

Readmissions Quality Collaborative Phase 2

Monthly Data Reporting Plan

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Please report on adults only.

For inpatient and outpatient reporting, Psychiatry and Substance Abuse Treatment services will report separately.

Within each reporting category, participating hospitals and health homes may choose whether to report separately for multiple services of the same type (e.g., outpatient mental health clinics at different sites) or whether to report aggregate data. Data may not be aggregated across reporting categories (e.g., inpatient psychiatry and inpatient substance abuse treatment).

“Behavioral Health” or “BH” encompasses both Psychiatry and Substance Abuse Treatment.

Emergency Departments report on most recent month. All others report on the previous month, in order to capture 30-day outcomes.

Revised September 3, 2015

Note: For a copy of this document that highlights revisions since the version distributed on May 19, please contact [PSYCKES Help](#).

Emergency Department (report on month just ended):

1. Number of Behavioral Health (BH) Emergency Department (ED) visits during [MONTH]

Psychiatric EDs or CPEPs should report the number of presentations to your ED/CPEP, and general EDs should report the number of presentations to the ED with a primary BH diagnosis.

2. Number of Behavioral Health ED visits during [MONTH] who are potential readmissions (discharged from BH within the past 30 days)

Include only those discharged from BH inpatient treatment; exclude those who had only ED visits or CPEP stays in the past 30 days.

3. Among those identified in question 2 (potential readmissions), the number admitted for BH inpatient treatment

Exclude those admitted for medical inpatient treatment.

4. Among those identified in question 3 (admitted to BH inpatient), the number for whom you had a consultation with a member of the most recent discharging team and/or current outpatient provider (but not necessarily a physician) before the decision to admit

Include only those for whom you had a consultation **and** admitted for BH inpatient treatment; exclude those who had a consultation and were discharged.

5. Among those identified in question 2 (potential readmissions), the number discharged to the community

Exclude those discharged to institutional/correctional settings where they are ineligible for any community supports.

6. Among those identified in question 5 (potential readmissions discharged to the community), the number discharged with a diversion plan that included a referral to higher level of care (e.g., partial hospital) and/or short-term care coordination follow-up provided by ED/hospital staff or community partner (e.g., Assertive Community Treatment (ACT), Health Home, peer bridger, etc.)

Include only potential readmissions; exclude others referred for these services.

Inpatient (report on patients discharged in the month before the month just ended):

Psychiatry and Substance Abuse Treatment services will report separately.

Excludes: transfers to other inpatient settings, referrals from detoxification (detox) to substance abuse rehabilitation (rehab), and discharges to State Psychiatric Centers

1. Number of discharges from the specified inpatient service during [MONTH]:

Among the discharges identified in question 1:

2. Warm hand-off: Number who received a face-to-face warm hand-off to at least one receiving provider (outpatient therapist, psychiatrist, health home, care/case manager, peer worker, etc.) during inpatient stay or on day of discharge.
3. Prior authorization:
 - a. Number for whom prior authorization for medication was obtained from insurer before discharge
 - b. **Optional:** Number not requiring prior authorization (e.g., not on medication, on oral haloperidol).
4. Medication fill at discharge:
 - a. Number who received a full supply of all medical and psychotropic medications at discharge (prescription(s) filled), *for the period clinically indicated*
 - b. **Optional:** Number for whom it was not applicable (e.g., not on medication, residence provides, etc.)
5. Follow-up phone call:
 - a. Unduplicated number who received a follow-up phone call within 72 hours to reinforce the discharge plan (Count only calls that included the 4 components of Project RED (Re-Engineered Discharge) calls: assess clinical status, review medications, review outpatient appointments, trouble-shoot any barriers)
 - b. Number for whom your staff made the call
 - c. Number for whom you verified that a community partner called
6. Discharge: Number whose discharge plan included a high-intensity step-down program (e.g., Partial hospitalization program), and/or community-based care coordination follow-up (e.g., health home, intensive case management, ACT, mobile crisis, visiting nurse, peer bridger, "Pathway Home")
7. Attendance at outpatient BH follow-up:
 - a. Number who attended the first post-discharge BH treatment visit within 0-7 days of discharge
 - b. Number who attended the first post-discharge BH treatment visit within 8-30 days of discharge
 - c. Number not seen for BH treatment within 30 days

Note: If a patient is brought at the time of discharge to outpatient for a session, it is counted as a warm hand-off **and** first outpatient visit; if a patient is brought at the time of discharge to outpatient to meet the therapist, but does not have a session, it is counted **only** as a warm-hand-off.

Inpatient, cont'd

8. 30-day readmissions to your own hospital
(Based on your hospital's EMR 30+ days post discharge)
 - a. Unduplicated number of discharges followed by readmission to any service within 30 days
 - b. Number admitted to inpatient psychiatry within 30 days
 - c. Number admitted to inpatient detox/rehab within 30 days (do not include those with a planned admission to inpatient rehab after discharge)
 - d. Number admitted to inpatient medical within 30 days

Outpatient (report on clients discharged during the month *before* the month just ended):

Psychiatry and Substance Abuse Treatment services will report separately.

1. Number of individuals on the census on the last day of [MONTH]
2. Number of individuals who were discharged to your program from a BH hospitalization at any hospital during [MONTH] (including new referrals and returning patients).

Note: Report on all patients whose date of discharge was in [MONTH]. Include any patients discharged to you, regardless of whether they were seen or admitted to your program.

Among those identified in question 2:

3. Number for whom you provided a face-to-face warm hand-off during inpatient stay or on day of discharge.

Note: May be conducted by any member of your program's staff who will follow the client in the community (therapist, psychiatrist, case manager, etc.).

4. Number for whom you provided a telephone or face-to-face reminder within 24 hours prior to the first post-discharge appointment that the client attended from the community.

Note: Reminder calls are expected before the first appointment that the patient attends **from the community**. If the first appointment is a warm hand-off on day of discharge, report on reminder calls made prior to the next appointment.

5. Number who attended an outpatient appointment at your program
 - a. Number who attended first visit within 0-7 days of discharge
 - b. Number who attended first visit within 8-30 days of discharge
 - c. Number not seen within 30 days
6. Number who were readmitted to any hospital (BH or medical) within 30 days after discharge to your program
 - a. Unduplicated number admitted to any inpatient service within 30 days
 - b. Number admitted to inpatient psychiatry within 30 days
 - c. Number admitted to inpatient detox/rehab within 30 days (do not include those with a planned admission to inpatient rehab after discharge)
 - d. Number admitted to inpatient medical within 30 days

Health Home (or case management/care coordination) (report on clients discharged during the month *before* the month just ended):

1. Number of individuals on census on last day of [MONTH]
2. Number of individuals who were discharged to your program from a BH hospitalization at any hospital during [MONTH] (including new referrals and returning patients).

Note: Report on all patients whose date of discharge was in [MONTH].

Among those identified in question 2:

3. Number for whom you provided a face-to-face warm hand-off during inpatient stay and/or on day of discharge.
4. Number for whom you provided a follow-up phone call or visit within 72 hours to reinforce the discharge plan (report only calls or visits that included the 4 components of Project RED calls: assess clinical status, review medications, review outpatient appointments, trouble-shoot any barriers).
5. Number you assisted in attending their first BH treatment visit **after** day of discharge. (Count only assistance for the first appointment the client attends *from the community*. Assistance may include: telephone or face-to-face reminder within 24 hours prior to appointment, escort to appointment, provide/arrange transportation, etc.)
6. Number who attended outpatient BH treatment appointment(s) **after** day of discharge to your program:
 - a. Number who attend **any** outpatient BH appointment within 30 days
 - b. Among those identified in 6a, the number who attended their **first** scheduled post-hospitalization BH treatment appointment
7. Number who were readmitted to any hospital (BH or medical) within 30 days after discharge to your program
 - a. Unduplicated number admitted to any inpatient service within 30 days
 - b. Number admitted to inpatient psychiatry within 30 days
 - c. Number admitted to inpatient detox/rehab within 30 days (do not include those with a planned admission to inpatient rehab after discharge)
 - d. Number admitted to inpatient medical within 30 days