Multi-disciplinary Neuropsychiatry Conference for Facilitation of Catatonia Transition of care: A Novel Intervention

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In the 24-months prior to this presentation, I declare the following ineligible company financial relationships: None

Other disclosures:

• Speaking honoraria: Presentation on case formulation at University of Alabama
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Learning Objectives

After today’s brief oral presentation, participants will be able to:

• Describe the challenges associated with transition of care for patients with catatonia and other severe psychiatric illness

• Recognize one approach to improving care transitions that has been successful in a complex healthcare system

• Review a few sample cases where this approach allowed for effective step down from inpatient to outpatient level of care
Care (dis)continuum

• Consult psychiatry services see some of the most medically and psychiatrically complex patients

• Caring for these patients in the hospital is only the beginning, but transition of care can be hard

• Identifying a team who can accept these patients and helping that team feel comfortable taking over care can feel like an insurmountable task
Care continuum

• Teaming with outpatient neuropsychiatry for warm handoff and ongoing case discussion can help to break down barriers to care

• Collaboration not only between inpatient and outpatient psychiatry, but also with many other specialties and ancillary services

• Different than a more traditional outpatient CL model where the same team follows the patient across settings
Our own experience
Weekly case conference
Weekly case conference
Weekly case conference

• Outpatient clinicians may be afraid to accept responsibility if they feel isolated or have no recourse for consultation or care escalation
• Accepting care of exceptionally complex patients is easier if there is open communication for consultation or care escalation
• Modeled after Brigham and Women’s Center for Brain Mind Medicine BNNP rounds
• Integrated across specialties to increase cross-talk, increase mutual vocabulary, improve integration of care, facilitate movement across specialties or in case of need for care level escalation, provide training opportunities
• Opportunities for providers with more face-to-face time to weigh in (OT, PT, ST, SW, behavioral psychology, etc.)
Case example

• Adolescent with neurodevelopmental disability, genetic mutation, new onset catatonia. Initially presented to the ED and admitted to CL due to poor PO intake. ECT initiated while in hospital

• 2\textsuperscript{nd} case consultation conference when patient developed seizures and required care escalation

• Facilitated transition of a patient needing frequent psychiatry visits for ECT. Ensured comprehensive workup while inpatient, including delivery of results post-discharge.
Case example

- School-age child with brain tumor, history of malignant catatonia, significant ongoing medical needs and on longstanding high doses of lorazepam. Spent many months in ICU and then inpatient rehabilitation.
- 2nd conference upon discharge from inpatient rehabilitation to facilitate coordination between many subspecialty providers managing multiple pharmacologic agents
- Allowed for discussion about step down and step up criteria
Case example

- Patient with severe neurodevelopmental disabilities, mania with catatonic features, seen in multiple complex care clinics, multiple discharges from ED with limited workup due to diagnostic overshadowing.
- Case conference to facilitate admission for comprehensive workup and pre-discharge planning.
- Reviewed comprehensive patient history and treatment course across multiple clinics, discussed ancillary services to consider upon discharge.
Conclusion

- This intervention has allowed for improved patient care and more collaborative relationships across sites
- This is a low cost and easily adaptable model that can be used across various healthcare settings
- Can provide support for inpatient or other higher level of care to facilitate discharge and develop community relationships
- Zoom/telemedicine conferences can facilitate across-town collaboration
Thank you!

- Time for questions
References

