



**Office of
Mental Health**

Decreasing Avoidable Readmissions: A Complex Challenge

Commissioner Ann Marie T. Sullivan, M.D.
New York State Office of Mental Health

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Transforming the HealthCare System

- The Triple Aim and the Affordable Care Act
- The New York State Transformation Process
- The New York State Mental Health Transformation



Strategy: The Triple Aim

- **Better Health Of The Population:**
 - Prevention and Maximizing Wellness
- **Better Care For Each Patient:**
 - Quality Care focused on patient choice, engagement, and satisfaction; clinical best practices; integrated care between medical and psychiatric services; coordinated care with Primary care Medical Home; Increase in insured patients requires increased access to care
- **Lower Cost:**
 - Performance based payment; More efficient and effective care focused on less admissions and readmissions and more comprehensive ambulatory care (e.g., Patient Centered Medical Home (PCMH)) and Behavioral Care; risk based models such as the Accountable Care Organization (ACO)



Triple Aim: Population Health

Collaborative Care:

- Collaborative/Integrated Care with Adult Primary Care Providers that screen for Depression and Substance Use and provide rapid access to treatment; School Based and Pediatrics collaborative care for children and adolescents
- Collaborative/ Integrated care in Behavioral Health with management and monitoring of chronic disease
- Integration Substance Use and Mental Health treatment in Behavioral Health settings
- Wellness Care for Individuals with Serious Mental Illness: Health and Recovery Plan (HARPs)
- Crisis respite services; employment and education supports; family supports; peer supports; physical health wellness; rehab; self directed care; skills training; financial management.



Triple Aim: Better Care for Each Patient

1. Patient Centered Care focused on patient choice, self directed care; engagement, and satisfaction;
2. Clinical best practices; integrated care between medical and psychiatric services; coordinated care that focuses on community based treatment; decreased inpatient use and decreased inpatient readmissions;
3. Easy access to services when and where they are needed in the community



Triple Aim: Lower Cost

- Performance based payment based on measured outcomes; More efficient and effective care focused on less admissions and readmissions and more comprehensive ambulatory care (PCMH; Behavioral Health Homes); risk based models such as the Accountable Care Organization (ACO)
- Managed Medicaid focused on reduction of unnecessary inpatient use and reinvestment of dollars in community based care; Integrated physical and behavioral health care.



DSRIP: Delivery System Redesign Implementation Plan

Medicaid Redesign Team (MRT) Waiver Amendment: \$8.0 Billion Allocation

- **\$500 Million for the Interim Access Assurance Fund (IAAF)** – Time limited funding to ensure current trusted and viable Medicaid safety net providers can fully participate in the DSRIP transformation without unproductive disruption.
- **\$6.42 Billion for Delivery System Reform Incentive Payments (DSRIP)** – Including DSRIP Planning Grants, DSRIP Provider Incentive Payments, and DSRIP Administrative costs and DSRIP related Workforce Transformation.
- **\$1.08 Billion for other Medicaid Redesign purposes** – This funding will support Health Home development, and investments in long term care workforce and enhanced behavioral health services, (1915i services).



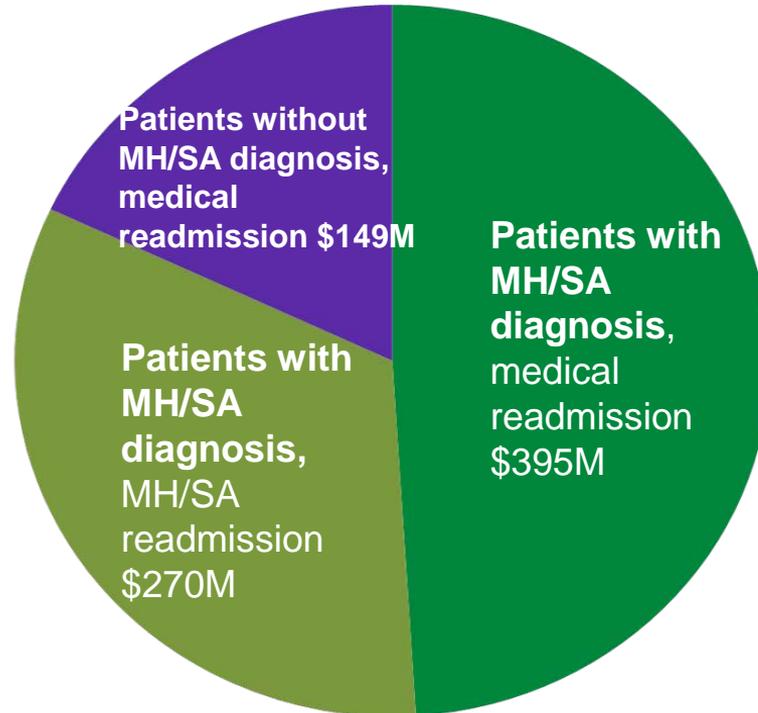
DSRIP and Behavioral Health

- PPSs (Performing Provider Systems) must have appropriate linkages to community and hospital based behavioral health services in their networks;
- All applicants had to include one behavioral health project and 26 of the 36 applications included Collaborative Care in Primary Care as one of their projects;
- Major request for regulatory relief was in collaborative care projects for Primary and Behavioral Health: relief of space requirements; dual licensure; visit thresholds; and billing restrictions;
- Systems will need to improve rates of readmission and decrease avoidable admissions for psychiatric patients;
- All payments must be 90% Value Based within 5 years.



The Need for Integrated Care:

Potentially Preventable Readmissions (PPR's)
New York State Costs \$814M (2007)



NY State Reinvestment

- Work with article 28 inpatient providers to develop a continuum of care that prevents hospital use by increasing mobile intervention teams; respite beds; home based crisis services for youth; and linking these to emergency rooms for admission diversion
- Housing: reinvestment housing dedicated to individuals leaving state and article 28 inpatient facilities; increased supports to housing providers to accept more complex patients
- Only lower beds when vacant for 90 days
- Reinvest \$110,000 for every bed closed
- Reinvestment of Medicaid dollars from closed inpatient units
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An Opportunity to Transform Mental Health Services



Community Services

Re-investment funding



Housing

Adult Home, re-investment,
MRT and other housing funds



Medicaid Managed Care

Integrated Managed Care
Health and Recovery Plans
(HARPs)
DSRIP



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A Few Numbers....

Community Services

\$25 Million pre investment to expand State and voluntary operated community services focused on reducing admissions and readmissions including crisis beds, respite, Home and community waiver slots, first episode psychosis teams, peer operated services.

If successful at reducing 400 beds at a reinvestment of 110,000 per bed then annual reinvestment will be 44 million

Planning for services with the Local Mental Hygiene Directors , OMH Regional Office and local stakeholders.

Housing

Currently 35,000 housing units in NY State

\$30 million to support residential units for individuals transitioning out of adult homes

625 New housing units from state reinvestment

Downstate and some upstate supported housing stipend increase of \$750 annually to cover higher cost rents.(10 million) Last year a \$550 increase

Additional Housing from MRT Initiative, NYNY 3 1200 beds and NY/NY 4 Housing 5,000 beds

Medicaid Managed Care

Include all individuals with serious mental illness in managed care July 2015.

\$20 Million for system readiness to develop infrastructure for managed care/ HARPs
\$10 Million to enhance clinic reimbursement for integrated behavioral and health care and implementation of the collaborative care model

30 million to establish waiver services for HARPs: peer supports; educational and employment supports; crisis respite; family supports and self directed care.
\$30 Million in Vital Access Provider (VAP) to preserve critical access to behavioral health inpatient and clinic services in some areas.
Medicaid reinvestment for inpatient article 28 closures



The Challenge of Readmissions

- Culture of treatment services
- Patients are complex
- Services are difficult to navigate
- Patients and families need to be true partners in care
- Multiple and unique “causes” for each readmission
- Reducing readmissions is hard work!



Culture Change Essential

- Every readmission is a treatment failure and requires a mini root cause analysis
- The right care after admission is just as important as the right care during the admission
- The right care after the admission is everyone on the team's responsibility
- Engaging the patient and family/support is everyone on the team's responsibility



The Complexity of our Patients is an Opportunity, Not a Burden

- We need to understand the multiple issues that cause a readmission
- We need to accept the challenge of working with the patient and support to resolve the issues that lead to readmission
- There is rarely only one cause for a readmission and each readmission is unique
- The complexity of the treatment plan needs to be clearly explained to the next level of care



Our System is Daunting

- Real and effective coordination of care is critical and all members of treatment team need to see their part in this coordination
- Every patient and family needs help in navigating the system
- We need to see this as our problem, not the patients



Partnership is Critical

- Only the patient can implement the treatment plan. The provider team merely assists
- Therefore the patient and family/support need to be involved in the plan and engaged in the plan
- Patients and supports needs and desires are critical to the plan



Project Red Evidence Based Practice for CHF Admissions: How Similar to Psychiatric Admissions

- Congestive Heart Failure (CHF) chosen by Centers for Medicare and Medicaid Services (CMS) due to high and often multiple readmissions, high level of disability, extremely costly to Medicare, and interventions available
- Patients are highly complex and need social and family supports
- Complex psychopharmacology often involved
- Patients find it difficult to understand and follow treatment regimens



Key Interventions: In Hospital

- Recent previous care providers and family/care givers contacted about patients care
- Plan for care is developed mutually with patient and care team; emphasizes patients concerns and desires
- Throughout the hospital stay all staff, including the physician work together with the patient on the plan for care including educating the patient about the diagnosis, tests, and treatment; explaining tests in the hospital that will be followed up after; including family/supports in ongoing planning and education
- In hospital treatment is best practices and recommended protocols followed; consultations when needed; (e.g. consider Clozapine or long acting injections in patients with Schizophrenia)



Key Interventions: In Hospital

- Medication Plan: Reconcile all meds with meds before hospital stay; emphasize any changes; in detail why and how to take meds; what to expect; what are side effects; is it covered by insurance; how will patient get meds; if family or supports do they understand the why and how; pharmacist is extremely helpful as part of the team



Key Interventions: Follow Up

- Follow up appointment in 2-3 days optimal; make appointment with patient, explain appointments, be sure transportation and time convenient and available and someone to accompany if indicated
- Follow up call or visit 24 to 48 hours
- What to do if a problem arises
- Who to call if a question



Key Interventions: Follow Up

- Outpatient Provider: receives all information about patient and plan for care
- Optimally contact is made if needed by phone, or a visit if possible
- Any care coordinators or case managers part of plan and contact with patient before leaving the hospital



Key Interventions

- “Discharge Advocate” utilized in research- assigned to high risk readmissions through out inpatient stay
- Well functioning team with high level of attention to all factors can also work but still needs someone “in charge” to keep staff involved



Case Studies from the Readmission Collaborative 2014



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Hospital #1

- **Upstate hospital**
- **54 Psychiatric Beds**
- **No Psychiatric Emergency Room (ER) or Comprehensive Psychiatric Emergency Program (CPEP)**



Emergency Department

- Chief of Psychiatry highly involved (began 12/2011)
 - Rounds in Emergency Department (ED) 7 days/week
 - Sees all psych patients to consult on disposition
 - Expert consultation
 - Sharing risk
 - Evaluates – why individual came back, what went wrong
 - Firm rule: all 30-day psychiatric readmissions must be approved in advance by Chief of Psychiatry
- ED Care Coordination and follow-up for high utilizers and high-need clients
 - Social worker links clients with appropriate resources, incl. BH, concrete services, medical care, health home
 - Follows patients, up to 2 weeks, to ensure engagement
 - ED docs more comfortable discharging w/ plan in place



Inpatient: Post-Discharge Case Management

- Short-Term Intensive Case Management Post Discharge
 - Makes realistic plan for medication access
 - Calls client to give appointment reminders, troubleshoot
 - Verifies attendance and, if necessary, reschedules
 - Follows clients until attends 1st appointment (up to 2wks)
- Health Home
 - Shares EMR with hospital, automatic alerts to HH if admitted client is HH Enrolled or HH Outreach
 - Reviews new inpatient admissions daily to identify those eligible for health home
 - Sees and engages clients during inpatient stay



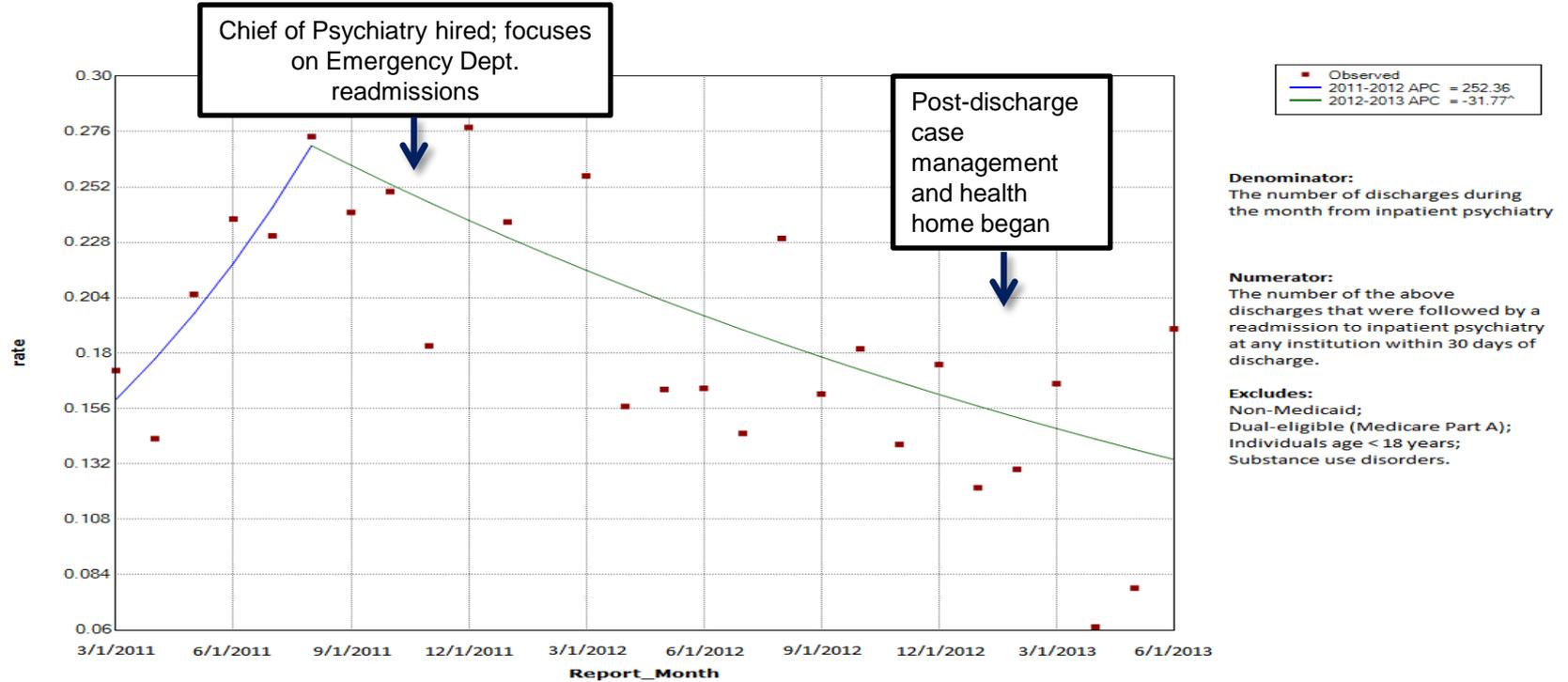
Outpatient: Care Integration

- Wellness Center: Outpatient mental health has co-located services
 - primary care clinic
 - concrete services kiosks
 - physical fitness (e.g. yoga)
- In-house ACA Patient Navigator Program enrolls clients in Medicaid or insurance program
- Health Home Care Management
 - Addresses medical, BH and concrete service needs



Outcomes: Psychiatric Readmissions

Based on Medicaid Data Analysis



The Annual Percent Change (APC) is significantly different from zero at alpha = 0.05



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Hospital #2

- New York City
- Large urban teaching hospital



Comprehensive Psychiatric Emergency Program (CPEP)

- Readmissions are flagged on CPEP whiteboard
- Potential readmissions are seen by inpatient discharging team before disposition. This has prevented “countless readmissions.”
- Partial Hospital staff check whiteboard and come to CPEP (diversion, warm handoff from CPEP)
- A performance improvement project on repeat ED presentations identified co-occurring Mental Illness (MI) and Substance Use Disorder SUD as a driver.
 - CPEP began routine screening for SUDs in late 2012.
 - All CPEP staff trained in EBPs for integrated treatment
 - Extended Observation Beds are used to re-stabilize patients with SUDs and avert readmission.



Inpatient Discharge Planning: Intensive Case Review for Repeat Admissions

- Readmissions are flagged on inpatient dashboard
- Repeat Admissions Committee identifies and reviews individuals who are high utilizers over time
- Case conferences for high utilizers /readmitted clients
 - Includes
 - community providers, e.g., Assertive Community Treatment (ACT), Case Managers (CM), residence.
 - patient and sometimes the family/caregiver
 - Institutional memory: They review past recommendations and previous discharge plans
 - Conference is ½ hour and may be held in the field



Post-Discharge: Short-Term Case Management

Short-term Intensive Case Management post discharge began in 2010

- Enhanced existing team of BA-level workers monitoring adherence to aftercare, to include clinical intervention
- Duration and intensity are based on client need
 - followed for 30, 60, or 90 days
 - intensive protocol for first 2 weeks if needed
 - In the field or by phone as needed
- Provides critical information back to discharging team and readmission case conference



Outpatient: Alternate Levels of Care, Outreach, Warm Handoff

- **Partial Hospitalization Program (PHP)** opened in July 2012.
 - Diversion from CPEP
 - Post-discharge step-down with warm hand-off and direct admission from inpatient
- **Crisis residence**
 - CPEP can discharge patients with housing problems to crisis residence
- **Intensive Outpatient Program (IOP)** being developed in the mental health outpatient department



Outcomes: Engagement in Aftercare

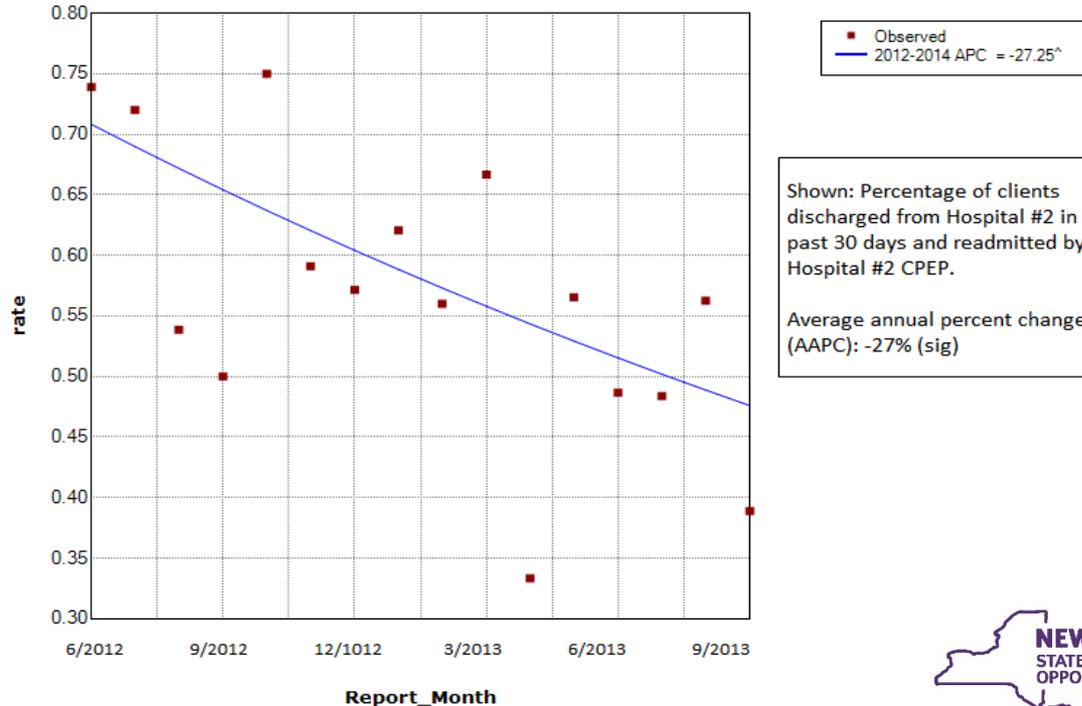
- Kept appointment post-discharge, within 30 days:
 - Previously, 30-40%
 - Currently, in the high 50%'s

Clients who miss appointment in the first 7 days may engage within 30 days with continued intervention.



Outcomes: Readmissions through CPEP Based on Medicaid Data Analysis

Hospital #2 "Front Door:"
Percentage of potential readmissions (discharged in past 30 days) who were readmitted by this hospital's CPEP



[^] The Annual Percent Change (APC) is significantly different from zero at alpha = 0.05

