KINGS COUNTY HOSPITAL CENTER

Readmissions Quality Collaborative - Lessons Learned

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Kings County Hospital Center (KCHC)

At a glance

- 205 Inpatient Beds
  - 6 Adult Inpatient Units
  - 3 Child & Adolescent Units (New Latency Unit)
- Comprehensive Psychiatric Emergency Program (CPEP)
  - Extended Observation
  - Crisis Residence
- Chemical Dependency
  - Detoxification
  - Outpatient treatment
- Outpatient Services
  - Adult Clinic
  - Child Clinic
  - Partial Hospitalization Program
SOME WAYS IN WHICH WE HAVE APPROACHED READMISSIONS
Identifying Readmissions Early

• Patient Identification
  • Behavioral Health Services (BHS) Dashboard
  • CPEP, Adult, and Child & Adolescent Inpatient Service (CAPIS)
    • 15 day
    • 30 day
    • 60 day
    • 90 day
    • 3X in a year
    • 5X in lifetime
# The Dashboard

![Kings County Hospital Dashboard](image)

## CPEP Readmissions

<table>
<thead>
<tr>
<th>View</th>
<th>Description</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>CPEP 15 day Readmissions</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>CPEP 30 day Readmissions</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>CPEP 60 day Readmissions</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>CPEP 90 day Readmissions</td>
<td>2</td>
<td></td>
</tr>
</tbody>
</table>

## Inpatient Readmissions

<table>
<thead>
<tr>
<th>View</th>
<th>Description</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>IP 15 day Readmissions</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>IP 30 day Readmissions</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>IP 60 day Readmissions</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>IP 90 day Readmissions</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>IP Admissions 3X in a year</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>IP Admissions 5X in their lifetime</td>
<td>1</td>
<td></td>
</tr>
</tbody>
</table>
Preventing Avoidable Readmissions through Collaboration

- CPEP consults with KCHC inpatient team for recipients recently discharged from inpatient service
- CPEP consults with KCHC outpatient providers
- Collaboration on treatment and disposition
Repeat Admission Process

• Repeat Admission Review Coordinator/Committee (RARC)
  • Identify those readmitted within 15 days (now 30 days), or 3 times in past 12 months or 5 or more times overall
• Facilitate readmission conferences
• Offer recommendations to treatment team
• Monitor if recommendations are carried out
• Provide consultation to the inpatient team
• Track and analyze data on readmissions
• Lead a twice-weekly clinical conference with readmissions committee members to review priority cases
## Repeat Admission Documentation

<table>
<thead>
<tr>
<th>Diagnosis/Formulaion</th>
<th>Axis I Diagnoses:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Axis II Diagnoses:</td>
</tr>
<tr>
<td></td>
<td>Axis III Diagnosis:</td>
</tr>
<tr>
<td></td>
<td>Axis IV Diagnosis:</td>
</tr>
<tr>
<td></td>
<td>Axis V (GAF):</td>
</tr>
<tr>
<td></td>
<td>Formulation:</td>
</tr>
<tr>
<td>Initial FU Appointment</td>
<td>patient did not attend initial follow-up appointment</td>
</tr>
<tr>
<td>Initial FU Provider</td>
<td>SUS ACT services</td>
</tr>
<tr>
<td>Initial FU Date/Time</td>
<td></td>
</tr>
<tr>
<td>Living Arrangements Upon Discharge</td>
<td>private residence/room rental</td>
</tr>
<tr>
<td>Previous Hospitalizations</td>
<td>reviewed</td>
</tr>
<tr>
<td>Additional Hospitalization History</td>
<td>Facility:</td>
</tr>
<tr>
<td></td>
<td>Date of Admission:</td>
</tr>
<tr>
<td></td>
<td>Date of Discharge:</td>
</tr>
<tr>
<td></td>
<td>Type of Admission: behavioral health (psychiatric)</td>
</tr>
<tr>
<td></td>
<td>Description:</td>
</tr>
<tr>
<td>Reason(s) for Readmission</td>
<td></td>
</tr>
<tr>
<td>Symptoms Precipitating Admission</td>
<td></td>
</tr>
<tr>
<td>Key Factors and Recommended Strategies</td>
<td></td>
</tr>
<tr>
<td>Recommended LOC Upon Transition</td>
<td></td>
</tr>
<tr>
<td>Residential Program</td>
<td></td>
</tr>
<tr>
<td>Recommended Community Supports/Sys</td>
<td></td>
</tr>
<tr>
<td>Other Recommended Service(s)</td>
<td></td>
</tr>
<tr>
<td>Narrative Summary</td>
<td></td>
</tr>
<tr>
<td>Attending Physician</td>
<td></td>
</tr>
</tbody>
</table>
15 Day Readmission Rate – Adult Inpatient
September 1, 2010 – February 28, 2014
15 Day Readmission Rate – Child and Adolescent Inpatient
September 1, 2010 – February 28, 2014
Koskinas* plus...

- Monitoring, Referral & Linkage Unit (MRLU)
  - Engage with patient prior to discharge
  - Follow-up with patient at residence within 72 hours of discharge and up to 90 days
  - **Provide reminder** calls for *all* appointments; psychiatric, substance abuse, and medical
  - Follow-up with clinic or program within 24 hours of appointment
  - Case management for duration of follow up period (including community engagement) using Critical Time Intervention Model

* Pursuant to the court’s decision in a suit brought by Koskinas against the Health and Hospitals Corporation (HHC), HHC hospitals developed the “Koskinas program,” in which staff follow up on discharged psychiatric patients.
MRLU

- Engage with family, providing support, education and additional resources
- Engage community providers across the continuum of care
- Make additional referrals if necessary
- Facilitate communication between all stakeholders involved in patient’s care
- Escort patients to appointment if indicated
- Close linkage with Mobile Crisis for first missed appointment
Connection to Aftercare from Kings County Hospital Center Inpatient Service:
7 Day Follow-Up

Percentage of Appointments kept within 7 days

- HHC
- Non-HHC

Years: 2009 - 2014
Quarters: Q1 - Q4
Connection to Aftercare from Kings County Hospital Center
Inpatient Service:
30 Day Follow-Up

Percentage of Appointment Kept

- HHC
- non-HHC
Successes

What works well:

• Aftercare plans now regularly address co-existing mental health, medical and substance abuse concerns
• Patients are being referred to the most appropriate and integrated setting post discharge or CPEP visit
• Improved safety planning as community integration progresses
• Reduction in length of stay and overall downward trend in readmissions
• Overall increase in connection to aftercare post discharge (7 day and 30 day)
Challenges

• Clinical disciplines taking an integrated (psychiatric + general health) approach to the readmission
• Staff buy-in to a process of internal consultation: belief in the process
• Readmissions representatives must be comfortable with detailed assessment, documentation and recommendations, as well as some resistance
• Multiple initiatives happening simultaneously – difficult to identify the impact of individual strategies
• High caseload for MRLU
• Renewed focus on transition in care from managed care, and care coordination makes for duplication in care!
Some other lessons…

• Psychiatric Services and Clinical Knowledge Enhancement System (PSYCKES) is invaluable (Periods of stability are just as important as hospitalizations!)
• Importance of multidisciplinary approach
• Importance of Integrated Services
• Importance of Community Partnerships and Shared Risk
• Family engagement, early and often
Next Steps

Focus on Connection to Aftercare
• Ensure that all patients discharged to programs within KCHC from Inpatient have aftercare appointment day of discharge
• Peer Counselor to escort patients to 1st Appointment and orient them to service area

Utilize Peer Bridgers to assist/collaborate with MRLU and patient in transition back into the community for identified high utilizers.
Thank You!