



Office of
Mental Health

Quality Collaborative Activities

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

Kate M. Sherman, LCSW
NYS Psychiatric Institute / NYS Office of Mental Health

Quality Improvement Project Goal



Quality Improvement (QI) Project Goal

Reduce readmissions to any hospital for any diagnosis and service within 30 day after discharge

Discharged from inpatient

- ❖ Psychiatry
- ❖ Detox/Rehab

Admitted within 30 days to any hospital's inpatient

- ❖ Psychiatry
- ❖ Detox/Rehab
- ❖ Medical
- ❖ Combined, all-cause



The Learning Collaborative Model

- ❖ Health care organizations work together toward a common goal
 - Conduct Continuous Quality Improvement (CQI) project
 - Identify and share successful strategies
 - Promote rapid adoption of best practices

- ❖ Background
 - Institute for Healthcare Improvement (IHI) model
 - GNYHA has used in medical-surgical



Hospital Activities



Form Readmissions Project Team

- ❖ Engaging a team that spans the continuum of care is crucial to success
- ❖ Leadership / medical “champion” is key
- ❖ Interdisciplinary
- ❖ Data manager – essential for monitoring / reporting



Conduct Quality Improvement (QI) Project

❖ Develop an action plan

- What will be done?
- Who will do it?
- When will it be done?
- How will it be measured?

❖ Implement project interventions in all settings

❖ Collect and use data

- Inform decisions; make course corrections as needed
- Monitor activities
- Recognize and share successes!



Using Data: The Root Cause Analysis

❖ Components of the Root Causes Analysis

- Chart reviews
 - Retrospective sample of readmissions
 - Use PSYCKES to generate sample and provide client data
- Interviews of current patient and families/caregivers
 - “5 why’s”

❖ Format

- Standardized format to report to the collaborative, pool data
- Developed by GNYHA/HANYS for medical readmissions pilot
- Selected by Steering Committee, adapted for BH

❖ Purpose

- Understand drivers of readmissions for your patients
- Inform your project – identify targets for intervention



Using Data: Ongoing Tracking

❖ Monitor your activities – Plan now for tracking data

- Flag target clients
 - Emergency Department: Potential readmissions (discharged past 30 days)
 - Inpatient: High utilizers, readmissions, high-need
 - Outpatient: Discharged to your program
- Track interventions delivered, and who got them
- Track attendance at first post-discharge appointment
- Build data collection into processes

❖ Dual Purpose of data collection

- Manage your quality improvement project
- Clinically useful (e.g., tracking outcomes of discharge plan provides information for subsequent discharge planning)



The Reporting Plan



Reporting by Participants

- ❖ Report on Root Cause Analysis and submit Action Plan
- ❖ Monthly milestone reporting
 - Progress toward project implementation
 - e.g. team formed, action plan developed
 - Not started / in progress / completed
- ❖ Monthly project activities and interventions
 - Clients at high risk of readmission identified
 - Interventions delivered
 - Outcomes
- ❖ Additional surveys as needed
- ❖ Final survey of outcomes and best practices



Monthly Reporting Process

- ❖ Brief on-line survey
 - Link is emailed and posted on the 5th of every month
 - Submit data by the 10th of each month for activities in the previous month

- ❖ Each participating program reports separately

- ❖ PSYCKES team aggregates and shares back on monthly call

- ❖ First data submission:
 - Milestones: March (Report on February progress)
 - Project interventions: May (Report on April activities)



Reporting by the Collaborative

- ❖ Aggregate QI self-report data (Monthly)
 - Your hospital/program data
 - Aggregate data for all participating hospitals/programs
 - De-identified data from participating hospitals/programs

- ❖ Medicaid Data Analysis
 - Baseline
 - Every 6 months
 - Evaluation



Support Provided by the Collaborative



Office of
Mental Health

Conferences, Calls and Site Visits

- ❖ Conferences
 - Kick-Off
 - Mid-point, share successful strategies
 - Conclusion

- ❖ Monthly learning Collaborative Calls
 - Interactive, report on progress
 - Rotation: all hospitals report on progress

- ❖ Site Visits (selected hospitals/programs)
 - Technical assistance
 - Identify best practices



The PSYCKES (Psychiatric Services and Clinical Knowledge Enhancement System) Application

- ❖ Clinical summary helps identify high utilizers and other readmission risk factors, and supports treatment planning and care coordination
 - (implement process for Consent)
- ❖ Access to data across treatment settings, including readmissions to other institutions after you discharge
- ❖ Readmissions quality indicators track progress
 - (retrospectively, data lag)
- ❖ Gather data for the Root Cause Analysis
 - Identify sample of readmitted clients
 - Data for chart reviews, e.g. pattern of medication non-adherence



PSYCKES Training and Technical Assistance

- ❖ Customized webinars for the Collaborative
 - Using PSYCKES to Support the Readmissions Project
 - Monthly Data Submission

- ❖ Standard PSYCKES webinars
 - Using PSYCKES for Clinicians
 - PSYCKES PHI Access Module

- ❖ PSYCKES Help: PSYCKES-Help@omh.ny.gov

- ❖ PSYCKES Website: www.psyckes.org



PSYCKES Website: Hospital Collaborative Page





Hospital Quality Collaborative

Log Into PSYCKES
Participants
Learning Collaborative
Project Tools
Clinical Resources
Project Impact
Using PSYCKES

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Quality Concerns

Initiatives

Free-standing Clinics

Hospital Collaborative

Children's Collaborative

OASAS Programs

Assertive Community Treatment (ACT)

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Emergency Rooms

Other Initiatives

Resources

QI Teams

Clinicians

Inpatient Providers

Consumers/Families

FAQs

Hospital Quality Collaborative

Reducing Behavioral Health Inpatient Readmissions

Overview of Project

The New York State Office of Mental Health (OMH), Greater New York Hospital Association (GNYHA), and Healthcare Association of New York State (HANYS) are co-sponsoring the Readmissions Quality Collaborative, focused on reducing readmission rates among adults discharged from behavioral health inpatient services. Participating hospitals work together to implement evidence-based clinical and operational interventions in the areas of medication practices, engagement in care, and treatment integration, in order to enhance care transitions and promote improved client outcomes. Data from the Psychiatric Services and Clinical Knowledge Enhancement System (PSYCKES) supports the quality improvement activities and helps to measure project impact.

News

Phase 2 of the Readmissions Quality Collaborative begins with a Kick-off Conference on January 30th at GNYHA. Hospitals interested in participating in this initiative should contact [PSYCKES Help](#) as soon as possible.

Calendar

Thursday, January 8, 2015	10 a.m. to 11 a.m	Webinar: PSYCKES for Managers and Administrators: Part 1
Tuesday, January 13, 2015	10:45 a.m. to noon	Webinar: Using PSYCKES for Clinicians

PSYCKES Website: Project Information, Tools, Resources

❖ Project Information

- Presentations from conferences (today) and trainings
- Calendar and registration links
- Reporting questions and links to surveys

❖ Project tools and structured instruments

- Quality Improvement: Action Plan, Root Cause Analysis
- Clinical: Shared by participating programs or developed by Readmissions Collaborative Team



Question and Answer

