Gentler Journeys: Easing Transitions of Care for Patients with Serious Mental Illness

August 27, 2024

CENTER OF EXCELLENCE FOR BEHAVIORAL HEALTH IN NURSING FACILITIES

Today's Event Host

Nikki Harris, MA, CBHC-BS

COE-NF TRAINING AND EDUCATION LEAD

Nikki serves as the training and education lead for the Center of Excellence for Behavioral Health in Nursing Facilities (COE-NF). For the past 20 years, Nikki has provided program implementation, development, management, external and internal trainings, policy development, quality assurance, and managed training coordination and technical support throughout the southeast region.

Previously, she served as the program manager for the Division of Behavioral Health and Substance Use Services within the South Carolina Department of Corrections.

She has a B.A. in psychology from the University of South Carolina, a M.A. in counseling from Webster University and is a certified behavioral specialist.

Today's Moderator

Sing Palat, MD, CMD

MEDICAL DIRECTOR, OPTUM SENIOR COMMUNITY CARE

Sing Palat, MD CMD is the president of CMDA, the medical director of Optum Senior Community Care, and a physician with Long-term Care Rehab. She completed medical school and internal medicine residency at the University of Pittsburgh and completed a geriatrics fellowship at the University of Colorado.

Today's Presenter

Lauren J. Gleason, MD, MPH, CMD

ASSOCIATE PROFESSOR OF MEDICINE, UNIVERSITY OF CHICAGO MEDICINE

Dr. Lauren Gleason is an associate professor of medicine at the University of Chicago Medicine. She graduated from the University at Buffalo School of Medicine, completed residency in internal medicine at University of Rochester before pursuing Geriatrics fellowship in the Harvard Multicampus Program and MPH in clinical effectiveness at Harvard T.H. Chan School of Public Health.

At the University of Chicago, she is the medical director for UChicago Post-Acute Care Continuum and medical director of South Shore Rehabilitation. She is a coinvestigator of a HRSA-Geriatric Workforce Enhancement Program and UCSF Grant to look at age-friendly EHR metrics. Her interests involve development and implementation of IHI age-friendly QI initiatives and improving quality of care for older adults in the health system.

At the University of Chicago, she is a Healthcare Delivery Science & Innovation (HDSI) Scholar. Nationally, Dr. Gleason is a member of the American Geriatrics Society Public Education Committee and AMDA Sub-Committee on Transitions of Care.

Today's Presenter

Nadia Abbas, MBBS LCSW

DIRECTOR OF CARE COORDINATION, UNIVERSITY OF CHICAGO MEDICINE

As the director of care coordination at UChicago Medicine, Nadia oversees pediatric, inpatient adult, and ER teams.

With a background in medicine and social work, she is dedicated to supporting teams and the patient population. Nadia is also passionate about strategy work and collaborating with leaders across the hospital to improve patient care and outcomes.

Today's Presenter

Barbara A. Bates, RN, MSN, DNS-MT, QCP-MT

NURSING EDUCATOR/ CONSULTANT

Barbara A. Bates has 50+ years of experience in geriatric psychiatry and LTC nursing, holding management, and administration positions. She has served as a chief of service, team leader and nurse administrator in the psychiatric system for 25 years. Following transfer to the NYS Veterans Home, Barbara worked as a director of nursing service II until retirement in 2008 with 38 years of service.

As an MSN, specializing in nursing education, she is a master teacher for DNS-CT and QCP through AAPCN. She has spoken nationally for HIN, AAPACN, and Pioneer Network. Barbara is currently employed by MedNet Concepts as a health care specialist and serves as the team leader for the behavioral healthcare review team. She also works for MDS Consultants and is an executive trainer. As a former member of the DNS-EAP committee for AAPACN, she also volunteers for the NYS Surrogate Decision-Making Committee, a NY Governor-appointed position. In 2019, she was awarded the Contributor of Year Award from AAPACN.

Today’s Presenter

Tana Whitt, MSN, APRN, PMHNP-BC

CHIEF CLINICAL OFFICER, MINDCARE SOLUTIONS

As the chief clinical officer at MindCare Solutions, Tana Whitt oversees clinical initiatives and operations, emphasizing process optimization and collaboration among clinical teams. She has a proven history of developing evidence-based care strategies and improving patient care outcomes.

Tana's key accomplishments include founding a new psychology department, spearheading value-based care initiatives, reorganizing the operations department for enhanced efficiency, creating a centralized care coordination HUB, redesigning the account manager department to boost collaboration, and implementing a comprehensive nurse practitioner model across multiple healthcare settings.

In addition to her role at MindCare, Tana serves as the vice-chair for The PALTC Behavioral Health Committee and consults with organizations to improve quality care metrics, evidence-based practice, and interdisciplinary care initiatives. She is also an accomplished speaker and advisor in the healthcare industry.

Learning Objectives

1. Describe specific challenges that exist when transitioning a person with serious mental illness (SMI) from an acute care setting to the nursing home, and from the nursing home to an acute care setting or the community.

2. Describe how to successfully manage the discharge of a patient with SMI.

3. Identify the psychological and psychiatric supports that are needed before, during and after transitions and determine when a referral to a psychiatric facility is needed.

4. Implement tools to ensure optimal communication between the behavioral health provider, medical provider, nursing, administrator, social worker, and other members of the interprofessional team.

Background – Case Presentation

- 59-year-old man
- Past medical history: schizophrenia since age 25
- Admitted to the hospital 6 days ago with foot pain
- Treated for osteomyelitis and requires six (6) weeks of intravenous antibiotics.
- Care team recommends subacute rehabilitation

- Exam: Vitals stable. Grossly oriented, alert. Heart/ lungs clear. Foot bandaged.
- Meds include intravenous vancomycin, IV cefepime, and olanzapine 10 mg po daily
- Social history: no family in the area, has been living in homeless shelters

Lauren J. Gleason, MD, MPH, CMD

Associate Professor of Medicine, University of Chicago Medicine

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Best Practices on Transitions of Care

- Summary of Hospital Course
- Psychiatric Condition
  - Accurate Diagnosis
  - Treatment tried in the past
- Medications
  - Clear instructions administration & timing
  - Formulary
  - What to do with PRNs
- Decision Making Capacity
- Follow-up appointment
- Goal of discharge to facility

Role of Interdisciplinary Team

Accurate picture of the resident treatment & care needs

- Treatment plan and communication
- Specific triggers, behaviors & approaches related to behavioral management

Provide the services to meet the resident needs per regulations

- staffing, training and competency
- Specialized providers: Access to Psychiatry, Psychology, LCSW, Behavior Management

Nadia Abbas, MBBS LCSW

Director of Care Coordination, University of Chicago Medicine

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PASRR- Level II

1. Initial Identification and Referral

- **Assessment**: Individuals entering long-term care facilities are initially screened using the Pre-Admission Screening and Resident Review (PASSRR) Level I tool to identify potential serious mental health issues or intellectual disabilities.
- **Referral**: If the Level I screen indicates possible concerns, a referral is made for a more in-depth PASSRR Level II evaluation.

2. Comprehensive Evaluation

- **Multidisciplinary Assessment**: A comprehensive assessment is conducted by a multidisciplinary team, including mental health professionals, to determine the individual's specific needs and appropriate care level.
- **Evaluation Components**: The evaluation includes psychiatric assessments, cognitive testing, functional assessments, medical history review, and interviews with the individual and their family

PASRR- Level II

3. Determination of Needs

- **Level of Care Decision**: The Level II assessment determines whether the individual has serious mental health concerns that require specialized services beyond what a typical nursing facility can provide.
- **Individualized Care Plan**: Based on the assessment, an individualized care plan is developed, detailing the necessary services and supports to address the identified mental health needs.

4. Specialized Services and Placement

- **Service Coordination**: The care plan may include specialized mental health services such as therapy, psychiatric care, medication management, and behavioral interventions.
- **Appropriate Placement**: Recommendations are made for the most suitable care setting, which may be a specialized mental health rehab facility if the individual's needs cannot be adequately met in a standard nursing facility.

Acute to post-acute- Ideally a SMRPH- (specialized mental health rehab facility)

Individualized Treatment Plans: Offers personalized treatment plans, including therapy, medication management, and skill-building activities, tailored to each patient's needs.

Comprehensive Support Services: Provides access to a range of support services, such as vocational training, social skills development, and recreational activities, to promote overall well-being.

Multidisciplinary Team Approach: This approach utilizes a team of mental health professionals, including psychiatrists, psychologists, social workers, and nurses, to deliver holistic care.

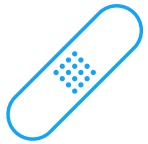
Medication Management: Ensures proper medication management and adherence through regular monitoring and adjustments as needed.

Psychoeducation: Educates patients and their families about mental illness, treatment options, and coping strategies to empower them and reduce stigma.

Acute to post-acute

Therapeutic Environment:

Creates a safe and supportive environment conducive to healing and recovery, with a focus on reducing stress and promoting mental health.



Crisis Intervention:

Provides immediate intervention and support for any crises that may arise, ensuring patient safety and stability.

Community Reintegration Support:

Assists patients in developing the skills and confidence needed to reintegrate into the community, including support with housing, employment, and social connections.

Structured Transition:

Provides a structured environment to help patients transition from acute hospital care to community living, reducing the risk of readmission.

Continuity of Care:

Facilitates seamless communication and coordination with the patient's healthcare providers to ensure continuity of care and ongoing support after discharge.

Acute to post-acute- NH for skilled needs concerns

- Staffing
- Medication concerns
- Lack of training/understanding of nonpharmacological interventions to manage behavioral challenges.
- A lack of or poorly integrated behavioral health services
- Lack of community resources to help patient integrate back into society
- Fear/concern regarding re-hospitalization in a psychiatric hospital

Barbara Bates, MSN

Nursing Educator/ Consultant

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Transition into the Nursing Home Community for Residents with SMI: Referral

Key Interdisciplinary Communication Needs

- Transparent look at resident's physical, psychosocial and mental health concerns – accurate diagnoses and supporting documentation
- Accurate picture of the resident treatment and care needs – share the treatment plan
- Medication needs – Can nursing home provide psych meds as currently ordered
- PASRR Screen – Level II need for SMI
- Nursing Home must be able to provide the behavior management services the resident needs – per regulation (staffing, training and competency, specialized providers (psychiatry, psychology, LCSW, etc.)

Transition into the NH Community for Residents with SMI: Resident

Resident transferring to Nursing Home Community

- Complete history, summary of physical and mental health care – need for records & where to obtain
- Each discipline involved – communicate summary of care and current status – written or hand off report (Not just nursing)
- Engaging and preparing the resident and family for transfer – accurate expectations
- Medication reconciliation – indication for use – special instructions – reason for consistent dose, non-formulary changes, indications for use, PRNs, etc.
- Communicate successful non-pharmacological approaches to behavior management: Specific triggers, behaviors and approaches related to behavioral management
- Support contact – sending facility

Bridging the GAP: Leveraging Technology and Interoperability in Transitions of Care

Tana Whitt, MSN, PMHNP-BC
Chief Operating Officer
MindCare Solutions

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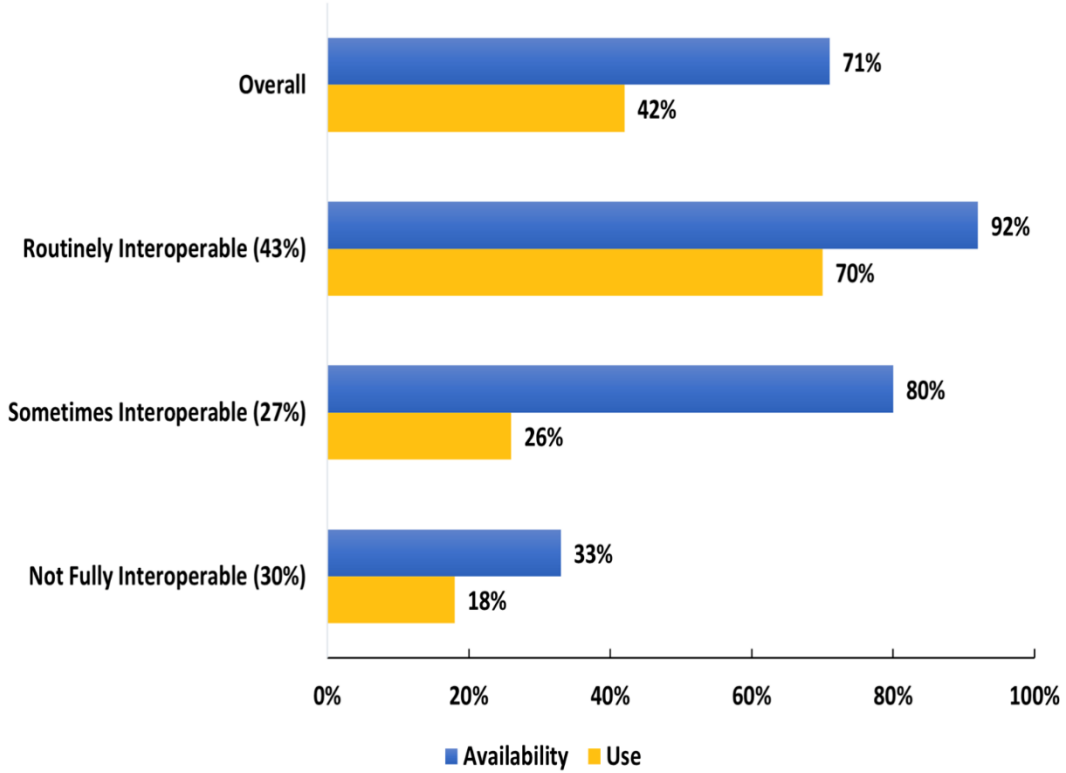
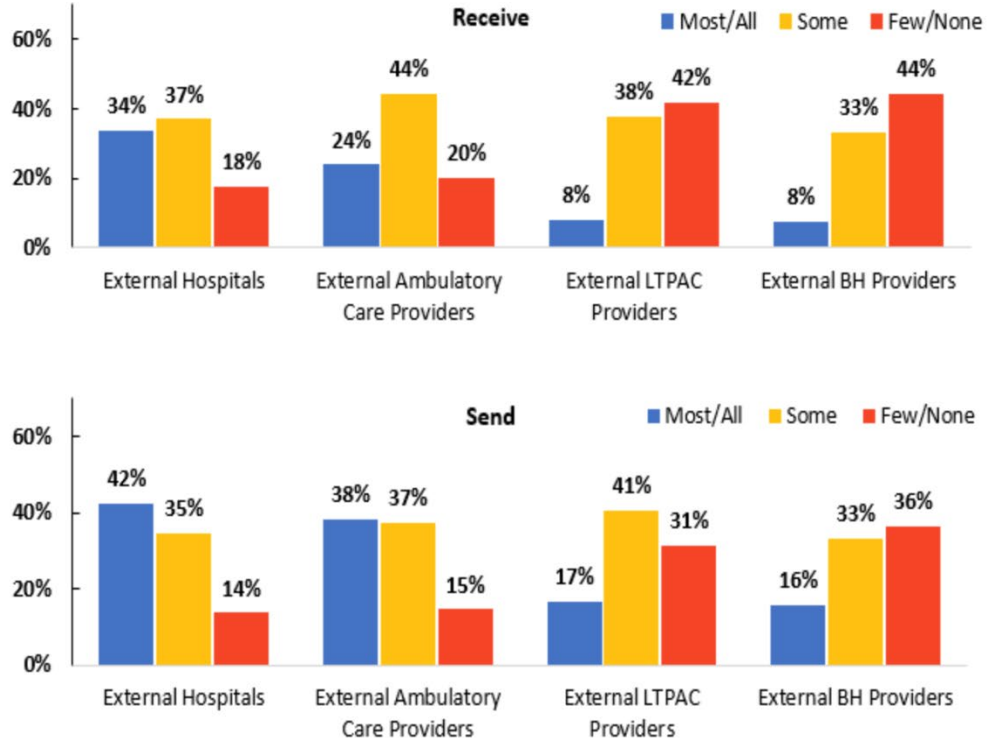
ONC Data Brief: Interoperable Exchange of Patient Health Information Among U.S. Hospitals: 2023

Figure 4: Availability and Use of Electronic Patient Health Information from External Providers at the Point of Care at Non-Federal Acute Care Hospitals, 2023



Source: HealthIT.gov. (2023). Interoperable exchange of patient health information among U.S. hospitals: 2023. Retrieved from HealthIT.gov

Figure 5: Ability of Non-Federal Acute Care Hospitals to Electronically Share (Send and Receive) Summary of Care Records with Outside Providers: 2023



Source: HealthIT.gov. (2023). Interoperable exchange of patient health information among U.S. hospitals: 2023. Retrieved from HealthIT.gov

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Persistent Challenges, Despite Improvements

- Fragmented Systems
- Data Silos
- Resource Disparities
- Usage Gaps
- Incomplete Data Sharing
- Technical Barriers
- Regulatory Hurdles

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Closing the GAP: Collaborative Actions for Healthcare Teams

- Adopt Standardized Communication Protocols
- Enhance Training and Education
- Utilize Interoperable Technology Tools
- Promote Cross-Provider Collaboration
- Advocate for Interoperability Standards
- Maintain Data Security Best Practices
- Engage with National Networks
- Facilitate Patient Access to Health Information
- Monitor and Report Interoperability Issues
- Support Resource Equity in Healthcare Settings

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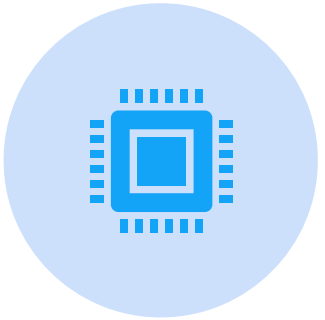
Key Takeaways

Effective transitions of care require accurate medical and mental health diagnoses, comprehensive treatment plans, and clear communication among interdisciplinary teams.



Enhancing standardized protocols, technology integration, collaboration and seamless data exchange is crucial improved patient care between acute, long-term, and behavioral health care settings.

Empowering health care teams with continuous education and resources helps address care gaps and promotes equitable access to high quality health care.

Ongoing efforts are needed to overcome technical and regulatory challenges facing patients with serious mental illness during transitions of care.

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Thank You!

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