

**The Children's Readmissions Collaborative
Kick-Off Conference
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**The Adult Behavioral Health
Readmissions Collaborative:
Lessons Learned**

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Methods:

Review of Models and Initiatives

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

Emergency Department (ER)

Prevent avoidable readmissions in ER

- Identify high utilizers and potential readmissions
- Consult with last inpatient team (they come to ER 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 (ER, 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)

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

Source(s): RARE, RQC

Family / Caregiver Involvement

Goals of family involvement

- 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
 - PSYCKES review
 - 4-quadrant model of assessment
 - Motivational interviewing
- Refer to providers of integrated treatment for aftercare

Source(s): RQC, EBP 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
Examples for children:
 - Partial Hospitalization Program (PHP)
 - Home-Based Crisis Intervention (HBCI)
 - Single Point Of Access(SPOA) / Waiver
 - Respite
 - Mobile Outreach Teams
 - Coming soon: Children's Health Homes

Source(s): RARE, RQC, Transitions

Follow Up Phone Calls

- Follow-up phone call to **client/family**
 - Within 72 hours
 - Clinical intervention, intensive (not reminder call)
 - Use teach-back method (don't read the med list)
 - Ideally by staff known to client
- 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.
 - For kids: Home-Based Crisis Intervention or other
- 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

“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): CTI, RARE, RQC, Transitions

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 ER 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

- Start with a root cause analysis of a sample of readmissions, including:
 - client/caregiver interviews
 - quantitative analysis
 - patient characteristics, setting discharged to, etc.
 - input from hospital staff and other providers
- Track interventions and outcomes over time, using continuous quality improvement methods.

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: BH, 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