Professionals in Epilepsy Care Symposium
Interprofessional Models and Collaborative Care

Symposium Co-Chairs:

Gigi Smith, Ph.D., MSN, CPNP

and

Janelle Wagner, Ph.D.

Saturday, December 5, 2015
Convention Center – Grand Ballroom AB

5:30 – 8:00 p.m.

GENERAL INFORMATION

Accreditation

The American Epilepsy Society is accredited by the Accreditation Council for Continuing Medical Education (ACCME) to provide continuing medical education for physicians.

Credit Designation

Physicians

The American Epilepsy Society designates this live activity for a maximum of 30.75 *AMA PRA Category 1 Credits*™. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

Physician Assistant

AAPA accepts certificates of participation for educational activities certified for *AMA PRA Category 1 Credit*™ from organizations accredited by ACCME or a recognized state medical society. Physician assistants may receive a maximum of 30.75 hours of Category 1 credit for completing this program.

Jointly provided by AKH Inc., Advancing Knowledge in Healthcare and the American Epilepsy Society.

Nursing

AKH Inc., Advancing Knowledge in Healthcare is accredited as a provider of continuing nursing education by the American Nurses Credentialing Center's Commission on Accreditation.

This activity is awarded 30.75 contact hours.

Nurse Practitioners

AKH Inc., Advancing Knowledge in Healthcare is accredited by the American Association of Nurse Practitioners as an approved provider of nurse practitioner continuing education. Provider Number: 030803. This program is accredited for 30.75 contact hours which includes 8 hours of pharmacology. Program ID #21547

This program was planned in accordance with AANP CE Standards and Policies and AANP Commercial Support Standards.

Pharmacy

AKH Inc., Advancing Knowledge in Healthcare is accredited by the Accreditation Council for Pharmacy Education as a provider of continuing pharmacy education.

Select portions of this Annual Meeting are approved for pharmacy CE credit. Specific hours of credit for approved presentations and Universal Activity Numbers assigned to those presentations are found in the educational schedules. Criteria for success: nursing and pharmacy credit is based on program attendance and online completion of a program evaluation/assessment.

If you have any questions about this CE activity, please contact AKH Inc. at service@akhcme.com.

International Credits

The American Medical Association has determined that non-U.S. licensed physicians who participate in this CME activity are eligible for *AMA PRA Category 1 Credits*™.

CME/CE Certificates

For those attendees who wish to claim CME or CE, there is an additional fee. Registrants can pay this fee as part of the registration process. Those who do not pre-purchase the credit will also have the ability to pay this fee at the time they attempt to claim credit. Fees for CME increase after January 16 and are a one-time charge per annual meeting.

The evaluation system will remain open through Friday, February 26, 2016. Evaluations must be completed by this date in order to record and receive your CME/CE certificate.

Member Fees:	$50 through January 15, 2016 $75 January 16 – February 26, 2016
Non-member Fees:	$75 through January 15, 2016 $100 January 16 – February 26, 2016

Attendance Certificate/International Attendees

A meeting attendance certificate will be available at the registration desk for international meeting attendees on Tuesday, December 8.

Policy on Commercial Support and Conflict of Interest

The AES maintains a policy on the use of commercial support, which assures that all educational activities sponsored by the AES provide in-depth presentations that are fair, balanced, independent and scientifically rigorous. All faculty, planning committee members, moderators, panel members, editors, and other individuals who are in a position to control content are required to disclose relevant relationships with commercial interests whose products relate to the content of the educational activity. All educational materials are reviewed for fair balance, scientific objectivity and levels of evidence. Disclosure of these relationships to the learners will be made through syllabus materials and the meeting app.

Disclosure of Unlabeled/Unapproved Uses

This educational program may include references to the use of products for indications not approved by the FDA. Faculty have been instructed to disclose to the learners when discussing the off-label, experimental or investigational use of a product. Opinions expressed with regard to unapproved uses of products are solely those of the faculty and are not endorsed by the AES.

OVERVIEW
Recent research and practice recommendations include that health professionals must work collaboratively to improve the delivery of care and outcomes for patients and families (RWJ, 2011). Interprofessional competency domains that all health care providers must address, including values/ethics for interprofessional practice, roles/responsibilities, interprofessional communication and teams and teamwork (IPEC, 2011). The IOM Report on epilepsy includes the recommendation to research and develop a quality framework for epilepsy care to increase access to care, quality of life and health outcomes (England et al., 2012). This symposium will present recent research and practice evidence regarding how providing interprofessional care assists health care teams to provide comprehensive lifespan care for persons with epilepsy and their families. Examples of existing interprofessional models of care will be reviewed in populations such as children, adolescents, adults and veterans. In addition, possible interventions to accommodate lack of resources and funding for interprofessional care models will also be addressed.

LEARNING OBJECTIVES
Following participation in this symposium, learners should be able to:

- Define interprofessional care collaboration and competencies
- Evaluate existing interprofessional models of care for patients and families with epilepsy
- Consider the development of strategies to meet specific patient/family care needs by optimizing patient care by using the unique and complementary abilities of all members of the team in an epilepsy center or community setting

TARGET AUDIENCE
Basic: Those new to epilepsy treatment or whose background in the specialty is limited, e.g., students, residents, general physicians, general neurologists and neurosurgeons, other professionals in epilepsy care, administrators.

Intermediate: Epilepsy fellows, epileptologists, epilepsy neurosurgeons, and other providers with experience in epilepsy care (e.g., advanced practice nurses, nurses, physician assistants), neuropsychologists, psychiatrists, basic and translational researchers.

Agenda
Co-chairs: Gigi Smith, Ph.D., MSN, CPNP and Janelle Wagner, Ph.D.

Introduction
Janelle Wagner, Ph.D.

A model of Integrated Behavioral Health
Shanna Guilfoyle, Ph.D.

Using medical Homes and Telehealth to Reach Pediatric Epilepsy Patients
Rick Boyle, M.S.Ed.

Caring for Individuals with Epilepsy and Developmental Disabilities: Collaborations with Developmental Behavioral Pediatrics
Jane Charles, M.D.

Collaborative Care of the Epilepsy Patient in the VA System
Karen Parko, M.D.

Conclusions
Gigi Smith, Ph.D., MSN, CPNP

Faculty Panel – All Faculty

Education Credit
2.5 CME Credits

Nurses may claim up to 2.5 contact hours for this session.

Pharmacy Credit
AKH Inc., Advancing Knowledge in Healthcare approves this knowledge-based activity for 2.5 contact hours (0.25 CEUs). UAN 0077-9999-15-033-L01-P. Initial Release Date: 12/5/2015.

The American Board of Psychiatry and Neurology has reviewed the Interprofessional Models and Collaborative Care Symposium and has approved this program as part of a comprehensive program, which is mandated by the ABMS as a necessary component of maintenance of certification.

Commercial Support Acknowledgement
Supported in part by educational grants from Eisai Inc., UCB, Inc., and Acorda Therapeutics.

FACULTY/PLANNER DISCLOSURES
It is the policy of the AES to make disclosures of financial relationships of faculty, planners and staff involved in the development of educational content transparent to learners. All faculty participating in continuing medical education activities are expected to disclose to the program audience (1) any real or apparent conflict(s) of interest related to the content of their presentation and (2) discussions of unlabeled or unapproved uses of drugs or medical devices. AES carefully reviews reported conflicts of interest (COI) and resolves those conflicts by having an independent reviewer from the Council on Education validate the content of all presentations for fair balance, scientific objectivity, and the absence of commercial bias. The American Epilepsy Society adheres to the ACCME's Essential Areas and Elements regarding industry support of continuing medical education; disclosure by faculty of commercial relationships, if any, and discussions of unlabeled or unapproved uses will be made.

FACULTY / PLANNER BIO AND DISCLOSURES
Georgette Smith, PhD, APRN, CPNP (Co-Chair)
Gigi Smith is an Associate Professor and the Associate Dean for Academics at the Medical University of South Carolina. Dr. Smith specializes in the care and research of children with epilepsy at the Comprehensive Epilepsy Center at MUSC. She is a co-investigator on a quality of life study in children with epilepsy and a CDC study on co-morbidities in epilepsy. She is also PI on a number of nursing educational grants.

Dr. Smith has indicated she has no financial relationships with commercial interests to disclose.

Janelle Wagner, Ph.D. (Co-Chair)
Dr. Wagner is a Research Associate Professor at the Medical University of SC. Dr. Wagner's program of research focuses on models of pediatric epilepsy perceptions, depression screening, and self-management intervention. She has been funded as PI by the national Epilepsy Foundation, Parents Against Childhood Epilepsy, and AES. She has also participated as a Co-I on three CDC funded epidemiological studies of epilepsy related outcomes and comorbidities. Dr. Wagner has 50+ peer-reviewed publications serves on national and international epilepsy task forces and committees.

Dr. Wagner has indicated she has no financial relationships with commercial interests to disclose.

Rick Boyle, M.S.Ed.
Currently, Rick is the Special Projects Director for the Epilepsy Foundation Western/Central PA. Over thirty years of experience in the fields of public education and human services in the areas of program development/implementation, training, technical assistance, advocacy and direct support for persons with a variety of disabilities and medical conditions. Areas of emphasis have included: epilepsy/seizure disorder, interagency collaboration, positive behavior support, secondary transition, person/family-

centered planning, building community partnerships, vocational rehabilitation and supported employment. Participation in a variety of local, statewide, and national committees and advisory boards.

Mr. Boyle has indicated he has no financial relationships with commercial interests to disclose.

Jane Charles, M.D.
Developmental/Behavioral pediatrician at the Medical University of South Carolina in Charleston, SC for 25 years. Main interests: autism spectrum disorders, intellectual disabilities across the lifespan.

Dr. Charles has indicated she has no financial relationships with commercial interests to disclose.

Shanna Guilfoyle, Ph.D.
Dr. Guilfoyle is faculty in the Division of Behavioral Medicine and Clinical Psychology at Cincinnati Children's Hospital Medical Center and an assistant professor within the Department of Pediatrics at the University of Cincinnati College of Medicine. Her primary research foci include 1) psychological comorbidities associated with pediatric epilepsy, and 2) family functioning to optimize pediatric epilepsy adherence and management. Dr. Guilfoyle provides clinical care within the New Onset Seizure Clinic as part of the Comprehensive Epilepsy Center to address psychological comorbidities and adherence barriers to pediatric epilepsy management. Multiple publications have demonstrated the benefits of integrated behavioral medicine services.

Dr. Guilfoyle has indicated she has no financial relationships with commercial interests to disclose.

Karen Parko, M.D.
Dr. Karen L. Parko is a Professor of Neurology at the University of California, San Francisco (UCSF), and the former National Director of the Veterans Affairs Epilepsy Centers of Excellence. She is a retired Commissioned Officer from the United States Public Health Service (USPHS). Dr. Parko's career focus has been on improving epilepsy care in disadvantaged populations.

Dr. Parko has indicated she has no financial relationships with commercial interests to disclose.

CME Reviewers
Sucheta Joshi, M.D.
I am trained as a Pediatric Neurologist and Epileptologist, and have a Masters in Clinical Research Design and Statistical Analysis. My clinical interests include caring for infants and children with difficult to treat epilepsy, and to improve access to care for underserved children. I am the Clinical Lead for the Pediatric Epilepsy Telemedicine Program in Michigan, which aims to improve access to care for children with epilepsy, using a medical home model. I am the Medical Director for the National Co-ordinating Center of the American Academy of Pediatrics for Children and Youth with Epilepsy. I am a co-investigator in the Pediatric Epilepsy Research Consortium (PERC), a multicenter group to study the rare pediatric epilepsies.

Dr. Joshi has indicated she has no financial relationships with commercial interests to disclose.

Jack Lin, M.D.
Dr. Jack Lin is an Associate Professor and the Director of the Comprehensive Epilepsy Program at the University of California, Irvine. Using advanced neuroimaging techniques, his research has uncovered neurodevelopemental impacts of new-onet pediatric epilepsies, examined brain network alterations associated with mood disorders in temporal lobe epilepsy, and delineated relationships between brain structural changes and cognitive deficits in a wide range of epilepsy syndromes. He serves as a a grant reviewer for the Epilepsy Foundation, an Ad hoc reviewer for many journals, a member of editorial board of Epilepsy and Behavior, member of several committees at the American Epilepsy Society

Dr. Lin discloses receiving support as Speakers Bureau from UCB and Sunovion Pharmaceuticals.

Jay Salpekar, M.D.
Jay Salpekar, M.D. is Director of the Neuropsychiatry in Epilepsy Program at Kennedy Krieger Institute, and on the full time faculty of Johns Hopkins University Medical School. He received B.A. and M.D. from Washington University in St. Louis and continued at Barnes Hospital for psychiatry residency. He completed a child and adolescent psychiatry fellowship at Yale University. Dr. Salpekar has over 70 publications including journal articles, abstracts, editorials, and book chapters. He is a reviewer for a dozen scientific journals and grant review panels, and serves on the editorial board for Epilepsy and Behavior. He is active in the American Epilepsy Society, American Neuropsychiatric Association, and the Epilepsy Foundation.

Dr. Salpekar has indicated he has no financial relationships with commercial interests to disclose.

Paul Levisohn, M.D. (Medical Content Specialist, AES)
Dr. Levisohn is a member of the faculty of the section of Pediatric Neurology at The University of Colorado School of Medicine and Children's Hospital Colorado Neuroscience Institute, having joined the faculty over 15 years ago following a similar period of time in the private practice of pediatric neurology. His academic career has focused on clinical care for children with epilepsy with particular interest in clinical trials and on the psychosocial impact of epilepsy. Dr. Levisohn is currently a consultant on medical content for CME activities to staff of AES. He is a member of the national Advisory Board of EF and has been chair of the advisory committee for the National Center of Project Access through EF.

Dr. Levisohn has indicated he has no financial relationships with commercial interests to disclose.

AKH STAFF / REVIEWERS
Dorothy Caputo, MA, BSN, RN (Lead Nurse Planner) has indicated she has no financial relationships with commercial interests to disclose.

Bernadette Marie Makar, MSN, NP-C, APRN-C (Nurse Planner) has indicated she has no financial relationships with commercial interests to disclose.

John P. Duffy, RPh, B.S. Pharmacy (Pharmacy Reviewer) has indicated he has no financial relationships with commercial interests to disclose.

AKH staff and planners have nothing to disclose.

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Nursing and Pharmacy credit (per session) is based on attendance as well as completion of an online evaluation form available at:

WWW.AKHCME.COM/2015AES

THIS MUST BE DONE BY JANUARY 15, 2016 TO RECEIVE YOUR CE CREDIT.
We cannot submit credit to NABP after this date.
If you have any questions, please contact AKH at service@akhcme.com.

DISCLAIMER
Opinions expressed with regard to unapproved uses of products are solely those of the faculty and are not endorsed by the American Epilepsy Society or any manufacturers of pharmaceuticals.

Professionals in Epilepsy Care Symposium: Interprofessional Models and Collaborative Care

Janelle L Wagner, PhD
Research Associate Professor
College of Nursing, Department of Pediatrics
Medical University of South Carolina

MUSC
MEDICAL UNIVERSITY of SOUTH CAROLINA

December 5, 2015

Disclosure

Nothing to disclose

Symposium Learning Objectives

- Define interprofessional care collaboration and competencies.
- Evaluate existing interprofessional models of care for patients and families with epilepsy.
- Consider the development of strategies to meet specific patient/family care needs by optimizing patient care by using the unique and complementary abilities of all members of the team in an epilepsy center or community setting.

Interprofessional Collaborative Practice

- "When multiple health workers from different professional backgrounds work together with patients, families, carers, and communities to deliver the highest quality of care."
  World Health Organization (2010)

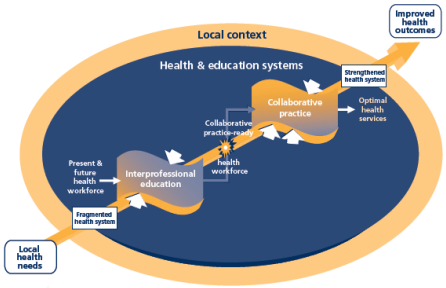
Interprofessional Team-based Care

- Care delivered by intentionally created, usually relatively small work groups in health care, who are recognized by others as well as themselves as having a collective identity and shared responsibility for a patient or group of patients
  Interprofessional Education Collaborative Expert Panel (2011)

Goal of Interprofessional Education Efforts

- Prepare all health professionals for ***deliberately*** working together with the common goal of building a safe and better patient-centered and community/ population oriented health care system.
  Interprofessional Education Collaborative Expert Panel (2011)

Interprofessional Education & Collaborative Practice



WHO, 2010

Interprofessional Collaborative Practice Competency Domains

Competency Domain 1:	Values/Ethics for Interprofessional Practice
Competency Domain 2:	Roles/Responsibilities
Competency Domain 3:	Interprofessional Communication
Competency Domain 4:	Teams and Teamwork

Interprofessional Education Collaborative Expert Panel (2011)

Interprofessional Collaboration in Epilepsy: 2012 IOM Report

- Recommendation 4: Improve the Early Identification of Epilepsy & Its Comorbid Health Conditions
  - "**collaborative effort**" to promote and disseminate screening programs
- Recommendation 6: Establish Accreditation of Epilepsy Centers & an Epilepsy Care Network
  - "Emphasize patient-centered care that focuses on **co-management approaches** with [**interprofessional care] providers**"

Interprofessional Collaboration in Epilepsy: 2012 IOM Report

- Recommendation 7: Improve Health Professional Education About the Epilepsies
  - "Explore & promote opportunities to expand the use of innovative **interprofessional educational** approaches"
- Recommendation 8: Improve Delivery & Coordination of Community Services
  - "in **collaboration** with state and local organizations, should **partner** with community service providers and epilepsy centers…"

Symposium Agenda

Introduction – Janelle Wagner, PhD

A Model of Integrated Behavioral Health - Shanna Guilfoyle, PhD

Using Medical Homes and Telehealth to Reach Pediatric Epilepsy Patients - Rick Boyle, Special Projects Director, Epilepsy Foundation of Western-Central Pennsylvania

Caring for Individuals with Epilepsy and Developmental Disabilities: Collaborations with Developmental Pediatrics - Jane Charles, MD

Collaborative Care of the Epilepsy Patient in the VA System - Karen Parko, MD

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World Health Organization (WHO). (2010). Framework for Action on Education & Collaborative Practice. Geneva: World Health Organization.

A Model of Integrated Behavioral Health Care

Shanna M. Guilfoyle, PhD
Katherine Junger, PhD
Avani Modi, PhD
Cincinnati Children's Hospital Medical Center

Cincinnati Children's
change the outcome

December 5, 2015

Disclosure

No disclosures to report

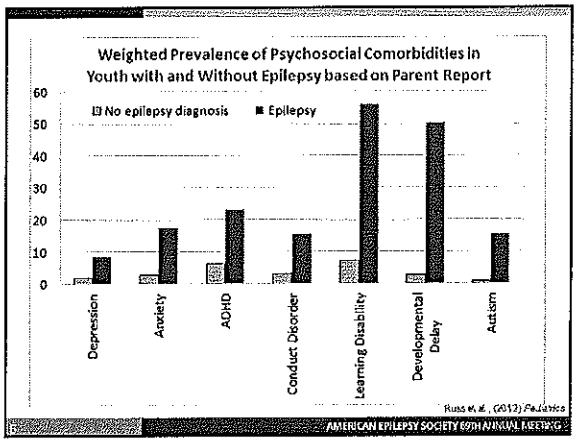
Learning Objectives

1. To highlight the increased risk of psychological comorbidities in pediatric epilepsy
2. To demonstrate development of an integrated model of care to target behavioral comorbidities in a new-onset seizure clinic
3. To illustrate the need to assess for baseline psychological functioning prior to epilepsy treatment and standardized behavioral health screening
4. To provide a case example to illustrate use of baseline psychological functioning and how an interdisciplinary team can address behavioral concerns and optimize epilepsy treatment and quality of life

Impact on Clinical Care and Practice

- Children with epilepsy are at an increased risk for psychological difficulties
- An integrated model of care is feasible, viable, and cost-effective
- Baseline psychological screening is clinically warranted
  - Epilepsy providers partnering with psychologists can distinguish AED side effects versus premorbid behavioral concerns
- Case example will be directly related to common issues within pediatric epilepsy and can have a direct impact on clinical care

Epilepsy: A Spectrum Disorder



Epilepsy: Spectrum Disorder

Epilepsy patients are at highest risk compared to any other chronic condition

- 34% prevalence rate for psychopathology (6.8 healthy)[1,2]
  - Depression (23-26%)
  - Suicidal ideation (15%)
  - Anxiety (15-20%)
  - Disruptive behaviors (28%)
    - ADHD
    - ODD
    - Aggression
    - Impulsivity
  - Learning disorders (42-50%)
  - Developmental delays (50%)[3]
  - Autism spectrum disorders(15-30%)

[1]Donn et al., (2009), *JAACAP*; [2]Ekinci et al. (2009) *Epilepsy & Behavior*; [3]Russ et al., (2012) *Pediatrics*

Epilepsy: Spectrum Disorder

ILAE	• Treatment Guidelines • Epilepsy Quality Indicators
FDA Recommendations	• Monitor psychological risk[3,4] • Monitor suicide risk
Consensus Statement	• Need for comprehensive care to proactively identify and treatment psychological comorbidities
FDA Alert	• 2008 FDA alert on increased risk for suicidality for all AEDs

[3]FDA (2006); [4]Hesdorffer & Kanner (2009) *Epilepsia*

New Onset Seizure Clinic
&
Epilepsy Psychosocial Service

New-Onset Seizure Clinic

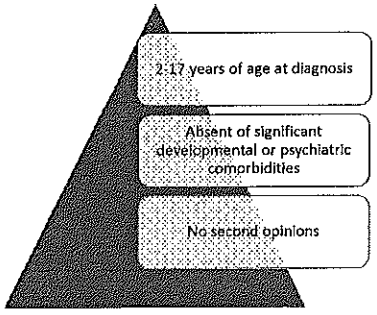
- The economic impact of pediatric epilepsy in the year following diagnosis is substantial
  - $20,000 in epilepsy-related charges in the 1st year (neurology clinic visits, procedures, lab tests)
- Cost reduction efforts would be optimized by improving seizure control and targeting health-related quality of life

Ryan et al. (2015), *Neurology*

New-Onset Seizure Clinic

- CCHMC 2015 Strategic Plan
  - Call for more interdisciplinary teams
- Comprehensive Epilepsy Center
  - Increasing recognition that psychological comorbidities impact quality of life
- Psychologists fully integrated into interdisciplinary teams
  - New Onset Seizure & Advanced Therapies Clinic
- Referral-based process for other providers

New-Onset Seizure Clinic

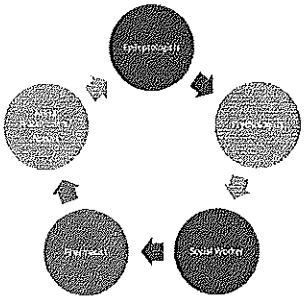


New-Onset Seizure Clinic

GOALS

No Seizures → No Side Effects → Best Quality of Life

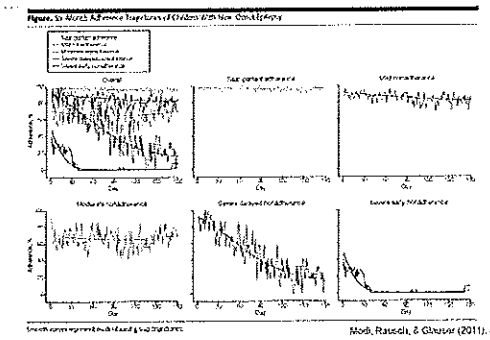
New-Onset Seizure Clinic



Routine Care

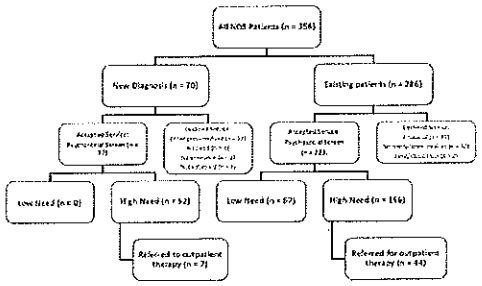
- Epileptologist conducts initial assessment, diagnosis, prescribes medication
- Pediatric nurse practitioner provides follow-up care quarterly
- Psychologist provides initial psychological assessment and provides consultations twice per year

New-Onset Seizure Clinic



Modi, Rausch, & Glauser (2011). *JAMA*

New-Onset Seizure Clinic



Guilfoyle, Jungas, & Modi. (2013). *CPPP*

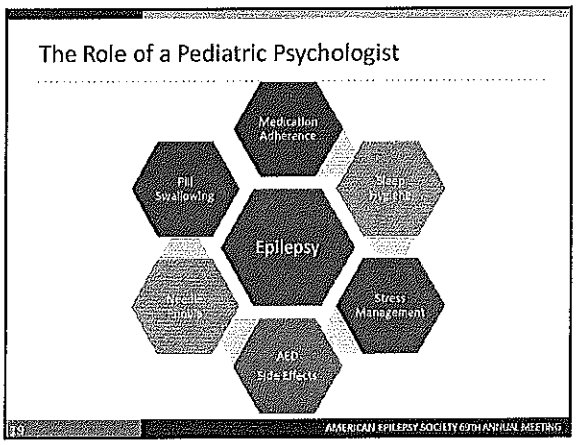
So What Do We Do?

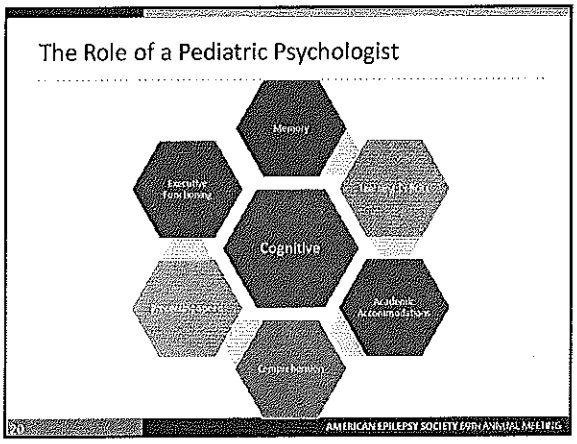
The Role of a Pediatric Psychologist

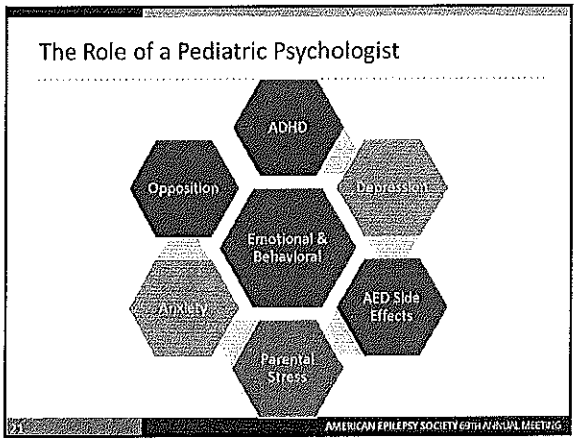
The Role of a Pediatric Psychologist

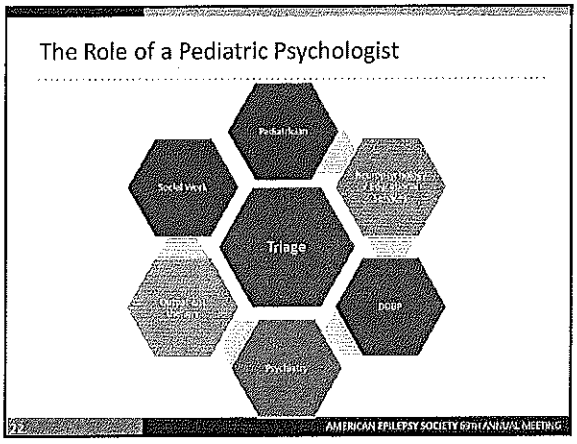
- Our goal: Identify those experiencing psychological symptoms and establish services so that symptoms decrease and quality of life improves

- Optimize quality of life
- Behavioral Management
- Depression/Suicidal Ideation
- Anxiety
- Better identify at diagnosis children who may be at risk for AED behavioral/mood side effects
- Enhance family functioning



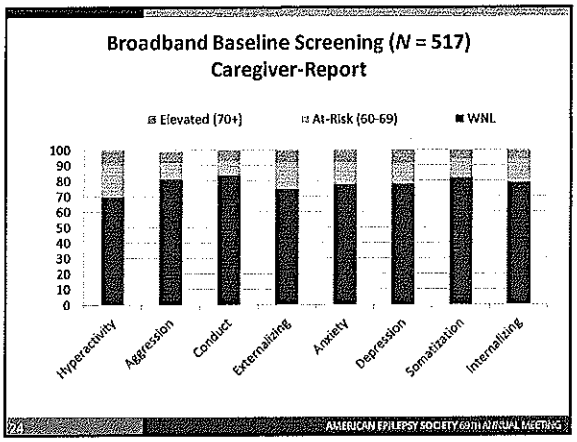


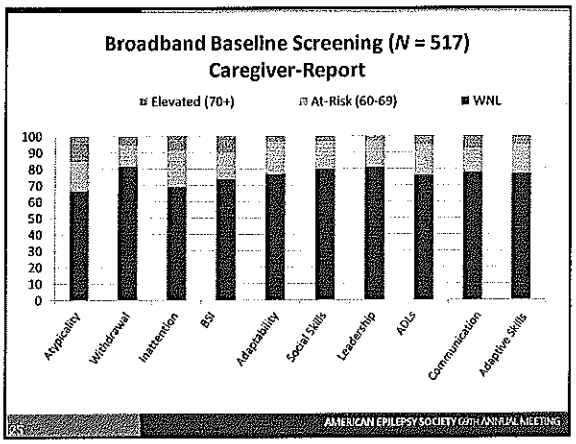


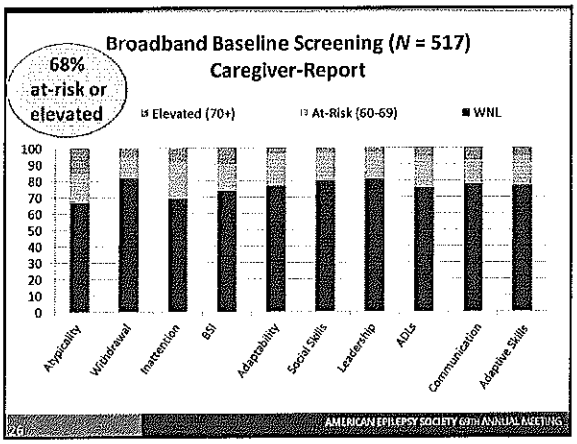


Baseline Psychological Screening:

Pediatric
New Onset Epilepsy




Broadband Baseline Screening (N = 517)
Caregiver-Report
Elevated (70+)
At-Risk (60-69)
WNL
100
90
80
70
60
50
40
30
20
10
0
Atypicality
Withdrawal
Inattention
BSI
Adaptability
Social Skills
Leadership
ADLs
Communication
Adaptive Skills
25
AMERICAN EPILEPSY SOCIETY 69TH ANNUAL MEETING


Broadband Baseline Screening (N = 517)
Caregiver-Report
68% at-risk or elevated
Elevated (70+)
At-Risk (60-69)
WNL
100
90
80
70
60
50
40
30
20
10
0
Atypicality
Withdrawal
Inattention
BSI
Adaptability
Social Skills
Leadership
ADLs
Communication
Adaptive Skills
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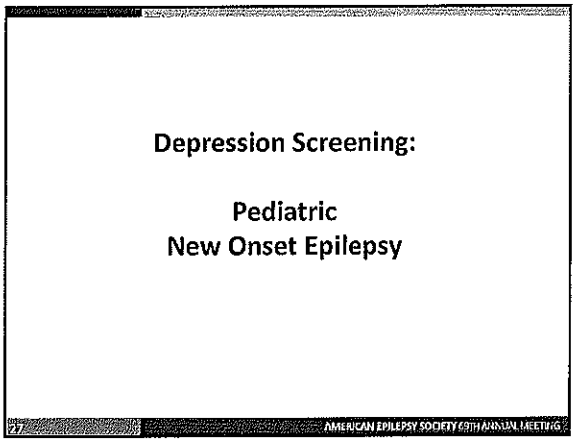
AMERICAN EPILEPSY SOCIETY 69TH ANNUAL MEETING


Depression Screening:
Pediatric
New Onset Epilepsy
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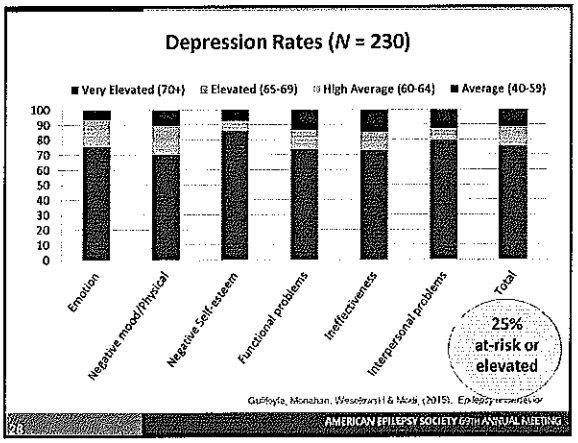
Depression Rates (N = 230)
Very Elevated (70+)
Elevated (65-69)
High Average (60-64)
Average (40-59)
100
90
80
70
60
50
40
30
20
10
0
Emotion
Negative mood/Physical
Negative Self-esteem
Functional problems
Ineffectiveness
Interpersonal problems
Total
25% at-risk or elevated
Gutiérrez, Monahan, Wesselhoft & Mott, (2015). Epilepsy & Behavior
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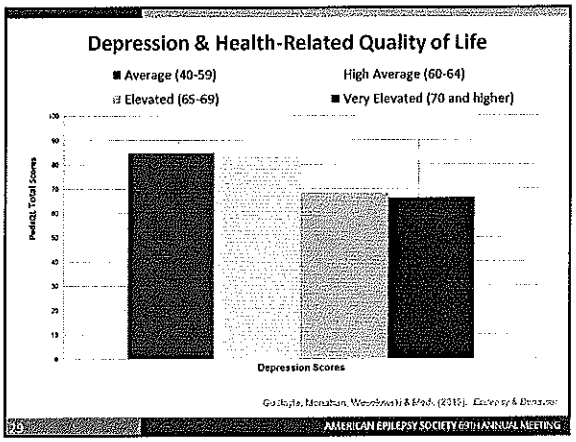
Depression & Health-Related Quality of Life
Average (40-59)
High Average (60-64)
Elevated (65-69)
Very Elevated (70 and higher)
Pediatric Total Scores
Depression Scores
Gutiérrez, Monahan, Wesselhoft & Mott, (2015). Epilepsy & Behavior
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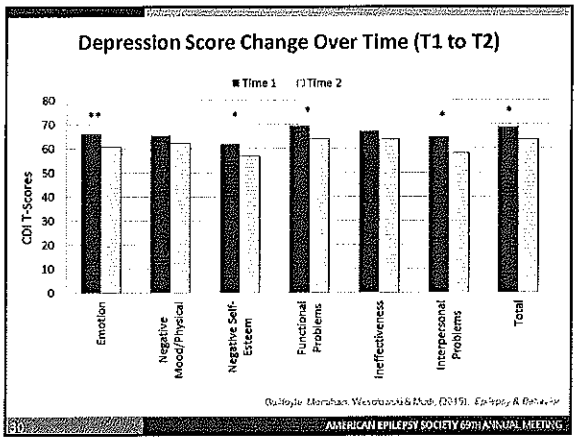
Depression Score Change Over Time (T1 to T2)
Time 1
Time 2
CDI T-Scores
80
70
60
50
40
30
20
10
0
Emotion
Negative Mood/Physical
Negative Self-Esteem
Functional Problems
Ineffectiveness
Interpersonal Problems
Total
Gutiérrez, Monahan, Wesselhoft & Mott, (2015). Epilepsy & Behavior
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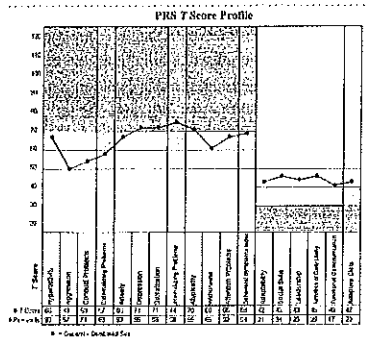
The Case of Mary

The Case of Mary

- 12 yo female diagnosed with unclassified epilepsy
- Levetiracetam initiated and controlling seizures
- 1-month follow-up
  - Father expressed concern of increased mood lability and behavioral disinhibition since starting Levetiracetam to nurse practitioner
  - Psychological interview by psychologist identified family history of bipolar disorder and patient with history of self-injurious behavior and mood dysregulation

Should Levetiracetam be discontinued and another AED initiated?

The Case of Mary



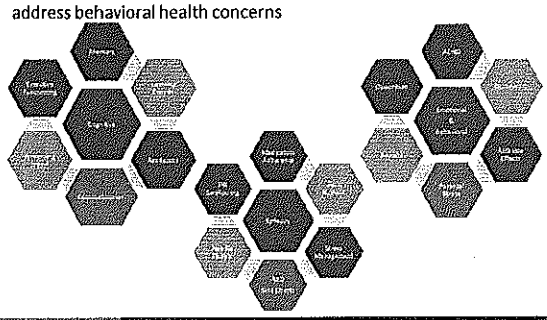
The Case of Mary

- Careful discussion between pharmacist, nurse practitioner, and psychologist to determine the etiology and timing of mood lability concerns
- Conclusion
  - Levetiracetam was concluded to not be sole contributor to mood lability and behavioral disinhibition given premorbid mood concerns and poor coping skills
  - Psychologist recommendations
    - Educated family about effective ways to manage increased mood lability
    - Initiate psychological services
    - Identify patterns to mood changes, intervene early with effective coping skills, reinforce use of adaptive coping skills
    - Handout provided

Conclusions

Conclusions

- Psychologists can be fully integrated into epilepsy care to proactively address behavioral health concerns



Conclusions

- New-onset epilepsy patients are at high risk for psychological comorbidities even prior to AED initiation
- Baseline psychological screening and a careful psychological assessment can be used to optimize AED tolerance by better identifying clear AED side effects
  - Etiology and timeline of symptoms
  - Baseline functioning prior to AED initiation

#AESmtg15

AMERICAN EPILEPSY SOCIETY

69TH ANNUAL MEETING DECEMBER 4 - 8, 2015 PHILADELPHIA, PA

Using Medical Homes and Telehealth to Reach Pediatric Epilepsy Patients

Rick Boyle, M.S.Ed.
Special Projects Director
Epilepsy Foundation Western/Central PA

December 5, 2015

AMERICAN EPILEPSY SOCIETY 69TH ANNUAL MEETING DECEMBER 4 - 8, 2015 PHILADELPHIA, PA

Disclosure

No conflict of interest

Objectives

- To describe the structure and process of a collaborative telemedicine pilot project
- To list the benefits to providers and families engaged in a collaborative telemedicine pilot project
- To discuss the enhanced care-coordination of a collaborative telemedicine approach

State and Regional Approaches to Improving Access to Services for Children and Youths with Epilepsy – HRSA grant 98MC26261

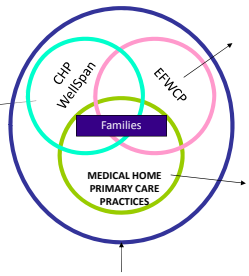
Overarching Goal:
To enhance the coordination of care between primary and specialty care (neurology) through telemedicine and other health education technology systems

Telemedicine Goal:
Pilot, refine and implement telemedicine visits among neurologists and children with epilepsy and their families in the child's pediatric primary care setting

Rural Pennsylvania Counties

PA Telemedicine Pilot Project Interprofessional Implementation Team

- Miya Asato, MD – Associate Professor, Division of Child Neurology, Children's Hospital of Pittsburgh, of UPMC
- Todd Barron, MD – Medical Director, WellSpan Neurosciences



- Peggy Beem – Jelley President & CEO
- Rick Boyle – Special Projects Director
- Jordan Hinds – Care Coord.
- Chelsea Fallier – Care Coord.
- Gretchen Knaub – Care Coord.

- Pediatric Care Specialists
- CCP Armstrong
- Keystone Rural Health Center
- JDC Pediatrics
- *PA Medical Home Initiative*

Evaluation
- Dianna Ploof, EdD Consultant

Community/School/Family Supports

Development of the Model

- Collaborate with PA Medical Home Initiative (PAAAP), sub-specialists, pediatric practices (PCP), CHP telemedicine program, EFWCP, Michigan grantee telemedicine project
- Jointly establish protocol for identifying patients and scheduling telemedicine appointments – repeat, non-complex, children and youth
- Jointly develop plan/workflow for telemedicine visits
- Identify and order telemedicine equipment
- Jointly develop process evaluation measures for child/family, PCP and neurologist

Telemedicine Appointment Work Flow

	CHP Neurology	CHP Telemedicine Program	Primary Care Practice	Epilepsy Foundation W/C PA
ID Patient	ID patients followed by PCP; works w PCP; schedules in EPIC.	Coordinator checks EPIC routinely,	PCP IDs patients that fit criteria	Provides family welcome letter to PCP
	----------Additional steps: scheduling, preparation work etc----------			
Day of appt	Neurologist will have reviewed records and talked w primary neurologist in advance	15 mins prior to appt confirm connection w PCP	telemed room set up 15 min prior to appt. Confirm connection	Coordinator arrives
Patient arrival	telemed note opened, meds reconciled, ROS completed	Available if needed	Patient welcomed; intro-duced to EF Coord, roomed, MA checks vitals; new test info faxed to Neuro office	Coordinator meets family; shares materials
Visit	Conducts visit, documents in EPIC note, completes clinical summary; prints and faxes to PCP office;. F/U visit scheduled	Available if needed	MA facilitates exam; confirms f/u telemed visit. Gives patient clinical summary	Coordinator present for appointment if family agrees
Billing	PNR completes billing		PCP office completes billing	
After visit	Neurologist completes provider survey, sends to evaluator		PCP completes experience survey; gives to EFWCP coord; provides space for family and EFWCP to meet.	Coord meets w family; asks family to complete telemed and cross-site surveys; reviews visit with family, follows up with care-coordination items

Implementation of pilot project

- Telemedicine appointments – 7 across 2 sites
- Collate data from initial visits: families, PCPs, specialists
- Share feedback with CHP, PCS, CCP Armstrong and EFWCP
- Summarize, synthesize learnings
- Adapt protocols for next cycle

Adjustments to process

- Revise parent survey with parent input
- Train PCPs/Staff via live or web-based Epilepsy 101
- Conduct pre-clinical encounter site visit by neurologist (where possible) and EFWCP staff to practice use of equipment and clarify expectations of on-site clinical staff for the hands-on assistance they provide of the visit.
- Neurologist adjusted pace of communicating remotely
- Review and adapt visit protocol, and patient identification and scheduling process for each new site

Impact on Clinical Care and Practice

- Access to sub-specialty care close to home
- More timely appointment
- Immediate medication adjustments
- Significantly less travel, cost, loss of work time
- Referral to community support services
  - Behavioral health, school supports, transition, advocacy
- Linkage with EFWCP

Telemedicine feedback

Family	Worked as well as in the neurologist's office	4.8
	Would recommend telemedicine to other families	4.8
	Care Coordinator helpful (advice, planning, resources)	4.8
Primary Care Clinician	Videoconferencing equipment worked well.	4.3
	Was easy for family, neurologist and me to communicate as a team	4.3
	Learned something new about epilepsy	4.2
Neurologist	Was able to address the child's/ family's concerns	4.8
	Got the physical information I needed without being present	4.2
	Patient/family seemed satisfied with the session	4.6

1=Strongly Disagree; 5=Strongly Agree

Telemedicine feedback, continued

Families:
- 100% said easier to see a neurologist this way
- 100% saved transportation and cost
- 50% saved time from work, could bring someone

Professionals:
- Addressed mental health and school issues (would not have happened at separate, in-office neuro visit)
- Saved families >120 miles and 2.5 hours of travel; one had no vehicle
- Reduced delay in getting care, and medication changes
- Helped PCP improve access to care for patient

Contact Information

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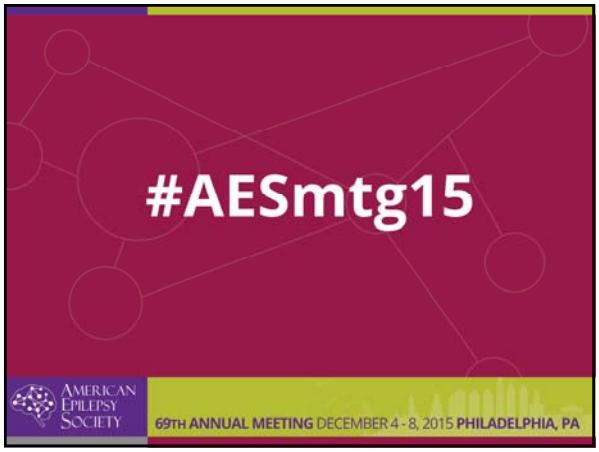


Caring for Individuals with Epilepsy and Developmental/Behavioral Disabilities: A Unique Collaboration with Developmental Pediatrics

Jane M. Charles, MD
Medical University of South Carolina

December 5, 2015

AMERICAN EPILEPSY SOCIETY 69TH ANNUAL MEETING DECEMBER 4 - 8, 2015 PHILADELPHIA, PA

Disclosure

No disclosures to report

Learning Objectives

1. To demonstrate development of an interprofessional model of care to for youth and caregivers of children with epilepsy and comorbid developmental/behavioral disorders.
2. To evaluate the impact of the clinic for families using a clinic case example.

Impact on Clinical Care and Practice

- MUSC Department of Pediatrics, Division of Developmental/Behavioral Pediatrics
  - 5 developmental pediatricians, 3 clinical psychologists, 2 neuropsychologists, 1 child psychiatrists, 2 social workers
  - One of three “Developmental Evaluation Centers” in South Carolina eastern 1/3 of State
  - Wide range of developmental disabilities and behavior disorders

Impact on Clinical Care and Practice

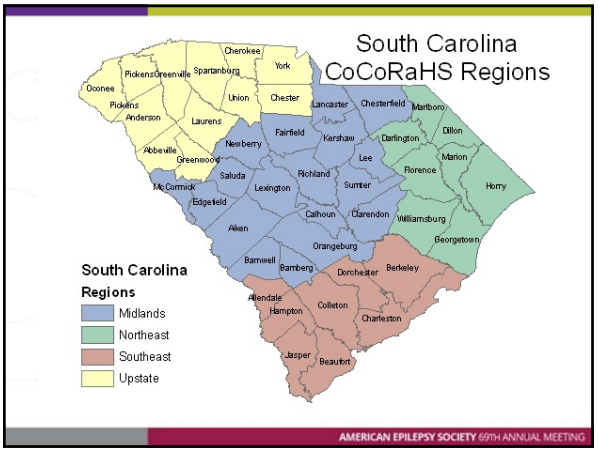
- MUSC Department of Pediatrics, Division of Developmental/Behavioral Pediatrics
  - Lowcountry Autism Foundation office in clinic
  - Unique contract with SC Medicaid to provide bundled services for DD population: multidisciplinary evaluations, can bill for time spent.

Impact on Clinical Care and Practice

- MUSC Comprehensive Epilepsy Center
  - One of two in the state of South Carolina
  - Multidisciplinary staff and faculty

Why did we come up with this clinic idea?

- South Carolina is primarily rural and resource poor for behavioral interventions and support
  - 3 large cities have the most medical facilities and providers
  - Only about a dozen developmental pediatricians in the state
  - County Mental Health Centers will not see persons with developmental disorders
  - Private behavioral health providers do not take Medicaid or private insurance, requiring upfront payment
  - TEFRA (Katie Beckett) Medicaid



Design of Clinic

- Meets one afternoon per month
- Developmental pediatrician, epilepsy center advance practice provider, and clinical psychologist
- Providers and family meet together for the complete visit, not separately like many multidisciplinary clinics
- Providers seek history for caregivers/patient and examine patient together updating:
  - Medical
  - Developmental
  - School and behavioral

Design of Clinic

- The clinic setting is a large room with various developmental toys
- Dimmer lighting
- Does not look like a clinic room
- Table with chairs for family and providers to meet around
- Provides a calmer environment for children who have behavioral issues and anxieties about clinic visits

The design of the clinic allows….

- Brainstorming about behaviors, treatment and interventions!
- Brainstorming about epilepsy, treatment and interventions
- As a team the providers and families consider the etiology of any concerns or changes:
  - Medication or treatment side effects for all diagnoses
  - New medical issue(s)
  - Change in environment or schedule
  - Sensory issue

Case….

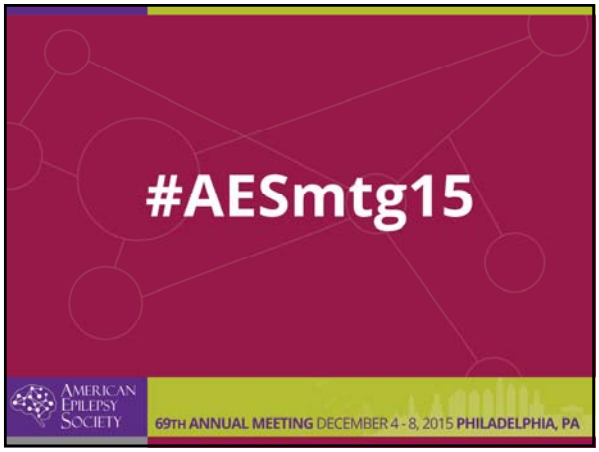
- Brandon, 16 yo WM
  - Idiopathic generalized epilepsy with clinical presentation of Lennox-Gastaut Syndrome, autism, moderate intellectual disability, disruptive behavior disorder, sleep disorder, hyperactivity
  - Lives with MGM (main caregiver)
  - Aggressive and disruptive behaviors at home and school

Case….

- Brandon, 16 yo WM
  - Epilepsy: Failed multiple AEDs, VNS in 2001 helpful but continues to have occasional seizure
  - Behaviors: stimulant, alpha agonist for hyperactivity, multiple trials of antipsychotics for agitation and aggression but always resulted in increased seizures, finally used Clonazepam for aggression, work with school & therapy interventionists
  - Sleep: Trazodone trial resulted in tics which persisted after discontinuation of the medication

Case….

- Brandon, 16 yo WM
  - Hyperactivity and aggression have decreased
  - MGM has tapered off the clonazepam and the alpha agonist, only on stimulant at this time
  - Doing very well in a self-contained class in local high school, fantastic teacher
  - MGM has reflected the clinic helps her to feel more confident in managing Brandon and working with the various agencies involved in his care; the clinic allow families to develop a plan with both disciplines and decreases confusion



Collaborative Care of the Epilepsy Patient in the VA System

Karen Parko, M.D.
Former National Director, VA Epilepsy Centers of Excellence
Professor of Neurology, UCSF School of Medicine
San Francisco, CA

Epilepsy Centers of Excellence
DEPARTMENT OF VETERANS AFFAIRS

August, 2015

AMERICAN EPILEPSY SOCIETY 69TH ANNUAL MEETING DECEMBER 4 - 8, 2015 PHILADELPHIA, PA

Disclosure

None

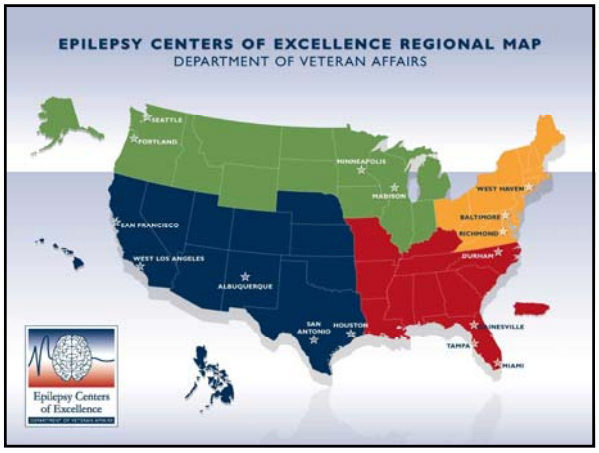
I have no affiliation or financial interest in the model discussed in this presentation (Project Echo)

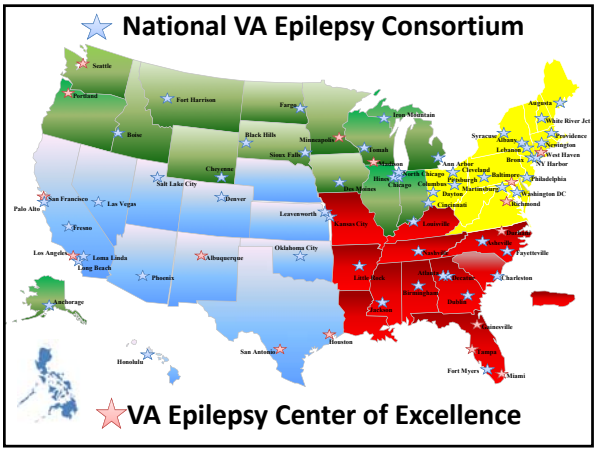
Learning Objectives

- Introduce SCAN-ECHO as existing interprofessional model of care for Veterans
- Consider other uses for this model

Impact on Clinical Care and Practice

- Practical application of interprofessional based care
  - Comprehensive Care
  - Professionals support each other
- Potential use in low resource or geographically isolated locations
  - Increased access to care
  - Increased Quality of Life
  - Improved Outcomes





Why Telehealth?

- **"Evolve VA information technology capacities to meet emerging customer/empowerment expectations of both VA customers and employees." -** From VA strategic plan 2014-2020
- **Changing Veteran population**
- **Need to maintain effective communications and VA infrastructure to provide quality care services**

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Telehealth Services offered VA Epilepsy Centers of Excellence

- Telephone clinic
- Video-teleconferencing with outpatient clinics/other medical centers
- Store and Forward
- eConsults
- Home video-teleconferencing
- SCAN-ECHO

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Clinical Video Telehealth

Patient at remote site

Physician in clinic

VA Epilepsy Centers Usage
- ✓ Outreach Epilepsy Clinics
- ✓ Can be done from patient's home
- ✓ Used to read EEG from remote areas (store and forward)

Interprofessional Collaboration

Traditional Telehealth Model

SCAN-ECHO

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Project Echo-2003

- ECHO (Extension for Community Healthcare Outcomes)
- Dr. Sanjeev Arora, hepatolgoist, UNM
- Designed to treat rural New Mexicans with hepatitis C that could not get specialty treatment where they lived
- Quality of Hepatitis C care provided by Project-ECHO team was equal to that of care provided by university-based specialists *
- VA Office of Specialty Care Transformation funded adaptation into the VA

*NEJM 2011; 364:2199-2207

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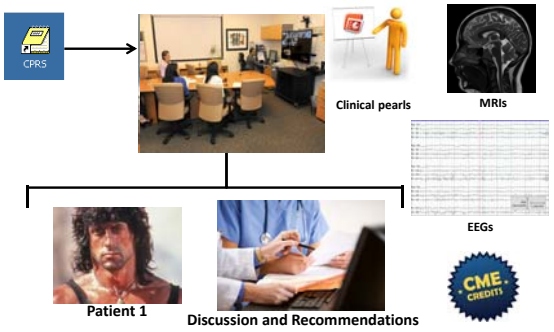
What is SCAN-ECHO?

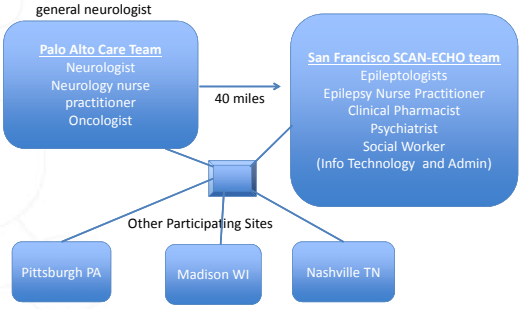
- Specialty Care Access Network-Extension for Community Healthcare Outcomes
- Provides consultation from intra-disciplinary specialist teams to **health care providers**
- Goal is to treat patients but also to build expertise in health care providers
  - Force Multiplier Effect

How does it work?



Case Presentation

- Referred from Palo Alto, CA VA by general neurology nurse practitioner and general neurologist



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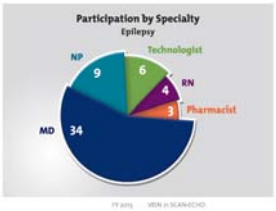
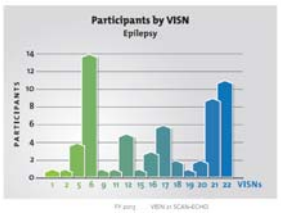
Benefits of SCAN-ECHO

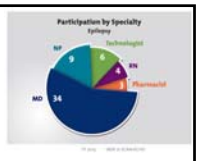
- To Veterans:
  - No longer need to travel long distances to see a specialist
  - Receive care locally and from familiar clinician
  - Multidisciplinary review of case
- To Referring Providers:
  - Case-based learning
  - Learn new skills and knowledge
  - Network with colleagues
  - Earn CME
- To VA health care system:
  - Shared specialist knowledge
  - Interprofessional team collaboration
  - Cost-savings

Epilepsy SCAN-ECHO - Participation





Clinicians participating in SCAN ECHO reported:



- Better management of Veterans with epilepsy
- Easier access and more straightforward channel of communication with specialists
- Improved patient outcomes from team-based care
- Reduced variation in epilepsy care
- Increased provider satisfaction with being able to virtually network with colleagues nationwide

Epilepsy SCAN-ECHO: Feedback

Successes

- Better management of Veterans with epilepsy
- Improved patient outcomes from interprofessional care
- Easier access and more straightforward communication
- Reduced variation in epilepsy care
- Increased provider satisfaction

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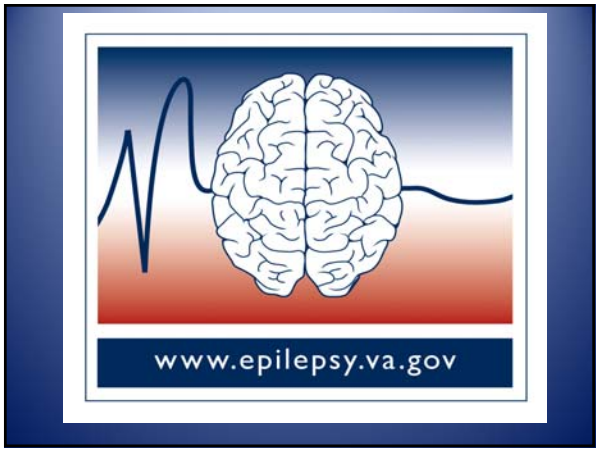

Conclusion - Professionals in Epilepsy Care Symposium: Interprofessional Models and Collaborative Care

Gigi Smith, PhD, APRN, CPNP-PC
Associate Professor & Associate Dean for Academics
College of Nursing
Medical University of South Carolina

MUSC COLLEGE of NURSING

December 5, 2015

American Epilepsy Society 69TH ANNUAL MEETING DECEMBER 4 - 8, 2015 PHILADELPHIA, PA

Disclosure

Nothing to disclose

Symposium Learning Objectives

- Define interprofessional care collaboration and competencies.
- Evaluate existing interprofessional models of care for patients and families with epilepsy.
- Consider the development of strategies to meet specific patient/family care needs by optimizing patient care by using the unique and complementary abilities of all members of the team in an epilepsy center or community setting.

Impact on Clinical Care and Practice

Symposium

Introduction – Janelle Wagner, PhD

A Model of Integrated Behavioral Health - Shanna Guilfoyle, PhD

Using Medical Homes and Telehealth to Reach Pediatric Epilepsy Patients - Rick Boyle, Special Projects Director, Epilepsy Foundation of Western-Central Pennsylvania

Caring for Individuals with Epilepsy and Developmental Disabilities: Collaborations with Developmental Pediatrics - Jane Charles, MD

Collaborative Care of the Epilepsy Patient in the VA System - Karen Parko, MD

Overview

- Research and practice recommendations call for health professionals to work collaboratively to
  - Improve delivery of care
  - Increase access to care
  - Improve quality of life and health care outcomes for patients and families

(RWJ, 2011; IPEC, 2011; England et al., 2012)

Overview

- This symposium reviewed 4 different models of interprofessional care for youth, adults and veterans

Take home points: Define interprofessional collaboration and competencies.

- Definition(s)

Take home points: Define interprofessional collaboration and competencies.

- Collaborations included interprofessional care models that identify and treat behavioral comorbidities in youth with epilepsy and identified:
  - Increasing access to care & improving health outcomes
  - Enhancing care coordination and involving a specialty organization
  - Unique clinic design to increase communication and family management

Take home points: Evaluate existing interprofessional models of care for patients and families with epilepsy

- Comprehensive epilepsy centers:
  - Using the interprofessional team to identify youth with psychological symptoms and treating to decrease symptoms and increase quality of life
  - Collaborating with medical home primary care practices, the Epilepsy Foundation, and Community/School/Family to enhance care coordination using telemedicine

Take home points: Evaluate existing interprofessional models of care for patients and families with epilepsy

- Comprehensive epilepsy centers:
  - Collaborating with Developmental/Behavioral Pediatrics to increase access to care, promote family team participation/management, and improve health outcomes
  - Using the interprofessional team to increase access to care and improve the health outcomes of the ever changing veteran population and enable professionals to support each other

Take home points: Consider the development of strategies to meet specific patient/family care needs using the unique and complementary abilities of all members of the team in an epilepsy center

- Interventions were:
  - Interprofessional and included patients/families as active participants
  - Involved other disciplines besides the epilepsy team including community agencies
  - Tailored to each site
  - Designed an innovation for the clinic setting or used telemedicine
  - Feasible and can be accomplished in other clinics or settings

Take home points: Outcomes thus far

- The interventions reviewed:
  - Improve access to care, efficiencies
  - Promote comprehensive treatment of the person living with epilepsy
  - Increase communication and provide referrals to specialists, community agencies, etc.
  - Improve quality of life and health outcomes
  - Increase provider satisfaction
  - Are feasible and can be accomplished in other clinics or settings and promote cost savings

Faculty panel

- Question cards from audience will be discussed
- Thank you for participating in the 2015 PEC Symposium!

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