

**The Readmissions Quality Collaborative  
Concluding Conference  
June 20, 2014**

**Lessons Learned and  
Recommendations**

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# Methods:

## Review of Models and Initiatives

- **RQC:** Behavioral Health Readmissions Quality Collaborative
- **Clinic CQI:** OMH Continuous Quality Improvement (CQI) Initiative for Health Promotion and Care Coordination
- **CTI:** Critical Time Interventions
- **Transitions:** Assertive Community Treatment (ACT) Transitions Project
- **RED:** Project 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 Department (ED)
  - Inpatient
  - Aftercare
- Managing the Project

# Emergency Department

# Prevent avoidable readmissions in ED

- Identify high utilizers and potential readmissions
- Consult/ approval by last inpatient team (they come to ED 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 (ED, 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)
- Check Medicaid status - enroll in Medicaid if eligible

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

Source(s): RARE, RQC

# Family / Caregiver Involvement

Goals of family involvement (or any natural supports)

- 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
  - Review of Psychiatric Services and Clinical Knowledge Enhancement System (PSYCKES)
  - 4-quadrant model of assessment
  - Motivational interviewing
- Refer to providers of integrated treatment for aftercare

Source(s): RQC, evidence-based practice 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
  - Partial Hospitalization Program (PHP)
  - Some clinics developing Intensive Outpatient (IOP) level of care
  - Identification of and coordination with existing services such as ACT

Source(s): RARE, RQC, Transitions

# Follow Up Phone Calls

- Follow-up phone call to **client/family**
  - Within 72 hours
  - Clinical intervention, intensive (not just a reminder call)
  - Use teach-back method (don't read the med list)
  - Ideally by staff known to client
  - Not “discharged” until made first outpatient appointment
- 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
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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.
- 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, e.g.: make another appointment if missed

Source(s): CTI, RARE, RQC, Transitions

\* 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.

# 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 ED 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 at project level and client level

- Start with a root cause analysis of a sample of readmissions, including:
  - client/caregiver interviews
  - quantitative analysis
  - input from hospital staff and other providers
- Track interventions and outcomes over time.

*“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): 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: behavioral health, 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