**TEAM: MENTAL HEALTH AND WELLNESS WING OF STRONG HOSPITAL**

**1-9200 ACUTE IN-PATIENT MEDICINE UNIT**

I would like to nominate 1-9200, the acute in-patient medicine unit located in the Mental Health and Wellness wing of Strong hospital. Formerly known as the Behavioral Medical Surgical Unit (BMSU), the multidisciplinary team on 1-9200 cares for complex patients who require acute medical care in the context of complex behavioral, social, and/or psychiatric needs.

The unit is unique not only in this hospital, but in the country. Few medical units exist to specifically address the needs of complex patients using an explicitly integrated biopsychosocial model of care\*. The 20-bed unit is staffed with dedicated staff who have demonstrated an interest in working with patients with complex psychosocial needs and includes: medical-surgical trained nurses, social workers, Nurse Practitioners and Physician Assistants (including 2 advanced care “nocturnists” who ensure full 24 hour coverage). There are a total of 7 full and part time attending physicians and one full time Pharm-D. In addition, the unit is actively involved in the educational mission of the university. The unit provides a learning environment for medical, pharmacy nursing, and physician assistant students. All University of Rochester Psychiatry residents spend 8 weeks on the unit during their intern year. Medical students and Geriatrics and Palliative Care Fellows periodically complete elective rotations on the unit.

Given the significant biopsychosocial challenges inherent to this particular patient population, we have devised a multidisplinary team based approach called “interdisciplinary rounds” to help facilitate and coordinate care. These meetings are held daily at 10AM and are attended by the unit social workers, the charge nurse for the day, Nurse Practitioners, Physician Assistants and attending Physicians on service. Also in attendance are residents, students or fellows, the PharmD, a member from consult/liason Psychiatry service, and occasionally a member from the chaplaincy service. The charge nurse is the facilitator of these meetings, ensuring that the meeting remains focused on coordinating issues related to day-to-day care, as well as planning for eventual hospital discharge to the community. Key issues include medical, psychiatric and nursing needs, critical medication questions, as well as the acute and long-term psychosocial issues that patients face. The charge-nurse also plays an important role in conveying the outcome of the interdisciplinary team meeting to the rest of the nursing and ancillary staff (e.g. nurse technicians).

It can be easily appreciated that there are many potential challenges which can place a significant strain on the functioning of such a team. First, there are patient-level challenges. Patients and their families often come to our unit after having been frustrated by their experiences elsewhere. Some with complex social needs may come from disadvantaged backgrounds, have low health literacy or worries about violence in the home or community. Others with psychiatric needs have felt discrimination from the medical field and are wary of medical interventions and treatments. Thus, building trust and developing an environment of respect is always a first priority. In addition, many patients have complex medication regimens and lack coordination of care across different specialties. Thus it is often incumbent on the team to take a step back with the patient to address their overall goals and priorities.

Second, there are trans-disciplinary challenges in a team-based unit such as this. Nurses, advanced care nurses and physicians each have different skills and may emphasize different aspects of patient care. This presents particular challenges with respect to defining roles and responsibilities while recognizing historical hierarchies and comfort-zones. Furthermore, internists, psychiatrists, social workers and pharmacists each focus on specific aspects of health that may emphasize different goals from each other. Thus the team needs to find ways to work toward common patient-centered goals.

Third, there are system-level challenges. The unit is both geographically and ideologically isolated from the rest of the medical units. This can lead to challenges for timely services but it can also result in furthering stigma. For example, consultants may inquire how violent or “crazy” a patient is before coming to see them. Similarly patients and families sometimes arrive on the unit worried that they are being admitted to a locked psychiatry unit or that they are transferred to our unit as punishment for their behavior.

In order to combat some of these challenges, we have being working towards redefining the unit in terms of our strengths and expertise. We are in the process of changing the name of the unit to reflect the nature of what we do and we are working with the office of Patient and Family Centered Care to develop educational materials for patients and families. More specific to the focus on team-based care, we are in the process of refining the goals and emphasis of our interdisciplinary rounds. Over the last several months we have re-organized the meetings so that they are no longer less physician-driven and less medically focused. The group consensus is that the meetings have improved considerably in that there is now more information presented that is deemed relevant to all who are present. This is confirmed by two recent measures of success: we have improved our targeted goal of improving hospital discharges before noon and coordinating outpatient follow up. However, concerns centering around communication and a coordinated system of engagement remain. There is still a sense that the rounds should remain brief, that there is a tendency for too much “editorializing” and that certain perspectives are missing (e.g. the charge nurse doesn’t always have the detailed information a patient’s individual nurse can bring). Ongoing initiatives for overcoming these challenges include using TeamSTEPPS strategies, having a team retreat to improve and implement an overall a plan for more effective communication and validation and developing an educational forum for discussing certain patients in more detail as case studies.

\* similar models: MPUs (medical psychiatric units) which exist at the Univeristy of Iowa and Stanford University; Acute Care for Elders (ACE) units which exists at Highland Hosptial and Complex Care Units (e.g. for pediatric patients with developmental disorders)