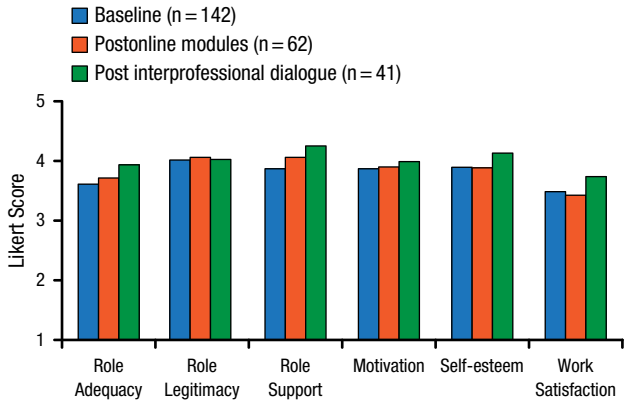
Figure 2. Drug and Drug Problems Perception Questionnaire Results



Reproduced with permission from KR Puskar, DrPH, RN.

The Interdisciplinary Education Perception Scale [Luecht RM et al. *J Allied Health.* 1990], an IPCP questionnaire, was also used to measure providers' perceptions of the interprofessional collaborative project and its importance. According to Dr Puskar, changes in scores from baseline to postdialogue showed that providers' perceptions of competence and autonomy improved as a result of the collaborative practice project, as did their perceptions of actual cooperation and their understanding of the value of others.

The Readiness for Interprofessional Learning Scale [Reid R et al. *Medical Education.* 2006] was also used, focusing on providers' attitudes to interprofessional learning with respect to teamwork, professional identity, and patient centeredness. Although scores on this questionnaire also improved from baseline to postdialogue, Dr Puskar indicated that the increases were not statistically significant.

Interprofessional education and practice therefore represent an effective way to strengthen substance use treatment capacity in rural areas. In her concluding remarks, Dr Puskar encouraged nurses to improve interprofessional communication, communicate with clients using SBIRT, communicate with team members, and suggest referrals when necessary.

VA Facility Upgrades Continuity of Mental Health Care

Written by Rita Buckley

The beneficial effects of postdischarge follow-up after inpatient hospitalizations have been documented [Kan CK et al. *Soc Psychiatry Psychiatr Epidemiol.* 2007], as has increased recidivism from lack of such care after discharge [Llgen MA et al. *Psychiatr Serv.* 2008].

Using this literature for evidence-based research, Linda I. Kaplan, RN, MSN, and Danielle Battinelli-Weng, RN, BSN, Veterans Affairs New York Harbor Healthcare System (VA NYHHS), Manhattan Campus, New York, New York, USA, presented a poster on a system-wide postdischarge initiative to improve continuity of care.

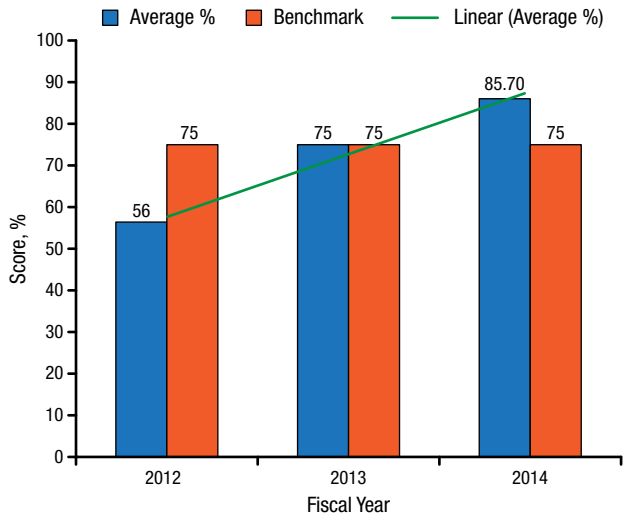
The 7-day follow-up is a Veterans Health Affairs (VHA) Performance Measure. It involves either seeing patients face-to-face or having in-depth telephone contact with them within 7 days of discharge. VA NYHHS's goal is to ensure continuity of care from the 17 North (17 N) inpatient admission process to the outpatient mental-health setting. This is part of the unit's effort to facilitate engagement and help veterans with psychiatric diagnoses make a successful transition to ongoing treatment in a less restrictive environment.

The VHA benchmark of 75% assures that appropriate interventions can be initiated in a timely manner if veterans clinically deteriorate due to nonadherence to medications and/or their treatment plan, or if they become a danger to themselves or others.

To meet the requirements of the VHA Performance Measure and ensure access to care within 7 days, 17 N adopted a 5-step program. Nursing staff educate patients from admission to discharge on the importance of outpatient follow-up care and the need to return or be contacted within 7 days of discharge. They then ensure that each patient has an active telephone number and is informed that they will be receiving postdischarge phone calls. A new spreadsheet for tracking the initiative was developed and slated for review by staff every day. Social workers on the 17 N unit call patients the day after discharge; if a social worker cannot reach the patient by phone, the case is handed off to the nursing staff, who continue to make calls. Evaluation of compliance with both postdischarge face-to-face provider meetings and telephone contact with patients is tracked on an ongoing basis.

The new procedures, which are best practices at other VHA facilities, were implemented in 2012. By the following fiscal year, VA NYHHS (17 N) exceeded the

Figure 1. 7-Day Mental Health Postdischarge Follow-Up: Fiscal Years 2012–2014



Reproduced with permission from LI Kaplan, RN, MSN.

benchmark for continuity of care with a score of 82%, a 26-point gain over results in 2012 (Figure 1).

This outcome demonstrates the importance of having psychiatric nurses educate and assist patients in adhering to their treatment plans. On the continuum of care, inpatient psychiatric treatment is only the first step toward recovery.

Nursing Intervention Could Promote Improvement in MetS Risk Factors

Written by Rita Buckley

Paula Bolton, MS, ANP-BC, McLean Hospital, Belmont, Massachusetts, USA, presented results from a study to determine if metabolic risk factors in patients diagnosed with serious mental illness (SMI) improved with motivational interviewing performed weekly and routine follow-up care.

Patients with major mental illnesses, such as schizophrenia and bipolar disorder, have an increased prevalence of metabolic syndrome (MetS) and its components (ie, risk factors for cardiovascular disease and type 2 diabetes). They lose 25 to 30 years of potential life in comparison with the general population, primarily due to premature cardiovascular mortality [Newcomer JW. *Am J Manag Care.* 2007]. The causes of increased cardiovascular risk in this population can include nondisease-related factors, such as poverty and reduced access to medical care, as well as adverse metabolic side effects associated with psychotropic medications, such as antipsychotic drugs.

In the study, initial patient screening was done for the presence of 2 risk factors for MetS; baseline waist circumference, vital signs, and biological measures (eg, triglycerides, glucose, high-density lipoprotein [HDL]). Once enrolled, participants completed a quality-of-life measure and developed a personalized health goal.

The intervention consisted of the following: (1) a weekly in-person meeting while hospitalized, and weekly telephone contact postdischarge, with a psychiatric nurse to discuss progress toward health goals utilizing motivational interviewing; (2) nurse practitioner visits for health assessment (physical examination) at postdischarge weeks 2, 6, 10, 14, and 18; (3) a psychiatric nurse visit immediately following for measurement of perceived progress toward health goals and motivational coaching; and (4) evaluation of biological measures at weeks 10 and 18 (eg, glucose, triglycerides, and HDL).

Thirty-eight patients (23 men, 15 women) aged 18 to 55 years enrolled in the study; of those, 11 completed it (28.9%). Measures included physiologic variables (blood pressure, weight, waist circumference, fasting glucose, and fasting lipids), Healthy Days Health-Related Quality of Life [CDC BRFSS Questionnaire. 2009], and the *My Progress Toward Goal* Semantic Differential Scale.

Those who completed the study were able to lose or maintain weight over the course of the research; 3 of them were also successful in smoking cessation. There were, however, only small improvements in some MetS risk factors and no change in others. For several weeks following discharge, most patients continued to have significant psychiatric symptoms, which were potential barriers to participation as well as to progress toward health goals. Lack of motivation, anhedonia, and poor decision-making skills were constant obstacles.

Despite these challenges, outpatient case management by nurses for those with SMI who are at risk for medical problems may provide needed psychosocial support and integration of medical and psychiatric care. At the same time, it can help patients navigate the health care system. All participants viewed the weekly telephone calls from the research nurse as helpful.

Longer-term studies need to be developed for this vulnerable patient population. Individuals with SMI are at high risk emotionally and medically, and thus require more support for longer periods of time to address medical issues related to MetS.