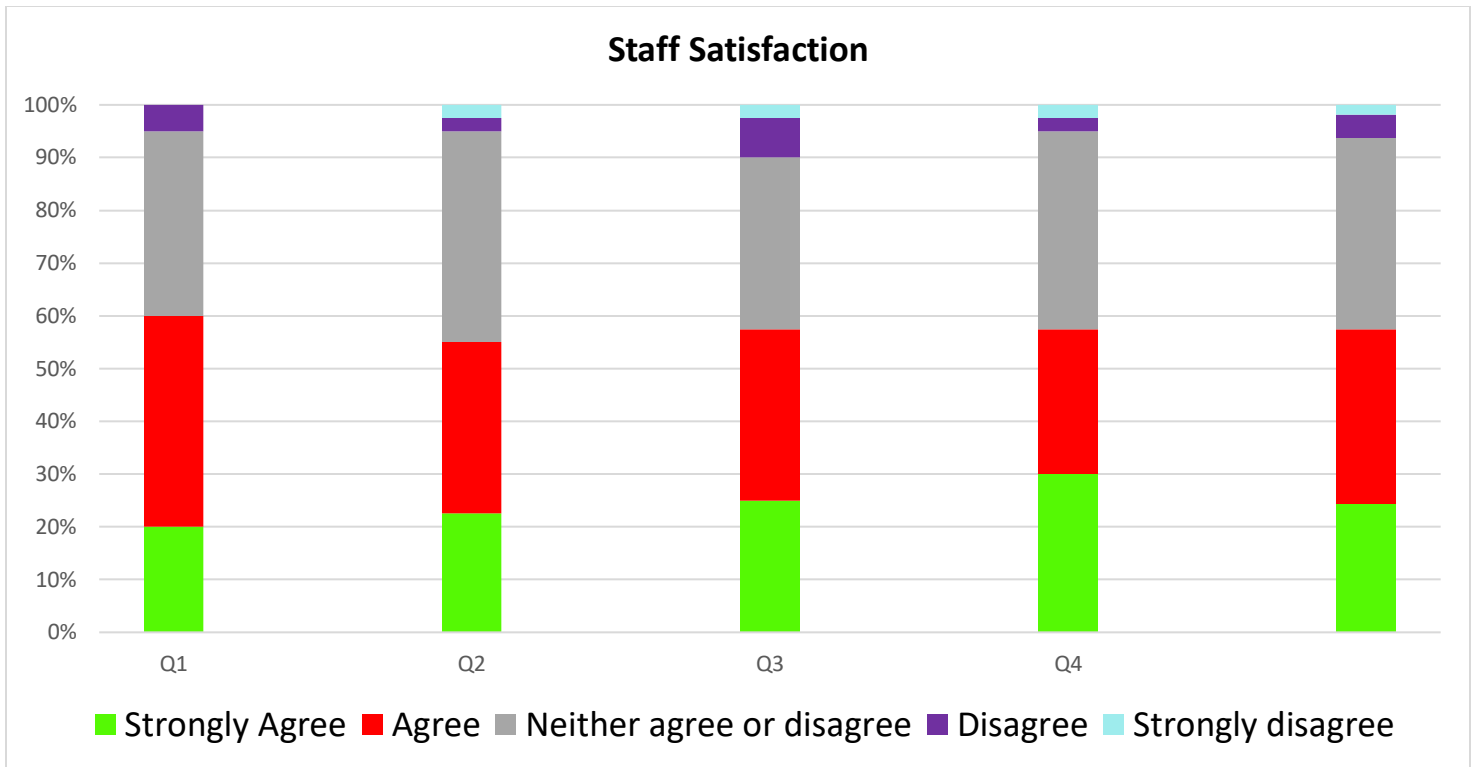


Questionnaire: In thinking about your recent transition from Mental Health clinic back to Primary Care, how would you rate experience:

1. The care coordination program helped me clearly understand what to expect during the transition.
2. The care coordination program helped me understand how to access the health care system for questions and/or follow-up care.
3. The care coordination program provided me with the support I needed to feel confident in transitioning my care back to Primary Care.
4. I found the care coordination program helpful for my care transition.
5. I think the care coordination program would be helpful for other Veterans transitioning their care back to Primary care.

Data: Pre and post 5-point Likert Scale: (1) Strongly disagree; (2) Disagree; (3) Neither agree nor disagree; (4) Agree; (5) Strongly agree.

## Appendix AL: Staff Satisfaction Questionnaire Results



Questionnaire: In thinking about your experience in caring for patients who have transitioned from Mental Health clinic back to Primary Care, how would you rate the following:

1. I found the care coordination program helpful in transitioning patients from Mental Health to Primary Care.
2. I found that the care coordination program provided the needed support to Veterans transitioning care back to Primary Care.
3. I found the care coordination program improved communication among the Veterans care team.
4. I think this program would be beneficial for continued use after the pilot period.

Data: Pre and post 5-point Likert Scale: (1) Strongly disagree; (2) Disagree; (3) Neither agree nor disagree; (4) Agree; (5) Strongly agree.

### Appendix AM: Actual Expense Report

#### Actual Expense Report

#### Pilot

**Grand Total \$ 827,080.91**

Expense Category	Expense Description	Explanation of Expense	Type of Cost	Volume	Cost per Unit	Total
Personnel	Psychiatrist wages	Psychiatrists participating in program. Hourly rate is an average based on organizational HR data.	Variable	4 hrs. a week x program length (3 months) = 48 hrs. X 50 Psychiatrist	\$75/hr.	\$ 180,000.00
Personnel	Psychologist wages	Psychologists participating in program. Hourly rate is an average based on organizational HR data.	Variable	4 hrs. a week x program length (3 months) = 48 hrs. X 35 Psychologist	\$44/hr.	\$ 73,920.00
Personnel	Clinical champion staff wage	A Psychologist has been appointed as clinical champion participating in the program	Variable	12 hrs. a week x program length (3 months) = 144 hrs.	\$44/hr.	\$ 6,336.00
Personnel	Primary Care Physician wages	Primary Care providers participating in program. Hourly rate is an average based on organizational HR data.	Variable	4 hrs. a week x program length (3 months) = 48 hrs. X 36 PC providers	\$106/hr.	\$ 183,168.00
Personnel	Primary Care Nurse Practitioner wages	Primary Care NP's participating in program. Hourly rate is an average based on organizational HR data.	Variable	4 hrs. a week x program length (3 months) = 48 hrs. X 13 NP providers	\$44/hr.	\$ 19,344.00

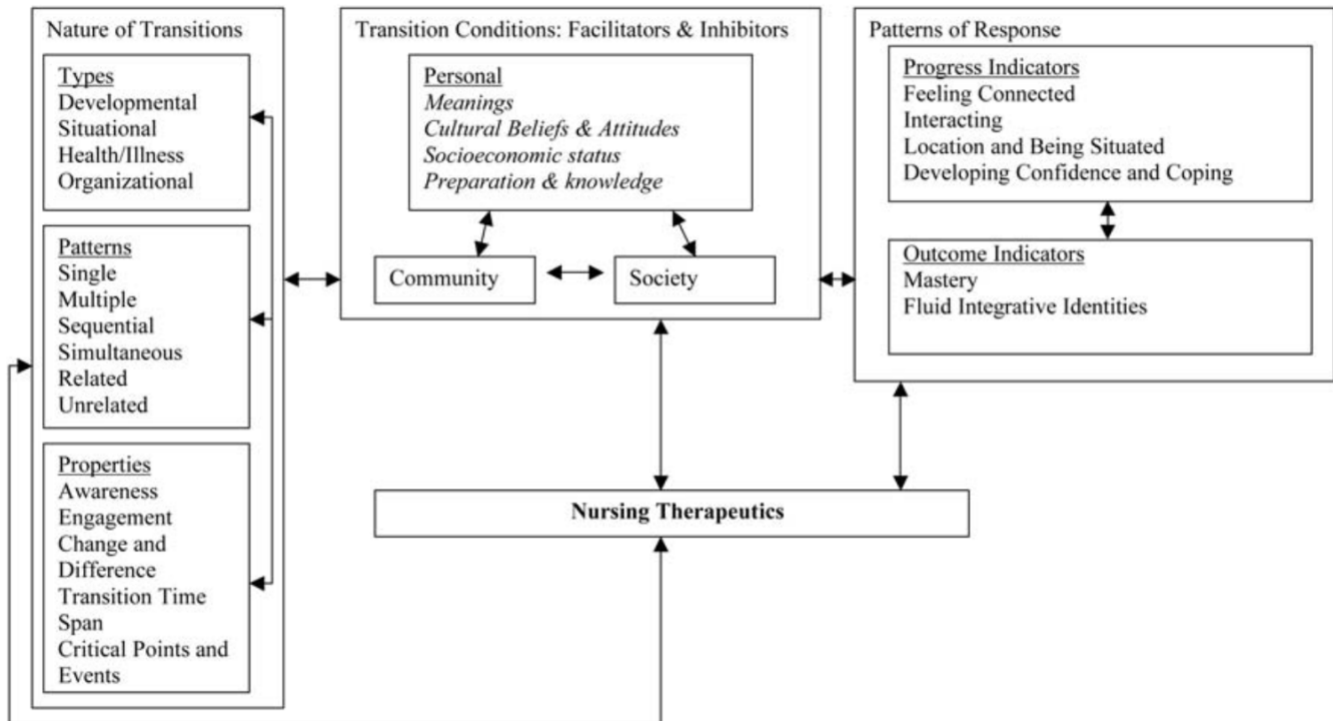
Personnel	RN staff wages	Primary Care RN's participating in program. Hourly rate is an average based on organizational HR data.	Variable	1 hr. a week x program length (3 months) = 12 hrs. x 72 RNs	\$31/hr.	\$	26,784.00
Personnel	Clerical staff wages	Administrative staff participating in program. Hourly rate is an average based on organizational HR data.	Variable	1 hr. a week x program length (3 months) = 12 hrs. X 101 admin staff	\$20/hr.	\$	24,240.00
Personnel	Informatics clinical application coordinator wages	Clinical application coordinator participating in program. Hourly rate is an average based on organizational HR data.	Variable	0.5 hrs. a week x program length (3 months) = 6 hours x 1 staff member	\$27/hr.	\$	162.00
Personnel	Financial advisor wages	Finance staff participating in program. Hourly rate is an average based on organizational HR data.	Variable	0.5 hrs. a week x program length (3 months) = 6 hours x 1 staff member	\$29/hr.	\$	174.00
Personnel	Executive leadership wages	Leadership participating in project review, procedures, education, and status. Hourly rate is an average based on organizational HR data.	Variable	Bimonthly 1 hour meeting with leadership = 6 hours x 3 staff members	\$110/hr.	\$	1,320.00
Personnel	IRB personnel wages	IRB staff reviewing and approving project proposal. Hourly rate is an average based on organizational HR data.	Variable	1 hr. x 2 members	\$110/hr.	\$	220.00

Personnel	Information technology staff wages	IT support for program implementation and evaluation. Hourly rate is an average based on organizational HR data.	Variable	0.5 hours a week x program length (3 months) = 6 hours x 1 staff member	\$26/hr.	\$	156.00
Personnel	DNP student	Project lead in program development, implementation (RN care coordinator), and evaluation. Hourly rate is an average based on organizational HR data.	Variable	8 hrs. a week x program length (3 months) = 96 hrs.	\$45/hr.	\$	4,320.00
Material & Supplies	Internet	Monthly high-speed internet fee	FIXED	3 months	\$89.99/month	\$	269.97
Material & Supplies	General office supplies	Pens, paper clips, sticky notes, etc.	FIXED	3 months 308 staff participating in program	\$50.00	\$	1,500.00
Equipment	Computer	Computer	FIXED		\$899/staff	\$	276,892.00
IT	Microsoft Office	Microsoft professional bundle	FIXED	1 unit	\$39.97	\$	39.97
IT	Adobe Pro	1 year subscription	FIXED	1 unit	\$179.99	\$	179.99
IT	Electronic education app	1 time fee	FIXED	1 unit	\$19.99	\$	19.99
IT	Online learning platform	1 time fee	FIXED	1 unit	\$59.99	\$	59.99
IT	Statistical software (Minitab)	1 year subscription	FIXED	1 unit	\$1,495.00	\$	1,495.00
IT	Telephone and service	3-month phone rental and use	FIXED	308 units	\$100	\$	30,800.00

## Figures

**Figure 1**

*Meleis' (2010) Middle-Range Transitions Theory*

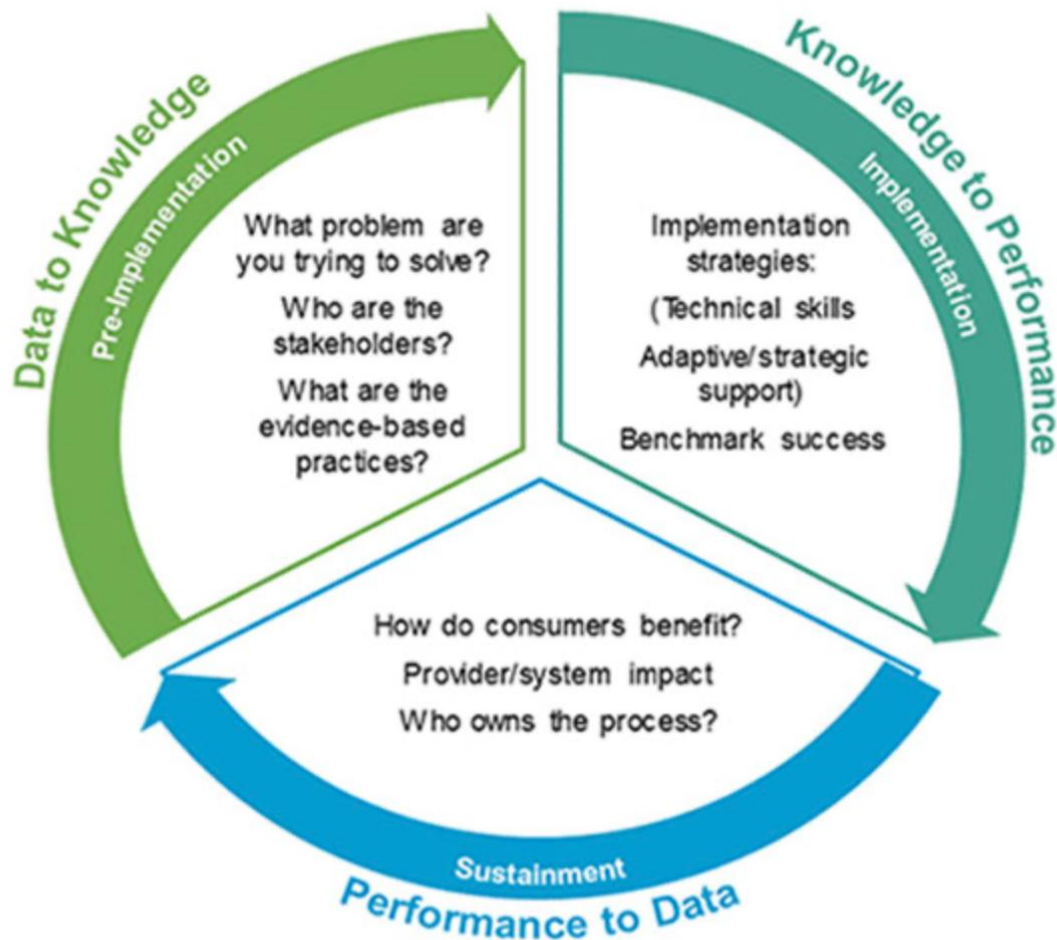


From *Transitions Theory: Middle Range and situation specific in nursing research and practice* (p. 56), by A. I. Meleis, 2010, New York, NY; Springer Publishing Company, LLC. Copyright 2010 by the Springer Publishing Company, LLC. Reproduced with permission.



**Figure 2**

*Veterans Administration's Quality Enhancement Research Initiative model (2019)*



From "Quality Enhancement Research Initiative Implementation Roadmap: Toward Sustainability of Evidence-based Practices in a Learning Health System," by Kilbourne et al., 2019, *Medical Care*, 57(10), p. S287.

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