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An unmet opportunity: intensive care transition interventions for individuals with “Serious Medical-Psychiatric Illnesses” (SMPI)

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Abstract

Individuals with serious mental illness and poorly managed medical conditions, referred to as having “serious medical-psychiatric illnesses” or SMPIs, are highly vulnerable to disruptions in care and resulting poor outcomes. Intensive integrated care management approaches are indicated when these individuals are hospitalized on medical-surgical inpatient units to ensure continuity of both medical and psychiatric services. This column describes a manualized intervention for hospitalized individuals with SMPI developed in a NIMH ALACRITY research center. The approach uses a critical time intervention model and incorporates motivational interviewing and shared decision making to maximize engagement and continuity of care for individuals with SMPI.

People with serious mental illnesses, such as recurrent major depressive disorder, bipolar disorder, or a schizophrenia spectrum disorder, have substantially shortened life expectancies (1). Much of this is due to chronic medical conditions associated with highly prevalent risk factors including nicotine/tobacco use, cardiometabolic conditions, and a sedentary lifestyle (2). Difficulties accessing and adhering to recommended medical care also increase risk of adverse outcomes and premature mortality among people with serious mental illness and chronic medical conditions, hereafter referred to as “serious medical-psychiatric illnesses” or SMPIs.

Individuals with SMPI are among the most expensive to manage with much of their health care costs attributable to management of medical rather than psychiatric conditions (3). While there are no available data regarding follow-up care of people with SMPI being discharged from medical-surgical units, one could assume that their follow-up rates are low given the combined burden of medical and psychiatric illness. A critical need exists to develop effective care transition interventions for adults with SMPI to prevent gaps in medical and mental health care during the period immediately following hospital inpatient care.

Intensive care management interventions have been developed for elderly persons with chronic medical or psychosocial problems requiring moderate or high-complexity medical decision-making (4,5). These time-limited services, which include low-intensity therapy and training to support self- and illness-management skills such as medication adherence, have been shown to improve rates of successful transition from hospital to community care (4,5). Despite their demonstrated effectiveness, these interventions are unlikely to meet the more complex psychosocial and medical needs of individuals with SMPIs who have unique care management needs related to: 1) severe functional deficits in multiple domains including self-care, social skills, and independent living; 2) cognitive deficits including reality distortions, impulsivity, and impaired problem-solving; and 3) perceived stigma and inadequate training of general healthcare professionals related to these patients' needs. People with SMPIs benefit from face-to-face intensive care management. They need care management that: 1) is persistent and in-person; 2) is delivered by care managers familiar with the local behavioral and primary care health systems—these individuals often engage with health care primarily through connections with psychiatric providers, which need to be leveraged to promote adherence with medical care; 3) is delivered by care managers who can use motivational interviewing, de-escalation, and reality testing techniques; 4) includes advocacy on behalf of the individual when they are not able to do so; and 5) mobilizes family and other key collateral persons to provide similar supports.

There are evidence-based interventions that can be adapted to meet the needs of individuals with SMPIs. Critical Time Intervention (CTI) is a time-limited intervention that mobilizes supports for high-risk people with mental illness during transition periods. It is characterized by frequent face-to-face visits by a trained care manager beginning prior to discharge from the hospital and maintained throughout a period of transition and engagement with community services, provision of practical and emotional supports, and building sustainable linkages to community-based providers services, family, and friends. CTI has been successfully applied to populations including adults with mental illness, homeless individuals with mental illness, and individuals transitioning from prison to the community (6–8). CTI services improve connections with community-based care among individuals who have high-health and social service costs. In one study, brief (3-month) CTI was associated with a significantly lower risk of hospital readmission within 30 days of hospital discharge (28% vs. 47%) (8).

Given its demonstrated effectiveness in other high-risk populations, CTI should be adapted as an approach to improve transitions from inpatient to outpatient care for individuals with SMPI. Our group is pilot testing a modified brief CTI intervention with funding through the NIMH OPAL (Optimizing and Personalizing interventions for people with Schizophrenia Across the Lifespan) Center at the New York State Psychiatric Institute. The OPAL Center was created in response to a NIMH Funding Opportunity Announcement (FOA) for Advanced Laboratories for Accelerating the Reach and Impact of Treatments for Youth and Adults with Mental Illness (ALACRITY) Research Centers, with the primary goal of accelerating the development and implementation of effective, individualized treatments for individuals with schizophrenia in real clinical settings.

We presume that CTI services will have a greater likelihood of success if they are built and evaluated through partnerships with hospital systems and managed care organizations. These partnerships help to ensure that services are not duplicative, but instead address relevant gaps in care management and meet the needs of patients. Our project adapted CTI for use with patients with schizophrenia who are admitted to one of two safety net hospitals in New York City for treatment of a chronic medical condition and will randomize eligible inpatients to receive either treatment as usual or treatment augmented with CTI services.

In addition to partnering with hospital systems, our CTI project also involved partnering with a Medicaid Managed Care Organization (MMCO) operating in New York State. A key element to our modified CTI model involves MMCO identification of high-need individuals with SMPI immediately upon inpatient admission to a medical-surgical unit. The MMCO links notification information received from hospitals daily to internal algorithms identifying individuals with SMPI. The MMCO identifies eligible participants upon hospital admission and notifies the hospital treatment team, which can engage the patient in the study prior to hospital discharge. The recruitment procedures are designed to take advantage of real-world circumstances in which the insurance payer, which has access to comprehensive prior service use data and can rapidly identify individuals with SMPI most at risk for disruptions in care. These partnerships are important in allowing the MMCO (and the research team) to examine the financial implications of providing CTI services. While the current project is funded through a federal grant, the expansion of such projects, should they prove to be effective, will ultimately be the responsibility of payers.

Based on key stakeholder input, we developed a modified CTI model for use by care managers. The manual (available as a download in the online supplementary material) covers three phases of CTI: 1) Engagement; 2) Transition and Linkage; and 3) Transfer of Care. Care managers hired by the research institute for this pilot study have substantial community-based care management experience and are supervised by a graduate level social worker. When eligible hospitalized patients are identified by the partner hospitals, the CTI team is notified and a care manager meets with the patient as soon as possible on the inpatient unit, prior to discharge. The care manager begins building rapport with the patient and assesses immediate post-discharge needs in this “Engagement” phase of the model. The care manager contacts the inpatient discharge planning team to understand the discharge plan, inform the team of their role, and coordinate efforts with available hospital care managers supporting the patient. In this initial phase, the CTI care manager is not scheduling appointments but is instead engaging with the patient and inpatient treatment team around successful implementation of the recommended discharge plan.

The “Transition and Linkage” phase begins at the time of hospital discharge. The care manager further refines the needs assessment and begins to connect the patient to relevant community supports. Areas of focus during this phase include continuity of medical and psychiatric care, transportation, housing, family support and social integration. The care manager will help the patient schedule follow-up appointments if needed and will accompany the patient to appointments to meet providers and orient them to the CTI services. Ongoing care coordination focuses on facilitating communication between the patient and the patient’s medical, and mental health providers, ensuring medication

adherence and attendance at community-based appointments. The care manager provides intensive phone and face-to-face visits with the patient during this phase, 1–2 times per week, and accompanies them to ongoing appointments as needed to ensure follow-up

In the final “Transition of Care” phase, priority is placed on strengthening the patient’s skills and sense of autonomy in managing service engagement and use, while reducing the number of face-to-face contacts. As this phase nears its end, the care manager organizes a final treatment planning meeting and “warm hand-off” between the patient and the MMCO care manager who will be involved in supporting his/her future care.

Our project’s Brief Critical Time Intervention (B-CTI) Manual (available as an on-line supplement) provides further details regarding specific activities in each of the three phases of care management and is meant to be a resource for providers interested in considering implementing such a service. Several questions remain regarding optimal use of CTI care managers. Ideal caseload size is unclear but likely should range from 15–20 patients per care manager, far lower than is typically seen in standard disease and care management programs. CTI care managers need to be comfortable working in fast-paced hospital settings and persistent in their efforts to both engage with patients and coordinate care with multiple providers. Inpatient providers and care managers are extremely busy and difficult to connect with, although our initial experiences suggest that they welcome involvement of an experienced care manager to help with patients they typically view as among the hardest to engage and unlikely to follow-up with aftercare. Similarly, care managers must be comfortable asserting themselves in an appropriate manner with outpatient providers, who typically initially show little time or interest in communicating with care managers. Accompanying the patient to aftercare appointments is critical as it allows care managers to meet office staff and providers and develop their trust and willingness to communicate.

The integration of medical and behavioral health services for people with SPMI presents numerous challenges. If we are to be successful in reducing risk of excess mortality among individuals with SMPI, a multi-level framework approach should be considered. Time-limited, community-based, intensive care management services such as that provided by CTI can make headway with the individual and environmental/social determinant factors associated with this risk by focusing on contributing individual behaviors and social supports. At the systems-level, CTI provides opportunities for improved care coordination, communication, and access to health and behavioral health services. By expanding use of integrated electronic medical records and health information systems, health care systems and MMCOs can also play a vital role in identifying, monitoring and coordinating care for these vulnerable patients.

Supplementary Material

Refer to Web version on PubMed Central for supplementary material.

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