An Effective Model to Reduce Psychiatric Readmissions

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PSYCHIATRY, MEDICAL AFFAIRS, LEADERSHIP, SOCIAL WORK, NURSING, CLINICAL RESOURCES MANAGEMENT

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Readmission to inpatient psychiatric care can have a significant impact on:

- cost of care per patient
- inpatient bed availability
- may have a negative influence on the patient’s and staff’s perception of treatment and progress
Identified Reasons for Readmission

- Premature discharge
- Inadequate discharge planning
- Lack of patient education
- Discharge plan failure
- Patient non adherence
- Lack of sufficient community support services
- Non-availability of appropriate outpatient care / insufficient timely access
The Behavioral Health Performance Improvement Committee has monitored 30 day psychiatric readmissions since 2008.

- Examined variables related to:
  - Patient population
  - Diagnostic profile
  - Payor source
  - Clinical team

- Variables assessed monthly, and trends identified
Aim and Strategy

• **Aim:**
  - To reduce inpatient psychiatric readmissions that occur within 30 days to below industry standard of 10%.

• **Strategy for Change:**
  - Initiate a program in collaboration with appropriate local partners
  - Implement targeted interventions for contributing factors identified above
Interventions

- Weekly readmission rounds (March 2009)
- Readmission audit tool (May 2009)
- Readmission focus in discharge planning meetings (May 2009)
- Teach-back method (November 2009)
- Wellness Recovery Action Plan (WRAP) (Nov. 2009)
- Outpatient follow-up appointments within 3 days of inpatient discharge (January 2010)
- Family engagement focus (January 2010)
Interventions, continued

- Patient readmission interviews initiated
- Post-discharge follow-up calls (January 2010)
- Outpatient hospital diversion groups (June 2010)
- Focus on improving community linkages and care transitions - collaboration with primary care providers (January 2011)
- Experimentation with “clinical bundle” (January 2011)
- Outpatient representation in weekly readmission rounds (January 2011)
- Initiation of home visit program (September 2011)
Tools Developed

- **Readmission Audit Tool**
  - Precipitant to admission
  - Discharge planning
  - Aftercare adherence
  - Barriers to community functioning
  - Patient education

- **Discharge Interview**
  - Discharge readiness assessment
  - Teach back questions
Summary of Outcomes to Date

- Hospital readmissions below 10%
- Hospital readmissions for patients with home visits below 5%
- Positive staff and patient response
Lessons Learned

- Psychiatric readmissions can be reduced using a multifaceted, multidisciplinary approach.
  - Improves client outcomes and client satisfaction
  - Reduces cost
  - Can be effectively achieved in a relatively low cost manner

- This process outlines a strategy for readmission reduction that promotes:
  - Innovation
  - Small tests of change
  - Continuous improvement process

- It requires partnership with patients, families, providers and payors.
Sustainability of Improvement

- The readmission reduction initiative is an ongoing effort with continued tests of change.

- The readmission reduction team is currently identifying opportunities for collaboration related to chronic medical conditions and appropriate Health Home partnerships.