Rapid Stabilization Inpatient Services in Systems of Care: Family-Centered, Youth Guided Interventions

Georgetown University Training Institutes

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Disclosures

Aradhana Bela Sood M.D.:
No disclosures to report
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No disclosures to report

Objectives

At the end of this Workshop, the participant will:

- Learn effective approaches for the reduction of coercive methods of treatment such as seclusion and restraint, including a collaborative model of inpatient care
- Learn how to implement changes to program models of inpatient care taking into account the need for shifts in program philosophy across all disciplines and team member
- Learn key concepts in developing programming for standard short inpatient stays with a focus on specific objectives of assessment and treatment planning
- Learn how to reduce rehospitalization in inpatient care by using transition planning for post-discharge care and an appreciation of systems of care within which they practice

Objectives

To do this, we will:

- Discuss the history of systems of care changes we have experienced in Virginia
- Present a model of change within the inpatient acute hospital setting at the Virginia Treatment Center for Children, and data supporting its effectiveness for reducing restraint and seclusion
- Present a model of change across systems in Virginia, starting with a structural model of inpatient care at VTCC that bridges into other outpatient care agencies, and emphasizes successful transitions between systems
- Evaluate the importance of inpatient acute hospitals as a center point for positive systems change and effective care for patients

History

- Early 1980s...
- Jane Knitzer and “Unclaimed Children” (1982)
- An acknowledgement of the complexity of serving children and families
- Comprehensive care model for children and adolescents with serious emotional problems (CASSP)
- Holistic orientation with family empowerment and cultural sensitivity

Systems of Care

- Stroul and Friedman, 1986:
  - Activities guided by the needs and preferences of the child and family using a strength based model
  - Services are based and managed within a multi-agency collaborative environment
  - All services and agencies consider the cultural context and characteristics of the child, family, and community (Burns and Hoopwood, 2002, Pumariega, 2003)
Systems of Care

- Assessment should be guided by an ecological context of the child and family.
- Use formal and informal supports from the community (a “wrap around” approach).
- Develop collaborative and strength-based care with families emphasizing partnership at both case planning and system planning level.
- Treatment planning should incorporate best practices and evidence.
- Provide a continuum of services that meet the needs of the child/family at any given point or anticipate those needs.


<table>
<thead>
<tr>
<th>Current Approach</th>
<th>New Approach</th>
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<tbody>
<tr>
<td>Care is based primarily on visits.</td>
<td>Care is based on continuous, trusting relationships.</td>
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<tr>
<td>Professional autonomy driven variability.</td>
<td>Care is customized according to needs and values.</td>
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<tr>
<td>Professional control care.</td>
<td>The patient is the source of control.</td>
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<tr>
<td>Information is a record.</td>
<td>Knowledge is shared and information is shared freely.</td>
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<tr>
<td>Decision making is based on training and experience.</td>
<td>Decision is evidence based.</td>
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<tr>
<td>No one bears an individual responsibility.</td>
<td>Safety is a system property.</td>
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<td>Secrecy is necessary.</td>
<td>Transparency if necessary.</td>
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<tr>
<td>System reacts to needs.</td>
<td>Needs are anticipated.</td>
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<td>Cost reduction sought.</td>
<td>Waste in constantly decreased.</td>
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<tr>
<td>Preference is given to professional roles over the system.</td>
<td>Cooperation between clinicians is a priority.</td>
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Where Does Inpatient Care Fit Into Systems of Care?

- Reasons for admission???
- Usually crisis stabilization
- Creative pharmacology...Take one off...put two on
- Revolving door
- Recidivism
- Self esteem and self efficacy spirals downwards both for child and family

Where Does Inpatient Care Fit Into Systems of Care?

- "Containment of crisis”
- Could the same care be given within a locked room?
- Functionality is unknown...Fairly traumatizing
- Yet Inpatient care remains a part of the system
- And that world is isolated from the rest of the system
Who Are We?

- Virginia Treatment Center for Children:
  - Child and Adolescent Psychiatry Division of Virginia Commonwealth University
- What we used to be (up to December 2008):
  - 46 beds: 18 RTC, 10 Day Treatment, 18 Inpatient Acute Outpatient Services
- As of 2009:
  - 24 Inpatient Acute Beds, RTC and Day Treatment Programs closed
  - Outpatient Services have grown
- Population served:
  - 3 to 18 year olds, all of Virginia
  - 60% Medicaid

Who Are We?

- Comprehensive Multidisciplinary Acute Team:
  - Psychiatry: 2 Faculty, 1 CAP Fellow, 1 Resident, Med Students
  - Psychology: 2 Faculty, 2 Post-Docs, 4 Interns
  - Social Work: 3 Full Time, 2 Students
  - Nursing: Magnet Rating
  - Occupational Therapy: 2 Full Time
  - Recreational Therapy: 2 Full Time
  - Education: City of Richmond Public School on site, IEP Coordinator

The Previous Philosophy

- Prior to 2006:
  - More of a traditional behavioral system
  - Implemented in all three programs: Acute, RTC, Day
  - Utilized point system – nursing and staff kept daily point sheets
  - Heavy emphasis on rules, rewards, consequences
  - Policies such as no hats on the unit
  - High rate of patient focus on points, behavioral responses to point deductions, use of chemical restraint, physical holds and seclusions

Program Changes

- Introduction of Comprehensive Crisis Management (CCM) in 2003:
  - Program emphasizing physical holds and restraints that are physically safe for children and adolescents
  - Training includes education on trauma-informed use of techniques to manage aggressive behaviors
  - As of 2013, using Therapeutic Options of Virginia
- Introduction of Collaborative Problem Solving (CPS) in 2006:
  - S. Ablon and R. Greene, 2002
  - Introduced as VTCC-wide change in philosophy toward the reduction of coercive elements of care

Program Changes

- Process of the Initiation of Change:
  - Several false starts: 8 month study of trauma and its ramifications: outside consultant; symposia
- Barriers/Challenges:
  - Staff mind set
  - Universally accepted models across the country
  - If we just hang in there, it will disappear
- Effectiveness and Monitoring:
  - Foggy at best

Seclusion and Restraint

- Organizational Culture and Seclusion/Restraint:
  - Authoritarianism (towards MI)
  - Social Restrictiveness (about MI)
  - Ethnically diverse male staff and most of psych nursing see S/R as positive
  - Lack of training re trauma informed care
  - More education: S/R less likely
  - Staffing ratios, transition times: higher number of restraints
  - What reduces S/R...
Seclusion and Restraint

- **Downsides:**
  - Harmful physical and psychological consequences of physicality of act
  - Power and control are often the dynamic; no rationality within an interaction
  - Only 8% agreement for reason to seclude and restrain
  - Negative view by patients, staff injuries, need for male staff
  - Mortality with restraints

- **Long term concerns:**
  - Counter to trauma informed care
  - Re-traumatization of a vulnerable population
  - Socializing into a rigid mind set (Morrison, 1990)

Seclusion and Restraint

- **VTCC Study of Predictors of Seclusion/Restraint in Children and Adolescents:**
  - **Methods:**
    - Systematic analysis of 1,465 admissions
    - Period: July 2007 to June 2009
    - All secluded/restrained children versus all admissions:
      - Variables:
        - gender
        - age
        - race
        - diagnosis (MDD, Mood disorders NOS, BPD 1, BPD NOS, ADHD, PTSD, Psychosis, other)

- **Population:**
  - Mean age: 12.8 years (SD=3.46)
  - Gender: females (47%, n=683)
  - Diagnosis based on discharge data base and discharge information form (diagnosis is generated by clinical interview, observation and multidisciplinary review)

- **Analysis:**
  - Logistic regression analysis comparing diagnosis, age, gender for secluded versus those who were not secluded

- **Results:**
  - 10.3% of all admitted children and adolescents were secluded (n=1465)
  - Gender is related to seclusion with males being 1.9 times more likely to be secluded (p=0.000; 95% confidence interval: 1.33-2.71)
  - Age is related to seclusion with seclusion rates decreasing with increasing age (OR=.83;p=0.000; 95% confidence interval: .79-.87). Most frequent age for seclusion: 7-10

- **Results related to diagnoses:**
  - Patients with a diagnosis of Bipolar disorder (NOS or type I) are > likely to be secluded than those w/o these dx (OR: 1.6, p=.033; 95% CI: 1.04-2.35)
  - Patients with a dx of ADHD are > likely to be secluded than those without ADHD (OR: 1.9, P=.000; CI: 1.36-2.84)
  - Patients with a dx of Mood d/o NOS are neither more nor less likely to be secluded (p=.52)
  - Patients with dx of MDD were less likely to be secluded than those without MDD (OR=.8; P=.000; 95% CI=0.53-1.21)
  - Patients with both BPD and ADHD are substantially more likely to be secluded than patients who do not have this co morbidity (OR=3.2; P=.000; 95% CI=1.96-5.26)

Seclusion and Restraint

- **Conclusions:**
  - Factors that predict seclusion and restrains in children and adolescents on an inpatient psychiatric unit are:
    - Male gender
    - Ages 7 to 10 yrs
    - Dx of BPD, BPD NOS, ADHD
    - Particularly if they are comorbid
Collaborative Problem Solving

What is Collaborative Problem Solving?
- Essentially it is a highly individualized approach to treatment planning for explosive children
- Designed to identify skills deficits in children and families and to foster growth in those areas
- The work is in drilling down to specific problems for each child, and teaching to those problems
- Active work is in the child’s lived experience of collaborating with adults
- With collaboration, the child provides input into each problem’s solution, fostering improved self-efficacy and skills

Options for Interacting with Children:
- Plan A: Intensifying the insistence of a command
  - Often results in an increase in explosive behaviors, a higher increase in intensity, and so on, and so on...
- Plan B: Utilizes empathic responses in the formulation of the problem with the child
  - Collaborative model
  - Designed to teach to lagging thinking skills
- Plan C: Reducing or removing expectations
  - Passive approach
  - Reduction of explosive behavior is achieved, expectations are not achieved

Plan B:
- With explosive children, follows a “surrogate frontal lobe” approach
- Three essential steps:
  - Empathy and Reassurance
  - Define the Problem
  - Invitation (to problem solving)
- Establish an alliance with the child to foster further collaboration and problem solving

Since Collaborative Problem Solving

VTCC Restraints per 1000 Patient Days

VTCC Staff Injuries caused by Patient Aggression
(From Workers Comp Data)
Seclusion and Restraint

Conclusions:
- Amplified but strategic psychopharmacological and collaborative preventive psychotherapeutic strategies aimed at the most likely population to be secluded or restrained during the hospital episode, has lead to an absolute reduction in seclusion and restraint.
- The case for data to guide programmatic changes and treatment interventions is strengthened by this study.

Transitional Model of Inpatient Care

Optimization of Continuity Between All Levels of Care:
- Providers: including Psychiatric, Medical, PCPs
- Services: Psychotherapy, OT, PT, ST, PT
- Agencies: DSS, CPS, In-Home Therapy, Community Service Board, FAPT
- Systems: Medical, Education, Community

Transitional Model of Inpatient Care: Protocol

<table>
<thead>
<tr>
<th>Time Line and Responsibility</th>
<th>Task</th>
<th>Objective</th>
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</thead>
</table>
| DAY 1: CORE TEAM | 1. Admission History and physical | Thorough multidisciplinary (combined intake whenever possible) evaluation with development of individualized plan of care based on:
- Thorough understanding of phenomenology
- Strength based focus on child and family
- Parent and child prioritize therapeutic concerns
- Financial/med mgmt/therapy/mentoring/agency liaison
- Make explicit to parents/guardians that child engaged in therapeutic work with child and
- Parent need to continue stay

Transitional Model of Inpatient Care

Emphasis on the Utilization of Inpatient Acute Care as the Nidus for Successful Transitions to Outpatient Services
- Focus is on Recommendations for "Ideal" Treatment Plans for Each Patient and Family
- Philosophy Follows Rule of Disposition Planning Starting on Day 1 of Admission
- Often Relies on "Out of the Box" Coordination of Care as Systems Rules and Regulations Further Limit Access to Care
### Transitional Model of Inpatient Care

<table>
<thead>
<tr>
<th>Responsibility</th>
<th>Task</th>
<th>Objective</th>
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<tbody>
<tr>
<td><strong>DAY 3:</strong></td>
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<tr>
<td><strong>CORE TEAM</strong></td>
<td>1. 1:1 therapy #2</td>
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<td></td>
<td>2. Family therapy #2</td>
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<td>3. Meeting with community stakeholders by phone or by direct contact</td>
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<td>4. Establishing a shared vision with child/family and OP Team for what might be the &quot;next steps&quot;</td>
<td>Consolidate Data</td>
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<tr>
<th>Responsibility</th>
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<tr>
<td><strong>DAY 4:</strong></td>
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<tr>
<td><strong>CORE TEAM and TFT</strong></td>
<td>1. 1:1 therapy #3</td>
<td></td>
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<tr>
<td></td>
<td>2. Family therapy #3</td>
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<td></td>
<td>3. Interface between Transition Facilitating Unit (TFT)</td>
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<td></td>
<td>- Core Team and</td>
<td></td>
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<td></td>
<td>- Child and family</td>
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<td></td>
<td></td>
<td>All 3 units (TFT, CT and Child Family) develop shared vision about the prioritized concerns and</td>
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<td></td>
<td></td>
<td>shared vision about next steps</td>
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<td>Articulation of OP and session goal</td>
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<tr>
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<th>Objective</th>
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<tr>
<td><strong>DAY 5:</strong></td>
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<tr>
<td><strong>CORE TEAM and TFT</strong></td>
<td>1. 1:1 therapy #4</td>
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<tr>
<td></td>
<td>2. Family therapy #4</td>
<td></td>
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<td></td>
<td>3. TFT increases link with Community (including Education)</td>
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<td></td>
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<td>TFT Mandate:</td>
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<tr>
<td></td>
<td></td>
<td>- Build relationships between all OP teams</td>
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<td>- Clearly articulate goal for achieving health and help from OP and child/family</td>
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<td></td>
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<td>- Establishing a shared vision with the child/family and their stability</td>
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<td></td>
<td></td>
<td>Strength-based approach</td>
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<tr>
<th>Responsibility</th>
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<th>Objective</th>
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<tr>
<td><strong>DAY 6:</strong></td>
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<tr>
<td><strong>CORE TEAM and TFT</strong></td>
<td>Continue the same transitional and core team work</td>
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<td>Set up bridge appointments with TFT for need and supportive therapy if permanent OP provider reappraisal further out than one week after discharge</td>
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<tr>
<th>Responsibility</th>
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<th>Objective</th>
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<tr>
<td><strong>DAY 7:</strong></td>
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<tr>
<td><strong>CORE TEAM and TFT</strong></td>
<td>Family therapy #5 with discharge</td>
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<td></td>
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<td>Step-down suggestions:</td>
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<tr>
<td></td>
<td></td>
<td>- All therapies in place</td>
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<tr>
<td></td>
<td></td>
<td>- Community team in place</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Responsibility</th>
<th>Task</th>
<th>Objective</th>
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<tbody>
<tr>
<td><strong>POST DISCHARGE SESSIONS 1-8:</strong></td>
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<tr>
<td><strong>TFT</strong></td>
<td>Weekly on an OP basis till permanent provider visit</td>
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<td>Usually no more than six months after discharge</td>
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<td></td>
<td>Provide both medication management and psychotherapy</td>
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<td>Facilitate links with services</td>
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Transition Facilitation Team

- **What Is It?**
  - **Who:** Small group of staff dedicated to ensuring smooth transitions between the inpatient and outpatient worlds for VTCC patients and families
  - **What:** Case management that follows the patient out of the hospital to the next point of care
  - **Where:** Embedded in both the inpatient acute unit, the outpatient clinics and the admissions team
  - **When:** TFT members are present in the inpatient team meetings each morning as well as in the clinics when post-discharge patients follow up (or don’t follow up)
  - **How:** TFT members actively assist in planning dispositions, case management, will make phone calls to ensure follow through with outpatient and community services, follow up when patients do not

Easing Access to Community Resources

- **Medical Home Model:**
  - If families encounter three “closed doors”, their search will likely stop there out of frustration.
  - Demonstrate the importance of establishing PCP and follow-up care as a health care priority for organizations and families
  - How to access up-to-date resources for selecting a PCP, thereby reducing recidivism and increasing “new” patient referrals
  - VTCC’s Guide for Patient Services (GPS) Quickplace tool

Optimizing Collaborations and Alliances

- For fast tracking services
- Reciprocally responding to their need to access CAP/other services
- Q3 monthly meeting with leaders of local referring agencies (round table) to reduce gaps in service, improve responsiveness to families

Transition Planning

- **Parent Education re: Acute Hospitalization**
- “Speakers in Schools” project
- Proposal from TFT for how to understand and impact recidivism
- Connect with Big Brother and Sisters, the YMCA, UMFS, Department of Social Services
- Learn how to go up the supervisory chain to advocate that links for services are established prior to discharge
- “Everyday is Golden”

Bridging the Outpatient Gap

- **VTCC Bridge Clinic:**
  - Established 2009 along with TFT
  - Primarily Fellow run clinic comprised of limited number of outpatient follow up appointments to provide appropriate follow through of care until the patient reaches the next provider
  - Staffed by TFT along with Fellows to provide ongoing case management
  - Allows for fast-tracking of follow up services for patients and has eliminated considerable lag times for patients awaiting appointments with the next provider

Bridging the Outpatient Gap

- **Children’s Mental Health Resource Center (CMHRC):**
  - Fully operational starting in 2010
  - VTCC outpatient consultation service to Richmond area Pediatricians
  - Educative-consultation model with endpoint being an increased skill set and level of confidence in the Pediatrician in diagnostics and treatment of mental health issues
  - Currently staffed by one faculty MD, one Fellow and a Program Manager
  - Currently funded through a grant from community stakeholders
  - Currently 2 participating Pediatrics practices (started with 5)
Future Directions

- Currently in planning stages for brand new VTCC building estimated to open in 2016
- Expansion to 32 inpatient beds with potential to flex to 48
- Expansion of CAP and psychology training programs
- Prime opportunity for maximizing service utilization and inter-agency alliances across Virginia
- Emphasis will be on inpatient sanctuary model with programming for bridging to outpatient services focused on primary prevention models and best evidence based practices

References


