Improving Continuity of Care in a Rural Mental Health System: Utilizing a Transitional Care Tool

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NURS 703B: DNP Project

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March 24, 2024

This paper is submitted in partial fulfillment of the requirements for the Doctor of Nursing Practice degree.

Abstract

This quality improvement project sought to improve continuity of care for mentally ill patients who receive services from a rural mental health care system. A literature review found that poor communication, especially during transitions, impedes continuity of care and leads to negative outcomes. Interprofessional collaboration in the form of communication and information exchange is integral to successful transitions and continuity of care. Improving discharge processes and utilizing tools that facilitate discharge can improve communication practices. This paper details the steps taken to improve the discharge process, including the development of a transitional care tool, in this rural mental health care system.

Problem Description

Globally, it is estimated that 792 million people experience mental illness (Ritchie & Roser, 2018), with Oregon having the highest prevalence of mental illness among all states (Mental Health America, 2023). Improving continuity of care for individuals requiring mental health services is a top priority to ensure equitable care for this population and reduce negative outcomes (Maurice et al., 2022; Nguyen et al., 2017; Nie et al., 2023). Healthcare consumers and professionals consider continuity of care essential to high-quality healthcare (Biringer et al., 2017; Bishop et al., 2018). An important aspect of continuity of care is communication between providers and between different practice settings. Information sharing and collaboration between providers are especially important for individuals with mental illness (Colaiaco et al., 2018; Jorgensen et al., 2020; Maurice et al., 2022; Nguyen et al., 2017) as they often receive care from a fragmented system that consists of multiple providers who do not coordinate services (Colaiaco et al., 2018; Jorgensen et al., 2020) in addition to experiencing numerous transitions in care. Poor transitions due to ineffective communication and/or information sharing result in discontinuity of care, which can worsen mental health symptoms and impede access to necessary follow-up care (Biringer et al., 2017; Maurice et al., 2022; Sheehan et al., 2021).

Many barriers, challenges, and issues exist for individuals with mental illness, especially during transitions in care. These include a lack of consultant-type relationships between providers, financial barriers, inadequate communication or coordination across services, a lack of timely communication of information, loss of patient-specific information during transitions, differences in clinic processes, practices, and/or training, and barriers related to information systems (Biringer et al., 2017; Colaiaco et al., 2018; Kim et al., 2023; Nguyen et al., 2017). Providing transitional care when patients move between different settings, levels of care, or providers, and coordinated discharge planning would help to improve continuity of care for these individuals (Kim et al., 2023; Redmond et al., 2018; Spencer & Punia, 2021; Tyler et al., 2019).

Communication and the sharing of information are required for effective transitional care (Iturriaga et al., 2021; McIntyre et al., 2022). The Community Mental Health organization in rural Eastern Oregon utilizes outdated documentation practices that do not meet new Oregon Administrative Rule requirements. Current practices require a records release of information form to be completed when there is a transition in care between settings and require providers to search a large volume of records for basic information such as previous medication trials, diagnoses, or past treatments administered. Also, each facility utilizes different methods and processes for discharge, resulting in incomplete or missing information, information not getting passed on during transition, and role confusion. Evidence exists for what barriers and challenges individuals with mental illness face during transitions in care, but there is a lack of available knowledge on optimal methods for improving the experiences of these individuals or how to alleviate the time burden placed on providers. This paper aims to identify factors relevant to improving these experiences for both providers and patients, therefore improving efficiency and health outcomes. A literature review will be conducted to determine the best evidence-based interventions for facilitating continuity of care for individuals with mental illness that can also improve provider efficiency.

Available Knowledge

Search Methods/Criteria/Results

Medline and Cochrane databases were searched. Search terms used were combinations of continuity of care, facilitating transitions, transitional care, transitional care tools, provider collaboration, data-sharing, and mental illness. Terms were combined using the Boolean operators “AND” and “OR.” Limits set included studies published within the last 5 years and written in English, with study design including reviews, systematic reviews, meta-analysis, and randomized control trials (RCTs). Necessary criteria for inclusion were studies that pertained to the identified practice problem and discussed interventions for improving continuity of care or

transitions via processes or tools, regardless of mental illness status, medical condition, or healthcare setting. Studies were excluded if they did not give sufficient detail of interventions, were not feasible for implementation due to cost or time constraints, and required major system-level changes before implementation. The initial search resulted in 1399 articles. After screening for duplicates and inclusion and exclusion criteria, a total of 5 articles were selected, with two additional articles related to communication tools selected from a review of references.

Literature Review

Literature is abundant on barriers related to transitions from the emergency room, primary care, or other similar settings and on interventions to improve this process for the patient; however, there is minimal research on the topic specifically related to patients with mental illness or which interventions work best. To understand the potential benefits of the interventions, it is important to understand some key barriers to effective transitions for this population. One factor that negatively influenced continuity of care during transition periods, which was mentioned in the majority of studies, was poor communication (Iturriaga et al., 2021; McIntyre et al., 2022; Nie et al., 2023; Spencer & Punia, 2021; Tang et al., 2018; Tang et al., 2019). All studies included agreed that interprofessional collaboration in the form of communication and information exchange was integral to successful transitions and continuity of care (Iturriaga et al., 2021; Kattel et al., 2020; McIntyre et al., 2022; Nie et al., 2023; Spencer & Punia, 2021; Tang et al., 2018; Tang et al., 2019).

Four of the included articles were related to improving discharge processes (Kattel et al., 2020; Plotnikoff et al., 2021; Spencer & Punia, 2021; Tyler et al., 2019), discussing barriers and facilitators to discharge (Plotnikoff et al., 2021), tools that can facilitate discharge (Kattel et al., 2020; Plotnikoff et al., 2021), and other interventions that can improve discharge processes such as Critical Time Intervention or Transitional Discharge Model (Tyler et al., 2019). Kattel et al. (2020) recommended using discharge summaries for information transfer though this was in the

form of discharge instructions for patient and caregiver benefit rather than follow-up providers. Plotnikoff et al. (2021) mentioned discharge assessments or letters (similar to discharge summaries) in addition to various other tools shown to help with discharge but this was again focused on the patient and/or caregiver rather than for provider follow-up purposes. Only three of the articles discussed actual tools to assist with information transfer and interprofessional collaboration (Iturriaga et al., 2021; Nie et al., 2023; Tang et al., 2019). Two tools were web-based platforms (Nie et al., 2023; Tang et al., 2019), and one was a transition care tool (Iturriaga et al., 2021). The transitional care tool (TCT) was a comprehensive yet brief, one-page summary document specific to incarcerated adults transitioning back into the community (Iturriaga et al., 2021). The TCT was not tested in real-world settings but showed promise in conveying important information and improving communication between settings and providers. A similar document will be developed and utilized to facilitate communication and improve transitions in this organization.

Rationale

To implement change effectively, it is important to utilize a framework that provides suitable guiding principles for the type of change you seek (Harrison et al., 2021). The Institute for Health Improvement (IHI) Model for Improvement (MFI) will be utilized to guide this project. The IHI MFI is a framework for problem identification, setting goals, and tracking improvement. This is done by first identifying an aim, then determining what measures will be used to decide if a change is an improvement, and concluding with what changes the improvement will cause. A Plan, Do, Study, Act (PDSA) cycle will be utilized to accomplish these tasks. This cycle allows researchers to rapidly test changes and make necessary modifications or revisions without wasting time or making a major change, only to find that the change is not a good one. One of the most commonly used tools for QI in healthcare is the MHI

framework and PDSA cycles (Christoff, 2018). Research has shown that quality improvement (QI) projects implementing PDSA cycles show progressive improvement (Knudsen et al., 2019).

Despite many advances in healthcare and the delivery of services, improvement is still needed in many areas. Equitable care for those with mental illness is one such area. Transitions to different levels of care, transfer of patients between providers, and discharge back into the community are fraught with challenges necessitating interventions that target this transition period (Hopkin et al., 2018; Iturriaga et al., 2021; Spencer & Punia, 2021; Tang et al., 2018; Tang et al., 2019). These individuals, especially those with mental illness, experience discontinuity of services and fragmented care (Colaiaco et al., 2018). At our clinical site, a root cause analysis (RCA) and cause and effect diagram were completed to determine internal issues that negatively affect the transition period (see Appendix A). Poor communication between mental health providers (MHP) upon transfers of care, between MHP and PCP, and between MHP and other levels of care or settings were found. A literature review supported interventions to facilitate communication between providers and agencies by utilizing a transitional care tool, which would have the added benefit of increasing provider efficiency by reducing time spent reviewing records for basic patient information such as mental health conditions and medications. The IHI framework will be utilized to develop this tool to improve continuity of care, interprofessional collaboration, efficiency of services, and improvement or elimination of disruption in services.

Aim

This project was intended to improve the transition process and continuity of care for individuals with mental illness who are engaged in services in the rural community mental health care system. Improving communication practices will help to ensure interprofessional collaboration and improved continuity of care (Colaiaco et al., 2018; Jorgensen et al., 2020; Maurice et al., 2022; Nguyen et al., 2017). Our RCA showed that

many factors contribute to poor transitions for this population. Current practices were evaluated, and new procedures implemented to improve this process. On October 16, 2023, the rural community health organization initiated a quality improvement project based on the IHI MFI framework, with the aim of improving data-sharing practices and continuity of care for patients with mental illness by standardizing the discharge process across facilities and developing a transitional care tool with completion of the tool occurring by February 1, 2024.

Method

Context

This QI project occurred within a rural community mental health organization in Eastern Oregon. The organization consists of numerous facilities in several different counties. Facilities include outpatient clinics (10), addiction recovery facilities (3), residential treatment facilities (5), and a small acute care facility (1). These facilities employ six Psychiatric Mental Health Nurse Practitioners (PMHNPs), one psychiatrist, one medical director, and numerous other staff such as therapists, peer support specialists, medical assistants, other qualified mental health providers (QMHPs), and administrative staff. Stakeholders involved in this project included administrators and/or managers of each facility and the primary IT staff member.

Intervention

This rural mental health organization had no standard procedures in place to facilitate continuity of care when discharging patients with mental illness. Each facility had different procedures for discharge and different staff members who were responsible for overseeing the process. As the first step, a standardized discharge process, which included the development of a transitional care tool, was formulated. Development of the process and tool used were completed based on Oregon Administrative Rules, stakeholder feedback, and evidence-based research from a literature review. Microsoft Teams meetings with stakeholders were primarily used for contact,

with email and telephone used as necessary. A pre-intervention survey was completed to determine stakeholder perceptions of the current discharge process and tools used and to gather feedback for necessary changes (see Appendix B for survey questions). Before initiating the use of this document, online training will be given, followed by a survey of all involved stakeholders to assess attitudes toward its use (see Appendix C for the post-training survey). Due to unforeseen circumstances, the online training and implementation of this project were not completed before the deadline. Survey documents were left with the organization to be completed when possible.

Study of the Intervention

The completed transitional care tool is intended to facilitate continuity of care, data-sharing, and collaboration among care team members. A survey, administered after the first informational meeting related to this project, was utilized to determine stakeholder perceptions of the current discharge process and tools used and to obtain feedback for improvements. Once training on the document is conducted, it is planned that another survey will be administered to determine the perceived usefulness of the document, facilitators or barriers for use, and where in the workflow it should go. The organization will track the percentage of stakeholders that completed the online training modules and any negative outcomes associated with the use or development of this tool.

Measures

Outcome measures for this project were the standardization of the discharge process, the development of a transitional care tool, its addition to the workflow, and eventual implementation. This measure was the first step in improving continuity of care practices within this organization. Process measures for this project would have been the percentage of stakeholders who completed the online training modules related to using the care tool and the presence of any negative outcomes as a result of initiating this project. These process measures

will assess adherence to the new workflow. The balancing measures for this project were a pre-intervention survey of stakeholder perceptions toward the prior discharge process and tools used, followed by a post-intervention survey of stakeholders on the usefulness of the document and to assess for any undue burden placed on them due to the increased workload and resulting attitude toward intervention. This measure evaluates the feasibility of implementing this intervention. Additionally, other factors that may influence this intervention, such as staff turnover, lack of adequate training, or lack of communication of expectation for completion, were monitored.

Analysis

Data analysis and the progression of changes related to the intervention are demonstrated using a timeline and run, line, and Pareto charts. The primary outcome measure, which is the transitional care tool, can be seen in Appendix D. Run Chart A shows the percent of completion of the tool over time and any confounding factors (see Appendix E). Line charts displaying quantitative data on survey responses can be found in Appendix F. Qualitative survey data collected from stakeholders revealed attitudes toward the intervention and their potential influence on the completion and use of the tool. For qualitative survey responses, Pareto charts were compiled to evaluate commonalities or other factors (see Appendix G). Additionally, to guide the refinement of the next PDSA cycle, contextual factors influencing the medians will be identified and discussed in the results section. Any outside influences were monitored throughout the QI project, and adjustments were made as needed.

Ethical Considerations

Improving continuity of care and facilitating the transition of individuals with mental illness reduces negative outcomes and improves continuity of care. Despite this, the rural community health organization does not have procedures in place to facilitate transitions or continuity of care for those with mental health conditions. Therefore, a document was developed to summarize patients' mental health care and facilitate their transition among settings or when

transferred to other providers. This document will initially increase the workload for clinicians, but once it is implemented consistently, it should actually decrease the workload as critical information such as diagnoses and medications trialed will be in one place and no longer require a lengthy review of records to find.

Acknowledgments The author would like to acknowledge the cooperation of the staff and clinicians in the study setting.

Conflicts of Interest There are no conflicts of interest to disclose.

Ethics Approval A Request for Determination was submitted to the OHSU Institutional Review Board (IRB) for review and determined not human research.

Results

Development of the new transitional care tool was easily implemented and completed, requiring only minimal modification of existing documentation and the addition of newly required components. Obtaining stakeholder engagement in the process was more difficult. The initial PDSA cycle was initiated on November 27, 2023. This cycle aimed to assess stakeholder perceptions of the current discharge process and tools used in addition to eliciting feedback on necessary improvements. The survey was intended to go out to anyone involved in the discharge process but had only been sent out to administrators and/or managers of each facility. In addition, the pre-intervention survey response rate for those it was sent to was very low, with only five out of twelve survey responses. This made it difficult to obtain sufficient data to assess overall perceptions of current processes. Most respondents were satisfied with the current discharge process and tools and who completed the discharge paperwork. All respondents were satisfied with the information in the current discharge documentation, and no feedback for improvements was given. The only suggestions were to keep it ‘streamlined’ and that the addition of more staff would be helpful. Pre-intervention survey questions can be seen in Appendix A with survey responses available in Appendix E and F. The next PDSA cycle, aimed

at assessing adherence to the new process and any negative outcomes associated with it, was not initiated due to the failure of the first PDSA cycle, the need to reassess, and the many unanticipated barriers encountered. With the project deadline approaching and these barriers and complications, the project was discontinued.

Discussion

Summary

While this QI project was fraught with barriers and unanticipated complications, some data was collected, and valuable knowledge was gained. Feedback received revealed that the majority of those who responded were satisfied with current processes, tools, workload distribution, and information contained in discharge documentation. However, due to the poor survey response and lack of adequate distribution, it is hard to draw conclusions from this data. The initial PDSA cycle revealed several problems with the project, which is the intended purpose of these cycles. These problems included poor stakeholder engagement and/or buy-in, resulting in poor survey response rates and misunderstandings related to who the pre-intervention survey was to be sent out to. Ultimately, this led to the discontinuation of the project, though the organization will continue with the original plan and conduct staff training on the new document, then will standardize the discharge process throughout their facilities.

Interpretation

In hindsight, it seems that there was inadequate communication of project details between the clinical site and me. Many factors, such as a delayed start on the project, distance between parties, unexpected absences, and poor communication practices, likely all contributed. Having only two primary contacts for this project and limited knowledge of organizational structure and current processes also affected results, making it difficult to determine, until after the fact, who should be involved in the first PDSA cycle. Being an outsider, I find it hard to know what factors affect stakeholder engagement the most, which is a priority for future work on any similar

projects in this organization. Other factors that may have impacted results include the fact that this organization recently became the main mental health care provider for the largest county in the area. This has led to rapid expansion amid severe staffing shortages leading to excessive workloads for current staff. Exploration of this as a factor in poor stakeholder engagement is warranted. The delayed opening of their new acute care facility may have also increased stress and drawn attention or resources away from the QI project.

Limitations

This project had numerous limitations. Since there was a deadline for project completion and a delayed start to the project, many steps were rushed or not completed. This contributed to poor stakeholder engagement and affected communication between those involved. These factors ultimately affected results and project completion.

Conclusion

While this QI project was unsuccessful, it provided valuable insight into barriers and complications that can arise and potential causes for those issues. The project also introduced the clinical site to the IHI MFI Framework for quality improvement projects and showed them the importance of completing PDSA cycles and getting staff engagement in the process. Knowledge gained during this project will benefit all parties involved, giving them experience that can be applied to future QI projects.

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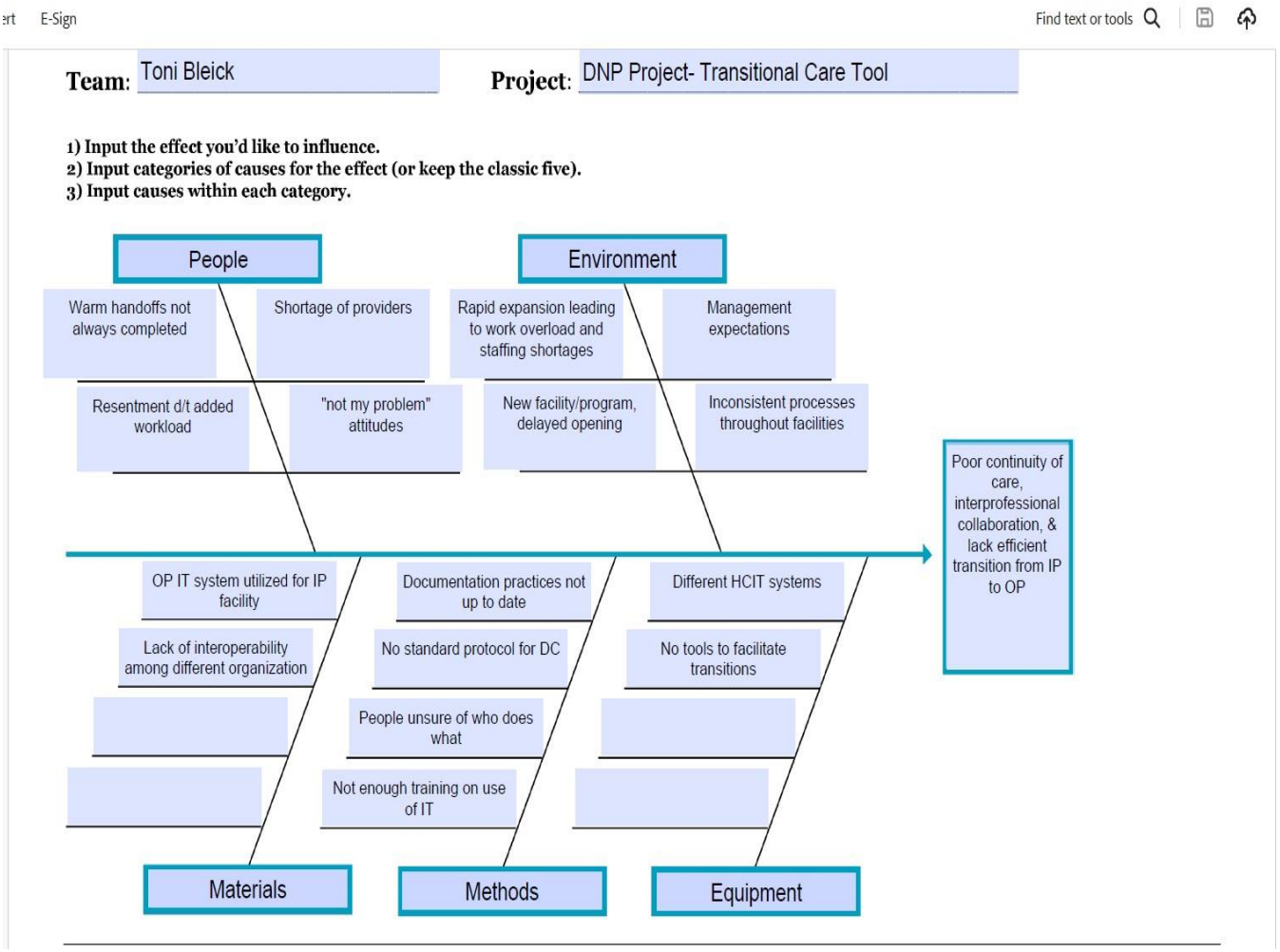
Appendix A

Cause & Effect Diagram



Appendix B

Pre-Intervention Survey Questions

Current Process Survey

Start of Block: Employee Satisfaction

Q1 The purpose of this survey is to collect feedback on your satisfaction with the current discharge processes and any suggestions you may have for improving it.

It should only take 7 to 8 minutes. Your feedback will be used to help us improve the current discharge processes and standardize them throughout the organization.

Q2 How satisfied or dissatisfied are you with the current discharge process at your facility?

- o Extremely satisfied (1)
- o Moderately satisfied (2)
- o Slightly satisfied (3)
- o Neither satisfied nor dissatisfied (4)
- o Slightly dissatisfied (5)
- o Moderately dissatisfied (6)
- o Extremely dissatisfied (7)

Q3 Please give brief summary of current discharge process at your facility and/or your involvement. (facility, who completes the discharge paperwork (RN, QMHP, etc.), what information is included, who the paperwork is given to (patient, caregiver, receiving facility, etc.)

_____

_____

_____

_____

_____

Q4 How satisfied or dissatisfied are you with the forms and/or tools used for discharge?

- o Extremely satisfied (1)
- o Moderately satisfied (2)
- o Slightly satisfied (3)
- o Neither satisfied nor dissatisfied (4)
- o Slightly dissatisfied (5)
- o Moderately dissatisfied (6)
- o Extremely dissatisfied (7)

Q5 How satisfied or dissatisfied are you with your current workload related to discharge?

- o Extremely satisfied (1)
- o Moderately satisfied (2)
- o Slightly satisfied (3)
- o Neither satisfied nor dissatisfied (4)
- o Slightly dissatisfied (5)
- o Moderately dissatisfied (6)
- o Extremely dissatisfied (7)

Q6 How satisfied or dissatisfied are you with who completes the discharge process?

- o Extremely satisfied (1)
- o Moderately satisfied (2)
- o Slightly satisfied (3)
- o Neither satisfied nor dissatisfied (4)
- o Slightly dissatisfied (5)
- o Moderately dissatisfied (6)
- o Extremely dissatisfied (7)

Q7 How satisfied or dissatisfied are you with the information that is included in the discharge paperwork?

- o Extremely satisfied (1)
- o Moderately satisfied (2)
- o Slightly satisfied (3)
- o Neither satisfied nor dissatisfied (4)
- o Slightly dissatisfied (5)
- o Moderately dissatisfied (6)
- o Extremely dissatisfied (7)

Q8 What, if any, information should be added to or deleted from the current discharge paperwork?

_____

_____

_____

_____

_____

Q9 If you could change anything about the current discharge process what would it be?

_____

_____

_____

_____

_____

Appendix C

Post-Training Survey Questions

Post-Training Survey

Q1 The purpose of this survey is to get feedback on the new discharge process and documentation. It should only take about 5 minutes to complete.

Q2 The transitional care tool (discharge documentation in Credible) will facilitate communication, collaboration, and data-sharing with care team members, therefore improving continuity of care.

- ○ Strongly Agree (1)
- ○ Somewhat agree (2)
- ○ Neither agree nor disagree (3)
- ○ Somewhat disagree (4)
- ○ Strongly disagree (5)

Q3 The transitional care tool (discharge documentation in Credible) is a useful document that provides valuable information to current staff, patients, and other outside healthcare providers.

- ○ Strongly Agree (4)
- ○ Somewhat Agree (5)
- ○ Neither Agree nor disagree (6)
- ○ Somewhat disagree (7)
- ○ Strongly disagree (8)

Q4 In my role within the organization, I will input information into and/or utilize information from the transitional care tool.

- Strongly agree (9)
- Somewhat agree (10)
- Neither agree nor disagree (11)
- Somewhat disagree (12)
- Strongly disagree (13)

Q5 It should not be my responsibility to complete the transitional care tool.

- Strongly Agree (1)
- Somewhat agree (2)
- Neither agree nor disagree (3)
- Somewhat disagree (4)
- Strongly disagree (5)

Q6 It should be the responsibility of _____ to complete the tool.

_____

Q7 The transitional care tool is easy to use.

- Strongly agree (10)
- Somewhat agree (9)
- Neither agree nor disagree (8)
- Somewhat disagree (7)
- Strongly disagree (6)

Q8 The transitional care tool contains all the necessary information to facilitate continuity of care, data-sharing, and collaboration among healthcare providers, patients, families, or others.

- ○ Strongly agree (10)
- ○ Somewhat agree (9)
- ○ Neither agree nor disagree (8)
- ○ Somewhat disagree (7)
- ○ Strongly disagree (6)

Q9 Please list any barriers or facilitators to the use of this document/tool, anything that should be added or removed, or any other feedback you would like to provide.

_____

_____

_____

_____

_____

Appendix D

Transitional Care Tool

Inpatient Hospital/Residential/Outpatient Facilities

DISCHARGE PLANNING

Client ID

Last Name:

First Name:

Preferred First Name

DOB:

Admission Date:

Status:
—SELECT—

Start Date:

End Date:

Legal Representative:*
- ◯ Yes (specify name and contact information)
- ◯ No

County of Responsibility

☐ **County Person Contact Name and Information****

Insurance:
—SELECT—

Prime Number if GOBHI:

Initial Payment Approved:
- ◯ Yes
- ◯ No

If approved, how many days:
—SELECT—

Updated authorization 1:

If approved, how many days:
—SELECT—

Updated authorization 2:

If approved, how many days:
—SELECT—

Updated authorization 3:

If approved, how many days:
—SELECT—

Planning Notes:
☐

Pretermination Meeting Completed?

☐ Yes (specify who attended and whether it was face-to-face or telehealth)

Date

☐ No (specify reason and barriers to scheduling)

What services was the client enrolled in prior to hospitalization?

☐ ACT
☐ CHW
☐ Case Management
☐ EASA
☐ Med Management
☐ Peer Support
☐ SUD
☐ Supported Employment
☐ Therapy

Housing prior to hospitalization:

Can client return to prior housing after discharge:

○ Yes
○ No (list referrals in **Housing Referral** category)

Trial visit Completed (Civil Commitment Only)

○ Yes
○ No (specify reason)

What services will client need once discharged:

☐ CHW
☐ Case Management
☐ Choice
☐ ID, BC, SS, etc.
☐ Med Management
☐ Peer Support
☐ Primary Care (PCP)
☐ SNAP
☐ SUD
☐ Supported Employment
☐ Taxi Tickets
☐ Therapy
☐ Other (specify)

Discharge Date:

Location of Discharge*

Transportation Scheduled:

Pick up date:

Pick up time:

Pick up location:

Pharmacy:

Prescriptions called in on:

Follow-up Needed

☐ 3 Day
☐ 7 Day

(Form Created: October 2023)

Medical Info

Diagnosis

Medication List

Functional Status

Complete

REACH - SUICIDE POTENTIAL

Past Suicide risk potential (If previously rated)

Past suicide attempt(s)? (If previously noted)

Date of last suicide attempt(s)? (If previously noted)

Last Safety Plan Date? (If previously noted)

Past Lethal Means Counseling (If previously noted)

Columbia Screening

Suicide Screening Date

Has there been a suicide attempt in the last 90 days?*

- ☐ Yes
- ☐ No
- ☐ Client under 10 years old - not screened
- ☐ Not Completed, explain

1. In the past month, have you wished you were dead or actually had any thoughts of killing yourself?*

- ☐ Yes
- ☐ No
- ☐ Client under 10 years old - not screened
- ☐ Not Completed, explain

Risk factor

History of past suicide attempt(s)?

- ☐ Yes
- ☐ No
- ☐ Unknown
- ☐ Client under 10 years old - not screened

Other Risk Factors

- ☐ Access to lethal means, particularly firearms
- ☐ Recent loss, including recent job loss
- ☐ Pending incarceration or homelessness
- ☐ Current or pending isolation or feeling alone
- ☐ Previous psychiatric diagnosis and treatment
- ☐ Dissatisfied with treatment
- ☐ Non-compliant with treatment
- ☐ Not receiving treatment
- ☐ Insomnia
- ☐ Hopelessness
- ☐ Major depressive episode
- ☐ Mixed affect episode (e.g. Bipolar)
- ☐ Command hallucinations to hurt self
- ☐ Chronic acute pain or other acute medical problems
- ☐ Highly impulsive behavior
- ☐ Substance abuse or dependence
- ☐ Agitation or severe anxiety
- ☐ Perceived burden on family or others
- ☐ Homicidal ideation
- ☐ Aggressive behavior towards others
- ☐ Refuses or feels unable to agree to safety plan
- ☐ Any history of sexual abuse
- ☐ Family history of suicide

- [ ] Daily thoughts of suicide
- [ ] Other (please explain)

Protective Factors

- [ ] Effective behavioral health care, including access to that care
- [ ] Fear of death or dying due to pain and suffering it might cause
- [ ] Self-esteem and a sense of purpose or meaning in life
- [ ] Identifies reasons for living
- [ ] Belief that suicide is immoral; high spirituality
- [ ] Responsibility to family or others; living with family
- [ ] Supportive social network of family or friends
- [ ] Engaged in work or school
- [ ] Engagement in discussion/treatment....reliability is likely high
- [ ] Other strength and protective factors (please explain)

Prompts for current access to means (assessment of means related to above current plans and access to weapons-particularly firearms)

Current access to means and summary of lethal means counseling provided ☐

Risk formulation

Risk status (Relative to others in a stated population)

- [ ] Higher
- [ ] Lower
- [ ] Same
- [ ] Unknown

Risk state (Relative to self at baseline)

- [ ] Higher
- [ ] Lower
- [ ] Same
- [ ] Unknown

Potential triggers/stressors (Forseeable changes that could quickly increase risk state) ☐

Prompts for rating suicide risk potential (If you did not complete screening, please select based on previous rating or use clinical intuition to select)

Low (No reported history of suicidal ideation/behavior OR Thoughts WITHOUT method, intent, plan, behavior OR Moderate risk factors and strong protective factors)

Moderate (Suicidal ideation with method WITHOUT plan, intent or bheavior in the past month OR Suicidal behavior more than 3 months ago OR Multiple risk factors and few protective factors)

High (Suicidal ideation with intent or intent with plan in past month OR Suicidal behavior within past 3 months)

Remember, clinical intuition is important. If you are unsure of what to rate, seek supervision before rating. Ask yourself, would you be surprised if this person attempted suicide? If not, they should be rated no lower than moderate and possibly high given the criteria above.

Today's suicide risk potential*

- [ ] Low
- [ ] Moderate
- [ ] High
- [ ] Client under 10 years old - not screened

Initial safety plan is REQUIRED if risk potential was rated as Moderate or High.)

**** Indicates required field***

Complete

HOUSING REFERRALS

Housing Referral 1
—SELECT—

Name of Facility:

Date of Referral:

Date of Notification:

- ○ Accepted
- ○ Denied, specify reason

Housing Referral 2
—SELECT—

Name of Facility:

Date of Referral:

Date of Notification:

- ○ Accepted
- ○ Denied, specify reason

Housing Referral 3
—SELECT—

Name of Facility:

Date of Referral:

Date of Notification:

- ○ Accepted
- ○ Denied, specify reason

Housing Referral 4
—SELECT—

Name of Facility:

Date of Referral:

Date of Notification:

- ○ Accepted
- ○ Denied, specify reason

Housing Referral 5
—SELECT—

Name of Facility:

Date of Referral:

Date of Notification:

- ○ Accepted
- ○ Denied, specify reason

DISCHARGE SUMMARY

CLIENT PROFILE

Client First Name

Client Last Name

Client Preferred First Name

Discharge Living Arrangements (Home, Name of Facility, etc)*

DOB:

New Living Arrangements:*

—SELECT—

Date Living Arrangements Changed:*

TREATMENT SUMMARY

Diagnosis(es) on file:

- ☐ **Presenting problem:****
- ☐ **Summary of Course of Treatment:****
- ☐ **Recommendations and Continuing Care:****

REFERRED TO

—SELECT—

PARTICIPATION IN DISCHARGE PLANNING *

- ☐ Client (or client's family) participated in discharge planning in the following ways:
- ☐ Client (or client's family) did not participate in discharge planning. The following attempts were made to engage the client (or family) in discharge planning:

DISCHARGE

Financial Information (Social Security, Money sent with them, Rep Payee information,etc)*

Pretermination Meeting Completed*

- ○ Completed (Specify date, who attended and how they attended)
- ○ Attempts made and unable to complete

Client discharging from the following facility:*

- ○ Columbia River Ranch
- ○ Juniper Ridge
- ○ Lakeview Heights
- ○ New Roads
- ○ REACH
- ○ Salmon Run
- ○ Westgate

Date of Discharge:*

Indicates required field

Complete

MEDICATION LIST

Medications on eMar

- [ ] **How many days of meds are released with client?****
- [ ] **How many days of scripts were sent with client?****

Sent a copy of MAR with Client

- ◯ **Yes**
- ◯ **No**

- [ ] **Notes**

List and Physical and/or Medical Concerns:*

◯

*** *Indicates required field***

Complete

FOLLOW UP APPOINTMENTS

Appointment 1

—SELECT—

Date:

Time:

Location:

Clinician/Provider:

Appointment 2

—SELECT—

Date:

Time:

Location:

Clinician/Provider:

Appointment 3

—SELECT—

Date:

Time:

Location:

Clinician/Provider:

Appointment 4

—SELECT—

Date:

Time:

Location:

Clinician/Provider:

Appointment 5

—SELECT—

Date:

Time:

Location:

Clinician/Provider:

METRICS

Client Treatment Status*

—SELECT—

MH Level of Care*

—SELECT—

*** *Indicates required field***

Complete

REACH-DISCHARGE ASMT

Assessment of Client's Condition upon Discharge ☐

Complete

REACH - MENTAL STATUS

☐ **GENERAL APPEARANCE**

ESTIMATED INTELLECTUAL ASSESSMENT

- ☐ above average
- ☐ average
- ☐ below average
- ☐ possible DD
- ☐ documented DD
- ☐ other observation(s)/additional information

ATTITUDE

- ☐ cooperative
- ☐ hostile
- ☐ open
- ☐ secretive
- ☐ evasive
- ☐ suspicious
- ☐ uninterested
- ☐ easily distracted
- ☐ focused
- ☐ defensive
- ☐ other observation(s)/additional information

AFFECT

- ☐ primarily appropriate
- ☐ primarily inappropriate
- ☐ flat
- ☐ restricted
- ☐ full
- ☐ expansive
- ☐ blunted
- ☐ flattened
- ☐ detached
- ☐ other observation(s)/additional information

MOOD

- ☐ neutral
- ☐ euthymic
- ☐ dysphoric
- ☐ euphoric
- ☐ angry
- ☐ anxious
- ☐ apathetic
- ☐ other observation(s)/additional information

SPEECH

- ☐ typical for age and intellect
- ☐ logical
- ☐ coherent
- ☐ sparse
- ☐ slow
- ☐ rapid
- ☐ rambling
- ☐ soft
- ☐ loud
- ☐ mumbling
- ☐ inaudible
- ☐ mute

- [ ] other observation(s)/additional information

ORIENTATION

- [ ] person
- [ ] place
- [ ] time
- [ ] situation
- [ ] other observation(s)/additional information

MEMORY

- [ ] unimpaired recent
- [ ] unimpaired remote
- [ ] impaired recent
- [ ] impaired remote
- [ ] other observation(s)/additional information

INSIGHT & JUDGEMENT

- [ ] good
- [ ] fair
- [ ] poor
- [ ] lacking
- [ ] other observation(s)/additional information

CONTACT WITH REALITY

- [ ] intact
- [ ] tenuous
- [ ] poor
- [ ] lacking
- [ ] other observation(s)/additional information

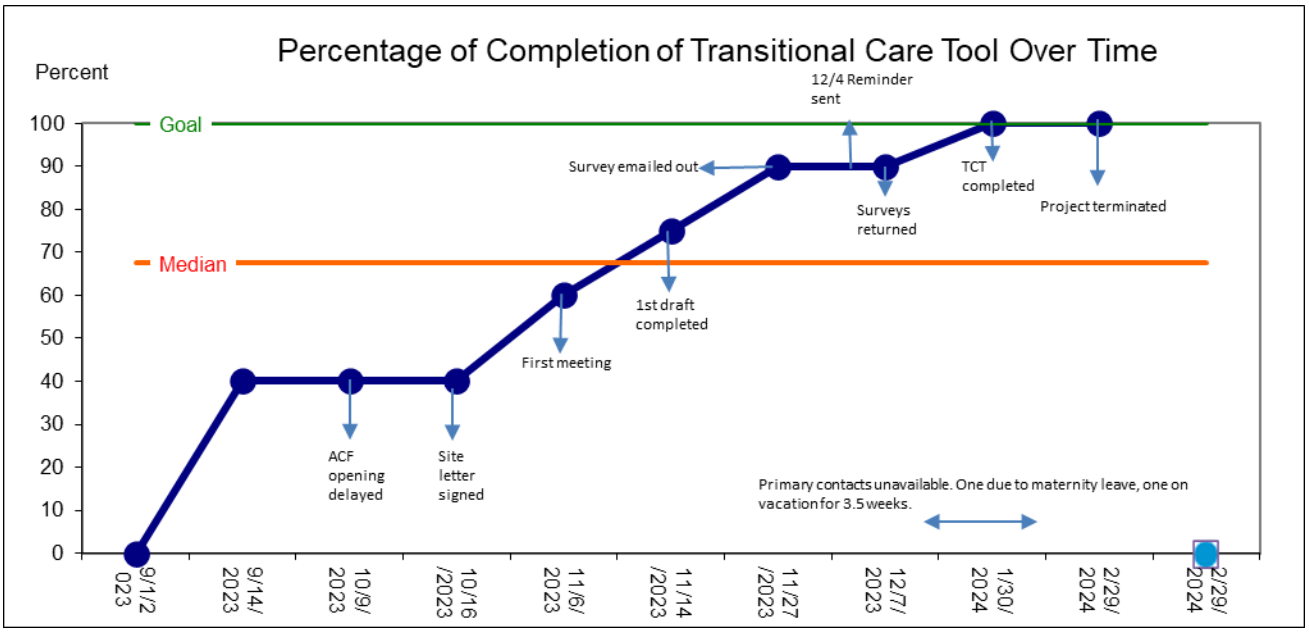
- [ ] **ADDITIONAL MENTAL STATUS OBSERVATIONS:**

Complete

Appendix E

Run Chart A

Rural Community Health Organization

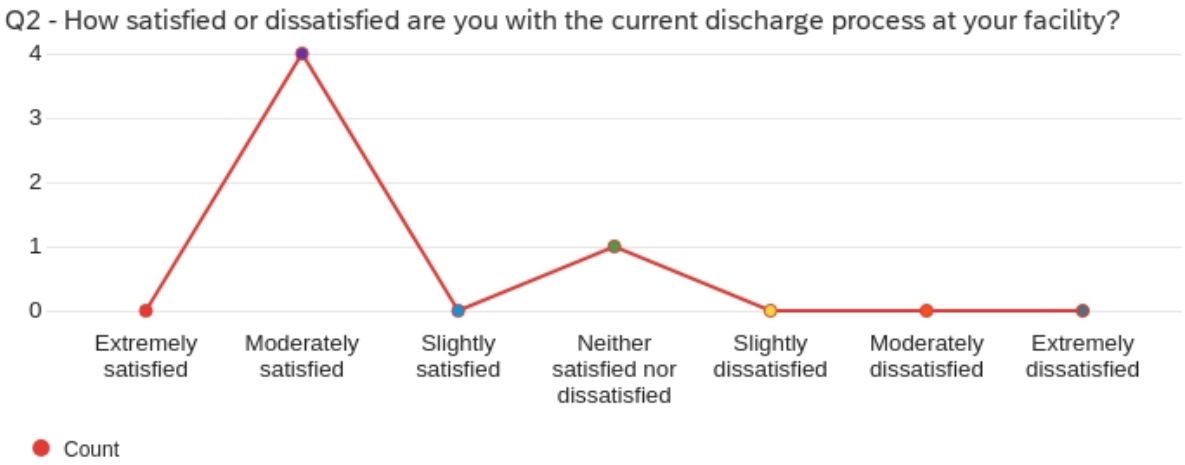


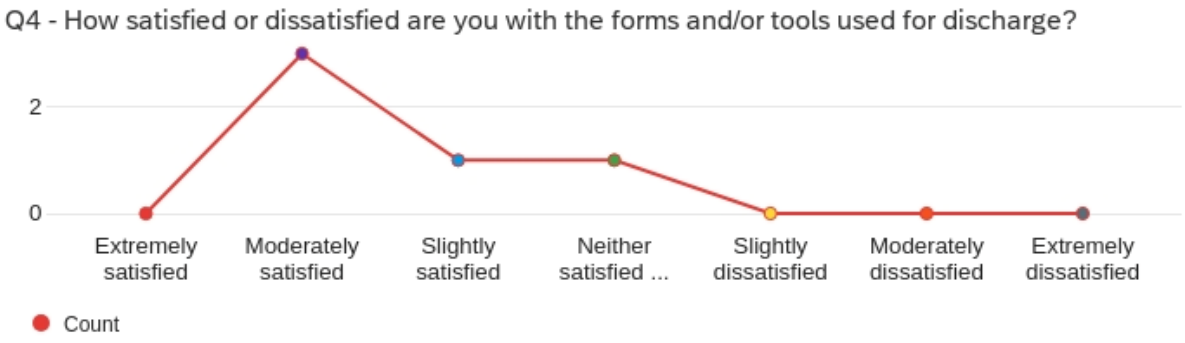
Appendix F

Line Charts

Rural Mental Health Organization

Pre-Intervention Survey Response-Quantitative Data





Q6 - How satisfied or dissatisfied are you with who completes the discharge process?

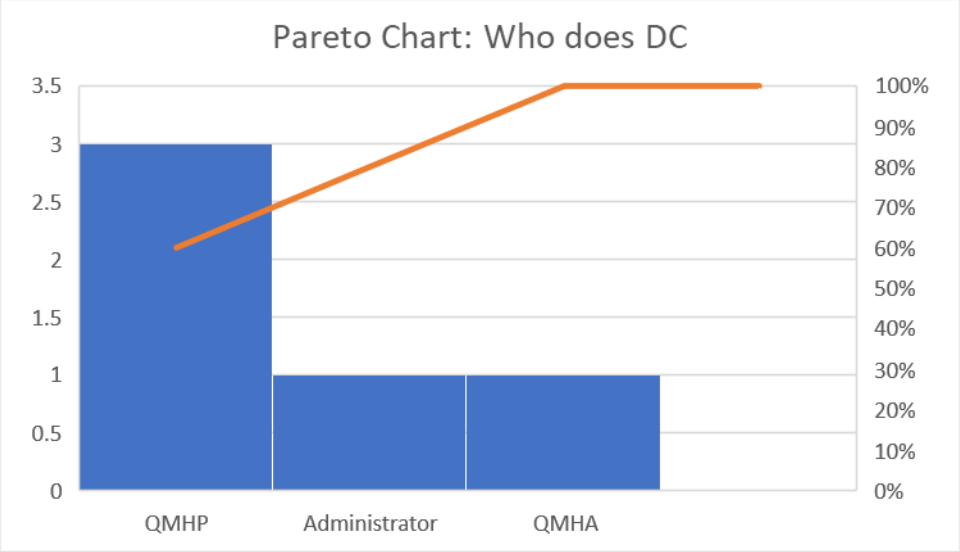
Q7 - How satisfied or dissatisfied are you with the information that is included in the discharge paperwork?

Appendix G

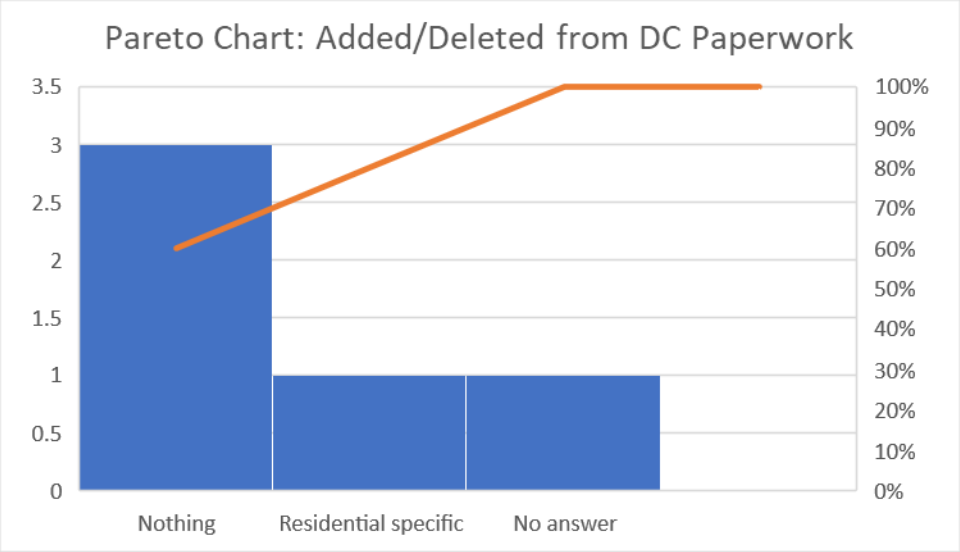
Pareto Charts

Rural Community Health Organization

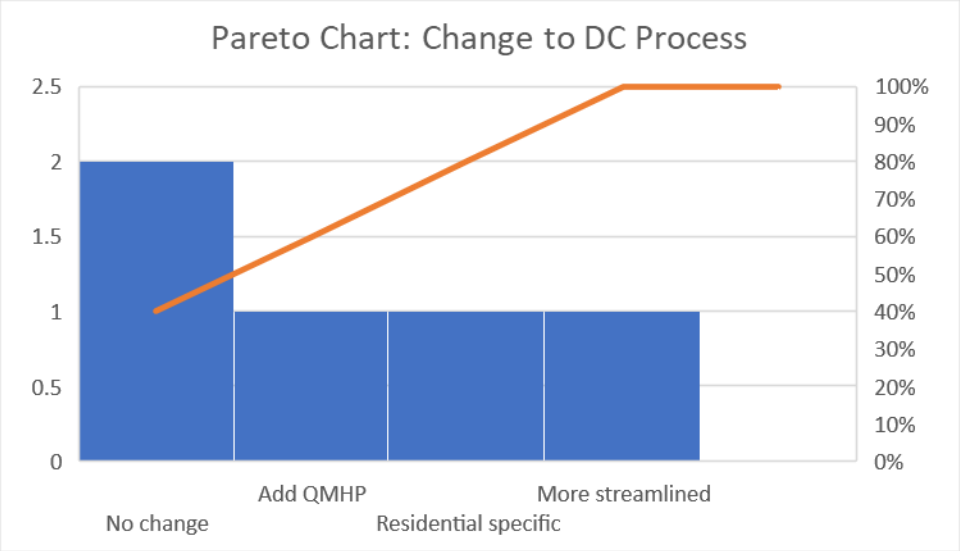
C1: Pre-Intervention Survey Response Q#3



C2: Pre-Intervention Survey Response Q#8



C3: Pre-Intervention Survey Response Q#9


Pareto Chart: Change to DC Process
2.5
2
1.5
1
0.5
0
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
No change
Add QMHP
Residential specific
More streamlined

Appendix H

Miscellaneous Project Paperwork

NOT HUMAN RESEARCH

October 17, 2023

Dear Investigator:

On 10/17/2023, the IRB reviewed the following submission:

Title of Study:	Improving Continuity of Care for the Mentally Ill via Data-Sharing and Collaboration: A Quality Improvement Project
Investigator:	Virginia Elder
IRB ID:	STUDY00026436
Funding:	None

The IRB determined that the proposed activity is not research involving human subjects. IRB review and approval is not required.

Certain changes to the research plan may affect this determination. Contact the IRB Office if your project changes and you have questions regarding the need for IRB oversight.

If this project involves the collection, use, or disclosure of Protected Health Information (PHI), you must comply with all applicable requirements under HIPAA. See the HIPAA and Research website and the Information Privacy and Security website for more information.

Sincerely,

The OHSU IRB Office

Letter of Support from Clinical Agency

Date: 10/10//2023

Dear Toni Bleick,

This letter confirms that l, Community Counseling Solutions, allow Toni Bleick (OHSU Doctor of ursing Practice Student) access to complete her DNP Final Project at our clinical site. The project will ke place from approximately 10/10/2023 to 2/28/2024.

This letter summarizes the core elements of the project proposal, already reviewed by the DNP Project Preceptor and clinical liaison (if applicable):

- Project Site(s): Community Counseling Solutions
- Project Plan: Use the following guidance to describe your project in a brief paragraph.
- Identified Clinical Problem: Poor continuity of care between inpatient facility and outpatient providers; provider time wasted on record searches; weak interprofessional collaboration between disciplines; disruption in care after discharge/transition to different level of care.
- Rationale: The Institute for Health Improvement (l HI) Model for Improvement (MFI) will be utilized to guide this project. The 1141 MFI is a framework used for problem identification, setting goals, and tracking improvement. Illis is done by identifying an aim, determining what measures will be used to decide if a change is an improvement, and concluding with what changes the improvement will cause. A Plan, Do, Study, Act (PDSA) cycle will be utilized to accomplish these tasks. This cycle allows researchers to rapidly test changes and make necessary modifications or revisions without wasting time or making a major change, only to find that the change is not good. One of the most commonly used healthcare QI tools is the MH] framework and PDSA cycles (Christoff, 2018). Research has shown that quality improvement (QI) projects implementing PDSA cycles show progressive improvement (Knudsen et al., 2019).

This framework will be utilized to develop a care summary document to improve continuity ofcare, interprofessional collaboration, efficiency of services, and improve or eliminate disruption in services.

- Specific Aims: By November I, 2023, Community Counseling Solutions will initiate a quality improvement project based on the Il-Il MFI framework, with

the aim of improving data-sharing practices and continuity of care for patients with mental illness by developing a care summary document and adding it to the current workflow process.

- Methods/Interventions/Measures: As the first step in the process, a care summary document will be developed. Development of the document will be completed based on provider feedback and evidence-based research from a literature review. The document will be introduced at a provider staff meeting, where feedback on the document will be gathered. The care summary will include, at a minimum, mental/medical health diagnoses, current medications, medication trials and reason for discontinuation, allergies, most current presenting symptoms or behaviors, and functional status. Any recommended changes or additions will be made, and the document will be emailed to the appropriate individuals for final approval. Before initiating the use of this document, a survey of all involved stakeholders will be conducted to assess attitudes toward its use.

Outcome measures for this project will be the development ofa care summary document, its addition to the workflow, and eventual implementation. This measure will be the first step in improving continuity of care for patients seeking care at this organization. Process measures for this project will be the percentage of stakeholders who attend meetings where education/training related to the development and/or completion ofcare summaries are discussed. Also, the presence of any negative outcomes as a result of initiating this project. These process measures will assess adherence to the new workflow. The balancing measures for this project will be a pre-intervention survey of stakeholder perceptions toward the document's usefulness followed by a post-intervention survey of stakeholders (if the document is implemented) to assess for any undue burden placed on them due to the increased workload and resulting attitude toward intervention. This measure will evaluate the feasibility of implementing this intervention. Additionally, other factors that may influence this intervention, such as staffturnover, lack ofadequate training, or communication of expectation for completion, will be monitored.

- Data Management: No PHI or patient data will be collected for the purpose of this project.

- Site(s) Support: CCS agrees to facilitate communication between the student and project participants via email, telephone, or video conferencing. No financial support or obligation will be asked for or given from any project participants.

O Other: [Outline any other agreements you and the organization have made to further the project, if applicable.]

During the project implementation and evaluation, Toni Bleick will provide regular updates and communicate any necessary changes to the DNP Project Preceptor.

Our organization looks forward to working with this student to complete their DNP project. If we have any Concerns about this project, we will contact Toni Bleick and Virginia Elder (student's DNP Project Chairperson). Regards,

Kara Pattinson, Medical Director

DNP Project Preceptor (Name, Job Title)

Email & Phone number: kara.pattinson@ccsemail.org 503-375-6711

Signature

10/16/23

Date Signed

Appendix I

Project Timeline