Project Interventions by Setting

Readmissions Quality Collaborative
Phase 2 Kick-Off Conference

Note: these slides have been re-formatted but are identical to those shown and distributed at the conference

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Project Goal
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Goal: Reduce 30-day readmissions for any reason, after discharge from inpatient behavioral health treatment.

- Discharge from behavioral health
  - Psychiatry
  - Detox
  - Rehab

- Readmission to any behavioral health or medical inpatient service at any institution
Guiding Principles

- Collaborate across the continuum of care
  - All service types: Psychiatry, substance abuse, medical, primary care, health homes, discharge planning, etc.
  - All settings: Emergency, inpatient, outpatient
  - External partners: managed care/ Health and Recovery Plans (HARPs), health homes, Performing Provider Systems (PPSs), community providers.

- Focus on care transitions: Patient is followed until he/she has made a successful transition

- “No silver bullet” - Implement a set of mutually reinforcing interventions, tailored to your hospital

- Standardize existing processes
Emergency Department

- Identify and flag potential readmissions (patients discharged from behavioral health inpatient within the past 30 days)
- Consultation / “2nd Opinion” before readmitting
  - If discharged from your hospital, inpatient discharging team comes to emergency department before disposition
  - If from another hospital: consult with their discharging team and/or patient’s community provider
  - Review what worked / didn’t work in previous discharge plan
- Care coordination in the Emergency Department for high-need patients
  - Refer to alternate levels of care
  - Address concrete needs
  - Follow up call to check on medication access and plan
Inpatient Setting

- Standardize specific elements of developing and teaching the discharge plan
  - Clear and easy to understand (like Project Re-Engineered Discharge (RED) format)
  - Medications: purpose, how to take, ensure access – i.e., obtain pre-certification
  - Appointments: first behavioral health (BH) appointment within 3-5 days, include both medical and BH, plan transportation
  - If a readmission, what will you do different this time?
  - Number to call for questions / problems: phone # of a provider who knows the plan and is known to the patient
  - Educate patient and caregiver re: plan, medication adherence, what to do / whom to call if a problem or question arises
  - Use structured teach-back tool to assess understanding

- Warm hand-off, whenever feasible
- Medication fill at discharge (BH and medical)
Post Discharge: Hospitals or Community Partners

- In-depth follow-up phone call within 72 hours
  - Intervention, not only a reminder (Project RED style)
  - Reinforce the plan
  - Review medications
  - Problem-solve

- Communicate plan to outpatient providers
  - Include detailed medication information, e.g., dates and dosages of Long-acting Injectable administration
  - Verify appointment is kept

- Follow up if appointment missed: new appointment

- For highest-need, highest-utilizing patients, provide active short-term case management
  - Intensity/duration determined by need
Health Home / Care Management

- Warm hand-off: Meet with the patient in the hospital before discharge

- Expedite discharge plan to
  - Behavioral health aftercare providers
  - Medical and primary care providers

- Post-discharge case management
  - In-depth follow-up phone call within 72 hours (as above)
  - Make appointment reminders
  - Follow up on missed appointments
Outpatient

- Warm hand-off, whenever feasible
- First post-discharge appointment within 3-5 days
- Identify and flag clients discharged to you from any behavioral health inpatient, and for these clients:
  - Make reminder calls before
    - First post-discharge appointment
    - First post-discharge prescriber appointment
- Follow up on non-adherence / non-admission
  - Track no-shows, canceled appointments, and whether they are admitted to the program
  - Call to inform the referrer if the client misses appointments or is non-admitted to the program
Recommended Structure for Cross-Setting Communication

Develop a care transitions committee that includes all behavioral health settings and medical representation, and community partners, including managed care organizations, receiving providers, residences, and other partners

- Meet monthly
- Invite community partners to participate on a quarterly basis
- Review readmissions / other sub-optimal transitions to identify opportunities for improvement
- Develop new / improved processes for care transitions and communication/documentation