

**The Children's Readmission Collaborative
Kick-Off Conference
April 28th , 2014**

**Quality Collaborative
Activities**

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The Collaborative and Quality Improvement Projects

The Learning Collaborative Model

- Hospitals work together toward a common goal
- Conduct Continuous Quality Improvement project
- Identify and share successful strategies
- Promotes rapid adoption of best practices
- Model used for adult inpatient behavioral health services through previous learning collaborative

The Children's Readmissions Quality Collaborative

- 14 Participant Applications Received to Date
 - Additional hospitals here to learn
 - Seeking Interested Members to Join a Learning Collaborative Advisory Committee
- 12+ months: now through May 2015
 - Implement project interventions
 - Track data
 - Initial Focus is on processes within the control of the hospital system
 - Hospital's internal processes
 - Collaboration with existing providers
 - Later phase(s) may address broader systems barriers

Hospital Activities: Form Quality Improvement Team

- Leadership / medical “champion” is key
- Project leads from relevant programs
- Interdisciplinary
- Data manager – crucial for monitoring / reporting

Hospital Activities: Continuous Quality Improvement (CQI)

- Program(s) to participate
 - Led by children's inpatient team, but encompasses the full continuum of care under that child inpatient's umbrella
 - Inpatient, outpatient, emergency
- Implement all strategies
 - Relevant to the care settings involved in the collaborative
 - Some flexibility in how each of the strategies get implemented (i.e. tools & staff deployed)

CQI Project: Implement Project Interventions

- **Emergency Department (ED)**
 - For recently discharged clients, the client's most recent inpatient treatment team conducts evaluation in the ED and consults on disposition
 - All clients are assessed for readmission risk
 - For those at higher risk of readmission, refer to Home Based Crisis Intervention (HBCI)/Single Point of Access (SPOA) (In the Future - Children's Health Home)

CQI Project: Implement Project Interventions

- Inpatient
 - For all patients:
 - Verify insurance formulary and provide formulary information to prescriber before initiating a course of medication
 - Develop and provide a discharge plan in the format of the Project Re-Engineering Discharge (RED) After Hospital Care Plan (AHCP)
 - Ensure access to medication post discharge
 - Obtain and verify pre-authorization
 - Fill prescriptions at discharge (client leaves with 30-day supply of medication(s) in hand)

Inpatient

- For patients at high risk of readmission:
 - Conduct an in-depth review or case conference (ideally including client and collaterals) for readmits and other high utilizers
 - Refer to SPOA / HCBI / Partial Hospitalization Program as appropriate
 - “Warm hand-off:” arrange for outpatient providers to meet with youth and/or family prior to discharge (whenever feasible- e.g., services in the same building, family has community-based care coordination)

CQI Project: Implement Project Interventions

■ Post-Discharge

- Make Follow-up phone call to family within 72 hours of discharge to reinforce discharge plan and address any potential barriers
- Make Follow-up phone call to providers to verify attendance at first appointment
 - Follow-up phone call to family if youth and family did not attend or do not engage in treatment

CQI Project: Implement Project Interventions

■ Receiving Provider

- Identify all youth receiving treatment in your program who were discharged from inpatient within the last 30 days
- Remind families prior to appointments (using phone or other communication) – at least the first appointment and first psychiatrist appointment
- Contact discharging hospital to inform of missed appointments or if the client/family does not engage in treatment

**Support Provided by
Greater New York Hospital
Association (GNYHA) and
Psychiatric Services and
Clinical Knowledge
Enhancement System
(PSYCKES)**

Conferences, Calls and Site Visits

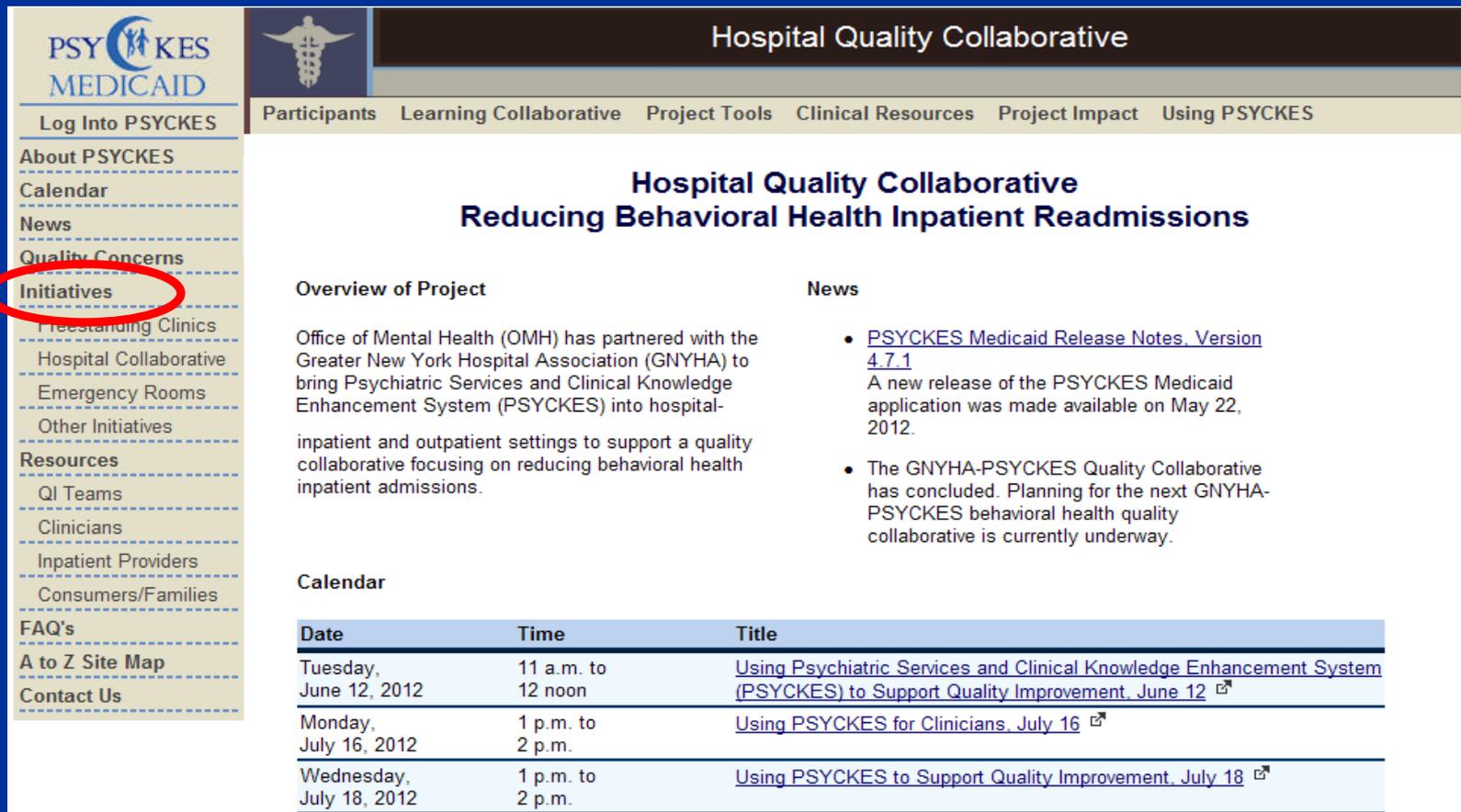
- Conferences
 - Kick-off
 - Mid-point, share successful strategies
 - Conclusion
- Monthly Learning Collaborative Calls
 - Interactive, report on progress
- Site Visits
 - Technical assistance
 - Identify best practices

OMH/P SYCKES Training and Technical Assistance

- Webinars for the Collaborative
 - Using PSYCKES to Support Quality Improvement
 - Monthly Data Submission
 - Using PSYCKES for Clinicians
- PSYCKES Help: PSYCKES-Help@omh.ny.gov
- PSYCKES Website: www.psyckes.org

PSYCKES Website: Children's Readmissions Collaborative Page – Coming Soon!

A webpage for the Children's Collaborative is in development. Project information, materials and resources will be posted.



The screenshot shows the PSYCKES Medicaid website interface. The top navigation bar includes "Hospital Quality Collaborative" and a menu with "Participants", "Learning Collaborative", "Project Tools", "Clinical Resources", "Project Impact", and "Using PSYCKES". The main content area is titled "Hospital Quality Collaborative Reducing Behavioral Health Inpatient Readmissions". It features an "Overview of Project" section, a "News" section with two bullet points, and a "Calendar" section with a table of upcoming events. A sidebar on the left contains a navigation menu with "Initiatives" circled in red.

PSYCKES MEDICAID

Log Into PSYCKES

About PSYCKES

Calendar

News

Quality Concerns

Initiatives

Understanding Clinics

Hospital Collaborative

Emergency Rooms

Other Initiatives

Resources

QI Teams

Clinicians

Inpatient Providers

Consumers/Families

FAQ's

A to Z Site Map

Contact Us

Hospital Quality Collaborative

Participants Learning Collaborative Project Tools Clinical Resources Project Impact Using PSYCKES

Hospital Quality Collaborative Reducing Behavioral Health Inpatient Readmissions

Overview of Project

Office of Mental Health (OMH) has partnered with the Greater New York Hospital Association (GNYHA) to bring Psychiatric Services and Clinical Knowledge Enhancement System (PSYCKES) into hospital-inpatient and outpatient settings to support a quality collaborative focusing on reducing behavioral health inpatient admissions.

News

- [PSYCKES Medicaid Release Notes, Version 4.7.1](#)
A new release of the PSYCKES Medicaid application was made available on May 22, 2012.
- The GNYHA-PSYCKES Quality Collaborative has concluded. Planning for the next GNYHA-PSYCKES behavioral health quality collaborative is currently underway.

Calendar

Date	Time	Title
Tuesday, June 12, 2012	11 a.m. to 12 noon	Using Psychiatric Services and Clinical Knowledge Enhancement System (PSYCKES) to Support Quality Improvement, June 12 
Monday, July 16, 2012	1 p.m. to 2 p.m.	Using PSYCKES for Clinicians, July 16 
Wednesday, July 18, 2012	1 p.m. to 2 p.m.	Using PSYCKES to Support Quality Improvement, July 18 

Clinical Tools & Templates

- Develop templates to assist with data collection
- Develop standardized tools as needed
 - Identify needed tools based on participants input

Project Data

Outcome Indicators in PSYCKES: Readmission Rates

- Key project metric: Inpatient psychiatric readmissions
Discharges from your hospital that were followed by readmission to any hospital
 - To same service type
 - Within 30 days of discharge
- Second project metric: Psychiatric readmissions among outpatient population
Individuals served in your hospital's outpatient programs that were admitted to any hospital and then readmitted anywhere within 30 days.

Project Reporting

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Hospitals Report Monthly to the Collaborative

- Emergency Departments
 - Number of ED visits
 - Number of potential inpatient readmissions
 - Number of actual readmissions
 - Who in the target population for intervention received each specific intervention
- Inpatient Programs:
 - Number of discharges
 - Number of individuals identified at high risk of readmission
 - For the whole population as well as the identified high-risk individuals who received each specific project intervention
- Outpatient Program
 - Number of recent discharges from inpatient
 - Number of individuals in the target population
 - Number of individuals in the target population that received each intervention

Monthly Reporting Process

- Brief on-line survey
- Each participating program reports separately
- Submit data by the 10th of each month for QI activities in the previous month
- First data submission: Report May QI Activities for June 13, 2014

Collaborative Reports to Hospitals

- Aggregated self-report data (monthly)
 - Hospital and program data vs. aggregate data
 - Hospitals and programs relative to each other
- Analysis of the Medicaid Data (periodically)
 - Key outcome: inpatient readmissions
 - Collaborative vs. non-participating hospitals
 - Other data elements to be determined by advisory committee

Additional Reporting

- Surveys
 - Start, middle, and end of project
 - Purposes
 - Increase understanding of children's readmissions
 - Identify successful strategies
 - Assess training and resource needs
- Ad hoc analyses based on needs and interests of the collaborative and participants

Question and Answer