

# **An Effective Model to Reduce Psychiatric Readmissions**



**SAMARITAN HOSPITAL, TROY, NEW YORK**

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

**Samaritan Hospital**

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# Context



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

# Readmission Analysis



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.