Yes, We Can! Build Bridges Back to the HCH Medical Home after Mental Health Hospitalization

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Partners on the road to health, hope and home
Duffy Health Center

**Mission:** to improve quality of life for persons who are homeless or at risk of homelessness on Cape Cod through community collaborations and the provision of integrated medical, mental health and addiction treatment, case management and housing support services.”

94 Main St., Hyannis, MA
GOALS OF WORKSHOP

- Participants will understand how adapting Critical Time Intervention strategies increase access and continuity of care back to the HCH health care home for mental health consumers.
- Participants will have an understanding of challenges with the Bridge project model.
- Participants will understand ways to replicate components of this model.
PROBLEM STATEMENT

- Revolving cycles of re-admission to hospital, including for inpatient psychiatric care and partial hospital program
- Lack of continuity of care in discharge planning
- Communication barriers with hospital
- Delays in access to outpatient behavioral health and medical follow up
- Patients’ health and recovery at risk
AIM STATEMENT

- Reduce re-admission rates to ER and Psychiatric Unit
- Improve continuity of care during transition to PCMH through *engagement*
- Facilitate access to *treatment* at the PCMH
- Improve patient *retention* and in doing so, outcomes
CRITICAL TIME INTERVENTION

Traditional Core Components – ADAPTED FOR BRIDGE TEAM
- Addresses a period of transition
- Time-limited
- Phased approach
- Focused
- Decreasing intensity over time
- Community-based
- No early discharge
- Small caseloads
- Harm reduction approach
- Weekly team supervision
- Regular full caseload review
WHY CTI?

- One reason that transitional periods are especially challenging is that clients are typically expected to navigate a complex and fragmented system of care.
- The transition period can also be a difficult time in the relationship between the client and his or her family and social network who may not be aware of how best to provide needed support.

Center for Advancement of Critical Time Intervention
www.criticaltime.org
CTI – WITHIN THE PCMH MODEL

CTI is time-limited and highly-focused...CTI’s emphasis is on mobilizing and strengthening client supports during the critical period of transition with the goal of ensuring that these supports remain in place afterwards.
Client Flow

- Outreach or Referral
- DHC
  - Existing with Services
  - Bridge Program
  - Not Eligible
- Outside Referral
PHASE 1 – ENGAGEMENT

- Purpose: To provide support and begin to connect client to Duffy as the Patient Centered Medical Home

- BRIDGE Team approach with distinct roles
  - CHW
  - LCSW
  - APRN
COMMUNITY HEALTH WORKER

Engagement objectives of the CHW:

- Explain and define PCMH pre-discharge
- Engage/re-engage with new and existing clients
- Schedule appointments in advance - expedites creating aftercare plans for continuity of care
- Provide appointment reminders (walking with clients!)
- Help clients prepare for appointments - accompanying them if needed.
- EHR registration
- Promote internal and external referrals
- Facilitate communications - hospital and Duffy
PHASE 1 – ENGAGEMENT cont.

Provide support and begin to connect client to Duffy as the Patient Centered Medical Home

- Team visits – Cape Cod Psychiatric Center
- Engage in collaborative assessments
- Meet with existing supports - staff
- Introduce client to new supports
- Give support and advice to client and caregivers
PHASE 1 ENGAGEMENT – cont.

Provide support and begin to connect client to Duffy as the Patient Centered Medical Home

- In reach to engage with patients
  - Targeted messages
  - Relationship building
  - Peer support
  - Hospital support
CASE STUDY - ENGAGEMENT

- (CHW services)

- Open Discussion
PHASE 2 - TREATMENT

PURPOSE: To continue engagement, provide treatment, and ensure access to care to Duffy as the Patient Centered Medical Home

- ROLES OF THE TEAM
  - APRN
  - LCSW
  - CHW
  - (Other - Connections...psychiatrist/med/CM)
PHASE 2 - TREATMENT

To continue engagement, provide treatment, and ensure access to care to Duffy as the Patient Centered Medical Home

- Overcoming barriers through rapid access - 24-72 hrs.
  - Medical officer of the day

- Triage officer of the day

- Fast track to Bridge group
Client Flow

- Name_________ Start Date______

  MD___ TOD___ BH___ Psych Referral___

  CM___ Benefits___ Special___________

  Graduation Date______
PHASE 2 - TREATMENT

To continue engagement, provide treatment, and ensure access to care to Duffy as the Patient Centered Medical Home

- **BRIDGE GROUP – 8 WEEKS**
  - overcomes the 3 week BH wait period
  - obtain consents and medical records
  - offers group counseling
  - individual patient assessment and treatment policy
  - update labs
  - medication management
  - community resources accessed
CASE STUDY - CTI

- (Brian’s case)

- Open Discussion
HOW DO WE DO ALL THIS?

- *SECRET WEAPON -*

SHARED MEDICAL APPOINTMENT
Shared Medical Appointments

- 1.5 hours long – billing considerations
  - Individual patient consents
  - Group facilitation
  - Individual medical visits (patients pulled out for medication mgmt. and medical review)
  - Chronic disease discussion
  - Peer support

- Putting Group Visits Into Practice - Massachusetts General Hospital
- Group Visit Starter Kit - Improving Chronic Illness Care
- http://www.annfammed.org/content/12/4/324.full
CASE STUDY – SMA

(Faith’s case)

Open Discussion
PHASE 3 – RETENTION

PURPOSE – To continue engagement and other strategies to help patient become an active participant in his or her own health, wellness, and recovery

- Patients transition to BH options
- Medical services are in place
- Patients feel comfortable to transition to other team members
PHASE 3 – RETENTION, cont.

PURPOSE – To use engagement and other strategies so patient becomes an active participant in his or her own health, wellness, and recovery.

- Roles of the team:
  - APRN
  - LCSW
  - CHW
  - ...OTHER?
OUTCOMES

P’s contacted in the hospital (N = 203)

P’s who presented to Duffy for follow up after discharge (n = 172; 85%)

P’s who received benefits counseling/assistance (n = 70; 41%)

P’s who kept medical appointments (n = 131; 76%)

P’s who kept BH appointments (n = 129; 75%)

P’s who met with a psychiatrist (n = 79; 46%)

P’s who had follow up with case managers (n = 46; 27%)

P’s who followed up with MAT team for addiction treatment (n = 21; 12%)
OUTCOMES cont.

- Open Discussion
MONITORING AND EVALUATING

- Regular intervals
- Team review
- Valid screens (QOL, BDI-II)
- Other:
CHALLENGES

- Open Discussion
System Level Benefits

These hands-on strategies help achieve PCMH, HRSA, and other agencies’ policies that require access and continuity of care for hospitalized patients discharged with mental health conditions.
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