The Children’s Readmissions Collaborative Kick-Off Conference
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The Adult Behavioral Health Readmissions Collaborative: Lessons Learned

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Methods: Review of Models and Initiatives

- **RQC**: Behavioral Health Readmissions Quality Collaborative
- **Clinic CQI**: OMH Continuous Quality Improvement Initiative for Health Promotion and Care Coordination
- **CTI**: Critical Time Interventions
- **Transitions**: Assertive Community Treatment (ACT) Transitions Project
- **RED**: Project RED (Re-Engineered Discharge)
- **STAAR**: State Action on Avoidable Readmissions
- **AHRQ**: Agency for Healthcare Research and Quality (AHRQ) Reducing Medicaid Readmissions Project
- **RARE**: Reducing Avoidable Readmissions Effectively

Note: all quotations are from RQC Midpoint Survey
Outline

- Interventions
  - Emergency Room
  - Inpatient
  - Aftercare
- Managing the Project
Emergency Department (ER)
Prevent avoidable readmissions in ER

- Identify high utilizers and potential readmissions
- Consult with last inpatient team (they come to ER to evaluate) and current outpatient provider before determining disposition.
  - Is the client’s status the same as last discharge?
  - Is another admission likely to be helpful?
  - Are there alternatives that could be tried?

Source(s): RQC
On Admission / During Inpatient Stay
Assessment

- Identify readmissions / high utilizers
- Conduct in-depth review or case conference
  - What was the last discharge plan? how well did it work?
  - Why were they readmitted (root causes)?
  - What can we do differently this time?
  - Review in treatment team meeting, cross department meetings (ER, inpatient, case workers, outpatient)

“Engaging the patient in reasons why the prior discharge failed can help staff gain insight.”

Source(s): STAAR, AHRQ, RQC
After Hospital Care Plan

- Develop and use After Hospital Care Plan (e.g. Project RED format), including
  - clear medication instructions
  - follow-up appointments (arranged before discharge)
  - contact information

- Educate client and family using teach-back method during inpatient stay

Source(s): Project RED (key intervention), STAAR, RARE
Access to Medication

Ensure access to medication post discharge

- Verify insurance formulary for meds before initiating
- Obtain and verify pre-authorization for meds before discharge
- Fill prescriptions at discharge: patients leave with meds in hand (or are walked to the pharmacy by staff)

“Make sure that the patient can afford the medications they are discharged on.”

Source(s): RARE, RQC
Family / Caregiver Involvement

Goals of family involvement

- Support evaluation
- Assess family needs
- Provide crisis intervention
- Deliver active education (teach-back) for after hospital care plan

“Family involvement is key to a patient's recovery.”

“Family support makes a tremendous difference with patient compliance.”

Source(s): RQC, CTI, STAAR, RED, RARE
Bridging and “Warm Hand-offs”

- Face to face meeting with receiving outpatient provider during inpatient stay or immediately upon discharge. Ideally:
  - Discharge planning meeting: outpatient provider, client, family, and inpatient team; and
  - Individual meeting/session: outpatient provider and client

Source(s): STAAR, RARE, RQC, Transitions Project, CTI
Co-Occurring Mental Health and Substance Use Disorders

- Provide Integrated Dual Diagnosis Treatment, e.g.:
  - Screening at intake
  - PSYCKES review
  - 4-quadrant model of assessment
  - Motivational interviewing

- Refer to providers of integrated treatment for aftercare

Source(s): RQC, EBP for co-occurring disorders
Post Discharge / Outpatient
Aftercare

- Follow-up appointment with after-care mental health provider within 3 days of discharge (5 at most)

- Use higher-intensity outpatient services for hospital diversion and hospital step-down
  Examples for children:
  - Partial Hospitalization Program (PHP)
  - Home-Based Crisis Intervention (HBCI)
  - Single Point Of Access (SPOA) / Waiver
  - Respite
  - Mobile Outreach Teams
  - Coming soon: Children’s Health Homes

Source(s): RARE, RQC, Transitions
Follow Up Phone Calls

- Follow-up phone call to **client/family**
  - Within 72 hours
  - Clinical intervention, intensive (not reminder call)
  - Use teach-back method (don’t read the med list)
  - Ideally by staff known to client

- Follow-up phone call to **provider**

  “Follow-up phone calls are very important, to make sure that discharged patients continue to take their meds and keep their follow up appointments.”

Source(s): Project RED (key component), RARE, RQC, Transitions
Follow-up Phone Call to Client: Project RED Key Components

1. Assess clinical status
2. Review and confirm each medication
3. Review follow-up appointments
4. Assess for barriers, problem-solve, and review what to do if a problem arises
5. After call: take any needed follow-up actions / inform treatment team of any issues
Short-Term Case Management

- Services may be provided by case manager, bridger, peer, enhanced Koskinas worker, etc.
  - For kids: Home-Based Crisis Intervention or other

- Key principles
  - Assess client risk/needs, adjust intensity and time frame accordingly
  - Include home visits if needed
  - Actively follow up on non-adherence to the plan

“Reducing behavioral health re-hospitalizations requires developing a system for close monitoring and tracking of patients identified as at-risk for re-hospitalization.”

Source(s): CTI, RARE, RQC, Transitions
Community Functioning / Support

- Build, practice and test self-management skills
  - Examples: filling pill boxes, keeping appointments
  - Skill-building at each level of care to prepare for next

- Refer to intensive community supports, e.g.:
  - ACT
  - Health Home / other care management

“Very helpful to establish referral links to Health Homes for care coordination services and ACT Teams.”

Source(s): RQC
Outpatient Crisis Management

- Outpatient programs develop strategies for crisis management, e.g.:
  - relapse prevention plans
  - monitoring for early warning signs
  - urgent care / walk-in appointments
  - on call availability

- Educate clients (and staff) not to use the ER for urgent care

Source(s): Clinic CQI
Managing the Project
Continuous Improvement Across All Settings

- No single solution
  - Portfolio of mutually reinforcing interventions
  - Ongoing incremental changes

- All relevant services within the hospital should participate and collaborate on the project

“There is definitely a need for increased collaboration between the inpatient and outpatient staff. Though we are one agency, and consider ourselves seamless, reviewing our internal referral process has demonstrated a disconnect in identifying and following up with patients deemed high-risk for readmission.”

Source(s): RED, STAAR, RARE, RQC, Transition
Data-Driven Decision Making

- Start with a root cause analysis of a sample of readmissions, including:
  - client/caregiver interviews
  - quantitative analysis
    - patient characteristics, setting discharged to, etc.
  - input from hospital staff and other providers
- Track interventions and outcomes over time, using continuous quality improvement methods.

Source(s): RED, STAAR, AHRQ, RQC
Collaboration across the Continuum of Care

- Know and engage your community partners
  - Standardize communication
  - Develop protocols for expedited referrals
  - Collaboration on treatment and discharge planning
  - Must include: BH, medical, housing

- Develop a relationship with at least one pharmacy

- Improved, real-time communication between inpatient and outpatient behavioral health providers and primary care physician

Source(s): STAAR, AHRQ, RQC, RED, RARE
Importance of Leadership

- Buy-in / Motivation
- Education
- Resource Allocation

“Behavioral health re-admissions can be reduced when providers use the proper, evidence-based treatments for serious mental health problems….”

“When administration plans a project without staff buy-in or support, it is doomed to be less successful than if staff had themselves designed the interventions/strategies. Any future collaborative project needs to incorporate more representation from front line staff.”
Question and Answer