LEARNING COHORTS AGENDA

24 October 2019 | 9:00am-2:30pm
The Philanthropy Center, 1020 W. Riverside Avenue

Goals: Participants walk away with ideas for best practices they can incorporate in their organizations around communications, business/financial incentives, and patient self-care, planting seeds for potential Y2 contract activities. Participants also have a better sense of the care transitions work – both expertise and challenges – of other organizations in our region.

8:30 - 9:00 AM	Breakfast & Networking	
9:00 - 9:15 AM	Welcome, Introductions, and Agenda Overview	Sarah Bollig Dorn Better Health Together
9:15 - 9:30 AM	Improving Care Transitions: The Big Picture • Ultimate objective • Check your assumptions • The value of feedback loops • Best solutions are local ones	Eric A. Coleman, MD, MPH Director, Care Transitions Program
9:30 - 10:40 AM	Mini-session #1: Communication Overview presentation (15 min) • Who "owns" the care plan and med list? • Role of sender versus receiver • Anticipatory guidance • Defining what elements are "essential"-the big 5 Case Presentation – NEW Alliance (5 min) Breakout groups (25 min) • What has been your experience in addressing similar challenges in promoting cross-setting communication? What have you tried and what did you learn? • Based on what you have been learning, what could have been done differently in this particular case? Reconvene larger group (25 min) • Feedback & insights from small group participants	Eric A. Coleman, MD, MPH
10:40 - 10:50 AM	Break	
10:50 - 12:00 PM	Mini-session #2: The Business Case Overview presentation (15 min) • Evolving financial incentives for improving care transitions • Making the business case for cross-setting collaboration/partnership	Eric A. Coleman, MD, MPH

	• Known and lesser known financial levers • The argument for taking a multi-faceted approach Case Presentation – Sunshine Terrace (5 min) Breakout groups (25 min) • What has been your experience in addressing similar challenges in identifying and pursuing financial incentives to improve care transitions? What have you tried and what did you learn? • Based on what you have been learning, what could have been done differently in this particular case? • What care transition delivery changes have you made to improve your finance/business model? Reconvene larger group (20 min) • Feedback & insights from small group participants	
12:00 - 12:30 PM	<u>Lunch</u>	
12:30 - 1:40 PM	<u>Mini-session #3: Patient Self-Care</u> Overview presentation (15 min) • Prepare for when no professionals are around • Do we inadvertently foster dependency? • Role of simulation to promote skill transfer • Tracking self-confidence across settings • Goal elicitation as a Rosetta Stone Case Presentation – STARS (5 min) Breakout groups (25 min) • *Please refrain from discussing your own challenges or those of your family members.* • What has been your experience in addressing similar challenges in promoting skills and confidence with self-care to your clients? What have you tried and what did you learn? • Based on what you have been learning, what could have been done differently in this particular case? Reconvene larger group (25 min) • Feedback & insights from small group participants	Eric A. Coleman, MD, MPH
1:40 - 2:00 PM	<u>Wrap-up</u> • Action steps going forward • Feedback & insights from participants	Dr. Eric Coleman
2:00 - 2:15 PM	<u>Next steps for the Learning Cohort</u>	Sarah Bollig Dorn Better Health Together

Case Study #1 – Communication

Organization: NEW Alliance Counseling

1. *Which category does this case study best illustrate?*

   Communication Business Case Patient Self-Care

2. *Brief overview of case and how it illustrates (Communication / Business Case / Self-Care). Mention the professionals/agencies/organizations involved. (2 min)*

   "Mike" was involved in Crisis Services and was subject to an Involuntary Treatment Act (ITA) and detained to NEWACS Evaluation and Treatment Center under a mental health (MH) ITA. During that time Mike received discharge planning services which involved an NEWACS outpatient provider coordinating clients' needs and services. Mike transitioned from an MH inpatient facility to a substance use disorder (SUD) inpatient facility and discharge planning services were continued.

   After release from inpatient on a Least Restrictive Alternative (LRA) court order, Mike was admitted to NEWACS Crisis Stabilization Facility (CSF). Mike was enrolled in outpatient MH and outpatient SUD services. When stabilized Mike was transitioned into the Long Term Stabilization Apartments and was connected with a case manager to assist in obtaining housing and access to community services. In addition, Mike also receives medication prescription management services and medication monitoring services with NEWACS.

   Case Manager/Peer Support has connected Mike to DSHS Home and Community Services (HaCS) to obtain assistance in housing and caregiver access, as well as, connections with primary care.

3. *Key client/patient information (de-identified): personal care goal(s), functional status, living environment including level of family support, ability to participate in care decisions, and top three most pressing health conditions. (2 min)*

   Mike is working with peer support/case manager to improve his basic living skills to include meal preparation; managing medication; personal hygiene; maintaining a home, etc.

   Mike is currently residing in NEWACS LTSA. Mike has family support with his mother and aunt, whom live close by and visit with him often.

   Mike struggles in making care decisions without prompting. He often requires introduction to interventions, education, and multiple attempts to engage Mike in his own care decisions.

   Most pressing health conditions are obesity, high blood pressure (late twenties), and extensive dental problems.

4. *What was attempted and what result was or was not achieved? What were your takeaways? What could have been done differently in this particular case? (1-2 min)*

   Mike was referred to medication prescription management and daily medication monitoring which he has fully engaged in. Mike has been willing to take medications and symptoms are well managed.

   Mike works well with provider and is able to communicate his needs, side effects, and symptoms.

   Mike was referred to assisted living facilities for long term housing. Mike has refused to consider a group living environment, to include, refusing to accompany peer support on a "field trip" to see what these facilities are like and what they have to offer.

   Mike is adamant that he wants to remain in the immediate Colville area near his family support.

Mike has been willing to allow case manager to assist with completing his Social Security Disability approval as he receives very minimal financial and food support.

Mike has been willing outpatient SUD group treatment; however, does not desire to attend outpatient MH group.

Takeaways:
Relationships are HUGE for Mike. He has had a couple of changes in outpatient clinician due to staff changeover and it has taken time for his new clinician to build/establish rapport. Mike has a lot of personnel strengths, is able to set boundaries, and is resilient.

Case Study #2 – Business Case

Organization: Sunshine Terrace (Sunshine Health Facilities)

1. *Which category does this case study best illustrate?*

   Communication Business Case Patient Self-Care

2. *Brief overview of case and how it illustrates (Communication / Business Case / Self-Care). Mention the professionals/agencies/organizations involved. (2 min)*

   As individuals begin to age and require higher levels of care, Sunshine Terrace (Assisted living facility with a behavioral health agency) is faced with the task of assisting with placement of behavioral health residential clients into a higher level of care. From this growing, identified need, a program at Sunshine Health and Rehab (Skilled Nursing Facility) was created under the supervision of administration and myself (as project manager) to help: 1.) Increase census at a higher Medicaid rate at a skilled nursing facility and 2.) Promote the philosophy of being a "campus of care" and having individuals with higher level of care needs with behavioral health issues placed in an appropriate level of care.

   Issues/Concerns:
   1.) Behavioral Health Clients at a skilled nursing facility that has not managed behavioral health individuals. This includes training/supporting staff.
   2.) Medicaid rates insufficient for daily cost of individual at Skill Nursing Facility
   3.) Medicare clients preferred.
   4.) Staff viewed client as "behavioral health client, very challenging"

3. *Key client/patient information (de-identified): personal care goal(s), functional status, living environment including level of family support, ability to participate in care decisions, and top three most pressing health conditions. (2 min)*

   Female residents in mid-late 60s, requiring more hands-on care with ADL care then our assisted living facility can provide. Chronic Schizophrenia/Schizoaffective disorder, with disturbing hallucinations/delusions including "having flesh removed, eaten, being poisoned, babies, being killed/murdered, etc). Refusal of medications for behavioral health and health related issues, thyroid issues (req. medication), diabetic, CoPD. Has a husband who visits daily, unable to live with husband, husband unable to assist with resident's care and encouraging client to

comply with care needs. Client was unwilling to shower, change clothing, and talk to medical professionals regarding medication, depression/mood.

Client makes poor care decisions often influenced by delusions. Top three most pressing health conditions: 1.) Treatment-resistant schizoaffective disorder. 2.) Hypothyroidism 3.) Diabetes 2 (choosing not to follow diabetic diet)

I wanted to place client from assisted living facility to skilled nursing facility.

4. *What was attempted and what result was or was not achieved? What were your takeaways? What could have been done differently in this particular case? (1-2 min)*

1.) Client was initially refused by our skilled nursing facility due to allegations made from delusional statements. Staff felt that she would be an "investigation nightmare" due to the allegations made that would require constant reports to state due to skilled nursing facility regulations. Client was assessed by DCR and placed in an evaluation treatment (E & T) for approximately a month.

2.) I worked to convince staff and administration that "client appeared worse on paper and in discussion" but in reality, was not. Offered clinical oversight by me and in-house social services. Discussed that, I personally felt that client would do better with more staff support in skilled nursing facility than was doing in assisted living facility.

3.) Ultimately facility accepted client. I had to work diligently with staff and prescriber to discuss appropriate medication review.

4.) Medicaid in skilled nursing facility is frowned upon due to low reimbursements

5.) Really uncertain as to what could have been done differently.

Current Update on Client:

1.) Client has had no medication refusals for past 2 weeks.

2.) Client was started on Depakote at 1000mg approximately a month ago. Client's mood has improved significantly. This was achieved by diligent and persistent establishment of rapport from myself and prescriber. Client now smiles and comes out of room more often.

3.) Recognized that interactions with Husband impacted behavior. Since Husband is PoA we were able to arrange a visitation schedule where Husband will call and get updates on client's behavior before visiting. Has helped to reinforce appropriate behaviors, including accusations against staff. May have helped differentiate between delusional statements and statements made as a behavior.

4.) Slowly becoming one of staff's favorites.

Case Study #3 – Patient Self-Care

Organization: Spokane Treatment & Recovery Services (STARS)

1. *Which category does this case study best illustrate?*

Communication Business Case <u>Patient Self-Care</u>

2. *Brief overview of case and how it illustrates (Communication / Business Case / Self-Care). Mention the professionals/agencies/organizations involved. (2 min)*

   The patient was a high utilizer of the ED, who originally came to us through our Providence Community Liaison program and Consistent Care. The patient openly conveyed that they weren't interested in being housed because, "they enjoyed the freedom of the homeless/street lifestyle". The patient also had a difficult time trusting anyone, especially professionals. The patient was opposed to consistently taking mental health medications because, "they believed the voices were good for them and the medications would drown them out". Many attempts at medication assisted treatment and SUD inpatient/outpatient were attempted but these attempts would always result in only very brief periods of sobriety. The patient would continually return to active use because, "they wanted to hear the voices and the substances enhanced them". It was clear that we had to get creative and work with many professionals, across agencies, if we were to find success in this case. In that way, it demonstrated communication/collaboration. It was also abundantly clear, we had to help the patient see the value in normal housing and consistent mental health medication/treatment. In this way, it demonstrated patient self-care.

3. *Key client/patient information (de-identified): personal care goal(s), functional status, living environment including level of family support, ability to participate in care decisions, and top three most pressing health conditions. (2 min)*

   First goal was to help patient see the value of being in a safe environment (the patient often left treatment due to a desire to be on the streets). If we were going to have success in the following goal(s), the patient would need to remain in a safe environment for an extended period. The next goal was to get the patient taking their MH medication regularly. Once those goals were achieved, the patient needed to move into an extended period of co-occurring treatment. Finally, move on to sober living and maintenance therapy/treatment. The patient had absolutely no support, other than the team of professionals working with them. The patient was able to participate in care decisions but would often minimize. The most pressing health conditions for this patient were Hepatitis C, High Blood Pressure, and of course the Mental Health. We worked with SMART Hub & Spoke, Consistent Care, and other providers to achieve these goals.

4. *What was attempted and what result was or was not achieved? What were your takeaways? What could have been done differently in this particular case? (1-2 min)*

   After numerous episodes in our withdrawal management program, we noticed the patient began to trust the STARS WM staff/facility. The patient would quickly leave other treatment providers but would always stay for as long as possible in our program. The final time the patient was with us, we tried something new. Instead of referring the patient to another treatment provider, we referred him to our co-occurring IOP program, but we kept the patient in our WM facility. The patient wasn't in withdrawal management as a patient but instead, they were just physically there. Their treatment was being provided by our IOP but anytime spent outside of IOP, was spent in WM, under the supervision of professionals, who the patient trusted. This gave us the opportunity to provide the patient with an extended period of MH medication management and ongoing therapy/treatment. Because the patient trusted STARS WM, they didn't leave. This also gave us the opportunity to grow the patient's trust with STARS as a whole and this led to even greater treatment opportunities. Once the patient was able to fully trust the process, the patient agreed to transfer into Cub House (Co-occurring recovery house). The patient eventually moved on from Cub House to sober living and as of last contact (October 2019), they're still in sober housing. We could have done a better job of immediately meeting the patient where they were at, rather than force them through "traditional methods". On the same token, it seems that traditional methods were all that we had at the time. We've since used this approach on other patients as well, but it took this case to break that mold.