

Re-Admission Project

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Teach Back Process

- ✓ **Brookhaven Behavioral Health begins the Discharge Planning process on the day a patient is admitted**
- ✓ **Multidisciplinary Team approach is utilized for the assessment process**



Initial Assessment and Discharge Evaluation

Daily Team meetings are held on Inpatient Psychiatric Unit

- ✓ **Multidisciplinary Team questions key areas of patient's presenting symptoms including:**
- ✓ **Their reason for admission**
- ✓ **Previous living arrangements**
- ✓ **Previous treatment provider**
- ✓ **Any community linkage: Case Manager (CM), Assisted Outpatient Treatment (AOT), Assertive Community Treatment (ACT), etc.**



Teach Back Process

Upon admission a screening tool is utilized during the patients first encounter with the treatment team to determine whether there is a high risk for readmission. This screening tool includes evaluation of:

- **2 or more psych hospitalizations within 6 months**
- **a history of readmission due to noncompliance with medications**
- **support in the community related to housing, family, social supports, finances, insurance and transportation**

Continuity of Care

Brookhaven Memorial Hospital (BMH) staff contact collateral and community agencies to engage them in discharge planning process

- **They are invited to attend daily treatment team meetings**
- **Ongoing communication amongst providers is critical to successful discharge planning**



Teach Back Process Enhanced Discharge Plans

If a patient is determined to be a high risk for readmission, enhanced discharge planning methods are utilized in an effort to prevent such an occurrence. These include but are not limited to:

- referring to CM/bridger, AOT, ACT, Health Homes if not already involved
- assisting patients with obtaining emergency Medicaid for those who qualify
- linkage with Sayville Project's Discharge Planning Team

Teach Back Process Enhanced Discharge Plans

- **Applying for the medication grant program**
- **Use of Peer Services with Federation of Organizations to assist patients with navigating aftercare needs**
- **Providing a 3 day supply of medication for those in need and/or going to emergency housing and may not be able to get scripts filled immediately**
- **Emergency hotline numbers and support group lists are given to all patients upon discharge**
- **Wellness plans are also completed for high risk patients so they have a written plan in front of them to refer to if in crisis**

Teach back: BMH Discharge Questions

- **Where will you be living?**
- **Where and when is your next aftercare psychiatric/ substance abuse appointment?**
- **Do you have a medical follow up appointment?**
- **How will you transport yourself to your appointment?**
- **Do you have a case manager? If yes, do you know their contact info and when you will see them?**



Teach back: BMH Discharge Questions

- **Do you have the funds to pay for your medications?**
- **Will you be able to prepare your meals?**
- **Please tell us what medications you will be taking?**
- **Do you have any questions for us?**

Follow-up and Outreach Performance Improvement Project



All patients are contacted post discharge to ensure that they are stable, and have attended, or plan to attend their aftercare appointments.