Integrated transitions of care for people experiencing acute mental health crises

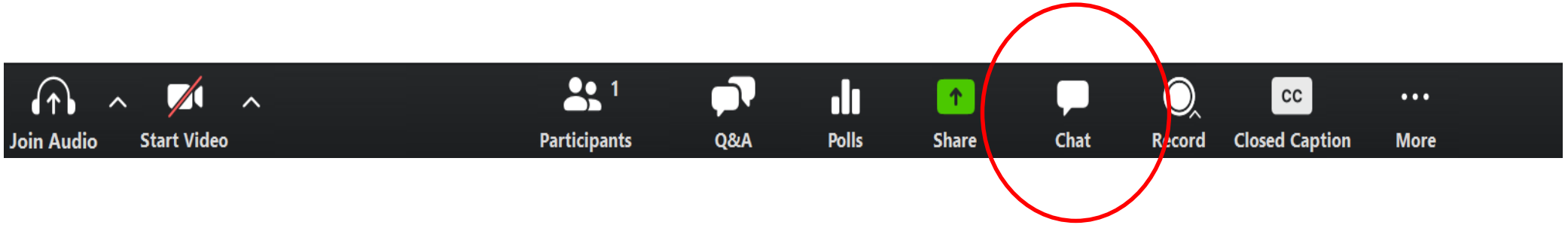
Kristina Monti, PhD, LCSW
Sara Kluge, LCSW
Madeline Gray, MSPH

Agenda

- Introduction – Rebecca Sax, National Center
- Housekeeping – Rebecca Sax
- Presentation:
  - Kristina Monti, PhD, LCSW, Mount Sinai Morningside
  - Sara Kluge, LCSW, Mount Sinai Morningside
  - Madeline Gray, MSPH, Mount Sinai Morningside
- Q&A
- Wrap-up & next steps – Rebecca Sax

Housekeeping

- This event will be recorded
- Please keep yourself on mute (by phone or on the Zoom platform)
- All questions and resources should be submitted through the chat feature
- Individuals will be selected to participate out loud. If you would prefer not to be called on, please place an asterisk (*) at the beginning of your chat
- To unmute your phone, press *6



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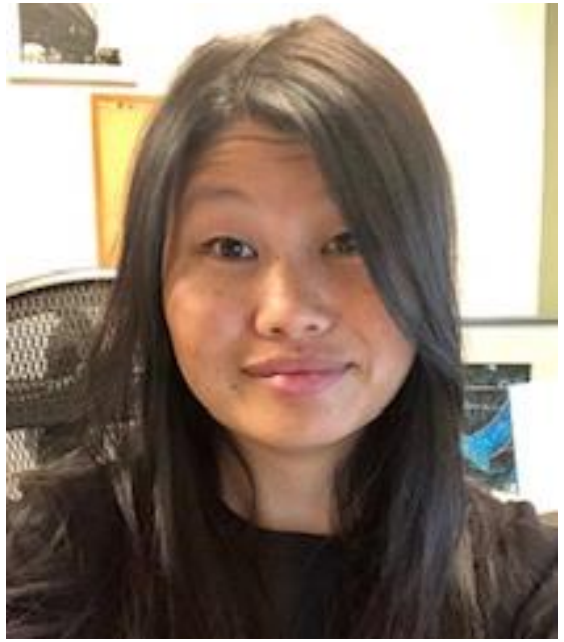

Sara Kluge, LCSW
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Integrated transitions of care for persons experiencing acute mental health crises

Mount Sinai

Happy Social Work Month!

TABLE OF CONTENTS

01 - SESSION OBJECTIVES

LEARN...

...how to develop strategies for the development of a cross-modality intervention that encompasses service delivery across acute care, community-based, and ambulatory settings.

UNDERSTAND...

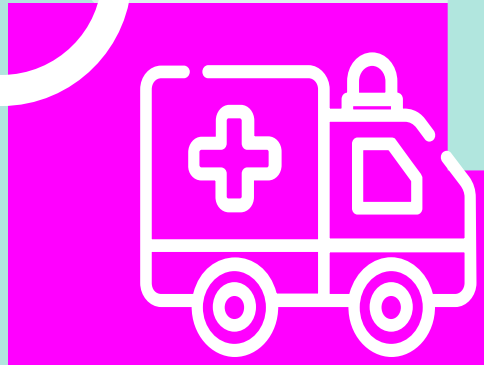
...the benefits of and opportunities for the integration of mental health peers into treatment teams and the complimentary role they have on a complex care initiative.

CONCEPTUALIZE...

...the difference between a community-based psychiatric crisis and a “transitional crisis” and the associated best practice for intervening.

02 - BACKGROUND

Our model started in the context of a rapid response mental health crisis pilot...



Mount Sinai Morningside

NYC WELL Talk. Text. Chat. 24/7

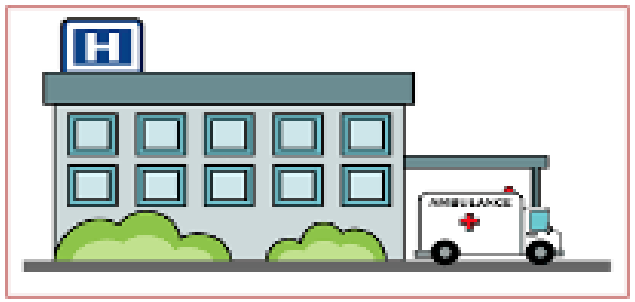
NEW YORK STATE | Office of Mental Health

NEW YORK STATE | Office of Addiction Services and Supports

NYC THE NEW YORK CITY DEPARTMENT OF HEALTH AND MENTAL HYGIENE

Psychiatric Crisis in the Community

911



CPEP

General ED

NYC WELL
Talk. Text. Chat.
24/7

911

Co-Response Team

Mobile Crisis Teams (Adult)

- Urgent: Within 24 hrs
- Non-Urgent: Within 48 hrs
- Post Crisis Follow Up: Within 72 hrs

Goals of the NYC BH Crisis Response Pilot

<2 hr

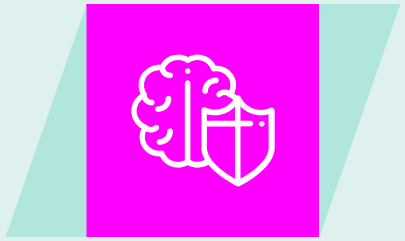
Implement Mobile Crisis Rapid Response

Reduce unnecessary ED visits

Reduce 30-day readmissions from ED and inpatient

Rapidly (24-48h) connect patients to care

Operationalize electronic referral transmission and workflow



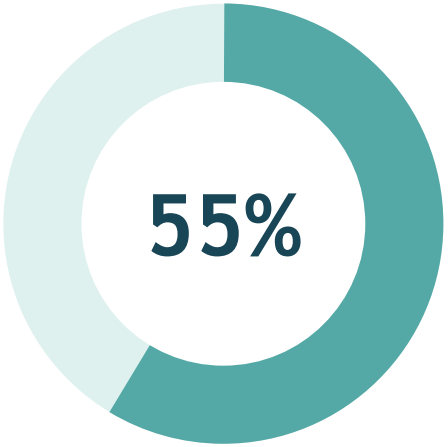
87%

REFERRALS RESPONDED TO IN UNDER 2 HOURS*

*Data collected from 1/1/17 - 4/11/18

Mobile Crisis - Linkage Types*

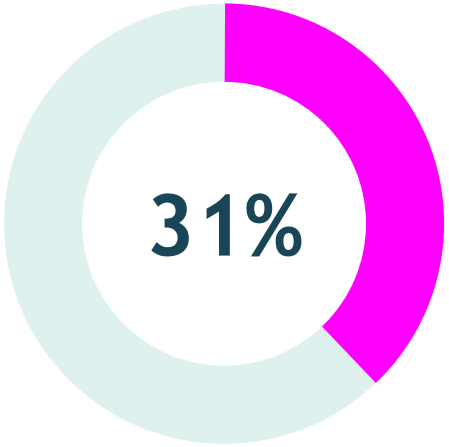
Linkage Appointment: Provider Type



Return to existing provider

(vs new provider intake)

Referral Source



Outpatient Mental Health Provider

(vs. family/friends, care managers, etc)

*Data collected from 1/1/17 - 4/11/18

Mobile Crisis - Referral Types*

TRUE CRISIS

- More likely to live in a shelter/assisted living residence (51%)
- Tend to have either psychotic DO (49%) or adjustment DO (15%) dx
- All MCT cases ending in removal to CPEP have come from this patient group (n = 4)

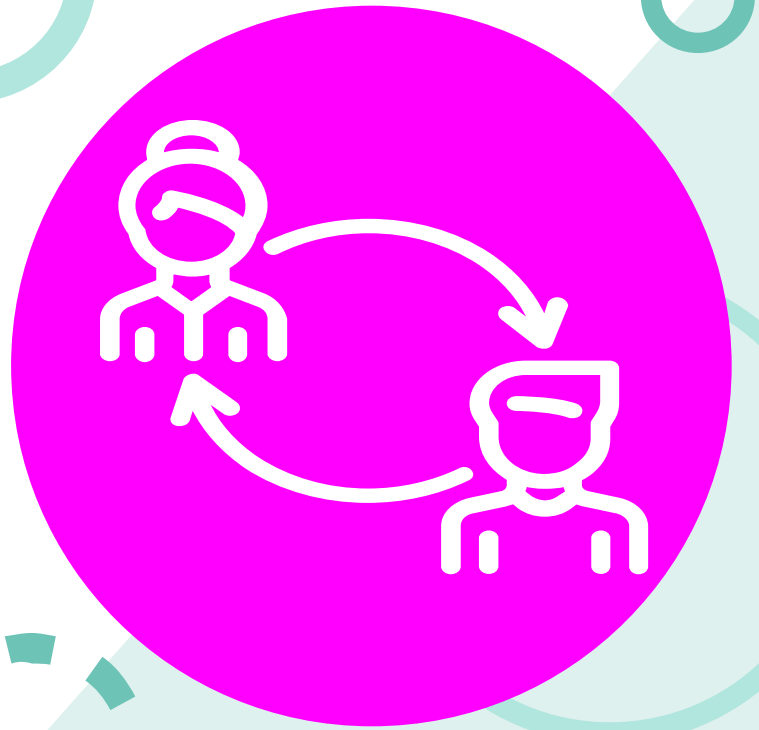
OUTREACH

- More likely to live independently (58%)
- Tend to have either mood DO (39%) or psychotic DO (24%) dx
- More likely to be successfully contacted & agree to f/u appointment

*Data collected from 1/1/17 - 4/11/18

03
METHODOLOGY

Creating a Mobile Outreach Team



Staffing

LICENSED SOCIAL WORKER

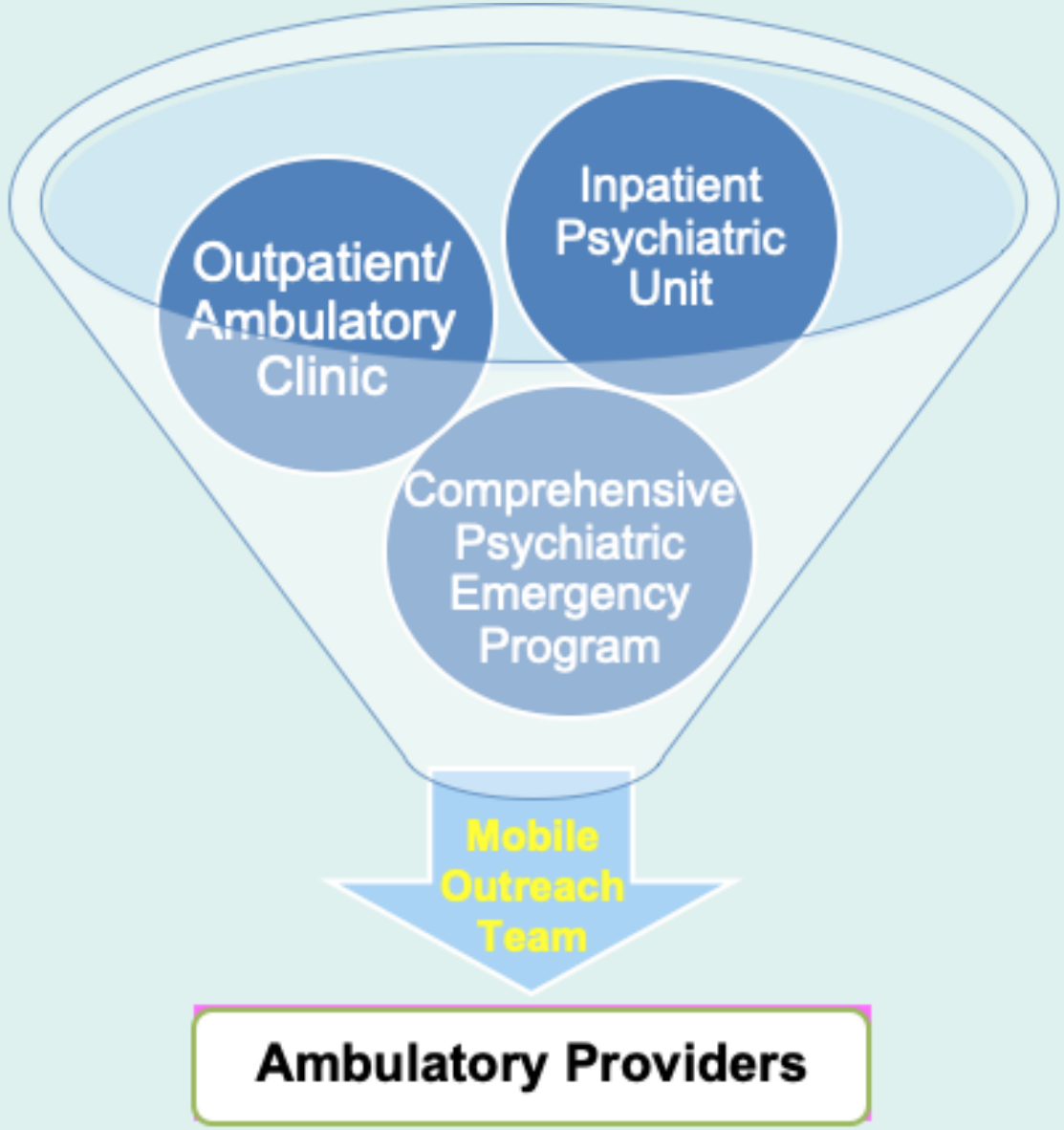
- Screens the referrals from various referral streams
- Provides psychotherapeutic strategies to educate and engage patients, assess for any psychosocial barriers,
- Connects to eligible services, uses motivational interviewing, and continues to assess patient mental status post discharge.

CREDENTIALED PEER COUNSELOR

- Someone with lived experience, recovery can be found in three pillars: medication management, coping strategies, and natural and professional supports.
- Peer Counselors provide hope to clients that recovery is possible, model for them sustained wellness, and let them know that they are not alone in their struggles.

Operational Model

- Focus on engagement and transitions of care from inpatient or CPEP to outpatient
- Assess non-urgent calls and re-engage with outpatient treatment and other referrals as needed



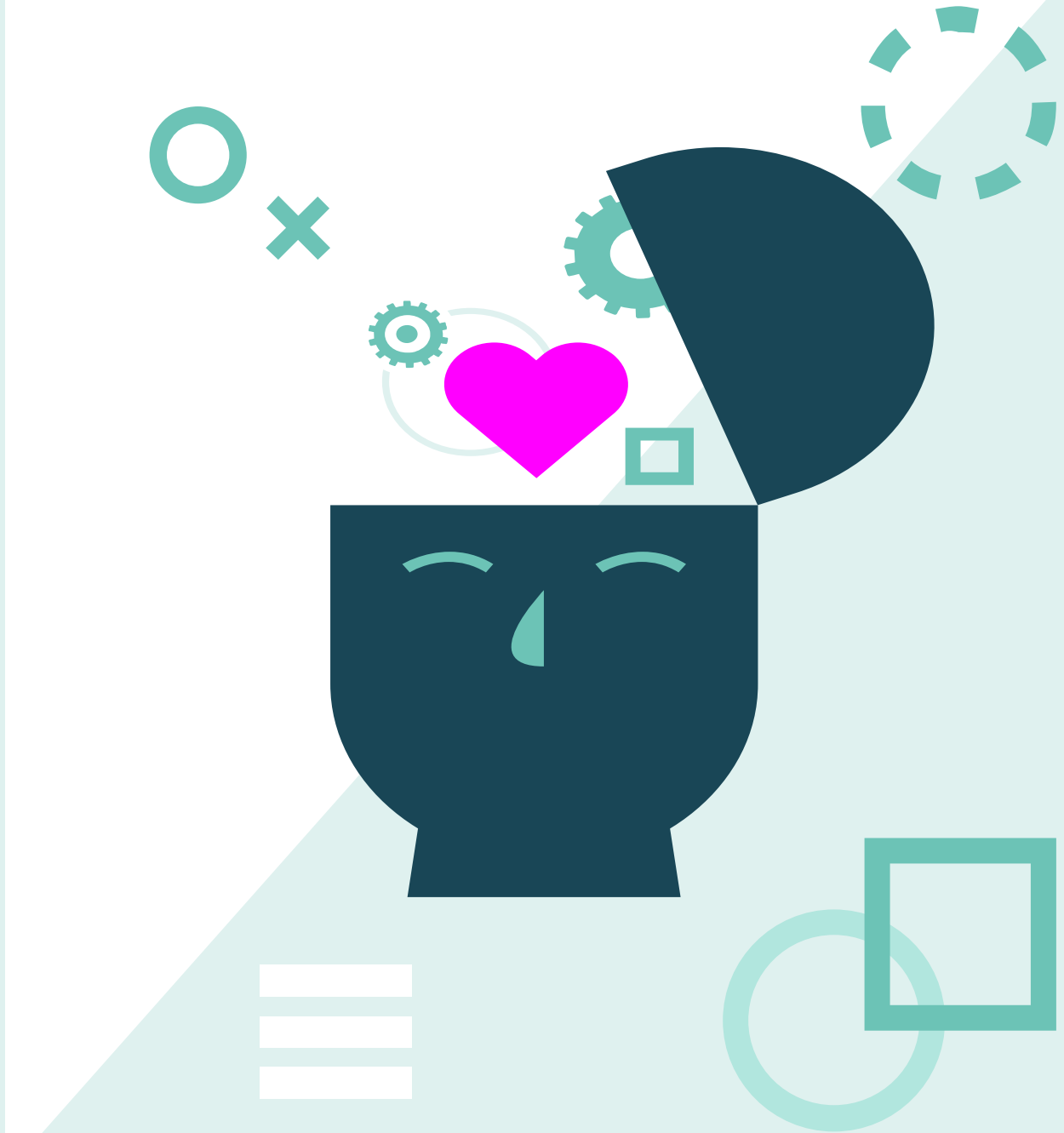
Data Collection & Analysis

- Data collection occurred between June 1, 2018 – September 30, 2020
  - Includes 3-month follow-up window for clinic retention and hospital readmission

- Data collected in monthly tracking sheets by MOT and maintained and collated in a master list by program leadership

- All percentages are calculated based on the denominator of **N = 258** unique referrals

04 - CASE EXAMPLES & FINDINGS



Case #1 - Overview

- ➔ PT is a 24 y/o F, born and raised in Uzbekistan, monolingual (Uzbeki)

- ➔ PT moved to US 5 yrs ago, is green card holder, PT was married, husband left 2 months later when discovered PT was pregnant

- ➔ PT 2 months pregnant. PT was BIB EMS after friend learned she made cuts with a knife on her wrists. PT has no formal MH past, diagnosis of Adjustment Disorder

Case #1 - Interventions

ENGAGEMENT

Used language services to build rapport, identify barriers: “I don’t know how I will pay rent,” (financial) “I have not seen a doctor for pregnancy” (lack of formal supports), “I have any support here” (Lack of informal supports), “I have no phone”

COMMUNITY VISIT

At home visit, escorts to appointments

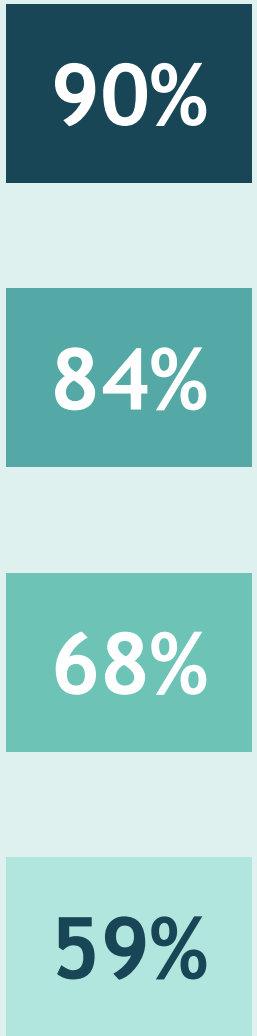
CARE COORDINATION

Track Phone, Insurance (PCAP), benefits

LINKAGES

Intake Clinic Appointment, OBGYN appt, Health Home and Rental Arrears program (HRA)

Mobile Outreach - Findings I



INTERVENTION PROVIDED

n = 233

1st APPOINTMENT ATTENDANCE

n = 217

2nd APPOINTMENT ATTENDANCE

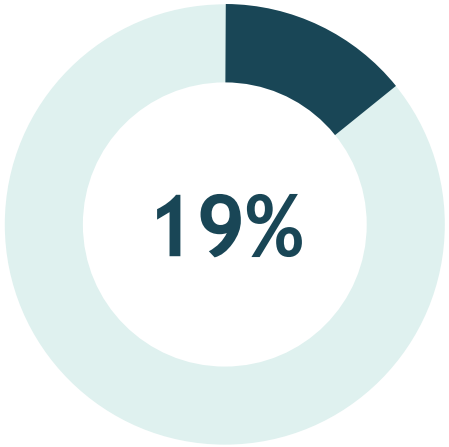
n = 176

3rd APPOINTMENT ATTENDANCE

n = 151

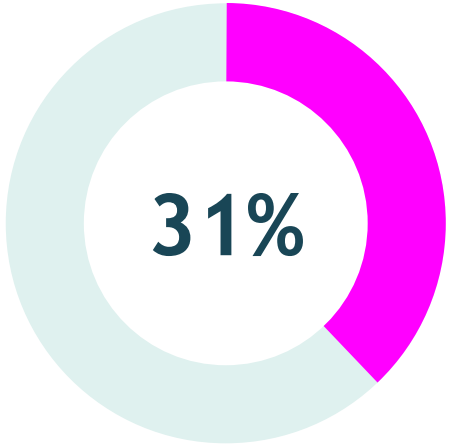
Mobile Outreach - Findings II

30-day Readmission, any cause



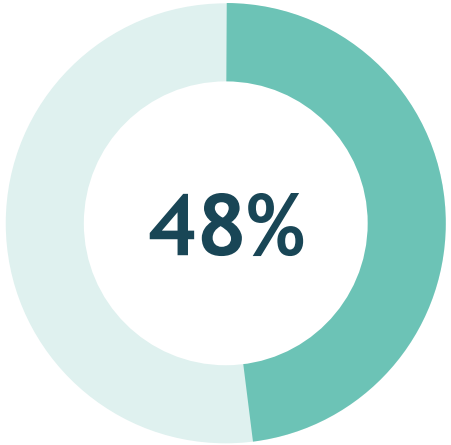
n = 49

90-day Readmission, any cause



n = 80

90-day Clinic Retention



n = 123

Case #2 - Overview

- ➔ PT is 18 y/o Senegalese, female, domiciled with biological mother, step father and 6 siblings (5 sisters with whom she shares one room), biological father in West Africa
- ➔ PT is in the 11th grade and attends high school, Diagnosis of Bipolar and Schizoaffective Disorder
- ➔ 6 prior hospitalizations since age 13 y/o
- ➔ On unit, PT turned 18. On the day of her birthday she had a physical altercation with nurse and charges were filed.
- ➔ PT was arrested post discharge.

Case #2 - Interventions

ENGAGEMENT

Used therapeutic approach to initiate engagement, Blank slate, Peer counselor introduction, Identified Barriers: “My family doesn’t help me!” (informal supports), “I don’t even know why I am here” (lack of insight/psychoeducation), “I need to find other housing” (Housing), Exchange contact info

COMMUNITY VISIT

Police Station

CARE COORDINATION

Rescheduled clinic intake appointment

LINKAGES

Intake Clinic Appointment, ACMH Housing Coordinator

05 - DISCUSSION & IMPLICATIONS

PRACTICE

- ➔ Engagement, engagement, engagement
- ➔ Meaningful Interventions

RESEARCH

- ➔ Replication in an open system
- ➔ Peer Specialist ←→ Social Worker

POLICY

- ➔ Coordinating the Coordinator

EDUCATION

- ➔ Leadership
- ➔ Intersection with Peers/Role of Peers

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MSBI and MSM

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ACMH

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Community Access

Educational Alliance

Housing Works

Institute for Family Health

New York City Health & Hospitals – Lincoln, Bellevue

New York Presbyterian Hospital – Columbia, Weill-Cornell

Richmond University Medical Center

Services for the Underserved

Association to Benefit Children, Inc.

Questions?

Submit your questions through the chat feature

If you prefer not to be called on, please place an asterisk (*) at the beginning of your chat

For more information

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Upcoming National Center webinars

March 31, 2:00 – 3:00 ET

Reducing hospital utilization in native Hawaiians by focusing on social determinants of health

April 13, 3:00 – 4:00 ET

Quality improvement in care provision for children with medical complexity: What does transformative family partnership look like within interprofessional teams?

April 29, 2:00 – 3:00 ET

JASA and Healthfirst: A community-based organization and health insurer partner to improve care transitions for older adults with complex health and social needs

Register at www.nationalcomplex.care

We want your feedback!

An evaluation survey will be sent out after this webinar

Thank you!

National Center for Complex Health and Social Needs
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