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University of Pittsburgh School of Medicine
Western Psychiatric Institute and Clinic of UPMC

Fifth Annual Clinician Educator Showcase

Western Psychiatric Institute and Clinic of UPMC
Pittsburgh, PA

October 20, 2016
11:45am-3:50pm
2016 CLINICIAN EDUCATOR SHOWCASE  
October 20, 2016  
Western Psychiatric Institute and Clinic of UPMC  
Pittsburgh, PA

11:30am-12:00pm  
Check In at Registration and Pick Up/Lunch  
(WPIC 2nd Floor Hallway)  
(Seating for lunch is available in the WPIC Auditorium or WPIC Rooms 292-295)

12:00pm-12:15pm  
WELCOME AND INTRODUCTION  
(WPIC Auditorium)  
David A. Lewis, MD - Distinguished Professor of Psychiatry and Neuroscience,  
Thomas Detre Professor of Academic Psychiatry, Chair, Department of Psychiatry  
University of Pittsburgh School of Medicine

12:15pm-1:00pm  
PLENARY SESSION - PROMOTING PHYSICIAN WELL-BEING  
(WPIC Auditorium)  
Dena Hofkosh, MD, MEd – Associate Dean for Faculty Affairs and Professor of Pediatrics,  
University of Pittsburgh School of Medicine

1:00pm-1:30pm  
SPEED DAT(A)ING SESSION  
(WPIC Auditorium)  
- Daniel Fishman, MD - PGY4, General Psychiatry Residency Program  
- Kimberly Clinbeam, MD - Fellow, Child and Adolescent Psychiatry Fellowship Program  
- Jin Cheng, MD - PGY4, General Psychiatry Residency Program  
- Neeta Shenai, MD - Fellow, Psychosomatic Fellowship Program

1:30pm-1:50pm  
Transition to Breakout Sessions

1:50pm-2:40pm  
BREAKOUTS - SESSION I  
(WPIC 292-293)  
BREAKOUT 1-A  
Understanding Insurance Coverage: A Practical Guide for Providers  
Session Chair: Manish Sapra, MD, MMM  
Presenters:  
Matthew Hurford, MD, Vice President of Medical Affairs, Community Care Behavioral Health Organization  
Manish Sapra, MD, MMM, Assistant Professor of Psychiatry and Associate Chief of Clinical Services,  
Network Hospitals & Affiliates, WPIC

(WPIC 294-295)  
BREAKOUT 1-B  
Violence Risk Management for Clinicians: Three Commonly Asked Questions  
Session Chair: Abhishek Jain, MD  
Presenters:  
Abhishek Jain, MD, Assistant Professor of Psychiatry, University of Pittsburgh School of Medicine  
John Rozel, MD, MSL, Assistant Professor of Psychiatry, University of Pittsburgh School of Medicine  
and Medical Director, reSolve Crisis Network, WPIC  
Camella Herisko, DNP, MSN, RN, PMHCNS-BC, CRNP, Vice President, Patient Care Services, WPIC  
Mark Zacharia, Esq., Associate Counsel, UPMC

(WPIC Auditorium)  
BREAKOUT 1-C  
Embedding Behavioral Health Care in Medical Settings: Challenges and Opportunities  
Session Chair: Lalith Kumar K. Solai, MD  
Presenters:  
Abigail Schlesinger, MD, Associate Professor of Psychiatry, University of Pittsburgh School of Medicine  
and Medical Director, Children's Hospital Outpatient Behavioral Health Services, Child and Family  
Counseling Center and the Center for Independence  
Priya Gopalan, MD, Assistant Professor of Psychiatry, University of Pittsburgh School of Medicine  
Daniel Varon, MD, Assistant Professor of Psychiatry, University of Pittsburgh School of Medicine  
Ellen Whyte, MD, Assistant Professor of Psychiatry, University of Pittsburgh School of Medicine  
Kenneth Nash, MD, MMM, Professor of Psychiatry, University of Pittsburgh School of Medicine  
and Vice Chair, Clinical Affairs for the Department of Psychiatry, and Chief of Clinical Services, WPIC  
Michael Travis, MD, Associate Professor of Psychiatry, University of Pittsburgh School of Medicine  
Lalith Kumar K. Solai, MD, Associate Professor of Psychiatry, University of Pittsburgh School of Medicine

2:40pm-3:00pm  
Break/Transition to Breakout Session II  
(Light refreshments available in hallway outside of WPIC Auditorium)
3:00pm-3:15pm  BREAKOUTS - SESSION II

WPIC 292-293  BREAKOUT 2-A
Making WPIC More Welcoming: Diversity, Inclusion, and Acceptance
Session Chair: Jason Rosenstock, MD
Presenters:
Jason Rosenstock, MD, Associate Professor of Psychiatry, University of Pittsburgh School of Medicine
Camellia Herisko, DNP, MSN, RN, PMHCNS-BC, CRNP, Vice President, Patient Care Services, WPIC
James E. Taylor, PhD, Chief Diversity & Inclusion Officer, UPMC
Carol Van Zile, LCSW, Director, Regulatory Compliance, WPIC
Hader Mansour, MD, Assistant Professor of Psychiatry, University of Pittsburgh School of Medicine
and Medical Director, 10th Floor Dual Diagnosis Unit, WPIC

WPIC 294-295  BREAKOUT 2-B
Mentoring Clinician Educators – Your Role on the Team
Session Chair: Alexis Fertig, MD, MPH
Presenters:
Alexis Fertig, MD, MPH, Assistant Professor of Psychiatry, University of Pittsburgh School of Medicine and
Co-Director, Clinician Educator Faculty Development Program
Karen Matthews, PhD, Distinguished Professor of Psychiatry, Epidemiology, Psychology, and Clinical
and Translational Science, University of Pittsburgh School of Medicine
Josh Hefferen, MSW – Program Director, Center for Children and Families, WPIC

WPIC Auditorium  BREAKOUT 2-C
Novel Applications of Technology to Enhance Psychiatric Treatment in Medical Settings
Session Chair: James Tew, Jr., MD
Presenters:
Eva Szigiethy, MD, PhD, Associate Professor of Psychiatry, Pediatrics, and Medicine, University of
Pittsburgh School of Medicine and Medical Director, Visceral Inflammation and Pain Center, UPMC
Shivdev Rao, MD, Assistant Professor of Medicine, University of Pittsburgh School of Medicine and
Vice President of Innovation, UPMC Enterprises
Miguel Regueiro, MD, AGAF, FACC, FACP, Professor of Medicine at the University of Pittsburgh School
of Medicine and Co-Director, Inflammatory Bowel Disease Center, UPMC
Mark Stabingas, MBA, Executive Vice President, UPMC Enterprises

3:15pm  Adjourn

3:15pm  Clinician Educator and Resident Reception

WPIC 413 A/B
PROGRAM OVERVIEW

The Annual Clinician Educator Showcase highlights the accomplishments of the faculty, physicians, and trainees in the Clinician-Educator career pathway and utilizes interactive plenary and breakout sessions to disseminate information on: strategies for career advancement for individuals in the Clinician-Educator pathway; clinical practice and quality improvements, and; resources and tools for enhancing teaching methods.

TARGET AUDIENCE

Residents, clinician-educator track psychiatrists, researchers engaged or interested in clinical research (e.g. service delivery, etc.), clinicians in both inpatient and ambulatory care facilities, students and other members of the WPIC community are invited to attend. Participation by all individuals is encouraged. Advance notification of any special needs will help us provide better service. Please notify us of your needs at least two weeks in advance of the program by calling Jeanie Knox Houtsinger at 412-246-6784.

LEARNING OBJECTIVES

At the conclusion of the program, participants should be able to:

- Describe strategies for building successful mentor/mentee relationships and disseminating knowledge relevant to the experience of clinician educators in their clinical and academic roles.
- Demonstrate increased awareness of innovative approaches to program and curriculum development aimed at improving care in behavioral health programs.
- Incorporate quality improvement strategies to increase efficiency and improve care in their own clinical and educational programs.
COURSE DIRECTOR

David A. Lewis, MD
Distinguished Professor of Psychiatry and Neuroscience, Thomas Detre Professor of Academic Psychiatry
Chair, Department of Psychiatry
University of Pittsburgh School of Medicine
Pittsburgh, PA

PLANNING COMMITTEE

Plenary Session: Promoting Physician Well-Being

Dena Hofkosh, MD, MEd
Associate Dean for Faculty Affairs and
Professor of Pediatrics
University of Pittsburgh School of Medicine Pittsburgh
Pittsburgh, PA

Breakout Session 1-A: Understanding Insurance Coverage: A Practical Guide for Providers

Manish Sapra, MD, MMM
Assistant Professor of Psychiatry
University of Pittsburgh School of Medicine
Associate Chief of Clinical Services, Network Hospitals & Affiliates
Western Psychiatric Institute and Clinic of UPMC
Pittsburgh, PA

Camellia Herisko, DNP, MSN, RN, PMHCNS-BC, CRNP
Vice President, Patient Care Services
Western Psychiatric Institute and Clinic of UPMC
Pittsburgh, PA

Breakout Session 1B: Violence Risk Management for Clinicians: Three Commonly Asked Questions

Abhishek Jain, MD
Assistant Professor of Psychiatry
University of Pittsburgh School of Medicine
Medical Director, Forensic Psychiatry Services
Western Psychiatric Institute and Clinic of UPMC, Pittsburgh, PA

Camellia Herisko, DNP, MSN, RN, PMHCNS-BC, CRNP
Vice President, Patient Care Services
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Breakout Session 1C: Embedding Behavioral Health Care in Medical Settings: Challenges and Opportunities

Kenneth Nash, MD, MMM
Professor of Psychiatry
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Vice Chair, Clinical Affairs for the Department of Psychiatry
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Director, Office of Residency Training
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Lalith K. Solai, MD
Associate Professor of Psychiatry
University of Pittsburgh School of Medicine
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Breakout Session 2A: Making WPIC More Welcoming: Diversity, Inclusion, and Acceptance

Camellia Herisko, DNP, MSN, RN, PMHCNS-BC, CRNP
Vice President, Patient Care Services
Western Psychiatric Institute and Clinic of UPMC
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Jason B. Rosenstock, MD
Associate Professor of Psychiatry
University of Pittsburgh School of Medicine
Director, Medical Student Education
Western Psychiatric Institute and Clinic of UPMC
Pittsburgh, PA

Breakout Session 2B: Mentoring Clinician Educators – Your Role on the Team

Alexis Fertig, MD, MPH
Assistant Professor of Psychiatry
University of Pittsburgh School of Medicine
Co-Director, Clinician Educator Faculty Development
Western Psychiatric Institute and Clinic of UPMC
Pittsburgh, PA

Jody Glance, MD
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Associate Director of Medical Student Education
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Karen A. Matthews, PhD
Distinguished Professor of Psychiatry, Epidemiology, Psychology, and Clinical and Translational Science
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Breakout Session 2C: Novel Applications of Technology to Enhance Psychiatric Treatment in Medical Settings

James D. Tew Jr., MD
Associate Professor of Psychiatry
University of Pittsburgh School of Medicine
Associate Chief of Clinical Services, Inpatient Services
Western Psychiatric Institute and Clinic of UPMC
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Michael Marcsisin, MD
Assistant Professor of Psychiatry
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FACULTY AND SHOWCASE PARTICIPANTS

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Mark Zacharia, Esq., Associate Counsel, UPMC, Pittsburgh, PA
PLENARY SESSION

PROMOTING PHYSICIAN WELL-BEING

Plenary Speaker: Dena Hofkosh, MD, MEd
Associate Dean for Faculty Affairs
Professor of Pediatrics, University of Pittsburgh School of Medicine

Learning Objectives: By the end of the session, participants will be able to:

1. Describe the needs of clinician-educators if academic and clinical productivity is to increase.
2. Understand the impact of physician well-being on academic and clinical productivity.
3. Describe initiatives aimed at promoting physician well-being.
Promoting Physician Well-Being and Resilience

Dena Hofkosh, MD, MEd
Associate Dean for Faculty Affairs
University of Pittsburgh School of Medicine
Department of Psychiatry-Clinician Educator Showcase
October 20, 2016

- No conflicts of interest to disclose

Physician Well-Being
Why well-being matters

Physician Suicide

The New York Times

Why Do Doctors Commit Suicide?

Two medical residents, from different programs, jumped to their deaths in separate incidents

Physician Suicide

- 400 each year in US
- Deaths among 25-39 year olds
  - 15% vs. 26%
- Male physicians: 50% higher
- Female physicians: 250% higher
- Higher completion rate
- Postmortem toxicology data—low rates of medication treatment for depression
Depression among residents: Meta analysis

- 32 cross-sectional
- 23 longitudinal
- Clinical interviews and self-report instruments
- 28.8% overall pooled prevalence of depression or depressive symptoms

Depression and Medication Errors

- BMJ
- Rates of medication errors among depressed and burnt out residents: prospective cohort study
- 20% depression rate
- 6x higher error rate among depressed residents
- Half of the residents who were depressed reported being unaware
- Very few were receiving treatment
Accidental death

- 3rd year resident in Emergency Medicine
- Switching from Nights to Days
- Found dead in bed
- Non-toxic level of self-prescribed Adderall
- Abnormal EKG, had not seen a physician
- Parents want her story told

Health of the Faculty

- Exercise more
- Less likely to be obese
- Less likely to smoke
- More stressed
- More likely to abuse prescription drugs
- Less likely to have a PCP
- Less likely to seek care

Self Care

Physician, heal thyself
Luke 4:23

That physician will hardly be thought very careful of the health of his patients if he neglects his own.

~ Galen 130-200 A.D.
Physician Self-care

- "...the secret of the care of the patient is in caring for the patient."
  - Peabody, 1926
- "The secret of the care of the patient is caring for oneself while caring for the patient."
  - Candib, 1995

Miracle on the Hudson

US AIRWAYS FLIGHT 1549
CAPTAIN CHESLEY (SULLY) SULLENBERGER III

A perfect team response to disaster

- All crew had PTSD for several months
- Poor sleep, hypertension, tachycardia
- Air traffic controller removed from duty for a month
- 1 crew member never returned to work
- No one went back to work immediately
The Second Victim

"Virtually every practitioner knows the sickening feeling of making a bad mistake. You feel singled out and exposed... You agonize about what to do, whether to tell anyone, what to say..."

- Wu, 2000

Emotional Impact of Perioperative Catastrophes

[Bar graph showing emotional impact of errors with categories such as feeling overwhelmed, anxiety, guilt, fear of litigation, shame, fear of judgment by colleagues, anger, professional self-doubt, dissatisfaction, loss of reputation, généralized anxiety, and the number of respondents.]

Georg, Anesth, NUR, Durieux, 2013
Time to Emotional Recovery

Shame
- Secrecy
- Silence
- Judgement

Burnout
- Emotional Exhaustion
- Depersonalization
- Reduced Personal Accomplishment

Threats to physician well-being

- Self-harm
- Suicide
- Stress of illness
- Loss of autonomy
- Inadequate payment
- Limited time with patients
- Burnout
- Depression
- Suicide
- Self-harm

Key Drivers of Distress for Physicians

- Excessive workload
- Inefficient work environment, inadequate support
- Problems with work-life integration and balance
- Loss of autonomy
- Loss of meaning in work

Epidemiology of burnout

- Medical students matriculate with BETTER well-being than their age-group peers
- Reverses early in medical school
- Poor well-being persists through medical school and residency
Increasing burnout reported among physicians

- 45.5% (n=3310) in 2011
- 54.4% (n=3680) in 2014
  - (P<0.001)

Burnout by Specialty 2015

Impact of burnout

- Decreased attention and concentration
- Substance abuse
- Poor decision making skills
- Decreased satisfaction
- Decreased treatment adherence
- Lengthened recovery time after discharge
- Attrition and burnout
- Reduced productivity and efficiency
- Medical errors
One of the mysteries of illness is that no one can be healed by anyone whose emptiness is greater than their own.

- Mark Nepo

Changing the conversation from burnout to well-being

Well-being

- A quality beyond physical and physiologic integrity
- Reflects the degree to which one
  - is oneself fully and authentically
  - experiences connection with others and the world
  - finds meaning in life and work
Resilience

- The capacity to respond to stress in a healthy way such that goals are achieved at minimal psychological and physical cost
- Beyond resilience--Post-traumatic growth and wisdom

Mindfulness: Paying Attention on Purpose

- The self-regulation of attention
- Allows for increased awareness of mental events in the present moment
- Characterized by curiosity, openness and acceptance toward one's own experiences, as they occur

Mindfulness metaphor - the antidote to frenzy

Mindfulness metaphor

- http://www.embracemindfulness.co.uk/presence-almonds/
Mindful Practice

Mindfulness is integral to the professional identity of physicians

Epstein 1995

JGIM

Stress Management and Resilience Training Among Department of Medicine Faculty: A Pilot Randomized Clinical Trial

Amit Brat, MD, MDt, Kavita Prasad, MD,1, Daniel Schroeder, MD, and Prathiba Vokkarapu, MDt

- 20 physician subjects
- 12 controls (wait list)
- Single 90 min session
- Relaxation and modified cognitive-behavioral therapy

Results

<table>
<thead>
<tr>
<th>Study (n=10)</th>
<th>Val6 (n=10)</th>
<th>F(1, 18)</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Control</td>
<td>0.54</td>
<td>0.05</td>
<td>0.05</td>
</tr>
<tr>
<td>Treatment</td>
<td>0.63</td>
<td>0.001</td>
<td>0.003</td>
</tr>
</tbody>
</table>

Table 1: Primary Outcome Measures from a Randomized Clinical Trial to Assess the Mindfulness Training Among Physicians
**Promoting mindfulness**

![Diagram](image)

*Abbreviated Mindfulness Intervention for Job Satisfac-
tion, Quality of Life, and Compassion in Primary Care*

**Clinicians: A Pilot Study**

**Figure 1.** Scores for the outcome measures compared at baseline and after intervention (n = 38 at baseline). (M ~ SEM, N = 38)

- **JAMA Internal Medicine**
- Intervention to Promote Physician Well-being, Job Satisfaction, and Professionalism: A Randomized Clinical Trial

- 74 physicians at Mayo Clinic
- 19 1-hour facilitated discussion groups every other week (total 9 months)
  - Mindfulness
  - Meaning in work
  - Reflection
  - Shared experience
  - Control and non-trial cohort

**Increased engagement**

**Decreased burnout**

![Graphs](image)
A mindful pause

“Just breathe”

Just breathe

What they said...

- Short-term meditation induces white matter changes in the anterior cingulate (PNAS)
- Meditation is associated with altered brain structure
- Mindfulness practice leads to increases in regional brain gray matter density
- Mindfulness-based stress reduction training impacts on intrinsic brain connectivity
- Brain Mechanisms Support the Modulation of Pain by Mindfulness Meditation (JNeurosci)

There's an App for that: brief mindfulness exercises

- 1 minute breathing
- A mindful pause
- Brief compassion meditation
- http://palousemindfulness.com/selfguidingml

Gratitude
Can gratitude promote well-being?

Studies of gratitude practice

- Randomized assignment
  - Gratitude
  - Hassles
  - Neutral
  - Daily or weekly recording of affect, coping, health, symptoms, overall life appraisal

Emmons and McCullough, 2003

Gratitude practice: results

- Gratitude group
  - Felt better about life as a whole
  - Fewer physical complaints
  - More time spent exercising
  - More optimistic
  - Improved sleep amount and quality

- Gratitude as a deliberate cognitive strategy can promote well-being
Peer Support

The American Balint Society

http://americanbalintsociety.org

Finding Meaning in Medicine Discussions

http://www.ishprograms.org/programs/ai-healthcare-professionals/

Summary recommendations from the literature: Individual

- Mindfulness based stress management
- Spiritual nurturing
- Gratitude-position life philosophy
- Self-care
- Meaning in work

The evidence (Colin West)

- Small samples
- Poorly controlled studies
- Most interventions on personal time
- Limited and poorly validated outcomes
- Focus on personal rather than shared responsibility with organization
Well being is a shared responsibility

Well-being as a physician competency

Demonstrate a commitment to physician health and well-being to foster optimal patient care:
- Mindful and reflective approach to practice
- Resilience for sustainable practice
- Responsibility to self, including personal care, in order to serve others

CanMEDS 2015 Physician Competency Framework

ACGME Well-Being Symposium
AMA: Steps Forward

UPMC GME Focus on Wellness
- Survey of trainees, program leadership and key faculty
- Sessions at 2016 GME Leadership conference
- On-going work on resource development and programming for residents and fellows

Impact of Organizational Leadership on Physician Burnout and Satisfaction
- 3000 physicians surveyed
- Positive leadership qualities:
  - Informing, engaging, inspiring, developing, valuing
- Leadership ratings highly correlated with burnout and satisfaction with organization
The IHI Triple Aim

Population Health

Experience of Care  Per Capita Cost

From Triple to Quadruple Aim: Care of the Patient Requires Care of the Provider

The Missing Aim


Physician wellness: a missing quality indicator

Organizational solutions

- Is well-being valued?
  - Policies
  - Leadership promotes positive core values
- Is well-being taught?
  - Training in stress management, well-being, recognition of distress
- Is well-being supported?
  - Workload, autonomy
  - "A physician only does what only a physician can do"

Physician-Organization Collaboration Reduces Physician Burnout and Promotes Engagement

To flourish, physicians need:
- Some degree of choice (control over their lives)
- Camaraderie (social connectedness)
- Opportunity for excellence (being part of something meaningful)

Organizational support for well-being

[Diagram with organizational support strategies]
We need to be well

- We are physicians with the responsibility to care for patients
- We are a faculty with the responsibility to teach, model and create an environment that fosters learning and growth in our students and trainees
- We are a community of colleagues

- You cannot give what you are not getting...
  - Various wise people
SPEED DAT(A)ING PRESENTATIONS
Catatonia and Delirium
Development of a Workshop for Non- Psychiatrists

Daniel Fishman, MD, PGY4
Mentors: Priya Gopalan, MD; Pierre Azzam, MD

Specific Aims

1. Assess the educational need among medicine and neurology residents regarding catatonia and delirium
2. Utilize a workshop to introduce the diagnostic classification, neurobiology, and treatment for catatonia and delirium, with emphasis on the differentiating features
3. Demonstrate the utility and practicality of a workshop for teaching these complex disorders

Delirium

- Acute disturbance in attention and awareness
- Evidence that it's secondary to a medical condition, substance intoxication or withdrawal, or medication side effect
- Increases six-month mortality: 18% vs. 34% in mechanically ventilated patients
Catatonia

- Catatonia is a syndrome, diagnosed by the presence of at least three of twelve psychomotor findings
- Classic signs include stupor, mutism and negativism
- Can be screened for and measured with the Bush-Francis Catatonia Rating Scale
- Patients describe a variety of subjective experiences
- Course is variable and can fluctuate in severity and quality

Why it’s important to differentiate

- 1.5 – 3% of general medical patients have catatonia
- 20% of general medical patients at tertiary care centers have delirium
- Patients may meet the diagnostic criteria for both
- The treatment for one, will potentially make the other worse

Methods

- A 10 question needs assessment distributed a month before the workshop
- Development of a 60 minute workshop
  - Case presentation
  - Video examples
  - Didactic portions
  - Interactive physical exam trainings
- 13 question post-test delivered immediately subsequent to the workshop
- Assessed changes in the residents' attitude towards catatonia and delirium, comfort in diagnosis and treatment, and knowledge
Results: Knowledge

<table>
<thead>
<tr>
<th>Knowledge question asked to participants</th>
<th>Pre-test participants who answered correctly</th>
<th>Post-test participants who answered correctly</th>
</tr>
</thead>
<tbody>
<tr>
<td>Which treatment has the highest success rate in treating catatonia?</td>
<td>11 (38)</td>
<td>20 (83)</td>
</tr>
<tr>
<td>Which neurotransmitters are thought to play a role in catatonia?</td>
<td>0 (0)</td>
<td>11 (46)</td>
</tr>
<tr>
<td>Which of the following is NOT a common physical examination finding seen in delirium?</td>
<td>7 (24)</td>
<td>10 (43)</td>
</tr>
<tr>
<td>How would you assess for delirium?</td>
<td>5 (7)</td>
<td>10 (83)</td>
</tr>
<tr>
<td>Similarities between delirium and catatonia include all of the following except?</td>
<td>9 (20)</td>
<td>14 (38)</td>
</tr>
</tbody>
</table>

Results: Attitude

- How relevant do you feel both catatonia and delirium are to your practice?

Conclusions and Future Directions

- A multimodal workshop appears to be a viable and successful tool for resident education on catatonia and delirium.
- Significant improvements demonstrated especially in the domains of comfort eliciting physical exam findings and knowledge.
- Supports expanded utilization of workshops as teaching tool for physical examination and interviewing.
- Considering development of further workshop topics versus a booster session on this topic to assess retention and expand dissemination.
Thank you to my mentors and colleagues for making this possible:
- Priya Gopalani, MD, WPIC
- Pierre Azzam, MD, WPIC
- David White, WPIC
- Drs. Julie Graziano, Darcy Moschenross, Morgan Faeder, Anderson Still, Yooeun Song, Joe Carley, Drew Calhoun, WPIC
- Drs. Mike Travis and Sansea Jacobson, ORT and AACE Track

Thank you all for your attention!

Any questions?
BACKGROUND

- Mentor definition: An active partner in an ongoing relationship who helps a mentee to maximize potential and reach personal and professional goals
- Supports doctors throughout training, yet many graduate without a clearly defined mentor
- Little known about the role of peer mentoring in psychiatry residency
- Mutually beneficial relationship

AIMS

- Implement a resident to resident mentoring program
- Increase resident satisfaction and support throughout the early years of residency
- Improve senior residents' opinions regarding mentoring
- Enhance mentoring opportunities throughout residency
METHODS
- Participants
  - Mentees: all incoming PGY1 residents
  - Mentors: volunteers from PGY3 and PGY4 classes
- Surveys - pre-intervention
  - PGY1: assess career goals and interests
  - PGY3/4: assess opinions about mentorship

METHODS
- Mentee-mentor pairs assigned by housestaff leadership
- Monthly meetings encouraged
- Surveys - post-intervention at 6 and 12 months
- Measured satisfaction, effectiveness, level of support, level of contact, and productivity

RESULTS

<table>
<thead>
<tr>
<th></th>
<th>6 months</th>
<th>12 months</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of mentor surveys completed</td>
<td>14 (82.4%)</td>
<td>14 (82.4%)</td>
</tr>
<tr>
<td>Number of mentee surveys completed</td>
<td>14 (82.4%)</td>
<td>13 (75.7%)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>7.3 meetings</th>
<th>10.6 meetings</th>
<th>13.8 meetings</th>
</tr>
</thead>
<tbody>
<tr>
<td>6 month survey</td>
<td>10 (76.9%)</td>
<td>14 (100%)</td>
<td>14 (100%)</td>
</tr>
<tr>
<td>12 month survey</td>
<td>2 (100%)</td>
<td>2 (100%)</td>
<td>2 (100%)</td>
</tr>
</tbody>
</table>
RESULTS

<table>
<thead>
<tr>
<th></th>
<th>6 month surveys</th>
<th>12 month surveys</th>
</tr>
</thead>
<tbody>
<tr>
<td>How beneficial experience was - mentors</td>
<td>3.5</td>
<td>3.5</td>
</tr>
<tr>
<td>How beneficial experience was - mentee</td>
<td>3.6</td>
<td>3.9</td>
</tr>
<tr>
<td>Mentor's perceived benefit to mentee</td>
<td>3.3</td>
<td>3.2*</td>
</tr>
<tr>
<td>Mentee satisfaction with residency</td>
<td>4.1</td>
<td>4.1</td>
</tr>
<tr>
<td>Comfort in the mentor role</td>
<td>4.1</td>
<td>3.9</td>
</tr>
<tr>
<td>Mentee's perceived level of support by residents</td>
<td>4.2</td>
<td>4.9</td>
</tr>
</tbody>
</table>

Based on a 5-point Likert scale

* p<.01

TOPICS DISCUSSED IN FREE RESPONSE

- Rotations
- Rotation-specific issues
- Pittsburgh
- Leadership
- Call
- Faculty mentorship
- Career goals
- Teaching
- Research track goals
- Medical student issues
- Wellness

REPORTED BARRIERS TO MEETING

- Schedule conflicts (19/18)
- Geography (11/8)
- Mentor/mentee seemed uninterested (6/4)
- Did not believe meeting would be useful (3/6)
- Mentor/mentee pairing was not a good fit (0/3)
- Comfort level (2/1)
- Mentee developed relationships with others (1/0)
- Maternity leave (0/1)
CONCLUSIONS/FUTURE DIRECTIONS

- Peer mentorship appears beneficial in psychiatry residency training
- Continued implementation with incoming PGY1 classes
- Providing more information about mentorship

ACKNOWLEDGEMENTS

- Priya Gopalan, MD
- Michael Travis, MD
- Pierre Azzam, MD
- Robin Valpey, MD
- Neeta Shenai, MD
- Dan Fishman, MD
BRIEF MOTIVATIONAL INTERVIEWING TRAINING FOR FAMILY MEDICINE RESIDENTS

JIN CHENG MD PGY-4
FAMILY MEDICINE / PSYCHIATRY

CHALLENGES
Unhealthy behaviors defined by the CDC includes:
- Physical inactivity
- Poor nutrition
- Tobacco use
- Alcohol use

Many chronic illnesses are preventable and it incurs significant cost.

MOTIVATIONAL INTERVIEWING
- A collaborative conversation style for strengthening a person's own motivation and commitment to change – Miller
- Evidence based
- Brief intervention in 15 minute interventions can lead to positive outcome
SPECIFIC AIMS

1) To create a motivational interviewing teaching curriculum in the residency

2) Determine if the teaching curriculum promoted changes in resident views in multiple domains using a survey

METHODS

• Course consist of lectures and role playing for 1 hour weekly for 4 sessions

• Small groups of 3 – 4 residents (21)

• Family Medicine residents PGY 1 to 3

METHODS

• Session 1 – Intro to MI / Spirit of MI

• Session 2 – Skills of MI (OARS)
  • Open-ended questions
  • Affirmations
  • Reflective statements
  • Summary

• Session 3 & 4 – Role Play and Immediate Feedback
METHODS

- Survey was developed using 6 point Likert Scale
- 1 (Strongly Disagree) ------- 6 (Strongly Agree)
- Comfort
- Satisfaction
- Confidence
- Brief motivational intervention can be effective
- Frustration with patient's regarding unhealthy behaviors
- Familiarity with Motivational Interviewing.

RESULTS

Survey results N=21

- Comfort
- Satisfaction
- Confidence

RESULTS

Survey results N=21

- Functional efficacy of Motivational Interviewing
- Frustration with patient's
- Familiarity with MI
DISCUSSION AND FUTURE DIRECTIONS

- Improvement in almost all survey domains except for frustration with patients
- Resident reported the role playing sessions were most helpful
- Record role play sessions can provide further details on resident improvement
- Implementing in other programs

REFERENCES


THANK YOU

- Dr. Barbara Nightingale
- Dr. Antoine Doutaihy
- Dr. Priya Gopalan
- Dr. Pierre Azzam
- Dr. Martin Johns
- Sherri Holland LCSW
- Dr. Neal Ryan
- AACE Track and Dr. Mike Travis
Background

- Pregnancy is a critical period for women afflicted with psychiatric illness

<table>
<thead>
<tr>
<th></th>
<th>1st Trimester</th>
<th>3rd Trimester</th>
<th>5 months post-partum</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol</td>
<td>12%</td>
<td>0.7%</td>
<td>0.4%</td>
</tr>
<tr>
<td>binge drinking</td>
<td>6%</td>
<td>1%</td>
<td>15.5%</td>
</tr>
<tr>
<td>smoking</td>
<td>21.0%</td>
<td>14.0%</td>
<td>37.5%</td>
</tr>
</tbody>
</table>

- Women with PTSD are 1.4x more likely to report substance use

• Evidence based treatment for SUDs and PTSD
  - Safety
  - Coping skills
  - 25 sessions
  - Individual or group
Specific Aims

- Quantify the types of trauma experienced
- Assess the barriers to care
- Determine the efficacy of a one time educational session

Methods

- Participants:
  - Screened by unit social worker by admitting diagnosis
  - Given Trauma History Questionnaire
- One time education individual session offered
  - Review specific symptoms of PTSD
  - Link between PTSD and SUDs
  - Discussion of safe coping skills
- Given list of local/national resources
- Pre- and post-session questionnaire

Data: Efficacy of Session

- 51 patients approached; 31 patients consented
- 23% reported they had no prior knowledge of the diagnosis and treatment of PTSD
- 90% of participants felt receiving information about PTSD, SUDs, coping skills, and resources was useful
Types of Trauma Experienced

<table>
<thead>
<tr>
<th>Type</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Violent Death</td>
<td>5</td>
</tr>
<tr>
<td>Medical</td>
<td>11</td>
</tr>
<tr>
<td>Captivity</td>
<td>6</td>
</tr>
<tr>
<td>Sexual assault</td>
<td>21</td>
</tr>
<tr>
<td>Assault (weapon)</td>
<td>15</td>
</tr>
<tr>
<td>Physical assault</td>
<td>26</td>
</tr>
<tr>
<td>Transportation Accident</td>
<td>24</td>
</tr>
<tr>
<td>Natural disaster</td>
<td>5</td>
</tr>
</tbody>
</table>

Barriers to Care

<table>
<thead>
<tr>
<th>Type</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Transportation</td>
<td>14</td>
</tr>
<tr>
<td>Money</td>
<td>11</td>
</tr>
<tr>
<td>Time Commitment</td>
<td>4</td>
</tr>
<tr>
<td>Negative Social Supports</td>
<td>5</td>
</tr>
<tr>
<td>Fear of treatment</td>
<td>3</td>
</tr>
<tr>
<td>Other</td>
<td>3</td>
</tr>
<tr>
<td>Privacy concerns</td>
<td>1</td>
</tr>
<tr>
<td>Perception of SUD's</td>
<td>0</td>
</tr>
</tbody>
</table>

Discussion

- “Seeking Safety” can be effectively adapted to a brief session
- Integrated model of care
- Limited research is available to guide the management of SUDs and trauma in pregnancy
Thank You

- Special thanks to
  - Priya Gopalan, MD
  - Jody Glaros, MD
  - Pierre Azzam, MD
  - Tina Towdley, MSW
  - Dawn Maguire, BSN, MSN
  - CRF & AACE track
BREAKOUTS - SESSION I
BREAKOUT 1A: UNDERSTANDING INSURANCE COVERAGE: A PRACTICAL GUIDE FOR PROVIDERS

Session Chair: Manish Sapra, MD, MMM

Session Leaders: Manish Sapra, MD, MMM and Camellia Herisko, DNP, MSN, RN, PMHCNS-BC, CRNP

Presentation: Understanding Insurance Coverage: Insurance, Managed Care and Reimbursement
Manish Sapra, MD
Assistant Professor of Psychiatry, University of Pittsburgh School of Medicine

Presentation: Value Based Contracting in Healthcare
Matthew Hurford, MD
Vice President of Medical Affairs, Community Care Behavioral Health Organization

Medicare, Medicaid and private sector health insurance programs are central to financing mental health and substance abuse services, especially in the inpatient settings. The concepts of insurance, managed care and reimbursement will be discussed. Participants will learn how public and private sector models of insurance operate in theory and practice. They will understand the implications of health care reform on changing payments from volume to value based care.

Learning Objectives: By the end of the session, participants will be able to:

1. Understand concepts of insurance, managed care and reimbursement.
2. Understand rationale for incentivizing value based care.
3. Understand some implications of healthcare reform.
Understanding Insurance Coverage: Insurance, Managed Care and Reimbursement
March 24th 2023, UPMC Wlerea

Objectives

- Understand concepts of insurance, managed care and reimbursement.
- Understand rationale for incentivizing value based care.
- Understand some implications of healthcare reform.

Insurance

- Premiums
- Pooling funds
- Reimbursement to cover losses/expenses
- "law of large numbers"
- Actuaries set premiums based on statistics and probability to approximate the rate of future claims
**But... Health Care is Complex**

---

**Risks to Insurance Companies**

- **Moral Hazard**
  - Behavior of the insured person changes due to coverage (increased utilization of the services)

- **Adverse Selection**
  - The consumer knows the most about their own needs.

---

"You got through surgery fine, but I regret to say some of your insurance coverage didn't make it."
Reimbursement Models

- Fee for service
  - Third Party payment
  - Who is the Customer?
  - Who is the decision maker?
- Capitation
  - Provider at Risk

Risk Management

- Co-Payments
- Co-Insurance
- Deductibles
- Managed Care (Create protocols / Medical necessity criteria / Prior authorizations / Precertification are some examples)
- Stop-Loss (Annual/ Lifetime limits)
- Restricting certain services
Mental Health Funding

- State and Local Funds
- Commercial
- Medicare
- Medicaid
State and Local Funds

- State hospitals
- Funding for mental health services for those not qualified for Medicaid
- Residential services

Trends:
- Decline in budgets
- Move funds to Medicaid
Medicaid

- Federal program administered by the states, with the federal government paying 50% to 70% of the costs
- "payer of last resort"
- Increasing share of behavioral health budget
- State programs have shifted programs to Medicaid programs
- Covers services not covered by other insurers (case management, ACT teams, etc.)
- ACA expanded Medicaid in several states

Employer-Based Private Insurance

- Employers pay all or part of the premium for their employees
- Premiums are tax-deductible business expense
- In behavioral health commercial policies historically focused on inpatient hospitalization

Figure 3.6: Distribution of MH Expeditures by Provider: 1996, 2003, and 2014
Mental Health Parity

- 1996 – The Mental Health Parity Act enacted requiring comparable annual and lifetime dollar limits
- 2008 – Mental Health Parity and Addiction Equity Act (MHPAEA) is signed into law, applying to large group health plans including employer-sponsored plans
- 2010 – Affordable Care Act extended MHPAEA to more health plans
- 2013 to 2016 – Final rules and regulations issued for managed care plans

Carve-in vs Carve-out

ACA

- Increases number of insured consumers
- Is coupled with Parity for Substance Use and Mental Health disorders
- Addresses Health Care costs through system redesign, comparative research, innovation grants
- Payment reforms to value quality over quantity
Rural Public Psychiatry Fellowship
http://www.ruralpsych.pitt.edu/

Weekly Series 2010-2011 Schedule
Thursdays 10:00–11:00AM

1/20/2011 Dr. Jennifer Chapman
Assessment and Treatment of HIV and EID in Substance Abuse

1/27/2011 Dr. Mary Schagger
Globally Significant Psychiatrists and their Houses: Ancient Greece

2/10/2011 intensive EID seminar & Dr. Mark Spaia
Use of Neuropsychiatric Medications in Hospital Settings

2/17/2011 Dr. Andrea Foy
Clinical Advocacy in Rural Environments: Experiences from the Future Is Here

The following are recorded videos that can be accessed on the website:

Dr. Amanda Schacter
Funding of HIV/Psychiatric Research, Policy, and Service

Dr. Matthew Spaia
Introduction to Health Systems Finance

Dr. Matthew Spaia
Managing Mental Health Paradoxes in Psychiatry
Partnering for Value: The Managed Care Perspective on Moving to Value-based Financing
Matthew O. Hurford, M.D. | VP of Medical Affairs
October 20, 2016

UPMC Operational Structure

University of Pittsburgh Medical Center (UPMC)

UPMC Insurance Services Division

UPMC Health Plan

Adolescent Developmental Group, Inc.

Community Care

• Behavioral health managed care company founded in 1996; part of UPMC and headquartered in Pittsburgh, PA
• Federally tax exempt non-profit 501(c)(3)
• Major focus is publicly-funded behavioral health care services; currently doing business in PA and NY
• Licensed as a Risk-Assuming PPO in PA
• Serving over 1.6 million individuals in 39 counties through a statewide network of over 1,800 providers
Community Care’s PA presence

Value-based contracting

- A strategy to promote quality and value by linking payment to outcomes.
- Contrasts with:
  - Fee-for-service, which incentives volume of care
  - Program-funding, which historically lacked link to outcomes

Drive towards value

- Unsustainable cost curve
- Affordable Care Act 2010
  - Hospital VBP program
  - Medicare Shared Savings and Accountable Care Organizations (ACOs)
  - CMS Innovation Center
- Commercial and Medicaid following Medicare
Medicare's ambitious agenda

Value-based payment models spectrum

Pay-for-Performance (P4P)

- Payment tied to specific metric(s)
  - Example: 5% bonus if inpatient psychiatric hospital achieves 30-day readmission target of 10% or less
- Built on FFS platform with little risk to the provider
- Often retrospective
- Challenges include: claims lag, adequacy of incentive, and one-sided financial relationship
Bundled payments aka case rates

- Single payment to provider or group of providers for an "episode of care"
  - Example: Single payment to a provider for continuum of care for individual with a substance use disorder from non-hospital rehab (30 days) to engagement with intensive outpatient (IOP) for period of 90 days.
- Includes outcome measures (e.g., UDS, days in community, employment)
- Seeks to optimize length of stay and deter overutilization
- Challenges include: defining the episode and the included services, danger of reduced lengths of stay after "break even" point for provider

Capitation

- Provider accepts payment for a population and bears some/all responsibility and risk for healthcare needs.
  - Example: A health system functions as an Accountable Care Organization (ACO) that receives per member/per month payment for 10,000 people and works to optimize health in order to achieve quality metrics and retain savings when need for high cost services decreases.
  - Highest level of risk
  - Need for risk adjustment
  - Complex clinically, administratively and analytically

Partnering for Value: ACT Pay-for-Performance
ACT Pay-for-Performance Initiative

- Goal: Incent providers of ACT services to reduce inpatient mental health (IPMH) utilization of ACT service recipients
- Collaboration between:
  - Two ACT providers in Allegheny County
  - Allegheny County, Office of Behavioral Health
  - Allegheny HealthChoices Inc. (AHCI)
  - Consumer Advisory Committee
  - Community Care

P4P Incentive Structure

- Providers can earn up to 110% of current fee schedule rate for ACT services:
  - 80% for all services rendered
  - 20% for meeting IPMH utilization goal
  - 10% for meeting long-term IPMH cost reduction goal

Reducing Inpatient Utilization & Costs
**P4P Approach**

- To be included in the P4P project, consumers needed to be HealthChoices-eligible for at least 80% of the measurement year.

- Model dashboard reports were developed so that providers could assess current performance and predict future P4P earnings based on various scenarios related to inpatient mental health services and ACT service utilization.

**ACT P4P Interactive Monitoring Tool**

**P4P Program Details**

- **Tiered earnings** available from a bonus pool created by withholding 20% of the established ACT service rate.

- Providers could earn 20% withheld and up to 10% bonus amount if they met the overall **target of reducing average inpatient mental health cost per person to $9,000 or less** during the calendar year.

- **Bonus earnings** increase as inpatient costs decrease.

- Providers needed to stay under an **established cap** for total ACT service utilization cost per person for the year of $25,000.
ACT/CTT P4P Outcomes

- In 2014, both providers earned the full 20% withhold amount and the maximum bonus earnings of 10% under the P4P model (increased revenue for ACT teams)
  - Provider A achieved a **64% reduction** in the average inpatient cost per person per year
  - Provider B achieved a **58% reduction** in the average inpatient cost per person per year
- In 2015, both providers further reduced the average inpatient cost per person per year!
  - Provider A achieved a **76% reduction** from the baseline year measure
  - Provider B achieved a **75% reduction** from the baseline year measure

UPMC Health Plan

Reduction in inpatient mental health

Average annual inpatient mental health days

<table>
<thead>
<tr>
<th>Provider</th>
<th>2012</th>
<th>2014</th>
<th>2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider A (n=224)</td>
<td>16.8</td>
<td>8.7</td>
<td><strong>6.9</strong></td>
</tr>
<tr>
<td>Provider B (n=126)</td>
<td>15.1</td>
<td>10.5</td>
<td><strong>6.6</strong></td>
</tr>
<tr>
<td>Combined</td>
<td>16.2</td>
<td>9.3</td>
<td><strong>6.8</strong></td>
</tr>
</tbody>
</table>

UPMC Health Plan

Savings

Average annual cost of ACT and IPMH

<table>
<thead>
<tr>
<th>Provider</th>
<th>2012</th>
<th>2014</th>
<th>2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACT $ per member, Provider A</td>
<td>$24,260</td>
<td>$19,321</td>
<td>$18,182</td>
</tr>
<tr>
<td>IPMH $ per member, Provider A</td>
<td>$9,921</td>
<td>$3,573</td>
<td><strong>$2,364</strong></td>
</tr>
<tr>
<td>ACT $ per member, Provider B</td>
<td>$15,835</td>
<td>$16,215</td>
<td><strong>$18,477</strong></td>
</tr>
<tr>
<td>IPMH $ per member, Provider B</td>
<td>$12,413</td>
<td>$8,979</td>
<td><strong>$3,486</strong></td>
</tr>
</tbody>
</table>

UPMC Health Plan
Measure for measure: lessons learned

Measurement

- Recognize the inherent anxiety in measurement.
- Collaborative approach
- Start with ultimate outcome then reverse engineer milestone process and performance metrics if necessary, for example:
  - Hiring, training, implementation, data reporting, quality improvement cycle, engagement, satisfaction, rate of scaling
- Introduce a culture of performance by measuring meaningful but attainable steps...just don’t stop at the landing.

Preparing for value: advice for all of us

- Understand your strengths
  - What is your competitive advantage?
- Can you demonstrate that people get better because of what you do?
- What additional resources do you need?
  - Add, hire or collaborate
- Be proactive
  - Partner, program and publicize/publish
VIOLENCE RISK MANAGEMENT FOR CLINICIANS: THREE COMMONLY ASKED QUESTIONS

Session Chair: Abhishek Jain, MD

Session Leaders: Abhishek Jain, MD and Camellia Herisko, DNP, MSN, RN, PMHCNS-BC, CRNP

Presentation: Introduction
Abhishek Jain, MD
Assistant Professor of Psychiatry, University of Pittsburgh School of Medicine

Presentation: Clinical - How Do I Actually Assess and Manage a Patient’s Violence Risk?
John Rosel, MD
Assistant Professor of Psychiatry, University of Pittsburgh School of Medicine

Presentation: What Concerns Should I Have about Being Sued if the Patient Becomes Violent in the Community?
Mark Zacharia, Esq.
Associate Counsel, UPMC

Presentation: How Do We Keep Our Hospital, Clinic, and Staff Safe?
Camellia Herisko, DNP, MSN, RN, PMHCNS-BC, CRNP
Vice President of Patient Care Services, Western Psychiatric Institute and Clinic of UPMC

Violence has been increasingly raised as a broad public health concern as well as a focus for clinical treatment. After clinicians identify a potential risk for violence in a patient, the questions they typically ask can be sorted into clinical (“How do I actually assess and manage a patient’s violence risk?”), legal (“What concerns should I have about being sued if the patient becomes violent in the community?”), and administrative (“How do we keep our hospital, clinic, and staff safe?”) concerns. In addressing these three questions, we will review recent WPIC clinical programs (e.g., Forensic Risk Assessment, Management, and Education [FRAME] and Clinical Homicide and Aggression Management Practices for Inpatient, Outpatient and Nontraditional Settings [CHAMPIONS]), and initiatives to address safety and security (e.g., Risk Committee and Threat Alert). We will have a panel discussion with clinical, legal, and administrative expertise.

Learning Objectives: By the end of this session, participants will be able to:

1. Discuss the current state of clinical violence risk assessment and management.
2. Identify three ways to reduce liability while treating potentially violent patients.
3. Summarize the available WPIC initiatives for operational safety and clinical management.
Violence Risk Management for Clinicians
Three Commonly Asked Questions

Abhishek Jain, MD
Jack Rozel, MD, MSL
Mark Zacharia, Esq.
Cami Herisko, DNP, RN, PMHCNS-BC, CRNP

Outline

1) How do I assess and manage a patient’s violence risk?
2) What concerns should I have about being sued if my patient becomes violent in the community?
3) How do we keep our hospital, clinic, and staff safe?

Objectives

• Discuss the current state of clinical violence risk assessment and management
• Identify three ways to reduce liability while treating potentially violent patients
• Summarize the available WPIC initiatives for operational safety and clinical management
Clinical Management of Violence Risk
Jack Rozel, MD, MSL
Medical Director, resolve Crisis Network
Assistant Professor of Psychiatry & Adjunct Professor of Law
University of Pittsburgh

Conflicts of Interest (Rozel)
- No industry involvement since 2007
- 2015-2016
  - Travel - Sinai Hospital, Supreme Court of the State of Pennsylvania, Carolina Health System
  - Writing - Haymarket Media
  - Consulting/Training - Region Six (Nebraska), Pennsylvania Psychiatric Institute / Penn State Hixson Medical Center
- Past
  - Consulting - JACP
  - Research Funding - Alesza, Janssen, NIMH
  - Conferences/Travel - Alesza, Lilly, Janssen, Wyeth Ayerst
  - Speakers' Bureau - Pennsylvania ACLU
  - Stock Holdings - Johnson & Johnson, United Health

What does mental health know about violence?
Which intervention would you choose?

- Decrease mass shootings 15-30%
- Decrease overall violence 5%
- A lot of false positives will be impacted
- 57,000,000 people
- Incarcerate the mentally ill

- Decrease mass shootings 98-99%
- Decrease overall violence 80%
- About 3 times as many false positives
- 150-170,000,000
- Incarcerate all men

Time to expand the dialogue about mental illness and violence

As easy as ABC!

A. Assessment
B. Behavior management
C. Conceptualization
D. Documentation
E. Effect a clinical plan
F. Follow up
G. Get help
Not yes/no
but if/then

Essential Violence Risk Factors

- Past history of violence, esp. with the identified target
- Hostile tone, edgy, untrusting
- Recent Acts or Intent > Ideation or Fantasy
- Warnings, explicit threats > implicit threats
- More specific plan (esp. with “evasive” features)
- Substance use

Also worth considering:
- Limited or loss of coping mechanisms or supports
- Low IQ / hx of TBI
- Recent increase in life stressors (housing, work issues)
- Impulsivity
- Suicidality, hopelessness
- Active symptoms of untreated/untreated mental illness

Pathway to Violence

- Attack
- Breach
- Preparation
- Research
- Ideation
- Grievance

→ Dynamic Risk Factors
→ Dynamic Protective Factors
←
Always ask about gun access

Access
Experience
Ideation or Intent
Operational plan or practice
Unconcerned with consequences

Intimate Partner Violence
A Pluripotent Risk Factor

- High rates of recidivism and escalation with same or new target
- Past IPV arrest is one of the best risk factors for future violent felony convictions
- IPV / violence against women increasingly recognized as a RF for rampage/mass shooting

Never worry alone
(Thomas Guthrie)

- Colleagues
- Supervisors
- Senior leadership
- Legal
- Security/Safety
- Forensic faculty
- Risk management
- Staff support
- EAP
Clinical
Homicide &
Aggression
Management
Practices for
Inpatient, Outpatient, &
Non-traditional Settings

What concerns should I have about being sued if my patient becomes violent in the community?

Mark Zacharia, Associate Counsel
UPMC Legal Department
Health Services Division
To establish a cause of action sounding in negligence, a party must demonstrate they were owed a duty of care by the defendant, the defendant breached this duty, and this breach resulted in injury and actual loss. Brisbane v. Outside In Sch. of Experiential Educ., Inc., 799 A.2d 89, 93 (Pa.Super.2002), citing Brezenski v. World Truck Transfer, 755 A.2d 36, 40 (Pa.Super.2000).

**Duty**
- you have a duty to provide care to your patient as a reasonably prudent physician would provide.

**Breach**
- you failed to provide that level of care that a reasonably prudent physician would provide.

**Causation**
- the breach of this duty of care was the cause of the harm suffered.

**Damages**
- because of the breach there are damages.

Physicians owe a duty of care to their patients.

Does this duty extend to a third party that has been injured by your patients behavior?

Generally speaking no, the courts have and are not willing to extend that duty to third parties.

It's a matter of foreseeability.
Doctor has no duty to control his patient’s driving habits or to protect third person from the injuries occasioned by unforeseeable accidents. *Cowley v. Suff*, 592 A.2d 1337 (1991)

Ophthalmologist not liable for death of a bicyclist, who was killed when she was struck by automobile driven by patient when the ophthalmologist failed to report patient's poor vision to Department of Transportation. *Wittsoeff v. Pokrass*, 733 A.2d 623 (1999)

Psychiatrist discontinued medication and discharged the patient who, several months later, strangled his live-in girlfriend to death. No duty to warn or otherwise protect a non-patient where the physician has not threatened to injure harm on a particular individual. *Dunkle v. Food Service East, Inc.*, 582 A.2d 1342 (1990)

---

If we allow recovery against mental health and mental retardation providers for harm caused by their patients except in the clearest of circumstances, we would paralyze a sector of society that performs a valuable service to those in need of mental health care. Thus, we decline to impose a duty of ordinary care under Restatement (Second) of Torts § 319 on providers of mental health and mental retardation services.


---

Where have they found a duty of warning?

- Duty to warn
  
  - Specific and immediate threat of serious bodily injury to an identifiable or readily identifiable person

  - The provider must take reasonable steps to warn the intended victim
- Gross Negligence (statutory via Mental Health Procedures Act)
  "Egregiously deviant conduct, [rather] than ordinary carelessness, inadvertence, laxity, or indifference. We hold that the legislature intended the term gross negligence to mean a form of negligence where the facts support substantially more than ordinary carelessness, inadvertence, laxity, or indifference. The behavior of the defendant must be flagrant, grossly deviating from the ordinary standard of care."
  - Where your patient has exhibited behavior that clearly indicates they are in need of inpatient treatment and an involuntary commitment should be pursued.
    - Did you attempt to 302 the patient? Is there a record of that attempt?

- In F.D.P. v. Ferrara, a patient was released to his legal guardian for the weekend. The guardian leaves him with his elderly father. The patient ends up sexually assaulting a young girl. The provider had no knowledge that the guardian was leaving the patient with his elderly father who could not watch him. Although the patient had a long history of issues, the court found that the provider was not grossly negligent.

- DeJesus v. U.S. Dept. of Veterans Affairs, the Court held that the VA acted grossly negligent by strongly encouraging discharge and failing to commit a patient who exhibited violent and suicidal tendencies when pulling a knife on another patient and shredding all of his belongings. Relying on expert testimony, releasing DeJesus constituted several egregious breaches of the appropriate standard of care, which resulted in DeJesus shooting four children and himself.

- The Mental Health Procedures Act standard for liability is gross negligence and covers all inpatient psychiatric care and involuntary outpatient care.

- For those clinicians providing voluntary outpatient care, a negligence standard would apply.
  - Who are you serving in addition to the patient?
    - Did you provide some level of care to the victim or hold yourself out as providing care to the victim and not just the patient?
Concerns:

What do you know?
- Is he/she making threats?
- Risky behavior?
- Others who may be harmed or affected?

Who is your patient?
Could your actions be seen as providing services to the patient’s family members, spouse, significant other, friends etc.?  
  » Negligence

Were there threats that you were aware of that would create a duty to warn?
  » Did you warn someone?
  » What did you say?
  » Did you document it?

Incentive Acknowledgment:

Did you consider the need for your patient to be involuntarily committed?
  
- No  
  » Why not?

- Yes  
  » Did you attempt to commit the patient?

Reminders:

Documentation is vital!

Is there a record of your attempt to obtain a commitment?

Always make an official request on the record for a 302 even if you are told it will probably not be granted.

In a duty to warn situation, document:
- The basis of your warning
- Who you contacted and when
- What you said to the person
Second Opinions
- Seek out peers and document their opinions
- Seek out legal counsel but do not document this discussion

How Do We Keep Our Hospital, Clinic, and Staff Safe?
Camii Herisko, DNP, RN, PMHCNS-BC, CRNP
Vice President, Patient Care Services, WPIC

Safety Operations and Methods

Safety
- Number one priority for the hospital
- Both patient and staff safety
- Monitor staff injuries associated with aggressive episodes
- Monitor patient-to-patient violence
- Goal is to continuously monitor, intervene and decrease these episodes
Safety Methods and Interventions

- Environmental
- Education/Training
- Processes/Protocols
- Staffing Methods

Environmental

- Body buttons
- Wall panic buttons
- Card Swipe/Key pad entrances
- Furniture
- New Unit Designs – location of staff stations
- Cameras
- Specific safety features
- Sensory Rooms

Education and Training

- Mandatory Crisis Training
- Advanced Crisis Training
- De-escalation Training
- Behavioral Management – least restrictive, positive approaches, safety plan standardization
- Sexual Behavior Training
Processes and Protocols
- Committees: Staff Injury Prevention, Restraint/Sedation, Healthcare Risk
- Patient Placement Strategies
- Safety Newsletter
- Staff Time Out
- Safety Planning
- Safety Officer Rounds
- Searches
- Contraband Management
- Milieu
- Threat Protocol
- Precautions
- RCA Process
- ASAP

Staffing Methods
- Acuity Management
- Staffing Strategies – Merck, GA
- Security/Police
- Amount and Type

Healthcare Risk Committees
- Formed this year
- Multi-disciplinary group: administrative and clinical staff
- Focus is to develop strategies to manage, assess and intervene in areas of patient aggression in order to provide safe and appropriate clinical care
- Sub-committees:
  - Precautions
  - PATINA (patients announcing threats if not admitted)
  - Violence Assessments
  - Threat Alert Program
BREAKOUT 1C: EMBEDDING BEHAVIORAL HEALTH CARE IN MEDICAL SETTINGS: CHALLENGES AND OPPORTUNITIES

Session Chair: LalithKumar K. Solai, MD

Session Leaders: Kenneth Nash, MD, MMM, Michael Travis, MD and LalithKumar K. Solai, MD

Presentation: Introduction
Abigail Schlesinger, MD
Associate Professor of Psychiatry, University of Pittsburgh School of Medicine

Presentation: Behavioral Health Care in a Medical Hospital Setting
Priya Gopalan, MD
Assistant Professor of Psychiatry, University of Pittsburgh School of Medicine

Presentation: Behavioral Health Care in a Long-Term Care Setting
Daniel Varon, MD
Assistant Professor of Psychiatry, University of Pittsburgh School of Medicine

Presentation: Behavioral Health Care in Adult Primary Care Office
Ellen Whyte, MD
Assistant Professor of Psychiatry, University of Pittsburgh School of Medicine

Providing behavioral health care in medical setting brings with it unique challenges. In this session we highlight three different settings in which behavioral health care is being provided and the special challenges that each site brings to it. Each speaker will focus on the biggest challenge in providing clinical care in their setting and how it has been successfully addressed.

Learning Objectives: By the end of this session, participants will be able to:

1. Enlist the benefits of embedding behavioral health care (BHC) in medical settings.
2. Describe some challenges in providing BHC in medical settings.
3. Describe some of the strategies in addressing the challenges of providing BHC in medical settings.
Embedding Behavioral Health Care in Medical Settings: Challenges and Opportunities

Abigail Schlesinger, MD
Break-out at 5th Annual Clinical Educator Showcase
October 20, 2016
Western Psychiatric Institute and Clinic

Goals & Objectives

- Describe benefits of embedding behavioral health care (BHC) in medical settings
- Describe challenges encountered providing BHC in medical settings
- Describe some of the strategies in addressing the challenges of providing BHC in medical settings

Framework for Access to Care (Psychiatric) (RID)

Access (fit between client & system)
The Triple Aim... And Beyond: The Quadruple Aim

- Enhancing patient experiences
- Improving population outcomes
- Controlling costs

Traditional and Evolving Models of Consultation

- Traditional Consultant
- Internal Consultant
- Collaborative Consultative Relationship

WP/CUA Embedded Behavioral Health Services

- Medical Hospital Setting:
  - Priya Gopalan, MD
- Long-Term Care Setting:
  - Daniel Varon, MD
- Adult Primary Care:
  - Ellen Whyte, MD
CLINICIAN EDUCATOR SHOWCASE:
PSYCHIATRY CONSULTATION-LIAISON SERVICE

Hospital Sites with Psychiatry CL
- PUM/MUH
- Select Specialty
- Magee
- Shadyside Hospital
- St. Margaret’s
- Passavant/Cranberry
- UPMC East
- Horizon (telepsychiatry consults)
- Jameson Hospital (to start likely in 2017)
- Mercy, McKeesport, Sewickley, etc – Under Dr. Manish Sopra

Psychiatry Consultation Services
Year-Round:
- Approximately 20 attending psychiatrists
- 11 nurse clinicians
- 3 office staff members
- 2 Psychosomatic Medicine fellows
**Psychiatry Consultation Services**

- Attending who work year-round (weekdays)
- Variable in FTE (10%-80%)
- Cross-coverage at outside hospitals
- Nurses who work year-round
- Residents work 10-week blocks
- See new cases on weekends
- Moonlighting resident back-up for follow-ups
- Students work 5-week blocks
- Casual RNs to target nursing PTO

**PM Education**

- Fellowship Director: Pierre Azzam, MD
- Resident Education: Priya Gopalani, MD
- Director of Medical Student Clerkship: Julie Graziano, MD
- Geriatric Fellowship: Sharon Altman, MD
- Family Medicine: Stephanie Richards, MD
- Psychosomatic Medicine Interest Group (Drs. Graziano, Azzam, Gopalani)
- Women’s Health Study Group (Drs. Glance and Gopalani)

**Reasons for Consultation**

- Anything you need help with!
- Depression
- Anxiety
- Adjustment
- Substance use
- DEC transfers
- WPIC transfers
- Anyone on a commitment
- Catatonia
- Trauma

Over 8000 consults per year
Challenges

What challenges might arise in a system this large?

- Workflow
- Resident/Student Experience
- Fellowship
- Weekend Coverage
- Vacation Coverage
- Handoff/Cross-Coverage
- Physician Morale
- Staff Morale and Retention
- Physician Recruitment
- CE Faculty/Academic Productivity
- Faculty Evaluations
- Hospital Admin/Culture
- High-Risk Patients
- High Utilizing Patients
- WPIC Transfers
- Medication Errors
- Documentation
- Billing
- Budget
- Data Collection
- Quality Clinical Care

Biggest Challenge

- Which would you say is the biggest challenge of this list and why?
The Challenge: Workflow & Systems-Based Practices

- Workflow management is under-taught in medicine
- Poor workflow management → dissatisfaction and burnout
- Areas of study:
  - Time on patient care, indirect patient contacts, administrative tasks, internal communications, simultaneous activities, interruptions (Machle et al)
  - Scheduling/registration, referrals, documentation, prescription-related activities, unscheduled tasks in an ambulatory practice (Rameiah et al)
  - Workarounds to disruptions at a trauma center (Kobayashi et al)
  - Workflow models for a medical emergency department (O'boshi et al)

Solution to Workflow Challenges

- Reduction in time for consult distribution by the central office
- Earlier assignment of cases in the day
- Holdover of routine late weekday consults
- Streamlining of documentation and transfer paperwork
- Eliminating superfluous documentation for all parties
- Compartmentalization of work responsibilities between graduate medical trainees and nurse clinicians (e.g., transfers)
Lessons Learned: Prioritize the Most Imminent

- Clinical care comes first
- Put out the fires as they arise
  - Changes to regulations
  - High risk/high utilizing patients
  - High census
  - Coverage
  - Deadlines often guide you

Lessons Learned: Respect Values

- Each hospital/administration/program has different values
- Learn what your system values
- Learn the financial structure (it’s important!)
- Respect the culture of the institution
- Listening and validating can go a long way!

Lessons Learned: Everything is Linked

Efficient workflow

Positive work environment

Better recruitment of trainees

Improved faculty/staff morale

Improved retention

Better education and service
The Challenge - Information

The Challenge

- Efficient exchange of accurate information
  - Person requesting the evaluation
    - Physician, nursing, family, pharmacy
  - Nursing staff
  - Medical Providers
  - Patient as a reliable informant
  - Relatives
  - Formulating a diagnosis and plan

Evaluating patients at NH
Evaluating patients at NH

- Understand the question
- Find the right person
- Look in the right place

Evaluating patients at a NH

- Identify key people at each NH
  - Social worker
  - Nurse practitioners
  - Nursing Unit Managers

- Establish specific strategies to simplify obtaining information
  - Nursing staff printing MAR
  - Emphasize the need to complete the entire consult request
Evaluating patients at the NH

- Identify consistent sources of information at different facilities
  - PowerChart
  - Vision
  - Paper chart
- Attempt to contact family when ever possible to obtain collateral and discuss plan

Evaluating patients at the NH

- Maintain open lines of communication with other providers
  - PCP
  - Gastrointestin
  - PA / CRNP
  - Pharmacy
  - PT/OTT/Speech

Conclusions

- Obtaining adequate information at the nursing home can be challenging but is not impossible
- Identify key people
- Taylor the use of resources depending on the facility
- Communicate with staff and other providers regularly
- Contact the family whenever possible
Adult Integrated Ambulatory Behavioral Health Service

Ellen M Whyte, MD
Medical Director
Adult Integrated Ambulatory Behavioral Health Service
UPMC Benedum Geriatric Center, Psychiatric Services
Assistant Professor of Psychiatry

WPIC INTEGRATED AMBULATORY BEHAVIORAL HEALTH SERVICE

Abigail Schlesinger MD  Medical Director, Integrated Ambulatory Beh Health
Ellen Whyte MD          Medical Director (Adult)
Barbara Nightingale MD  Associate Medical Director (Adult)
Monique Jackson MA      Director, Ambulatory Services
Jack Cahalane PhD, MPH  Chief, Adult Services

Adult Integrated Behavioral Health Service

Goal: Embed a behavioral health team within the primary care setting to provide time limited services to moderately ill patients in collaboration with the primary care team.

The embedded behavioral health team includes
➢ A Behavioral Health Specialist (LCSW)
➢ A Psychiatrist (in person or by phone).
Adult Integrated Behavioral Health Service

Service started in March 2015.

As of October 1 2016:
- 2 CMI Hubs (20,000+ covered lives per hub)
- 3 PC practices
- 5.5 FTE Behavioral Health Specialists
- 0.5 FTE Psychiatrists


Solution
Cultural Anthropology

Anthropology: the study of humans within societies.

Culture: a "complex whole which includes knowledge, beliefs, art, morals, law, customs and any other capabilities and habits acquired by man as a member of society." [E.B. Tylor]
Unexpected consequences...
...when the PC team does not understand the world of Behavioral Health:

- The embedded BH team can do EVERYTHING!
  - Everything BH is 'owned' by the BH team (NON-collaborative care)
  - Concern that some patients are referred out of the model
  - Nebulous reasons for referral

The Culture of Primary Care

- Caring for the whole person
- Caring for the entire family
- Less rigid boundaries
- Time pressures: brief appointments, walk-ins

Unexpected consequences...
...when the BH team did not initially understand about working in the world of Primary Care:

- Write long notes using 'psychobabble'
- Select goals that did not fit the short term model
- Focus exclusively on the patient in front of us
- BH treatment of staff or their immediate families
Bridging the Cultural Divide

De-mystifying BH through Education

Formal

➢ Mid-Atlantic Geriatric Workforce Education Program (PI: Schultz, HRSA U1Q HP208766-02)
➢ ADHD in Adults (in development)

Informal

➢ curbside consultation
➢ brief educational patient notes

Bridging the Cultural Divide

Solicit regular feedback from our PC colleagues

Formal

➢ Annual program review

Informal

➢ Anytime and Anywhere

Thank You.
BREAKOUTS - SESSION II
BREAKOUT 2A: MAKING WPIC MORE WELCOMING: DIVERSITY, INCLUSION, AND ACCEPTANCE

Session Chair: Jason Rosenstock, MD

Session Leaders: Camellia Herisko, DNP, MSN, RN, PMHCNS-BC, CRNP and Jason Rosenstock, MD

Presentation: Introduction/Overview
Jason B. Rosenstock, MD
Associate Professor of Psychiatry, University of Pittsburgh School of Medicine

Camellia Herisko, DNP, MSN, RN, PMHCNS-BC, CRNP
Vice President of Patient Care Services, Western Psychiatric Institute and Clinic of UPMC

Presentation: System-Wide Perspective
James E. Taylor, PhD
Chief Diversity & Inclusion Officer, UPMC

Presentation: Diversity/Inclusion at WPIC
Carol Van Zile, LCSW
Director, Regulatory Compliance, Western Psychiatric Institute and Clinic of UPMC

Presentation: Stigma/Acceptance of Patients
Hader Mansour, MD
Assistant Professor of Psychiatry, University of Pittsburgh School of Medicine

How can we accept people different than us, especially our patients? We struggle with inclusion, even though we know the importance. And at WPIC, we know that our patients face incredible stigma just for having a behavioral health issue—providers both outside of and within WPIC may have negative attitudes towards people with “differences” that affect care and teaching. In this session, we will explore how difference impacts our workplace for patients and trainees, and we will examine strategies that we can utilize that can make WPIC more welcoming and accepting of diversity.

Learning Objectives: By the end of this session, participants will be able to:

1. Summarize the importance of culture and inclusion for both patients and trainees.
2. Identify ways that UPMC in general and WPIC in particular can be more welcoming to a diverse population.
3. Describe institutional resources and programs that will help professionals in creating a climate of inclusion throughout, particularly fighting against the stigma of mental illness.
Making WPIC More Welcoming: Diversity, Inclusion, and Acceptance

WPIC Clinician Educator Showcase
October 20, 2016

Organizers
- Cami Herisko, DNP, MSN, RN, FMHCA-BC, CRNP
- Jason Rosenstock, MD

Featured Speakers
- James E. Taylor, PhD
- Carol VanZile, LCSW
- Hader Mansour, MD

Learning objectives
By the end of this session, participants will be able to:

1. Appreciate the importance of culture and inclusion for both patients and trainees
2. Identify ways that UPMC in general and WPIC in particular can be more welcoming to a diverse population
3. Describe institutional resources and programs that will help professionals in creating a climate of inclusion throughout, particularly fighting against the stigma of mental illness
Session Overview

UPMC: Serving a Diverse Population

James E. Taylor, PhD
Chief Diversity and Inclusion Officer,
UPMC
taylorje@upmc.edu

Simply put, diversity is how we achieve our mission and grow our business.
Our Beliefs About Diversity & Inclusion

- Diverse employee representation at all levels can help ensure that we have the knowledge, critical thinking, and innovation required of a leading integrated health care delivery system.
- Demographic epidemiological variations exist across racial and ethnic groups in terms of vulnerability and health risks, incidence, and prevalence rates of a variety of chronic conditions.
- Shifting demographic trends are forcing health care delivery systems to assess their marketing, service, and product delivery, and human resource strategies to remain competitive in the changing labor and consumer markets.
- The median age of populations of color is more than 10 years younger than the majority population and comprises a greater proportion of the young, healthy segment of our communities.
- Diversity management will prepare us to respond appropriately to the increasing demands of state and federal efforts aimed at health care reform, thereby facilitating compliance and reducing legal liability.

UPMC Diversity & Inclusion Agenda

- Workforce Balance - Enhance the diversity and culture awareness skills of our employees
- Healthcare provider - Enhance cultural understanding and awareness in our patient care for the needs of our increasingly diverse patient population
- Diversity - Develop the health status of those who are not served or the underserved in our region
- Patient Placement - Ensure our patient placement is reflective of the demographics of the region

Workforce
UPMC Human Capital Profile

[Diagram of workforce demographics]
The "Most" Lists...

WPIC:
Serving a Diverse Population

Carol Van Zile, LCSW
Director, Regulatory Compliance, WPIC
vanzilec@upmc.edu

WPIC: Serving a Diverse Population

GOLDEN RULE.
• Treat others the way you want to be treated.

PLATINUM RULE*.
• Treat others the way they want to be treated.

WPIC: Serving a Diverse Population

- Awareness is the Key to Change:
  - Training
  - Environment
  - Best Practices
  - Culture-specific knowledge
- Build Relationships:
  - Ask, don’t assume
  - Learn what you don’t know
- Making Change Happen:
  - New opportunities
  - Vision for the future
  - Available, Accessible, & Acceptable Mental Health Services

Stigma and Mental Illness

Hader Mansour
Assistant Professor of Psychiatry
mansourha@upmc.edu

Stigma: A mark of disgrace/discredit

Def: The process by which the reaction of others spoils normal identity. These reactions come from prejudgment of a person based on limited information (Goffman 1963)

- A broad term which is used to describe the negative and stereotypical thoughts, attitudes, and feelings about people on the basis of the traits of a person
- A process whereby certain individuals/group are unjustifiably rendered shameful, excluded and discriminated against (WHO, 2002)
Stigma in Psychiatry

- Individuals with mental illness have the dual burden of coping with the symptoms of the mental illness as well as the societal stigmatization of their illness
- Social stigma vs Perceived stigma/Self
- Overt stigma vs Subtle stigma

Stigma can be towards

- Individuals/groups
  - Religion
  - Color
  - Race
  - Sexual orientation
- Diagnoses
  - Schizophrenia
  - Mental retardation
  - Substance use
  - Anxiety
  - Depression
  - Dementia
  - Personality disorder
Causes

- Ignorance/misconceptions
- Media
- Diagnosis

Burden

Self
- Shame and low self-esteem
- Isolation and hopelessness
- Refusal of treatment

Burden

Friendships/Intimate Relationships
- Divorce/separation
- Disappearance of friends

Home
- Negative reactions by family e.g. lazy/weak
- No home, high rates of homelessness
- Neighbourhood reactions to residential care

Work
- Loss of job/lack of employment
- Lower rate of pay
- Likely to be bullied/harassed

Health Care
- Lack of motivation to seek help for fear of stigma
- Labelled certain diagnoses
Challenging stigma

- Education
- Contact
- Protest

Fighting stigma: NAMI

- Talk openly about mental health
- Educate yourself and others about mental health
- Be conscious of your language
- Encourage equality in how people perceive physical illness and mental illness
- Show empathy and compassion for those living with a mental health condition
- Stop the criminalization of those who live with mental illness
- Push back against the way people who live with mental illness are portrayed in the media
- See the person, not the illness
- Advocate for mental health reform

Coping with stigma

- Remember you - are NOT your illness
- Remember - treatment works
- Remember - you are not alone
Discussion

Conclusions

- Diversity and inclusion are crucially important for our health system and hospital/clinic; if we want to appropriately serve the people of our community.

- The "platinum rule" should guide our interactions with patients and families at WPRC, a way of insuring culturally competent care.

- Be aware of differences, don't assume, and ask questions.

- Patients with behavioral health conditions face significant stigma that we must acknowledge and help fight against to improve outcomes.
MENTORING CLINICIAN EDUCATORS – YOUR ROLE ON THE TEAM

Session Chair: Alexis Fertig, MD, MPH
Session Leaders: Alexis Fertig, MD, MPH, Karen Matthews, PhD and Jody Glance, MD
Presentation: Overview of Mentoring Roles
Karen A. Matthews, PhD
Distinguished Professor of Psychiatry and Professor of Psychology and Epidemiology
University of Pittsburgh School of Medicine

Presentation: Mentoring in Action
Alexis M. Fertig, MD, MPH
Assistant Professor of Psychiatry, University of Pittsburgh School of Medicine

Josh Hefferen, MSW
Program Director, Center for Children and Families, Western Psychiatric Institute and Clinic of UPMC

Presentation: Guided Self-Reflection and Small Group Discussion

This breakout session will provide an overview of the various roles that mentors have when working with mentees. Speakers will give examples of their work with mentees to illustrate mentoring in different settings of an academic medical center. Participants will be given an opportunity to evaluate their own roles as mentors and brainstorm ways they can improve and/or expand on their mentoring.

Learning Objectives: By the end of this session, participants will be able to:

1. Discuss the different roles a mentor can have.
2. Understand their own strengths as a potential mentor.
3. Recognize the variety of opportunities to serve as a mentor in an academic medical center.
Mentoring Clinician Educators:  
Your Role on the Team

Overview of Session

- Overview of mentoring roles and principles of good mentoring, Karen Matthews, Ph.D.
- Illustrations of mentoring in action:  
  Alexis Fertig, M.D. with C/E faculty  
  Jody Glance, M.D. with residents  
  Josh Hefferen, LCSW with therapists  
- General discussion
Origins of Mentor

- In Greek mythology, Mentor was a friend of Odysseus who placed Mentor in charge of his son, Telemachus, when Odysseus went to war.
- Mentor encouraged Telemachus to stand up against the suitors of his mother and find his father.
- (Mentor really was Athena!)
- Mentor has been adopted to mean someone who imparts wisdom and shares knowledge with less experienced colleagues.
- First use of term in a 1699 book by French writer Francois Fenelon with lead character of Mentor.

What roles can the mentoring team fill?

(adapted from Audrey J. Murrell, Katz School of Business)

- Coach – Skill development
- Supporter – Validation of mentee’s contributions
- Protector – Buffer for negative outcomes
- Networker – Linking mentee to others
- Sounding board – Providing guidance
- Sponsor – Support for advancement
- Investor – Provides "stretch" opportunities
- Role model – Positive example
How best to fill the mentoring roles?

"I'd like to mentor you. We can start by you getting me some coffee."

K. Spear

How best to fill the mentoring roles?:
A few ideas

- Be available
- Actively listen and ask questions
- Give positive feedback and constructive criticism
- Help to track progress and formulate goals
- Be aware of one's own strengths and weaknesses
Being a good mentor

- Know yourself
- Know your mentee
- Know parameters of the relationship

Stages of Mentoring Relationship (Kram 1985)

- Initiation
- Cultivation
- Separation
- Redefinition
General Discussion

- What skills have been useful?
- What are the barriers to successful mentoring?
- What are the costs and benefits of mentoring?
BREAKOUT 2-C: NOVEL APPLICATIONS OF TECHNOLOGY TO ENHANCE PSYCHIATRIC TREATMENT IN MEDICAL SETTINGS

Session Chair: James Tew, Jr., MD
Session Leaders: James Tew, Jr., MD and Michael Marcisyn, MD

Presentation: Introduction
James D. Tew, Jr., MD
Associate Professor of Psychiatry, University of Pittsburgh School of Medicine

Presentation: Novel Applications of Technology to Enhance Psychiatric Treatment in Medical Settings
Eva Szegedy, MD, PhD
Associate Professor of Psychiatry, Pediatrics, and Medicine
University of Pittsburgh School of Medicine

Miguel Regueiro, MD, AGAF, FACP
Professor of Medicine at the University of Pittsburgh School of Medicine

Mark Stabingas, BA, MBA
Executive Vice President, UPMC Enterprises

Brief Technology Demonstration of AUGR Application
Shivdev Rao, MD
Assistant Professor of Medicine, University of Pittsburgh School of Medicine
Vice President of Innovation, UPMC Enterprises

Individuals with comorbid inflammatory bowel disease and psychiatric illness are amongst the highest health-service utilizers in the UPMC System. Frequently, their numerous contacts with the medical system are costly, and personally dissatisfying. Dr. Szegedy (Psychiatry) and Dr. Rao (Internal Medicine), with the support of UPMC Enterprises, have partnered to develop a comprehensive medical home for this population. The model combines physician-led mid-level provider interventions with “Smartphone App” real-time patient tracking technology. With this approach, they monitor their patients and provide meaningful interventions and guidance as their patients move through our complex healthcare delivery system. In what may eventually become a standard strategy for complex disease management, their goal is to improve the patient experience, control costs, and reduce unnecessary tests and procedures.

Learning Objectives: By the end of this session, participants will be able to:

1. Describe basic concepts of decision theory and how clinicians assess and respond to risk.
2. Articulate how ‘optimal risk’ assessment can vary depending on the clinical environment and resources available where the assessment takes place.
3. Explore the challenges of balancing patient autonomy with risk tolerance.
Novel Applications of Technology to
Enhance Psychiatric Treatment in
Medical Settings

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Objectives:
1) Medical Home concept of care
2) How can technology enhance behavioral care?
3) Role of UPMC Enterprises in launching novel health care solutions

Medical Subspecialty Medical Home: Definition and Rationale

Personal physicians and their teams providing first contact and continuous care
- Team-building and behavioral education for entire team
- Quantify physical and behavioral complexity to tailor treatment tracks
- Best use of virtual technologies to enhance delivery with scalable quality
- Financial model for improving clinical quality and reducing costs

- 2 million Americans affected and incidence increasing (young age)
- Inflammation in the gastrointestinal tract
- Leads to bowel damage that may require surgery
- Life-long disease - treatment costly

An IBD medical economic whole-population cost model: a plan for the high outliers

30% of patients account for 75% of cost
Medical subspecialty home for whom?

- Inclusion criteria
  - UPMC HP Insurance with Crohn's or UC (n=3000)
  - 18 to 50 years of age
  - The primary need for their medical care is IBD

- > 50% of IBD patients have pain, stress, coping difficulties, anxiety/depression, and fatigue that lead to worsening disease course and increased healthcare utilization.

- IBD ranks as top three expensive medical diseases in most tertiary care medical centers due to relapsing remitting course, expensive medications, surgery AND unmet psychosocial needs.

Patient-centered subspecialty medical home?

- Use a team-approach to provide high quality, comprehensive, cost-effective healthcare to patients with IBD with heavy medical utilization yet poor outcomes (n=700)
- Integrated medical, behavioral, dietary, social services care at medical point of service
- Collaborating with our UPMC Health Plan (insurance payer) to couple a new collaborative model with health care payment reform strategies.
  - by decreasing utilization = return on investment

The IBD Medical Home Team

- Nurse practitioner (HP)
- Nurse Coordinator (HP)
- Dietitian (HP)
- Social worker (HP)
- Patient peer support team
- Schedulers
- Research Coordinator
- Psychiatrist (5 HP supported)
- Team Administrator
- Gastroenterologists
- Colorectal Surgeons
- Pain Specialists
- Nurse Liaison to Home – RACE
- Health Coach – Rx for Wellness
IBD Total Care Medical Home: Team-based, patient-centered, coordinated care

- Doctor
- Psychiatric
- Social worker
- Nurse and nurse practitioner

Keywords: Total Care, IBD, Patient Centered, Coordinated Care

UPMC

The IBD Model of Care: Collaboration and Coordination
Behavioral Targets

- *Psychiatric comorbidity*: Depression, anxiety, chronic pain, substance abuse (opioids)
- *Life*: Stress
- *Illness self-management*: Coping, perceptions, self-soothing

IBD Total Care- Baseline Patient Characteristics

- Total # 412
- Psychopathology
  - 24% depression
  - 38% anxiety
  - (40% have anxiety and or depression)
  - 60% self-reported pain (25% of total have chronic functional pain)
  - 15% opioids
- IBD Activity (active disease, surgical, IBD complications)
  - 26% highly active disease

CASE EXAMPLE (Heidi) “I can’t keep living with this much bowel pain”

- 44 year old female
- Crohn’s disease
- IBD Medication- Anti-TNF (biologic)
- On opioids—started at ER visit for abdominal pain
- Recent colonoscopy—mild IBD activity
- Chronic abdominal pain—constant
- No surgeries
- Currently depressed and poor sleep
- “I wish I was dead”
- Life stress—recent divorce
- Poor psychosocial support
- History of depression and panic attacks
- Previously on various, antidepressants
- No past behavioral therapy
### Understanding IBD Medical Home Patients: Complexity Grid (Kathol 2010)

<table>
<thead>
<tr>
<th>Domain</th>
<th>Complexity Item</th>
<th>Current State</th>
<th>Vulnerability</th>
</tr>
</thead>
<tbody>
<tr>
<td>Biological</td>
<td>Chronicity</td>
<td>Symptom</td>
<td>Complications and Life Threat</td>
</tr>
<tr>
<td></td>
<td>Diagnosis</td>
<td>severity/Impairment</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Dilemma</td>
<td>Diagnostic/Therapeutic challenge</td>
<td></td>
</tr>
<tr>
<td>Psychological</td>
<td>Mental Health Fix</td>
<td>Resistance to Treatment</td>
<td>Mental Health Threat</td>
</tr>
<tr>
<td></td>
<td>Barriers to coping</td>
<td>Mental Health symptoms</td>
<td></td>
</tr>
<tr>
<td>Social</td>
<td>Job and Leisure</td>
<td>Residence Stability</td>
<td>Social Vulnerability</td>
</tr>
<tr>
<td>Health System</td>
<td>Relationships</td>
<td>Social Support</td>
<td></td>
</tr>
<tr>
<td>Domain</td>
<td>Access to care</td>
<td>Getting needed services</td>
<td>Health System Impediments</td>
</tr>
<tr>
<td></td>
<td>Treatment</td>
<td>Coordination of care</td>
<td></td>
</tr>
</tbody>
</table>

### Development of Scoring Grid for UPMC IBD Complexity Grid Subscales

**IBD COMPLEXITY GRID SCORING ITEM EXAMPLES**

**BIOLOGICAL- Current**
- None
- Mild
- Moderate
- Severe
- Extreme
- Not assessed

**BIOLOGICAL-History**
- None
- Mild
- Moderate
- Severe
- Extreme
- Not assessed

**PSYCHOLOGICAL- Current**
- None
- Mild
- Moderate
- Severe
- Extreme
- Not assessed

**PSYCHOLOGICAL- History**
- None
- Mild
- Moderate
- Severe
- Extreme
- Not assessed

**TOTAL SCORE: 0-60**

### Mapping Complexity Scores to Determine: 1) Level of Care; 2) Focus of Care

**Level 1:** Score ≤ 20; **Low impact:** Routine IBD care; little need for comprehensive team, health coaching, education or help coming out of acute situation (inpatient stay); brief management involvement, Psychological issues stable. 
**GOAL:** PREVENTIVE

**Level 2:** Score 21-32; **Moderate impact:** Standard care management, physical, social, behavioral and health system domains; develop care plan with priorities based on subscores; assistance to patient in course and health system factors impeding appropriate care; untreated psychiatric comorbidity; social, coping, and health system challenges.
**GOAL:** REMISSION

**Level 3:** Score ≥ 33; **High impact:** extended care management with persistent, complex and multiple problems; long-term high service use; Complex clinical situation; concurrent physical and mental conditions with long-term service use.
**GOAL:** STABILIZATION
Case Example: Heidi
• 44 year old female with Crohn's disease x 8 years
• Chronic abdominal pain
• Intermittently compliant with IBD medication (biologic)
• 6 ER visits and 2 hospitalizations in past 6 months
• Escalating use of opioids
• Intake screening information:
  • Poor quality of life
  • High depression and anxiety severity
  • Mild IBD activity

TOTAL SCORE 94.

Treatment Targets

HEIDI'S OBSTACLES:
• IBD Medication Non-adherence (Knowledge Gap)
• Depression (Low Motivation)
• Passive coping with pain (Opioid as magic pill)
• Pessimistic illness perception (Catastrophizing)

TEAM OPPORTUNITIES:
• Strengthening medical decision-making skills
• Build strong therapeutic bond
• Motivational Interviewing
• Managing stress/emotions/cognitions/pain with CBT
• Role of psychotropics

Target Psychopathology: Stepped Behavioral Treatment

• OPTIONS FOR HEIDI
  Tele-medicine Availability
  Screening
  UPAC Health Coach
  Virtual Stress Management
  Social worker (Behavioral therapy)
  Psychiatric consultation (medications)

AXIS I Major Depression, moderate
Generalized Anxiety Disorder
Opioid Dependence
AXIS III IBD-IRritable Bowel Syndrome

HEIDI
• Extreme psychopathology
  Worried well
Problem

Patients get treated in emergency rooms and admitted to hospitals but their usual health care providers find out about these events after the fact. Patients get duplicate testing and inappropriate treatments because ER and hospital teams don’t know the patient history and nuances of care as well as their usual providers do. Unnecessary or unplanned care is wasted healthcare cost that can be reduced or eliminated if a patient’s usual providers are able to intervene in time with appropriate care recommendations.

Solution

Mobile alerts are proactively pushed to providers and care teams as soon as their patient enters an ER or hospital facility.
Solution
Relevant context about each patient & the ability to instantly act placed at every provider's fingertips.

Solution
Real time fine-grained data analytics for the entire care team to intuitively discover new insights and coordinate care better together.

IBD Total Care: Number of ER and Hospital Admissions Per Month
• AUGR data (number of events (not necessarily unique patients)}

Activates Total Care Treatment Pathways
Demonstration

Lantern – provides mobile, personalized CBT programs for stress/anxiety/sleep using web-based tools and non-clinical coaches to reinforce learning.
https://golantern.com/

Case Example: Heidi: 12 months post IBD Total Care Medical Home enrollment

Change in PERCENTAGE CONTRIBUTION of Complexity subscales over 12 months post IBD TDDCAL CARE MEDICAL HOME Enrollment

Total Complexity Score
From 54 to 25

Biggest contributor to clinical change is behavioral improvement

@Dr. Sue Shapiro is an employee of University of Pittsburgh Physicians, which is an affiliate of UPMC. UPMC has a financial interest in Tree Networks, Inc., which develops and commercializes the Lantern products and services.
**IBD Total Care Outcomes: Patient Distribution by Complexity Grid**

<table>
<thead>
<tr>
<th>Complexity Scores</th>
<th>Baseline (Total n=214)</th>
<th>9-12 month follow-up (n=214)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Green = 120</td>
<td>Green = 143</td>
<td></td>
</tr>
<tr>
<td>Yellow = 56</td>
<td>Yellow = 53</td>
<td></td>
</tr>
<tr>
<td>Red = 38 (18%)</td>
<td>Red = 18 (10%)</td>
<td></td>
</tr>
</tbody>
</table>

**Heidi: Value = Quality/Cost**

- Improving quality
  - Increased medical adherence
  - Reduced depression and anxiety
  - Increased pain control and decreased narcotic use
  - Increased quality of life and productivity

- Reducing costs
  - Reduced unplanned care (ER visits and hospitalizations)
  - Using behavioral interventions first then generic psychotropics and those on formulary
  - Coordinated care more efficient and scalable

**UPMC Enterprises — Commercialization Arm of UPMC**

UPMC partners with companies through commercialization agreements combined with strategic investments. In 2018 UPMC has contributed to five funding rounds, greater than $15 million, the companies involved in these rounds raised a combined total of more than $40 million.

By developing and investing in exceptional health care innovations, our team takes full advantage of the vast clinical, technical, and financial resources of UPMC in order to solve the most complex problems facing our industry, drawing from the more than 20,000 employees of UPMC Enterprises and the partner companies in the Pittsburgh region.
Working with UPMC Enterprises

UPMC Enterprises Domains
- Clinical Tools: Use data-driven and patient-centric clinical tools that influence care delivery.
- Population Health: Use data to manage risk and address new revenue models.
- Business Services & Infrastructure: Develop ways to use technology to streamline business processes, delivery, and improve operational efficiency.
- Consumer: Help meet how we engage with consumers to improve care & build relationships.

Partnering with UPMC Enterprises
- Discovery and Assessment:
  - Explore and define the problem space
- Threats Development:
  - Develop a unique perspective on solution leveraging UPMC
- Clinical Sponsorship:
  - Act as internal champion for funding support
- Product Development:
  - Engage with teams/company contributing expertise
- Clinical Validation:
  - Lead/support evidence generation strategy
- Advocacy and Scaling:
  - Serve as product/company evangelist, subject matter expert