Care Transition for Patients with Complex Behavioral Health Needs

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Care Transition of Complex Behavioral Health Patient

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Care Coordination

• “A collaborative process of assessment, planning, facilitation and advocacy for options and services to meet an individual's health needs through communication and available resources to promote quality cost-effective outcomes.”

- The Case Management Society of America
Patients with Complex Behavioral Health Care Needs

Who Are They?????

10% of Your Population Utilizes 60% of Your Resources

- Younger population (40 - 65)
- Substance abuse w/co-occurring medical needs
- Lack family/community support, homeless
- Unmanaged mental health or behaviors
- Underfunded, unrepresented
Needs not Complex, BUT Numerous

Typical Needs:
- Source of income
- Adequate nutrition
- Transportation to follow up appointments
- Safe housing (transitional or permanent)
- Telephone to communicate with care providers
- Obtaining medications and understanding instructions

Barriers to Care
Transition/Care Coordination

- Fragmented delivery care system
- Timely access to community services, i.e., transitional housing, primary care MD, FQHCs, crisis centers
- Inadequate training of care team members
- Lack of funding sources
- Insurers drive service delivery
Barriers to Care Transition/Care Coordination

- Information silos
- Lack of patients’ capacity to navigate complex health care system to meet their needs
- Lack of patient’s support system, i.e., family, significant other
- Tasks of making connections among multiple care providers and linking each intervention

Our Starting Point

- Identify the “Outliers”
- Identify “silos” of care
- Identify our community partnerships
- Identify gaps in transitioning complex patients
Reduced Hospital ER Capacity

- Fragmented care beginning with the initial patient assessment
  Behavioral health needs vs. medical management needs
- Lack of trained mental health professionals, i.e., delirium versus mental health crisis
- Increased observation days while awaiting appropriate placement/transition of care
- Intensive ER Case Management services

Most Challenging

Current reimbursement focuses on phases of a patient’s illness as defined by a specific site of service, rather than on the characteristics or care needs of the patient.
Partners

Service Inventory

• Mission
• Services/Programs
• Target Population
• Current Coordination Activities
It Takes Innovation

t h i n k i n g

THE BOX

Commitment

Total Patient Population Management
Partnership Behaviors

• A shared understanding of goals
• Effective communication
• Shared decision making – collaboration

Our Start at Innovation

• Collaboration within a provider network
• Escalated patient referral
• SNF Transition Liaison Program
• Complex care team (in design)
• Community non-clinical case management
Behavior Health Collaborative

Barriers Identified:
- Lack of transportation
- Lack of adequate housing
- Lack of awareness of services available
- Lack of primary care provider
- Lack of substance abuse services
- Transitional care patient tracking, i.e., acute>inpatient/outpatient mental services>SNF to community

Improving Care Transitions

- Daily complex case huddles
- Weekly complex case IDT review
- Telepsych consult in the ER as needed
- Addressed fragmented care> Nursing, Pharmacy>Case Managers>Specialists>Hospitalists>Social Services to coordinate plan of care
Improving Care Transitions (cont.)

• Exploring short term transitional housing
• Educating ED case managers on resources/options
• Educating case managers
• Educating nursing services

Case Study #1 – Escalation Process

63-year-old female long term resident of a SNF. Hx Schizophrenia and severe scoliosis with severe restrictive lung disease.
- Had been managed in a SNF for years
- Had been on hospice for almost a year and they were managing her pain and her increasing behaviors, i.e., screaming, increased pacing
- Had been on hospice secondary to a long hx of restrictive lung disease from severe scoliosis
Case Study #1

- Admitted to acute hospital for unmanaged verbal/physical aggressive behavior
- Initially placed in physical restraints and 24-hour sitter
- Psych consult and hospitalist assigned
- Pt. requires assist with ADLs; continues to demonstrate verbal and physical aggression and non-compliance with medication regime
- LOS 15 days
- Patient escalated for return to SNF placement

Case Study #2 – Community Care Management

- 40-year-old female with long Hx of substance abuse
- Prior to acute she was homeless
- Insurer: managed Medi-Cal
- Admitted for wound care and IV antibiotics
- Requires wound vac through acute hosp stay
- Has an involved daughter that lives in Southern CA and wants Mom to relocate there
- Currently lacks funding for housing
- LOS 12 days
Case Study #2

Patient needs:
• Replacement of California ID
• Temporary housing while re-establishing Medi-Cal
• Neuro Consult/Eval to obtain SSI (will take a few months)
• Assistance picking up medications
• Transport to FHQC for follow up appts

Support needs to continue until SSI approved and she is able to relocate to Southern CA

Case Study #3 – Complex Team

• 32-year-old with Hx of IV drug abuse, non-compliance and positive for syphilis; also Hx of Hep C, HIV/AIDS
• Insurer: managed Medi-Cal
• Admitted for pyelonephritis
• ADL independent, alert and oriented
• LOS: 7 days
**Case Study #3**

Patient needs:
- Vancomycin 1g IV q8 for 3 more weeks with blood monitoring
- Identify SNF willing to accept this patient. Home infusion is not an option due to Hx IV drug use
- Plan to return home after short-term SNF stay

**Case Study #4 – Telepsych**

- Male patient in his 40s brought to ER for increasing aggressive, violent behavior in room and board housing
- Patient admitted to being off his medications
- Identified that patient had previous medical support through community clinic
- Patient remained in observation while Telepsych Consultation was utilized to get patient back on appropriate medication
- Room and board refusing to accept patient back
**Case Study #4**

Patient needs:
- Alternative housing placement
- Sought support from Community Placement Agency with experience in placing “difficult to place” patients
- Re-connect with community clinic for follow up care for co-occurring mental health and substance abuse condition

**Failure Is:**

When the individual’s overall plan of care plan falls on the lap of the individual alone without effective partnering or support.
**Bottom Line**

It’s All About Partnerships

- Development of collaborative partnerships with vital continuum providers
- Improved options for complex patient placement & avoid ↑ LOS
- Improved warm handoff
- Improved patient experience and quality care outcomes
- Right care at the right time in the right care setting
My Wish List

- Interoperable electronic health records
- Moving from coverage to care
- Improve reimbursement systems that focuses on phases of a patient’s illness and characteristics of the patient’s care needs, rather than on site of care
- Improve timely access to services, i.e., transitional housing and primary care MDs
- Improve communication among care providers
Thank You

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