



Kings County Hospital Center

Established 1831



KINGS COUNTY HOSPITAL CENTER

Readmissions Quality Collaborative - Lessons Learned

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Kings County Hospital Center (KCHC)

At a glance

- 205 Inpatient Beds
 - 6 Adult Inpatient Units
 - 3 Child & Adolescent Units (New Latency Unit)
- Comprehensive Psychiatric Emergency Program (CPEP)
 - Extended Observation
 - Crisis Residence
- Chemical Dependency
 - Detoxification
 - Outpatient treatment
- Outpatient Services
 - Adult Clinic
 - Child Clinic
 - Partial Hospitalization Program

SOME WAYS IN WHICH WE HAVE APPROACHED READMISSIONS

Identifying Readmissions Early

- Patient Identification
 - Behavioral Health Services (BHS) Dashboard
 - CPEP, Adult, and Child & Adolescent Inpatient Service (CAPIS)
 - 15 day
 - 30 day
 - 60 day
 - 90 day
 - 3X in a year
 - 5X in lifetime

The Dashboard

KINGS COUNTY HOSPITAL DASHBOARD
Behavioral Health

WELCOME, LORA GIACOMONI

CPEP READMISSIONS		
VIEW	DESCRIPTION	VALUE
	CPEP 15 day Readmissions	0
	CPEP 30 day Readmissions	2
	CPEP 60 day Readmissions	3
	CPEP 90 day Readmissions	2

INPATIENT READMISSIONS		
VIEW	DESCRIPTION	VALUE
	IP 15 day Readmissions	0
	IP 30 day Readmissions	0
	IP 60 day Readmissions	1
	IP 90 day Readmissions	1
	IP Admissions 3X in a year	1
	IP Admissions 5X in their lifetime	1

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Preventing Avoidable Readmissions through Collaboration

- CPEP consults with KCHC inpatient team for recipients recently discharged from inpatient service
- CPEP consults with KCHC outpatient providers
- Collaboration on treatment and disposition

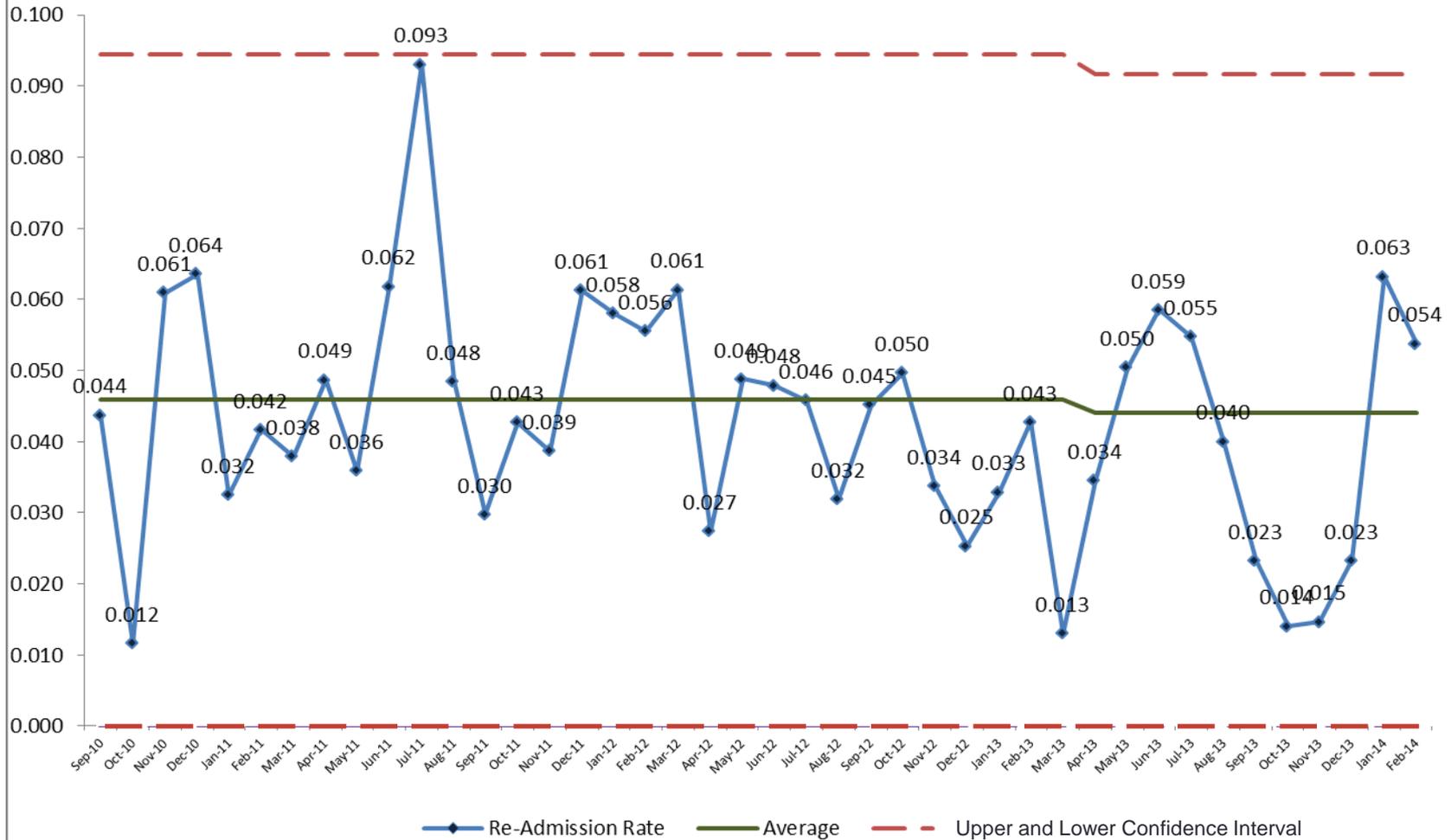
Repeat Admission Process

- Repeat Admission Review Coordinator/Committee (RARC)
 - Identify those readmitted within 15 days (now 30 days), or 3 times in past 12 months or 5 or more times overall
 - Facilitate readmission conferences
 - Offer recommendations to treatment team
 - Monitor if recommendations are carried out
 - Provide consultation to the inpatient team
 - Track and analyze data on readmissions
 - Lead a twice-weekly clinical conference with readmissions committee members to review priority cases

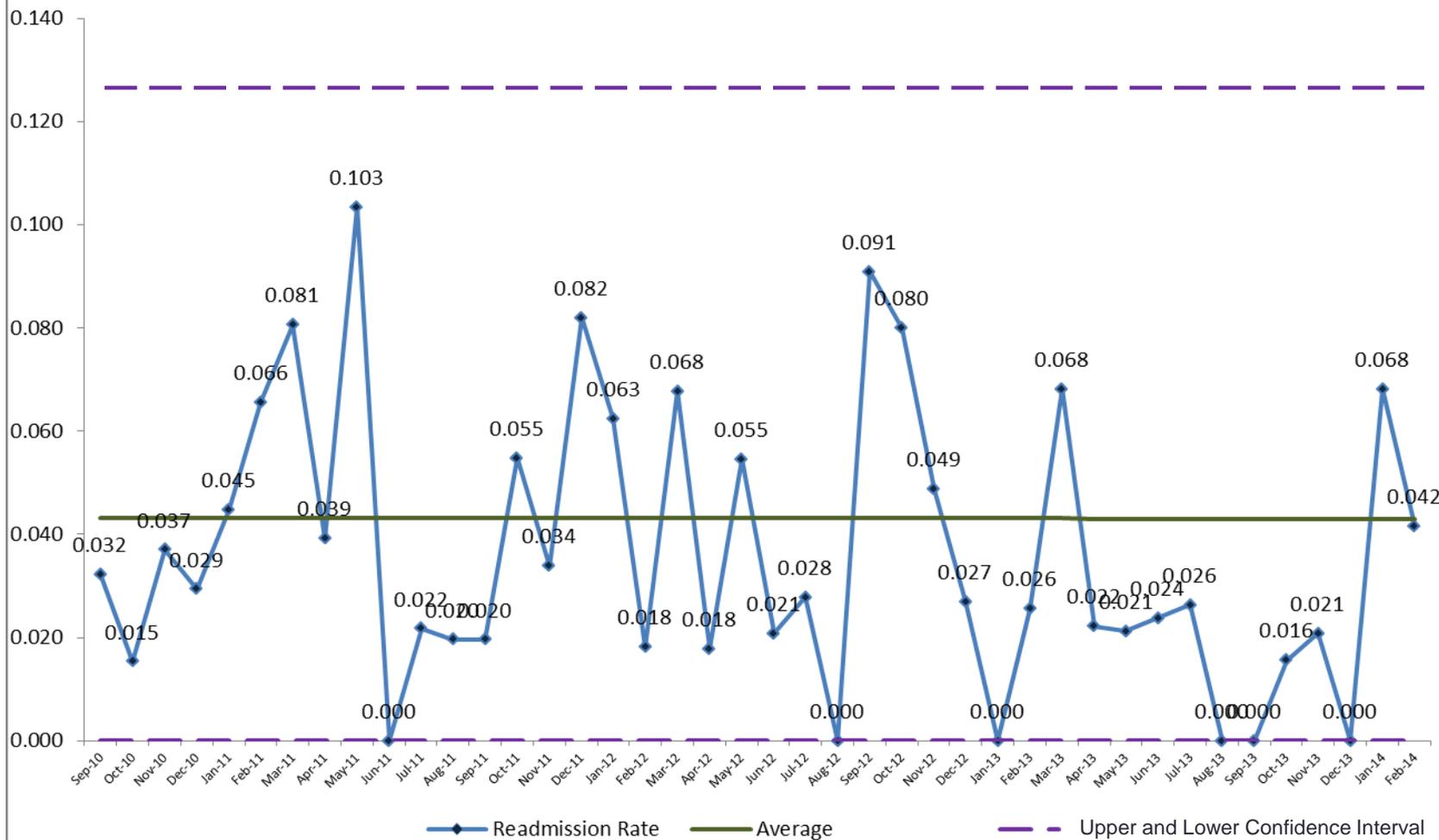
Repeat Admission Documentation

Diagnosis/Formulation	Axis I Diagnoses: Axis II Diagnoses: Axis III Diagnosis: Axis IV Diagnosis: Axis V (GAF): Formulation:
Initial F/U Appointment	patient did not attend initial follow-up appointment
Initial F/U Provider	SUS ACT services
Initial F/U Date/Time	
Living Arrangements Upon Discharge	private residence/room rental
Previous Hospitalizations	reviewed
Additional Hospitalization History	Facility: Date of Admission: Date of Discharge: Type of Admission: behavioral health (psychiatric) Description:
Reason(s) for Readmission	
Symptoms Precipitating Admission	
Key Factors and Recommended Strategies	
Recommended LOC Upon Transition	
Residential Program	
Recommended Community Supports/Services	
Other Recommended Service(s)	
Narrative/Summary	
Attending Physician	

15 Day Readmission Rate – Adult Inpatient September 1, 2010 – February 28, 2014



15 Day Readmission Rate – Child and Adolescent Inpatient September 1, 2010 – February 28, 2014



Koskinas* plus...

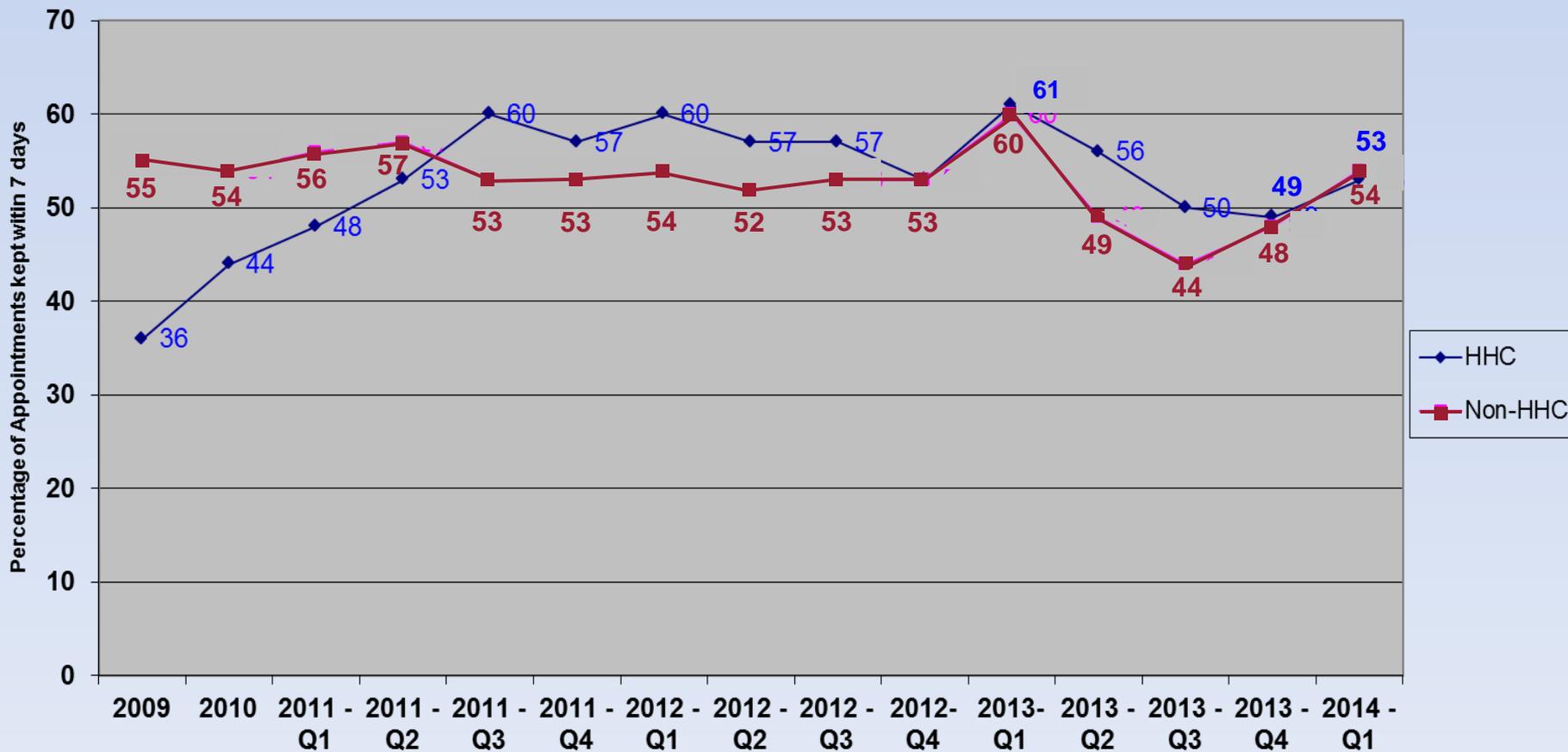
- **Monitoring, Referral & Linkage Unit (MRLU)**
 - Engage with patient prior to discharge
 - Follow-up with patient at residence within 72 hours of discharge and up to 90 days
 - **Provide reminder** calls for *all* appointments; psychiatric, substance abuse, and medical
 - Follow-up with clinic or program within 24 hours of appointment
 - Case management for duration of follow up period (including community engagement) using Critical Time Intervention Model

* 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.

MRLU

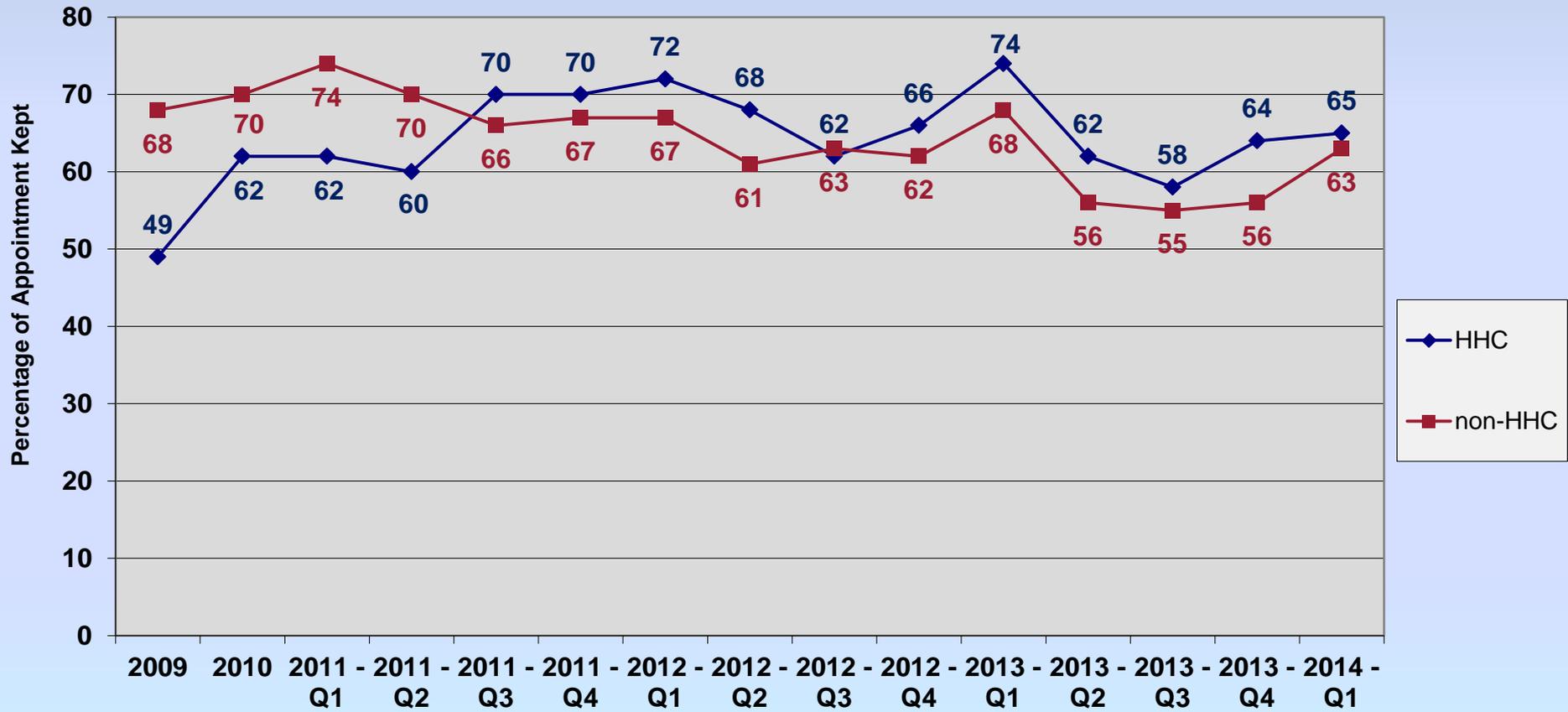
- Engage with family, providing support, education and additional resources
- Engage community providers across the continuum of care
- Make additional referrals if necessary
- Facilitate communication between all stakeholders involved in patient's care
- Escort patients to appointment if indicated
- Close linkage with Mobile Crisis for first missed appointment

Connection to Aftercare from Kings County Hospital Center Inpatient Service: 7 Day Follow-Up



Connection to Aftercare from Kings County Hospital Center

Inpatient Service: 30 Day Follow-Up



Successes

What works well:

- Aftercare plans now regularly address co-existing mental health, medical and substance abuse concerns
- Patients are being referred to the most appropriate and integrated setting post discharge or CPEP visit
- Improved safety planning as community integration progresses
- Reduction in length of stay and overall downward trend in readmissions
- Overall increase in connection to aftercare post discharge (7 day and 30 day)

Challenges

- Clinical disciplines taking an integrated (psychiatric + general health) approach to the readmission
- Staff buy-in to a process of internal consultation: belief in the process
- Readmissions representatives must be comfortable with detailed assessment, documentation and recommendations, as well as some resistance
- Multiple initiatives happening simultaneously – difficult to identify the impact of individual strategies
- High caseload for MRLU
- Renewed focus on transition in care from managed care, and care coordination makes for duplication in care!

Some other lessons...

- Psychiatric Services and Clinical Knowledge Enhancement System (PSYCKES) is invaluable (Periods of stability are just as important as hospitalizations!)
- Importance of multidisciplinary approach
- Importance of Integrated Services
- Importance of Community Partnerships and Shared Risk
- Family engagement, early and often

Next Steps

Focus on Connection to Aftercare

- Ensure that all patients discharged to programs within KCHC from Inpatient have aftercare appointment day of discharge
- Peer Counselor to escort patients to 1st Appointment and orient them to service area

Utilize Peer Bridgers to assist/collaborate with MRLU and patient in transition back into the community for identified high utilizers.

Thank You!