Care at the Core
Lessons Learned from a Combined Health and Counseling Services

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INTRODUCTION

• Review of lessons learned in a combined college medical/behavioral health setting

• Sharing a paradigm that emerged as we reflected on the development of our combined college medical/behavioral health service

• “One University’s experience”
Founded in 1898, Northeastern University is a private research university located in the heart of Boston. Northeastern is a leader in worldwide experiential learning, urban engagement, and interdisciplinary research that meets global and societal needs. Our broad mix of experience-based education programs—our signature cooperative education program, as well as student research, service learning, and global learning—build the connections that enable students to transform their lives.

The University offers a comprehensive range of undergraduate and graduate programs leading to degrees through the doctorate in nine colleges and schools.
A University on the Move: 2006 - 2013

- **Enormous demand**: 47,300 undergraduate applications and SAT trending upwards by 160 points
- **Global education excellence**: 2153 students in 92 countries
- Two (2) graduate campuses in Charlotte and Seattle
- 5-fold increase in international enrollment
- Seven (7) national research centers
- **Current enrollment**: 16,685 undergraduates
  30,575 total enrollment
Developmental steps were sequential.
Developmental steps were observable over a number of major functional dimensions.
Growth in all dimensions was interdependent.
DEVELOPMENTAL AREAS OF INTEGRATION

1. Clinical Service Delivery and related administrative support
2. Campus and Community Integration
3. Staff Acculturation and Affirmation
CLINICAL SERVICE DELIVERY

**Co-location**
Separate clinical and administrative operations and goals. Separate reporting lines.

**“Merged” Service**
Shared staff meetings and administrative staff.

**Management Team**
Integrated team contribution to policy and procedure.

**Integrated Treatment Functions**

**Integrated Treatment and Wellness Models**
Anticipatory health initiatives. Exemplary coordinated response to health concerns.
NORTHEASTERN UNIVERSITY CAMPUS MAP
CAMPUS AND COMMUNITY INTEGRATION

Disrupted Service and Campus Relationships
Community disorientation.

Referral and Primary Treatment Resource
Growing campus familiarity with available services. State of clarification.

Consultant
Respondent to crises. Participation in campus programming.

Partnerships and Network Integration
Routine inter-departmental systems and interactions. University-wide relationships.

Leadership in University Student Health Vision
Setting campus health priorities. Aligning health vision with university aspirations.
STAFF ACCULTURATION AND AFFIRMATION

Staff Disruption
Professional identity challenged. Role uncertainty. Uncertainty about leadership. Top down management.

Recognition of Redefined Practice and Role
Coexistence and cooperation among disciplines and staff. Informal centers of authority.

Acceptance
Agreement on service goals and standards, common practices and norms. Conflict resolution. Recognition of leadership.

Common culture
Inclusion of diverse approaches. Inter-disciplinary respect. Mutual commitment to service excellence. Leadership vision driven.

Shared Identity
Embracing shared professional identity, vision of care and mission. Role clarity. Progress toward individual professional goals.
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Staff Acculturation and Affirmation
Merger Timeline

Lane Health Center

- **1956-68:** Operated as a Counseling and Testing Center
- **1963-93:** Operated as an infirmary
- **1968-2005:** Included psychiatric consultations and group counseling

University Health and Counseling Services

- **1993-2005:** Emerged as a primary care model
- **2005:** Moved into newly renovated combined space

Center for Counseling and Student Development
REPORTING STRUCTURE

Pre-Merger:

- VP Finance
- VP Student Affairs
- Lane Health Center
- Center for Counseling and Student Development

Post-Merger:

- Senior VP Enrollment Management & Student Affairs
- University Health and Counseling Services (UHCS)
As of 2005-2006, we had:

- Moved into one location, and
- Agreed that our common goal was to address student needs with high quality care.

Yet, as the work of Walker and Collins found:

“[F]inancial and organizational barriers to integrating care (such as professional identity issues, history of different systems and perspectives on confidentiality) are often serious barriers to a widespread implementation of a more integrated care model.”
• Operational differences between services
  • Separate clinical record and issues of confidentiality
  • Separate scheduling and documentation systems
• Interruptions in established relationships with campus constituencies
• Lack of understanding of function and role
Recognition of Redefined Practice and Role

Acceptance

Shared Identity

Common culture

Staff Disruption

- Collaborative based decision making vs. top down decision making
- Uncertainty about new and unfamiliar clinical and administrative leadership
- Competition for resources
- Large staff turnover
AN EARLY ATTEMPT TO MOVE TOWARDS INTEGRATED CARE

- Attempt to work together without knowing your colleagues
- Roles and professional identities challenged without the time or opportunity to work these out
- Top down decision with limited buy-in from stakeholders
- Limited infrastructure to support success
- Impact on students/clients/patients

| Staff Disruption | Recognition of Redefined Practice and Role | Acceptance | Common culture | Shared Identity | Northeastern |
Stabilization

- Staffing stabilizes
- Leadership is more predictable and receptive to input
- Avenues for medical and behavioral health to work together identified
  - Eating Disorders Task Force
  - Presentations to combined staff
  - Combined learning opportunities
- Creation of common and individual group protocols

Staff Disruption

- Recognition of Redefined Practice and Role
- Acceptance
- Common culture
- Shared Identity

Northeastern
APPRECIATION OF ROLES AND FUNCTIONS

- Mutual appreciation of individual roles and functions
- Respect for each group’s expertise and knowledge
- Continuing and greater collaboration between groups
  - Ease of communication
  - Freedom in seeking consultation across disciplines
- Acceptance of and respect for leadership
  - Responsiveness indicating that input is valued and acknowledged
  - Contributing members of the decision making process
  - Some control of schedule and time

Staff Disruption  Recognition of Redefined Practice and Role  Acceptance  Common Culture  Shared Identity
INTEGRATED CARE

- Common vision related to student and campus needs
  - Immediate response and on-call responsibilities
  - Student friendly hours
  - Increased availability for urgent care
  - Response for campus crises
LETTING GO
AND
MOVING TOWARDS
Clinical Adoption of the Depression Collaborative
In 2006, the College Breakthrough Series-Depression (CBS-D) funded by the Aetna Foundation and the New York Community Trust was piloted with a group of 6 residential college health center teams organized by Dr. Henry Chung et al.

The one year pilot program involved:
1. In-depth and periodic training,
2. the implementation of PHQ2 and PHQ9 depression screening to all students who presented for medical visits,
3. database creation and maintenance,
4. monthly reports, and
5. case management follow-up for identified high risk students.
Over 80% of the suicides reported were by students with no current or prior mental health treatment. (Gallagher, 2005)

As many as 40% of adults saw a PCP at least once within one month of a lethal suicide attempt. (Pirkis & Burgess, 1998)

Health Minds Study at NYU indicated that 80% of students with serious suicidal ideation did use medical services; but, only 30% use counseling.

Only 34% of students with clinical depression or other mood disorders reported having any form of treatment.
PATIENT HEALTH QUESTIONNAIRE

- Mental health screening at every medical health visit.
- Immediate scoring of the Patient Health Questionnaire (PHQ).
  - 0-4 with no suicidality – usually no discussion needed
  - 5-9 score reviewed and patient asked to return to reassess with either behavioral health or medicine
  - 10-14 score reviewed and patient asked to schedule behavioral health visit prior to leaving the building
  - >15 or any level of suicidality, the patient to remain until cleared by behavioral health team
- Same-day behavioral health response to acute illness.
- Creation of a registry of patients for the on-going care of seriously ill patients.
EXISTING STRESSORS

- Staff acculturation
- Increase complexity of college health
- Increased demand for services
- Increased severity of illness
- Students with greater academic, financial and social stressors
- Helicopter parents
- Primary care vs. urgent care
- Long term counseling vs. acute care
- Pharmacology demands
- “The customer service approach” – “Concierge Service”
Recognition of Redefined Practice and Role

Acceptance

Shared Identity

Common culture

Staff Disruption

Referral and Primary Treatment Resource

Consultant

Partnerships and Network Integration

Leadership in University Student Health Vision

Co-location

“Merged” Service

Management Team

Integrated Treatment Functions

Integrated Treatment and Wellness Models

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Campus and Community Integration

Staff Acculturation and Affirmation

Clinical Services Delivery
STRESSORS CREATED BY COLLABORATIVE

• It was a new source of emergent visit demand for behavioral health.
• It was a new workload and time demand for every medical health visit.
• It created a time sensitive demand for coordination between the medical and behavioral health clinicians.
• It created a need for appropriate documentation of volatile data.
• It was coincident with the implementation of a new electronic medical record system.
The learning curve with schedules and time blocks meant clinicians were at risk of feeling disrespected.

- Counseling sessions were interrupted.
- Confusion over scheduling created a perception of delay among the medical team over the behavioral health response to emergent depression screening results.
- Switch to paper form of PHQ to facilitate conversation with student
- Concerns over proper electronic medical record documentation
As a result, we screened a low percentage of students presenting for medical encounters.

We failed to fully enroll and follow a significant number of students in the registry.

Staff questioned the process for depression screening.
SO, WHY DID WE FAIL?

- No buy-in
- Failure to manage workload
- Failure to create a system to make the process easy
- No resources to support registry tasks
- Reluctance of medical staff to own and act on information
- Medical staff had not fully accepted more holistic view of college health
- Culture among medical staff was not focused on “students” but remained focused on “patients”
WHAT WE LEARNED

• We learned a process --- the hard way.
• We learned how the two sides worked.
• The medical clinicians increased their behavioral health sophistication.
• We learned to handle risky data.
• We learned the respective strengths of our individual staff members.
• We learned how to ask the right questions.
Committing to depression screening was core to a combined practice.

Depression screening was resurrected within the limits of our resources, and with process that worked within our practice.

Coordination has improved, anxiety has been relieved and disruption has been reduced.

We are now screening for depressive illness at more than 85% of our medical health visits.
When you start to view yourself as a team you start to act like one.

• When challenges present themselves, an integrated response becomes second nature.

• New avenues of care can be envisioned and created.

• The team can be expanded by recruiting other allies on campus.
Creation of Smoking Cessation Program
Northeastern University Smoke-free Campus Initiative

Northeastern University has created a committee of students, faculty, staff, and representatives from local organizations to explore a smoke-free campus. While buildings on Northeastern’s campus are already smoke- and tobacco-free, the university feels it necessary to explore the potential for a campus-wide policy.

Under the leadership of Bouvé College of Health Sciences dean, Terry Fulmer, the committee will seek input from the university community through a series of surveys, meetings and forums. The committee will also review initiatives at other college campuses in developing a set of recommendations for Northeastern in 2013.

Campus announcements

Recommendations ahead on smoke-free campus initiative News@Northeastern 03.21.13
Smoke-free campus debate moves to Faculty Senate News@Northeastern 02.14.13
Northeastern to explore smoke-free campus News@Northeastern 12.5.12
Open forum continues discussion on smoke-free campus initiative News@Northeastern 1.30.13

Learn about smoking cessation resources at Northeastern
SMOKING CESSATION SERVICES

• **Historical Services**
  • Medical visits at no cost to students
  • Individual and group therapy at no cost to students
  • Northeastern University Student Health Plan (NUSHP)-variety of resources through Blue Cross Blue Shield of MA

• **New service**
  • Highlight use of technology
  • Research based
  • Outcome driven
  • Interdisciplinary holistic care model
  • Time frame for implementation-3 weeks
READY TO QUIT!
PROGRAM COMPONENTS

An initial meeting to discuss a personalized smoking cessation plan

Encouraging text messaging that gives the student support to remain tobacco free.

Weekly follow-up phone calls and coaching meetings twice a month with a registered nurse.

Opportunity to meet with a behavioral health therapist for concerns about quitting.

Monthly follow-up meetings with a medical provider to support progress.
Staff - Embracing a Shared Professional Identity

- Program was created to have the best chance of success with college age students, and without regard to a particular service

- Clarity of role for each of medicine, nursing, and behavioral health

- Focused on the goal of providing best service we could deliver to students as college health providers—in support of a University initiative
UHCS was Recognized as having a Leadership Role in University Student Health Vision

- Member of the exploratory committee re: campus wide smoke-free policy
- Served as a representative of the exploratory committee with students, faculty senate and staff
- Reinforced relationships with other interested stakeholders
Smoking Cessation Initiative is an example of an Integrated Treatment and Wellness Model

- Designed to contribute to and benefit from overall campus initiative
- Coordinated effort:
  - Buy-in was assisted by engaging champions from each service
  - Content leaders existed throughout UHCS (without regard to practice tradition)
  - Understanding of the overall functioning of the unit and could appreciate the workflow impact of the new program
Reflection and Conclusion
Success involved:

- Attention to clinical competencies and coordination, relationships with community, and one another
- Appreciating one another’s roles, contributions and needs
- Clinical and administrative integration
REFLECTION

Success involved:

• Professional identification as college health clinicians
• Celebrating victories together
• Continually striving for excellence