

**The Readmissions Quality Collaborative
Concluding Conference
June 20, 2014**

**Quality Collaborative
Activities and
Progress To Date**

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Collaborative Participants, Activities and Time Line

Collaborative Participants and Methods

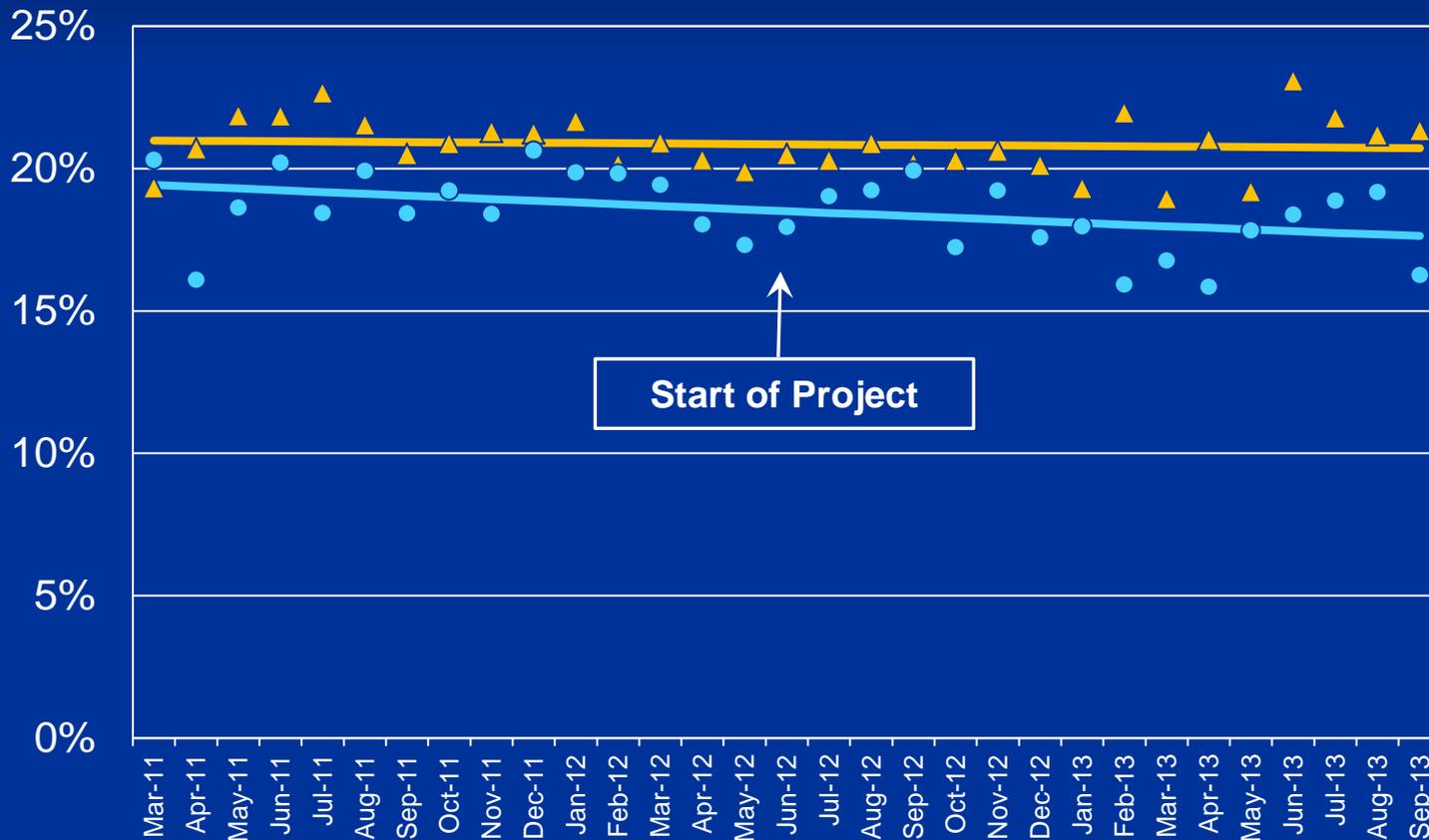
- 42 participating hospitals statewide
 - Open to inpatient, outpatient and emergency departments
 - Multiple services encouraged to participate
- Project focus: menu of options in 3 domains
 - Medication strategies
 - Outpatient engagement
 - Integrated dual diagnosis treatment
- Enhanced discharged planning in Inpatient and Emergency Services

Activities and Time Line

- 6/2012 - 12/2012: Kick-off and Planning
 - Begin monthly calls
 - Project Planning form due 10/2012
 - Note: Superstorm Sandy 10/2012
- 1/2013 - 6/2013: Begin delivering and tracking interventions (monthly reporting), Midpoint Conference
 - Decision to extend Collaborative through 6/2014
- 7/2013 - 6/2014: Site Visits (n=15) and Calls (n=3)
- 11/2013: Midpoint Survey
- 6/2014: End / Concluding Conference

Project Data: Inpatient Services

Readmissions within 30 Days of Discharge from Inpatient Psychiatry Length of Stay 4+ Days



Average Annual Percent Change
6/2012 to 9/2013

Participating:
-0.5
(not significant)

Non-Participating:
-3.8
(significant)

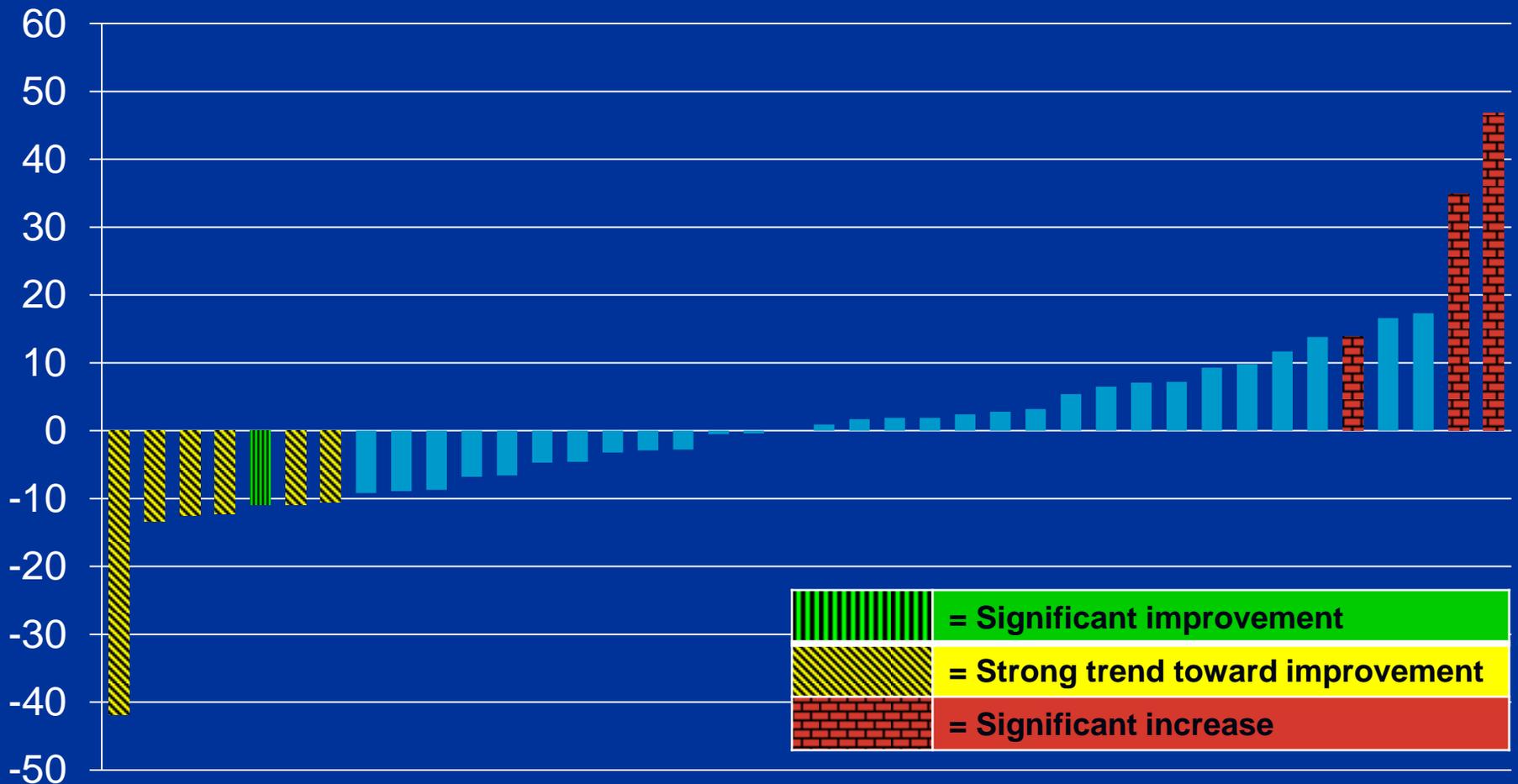
Includes age 18+
Excludes substance use disorders (SUD)

- ▲ Participating Observed Readmission Rate
- NonParticipating Observed Readmission Rate
- Participating Modeled Readmission Rate
- NonParticipating Modeled Readmission Rate

Readmissions within 30 Days of Discharge from Inpatient Psychiatry

Length of Stay 4+ Days

Average Annual Percent Change (AAPC), 6/2012 – 9/2013
by Hospital



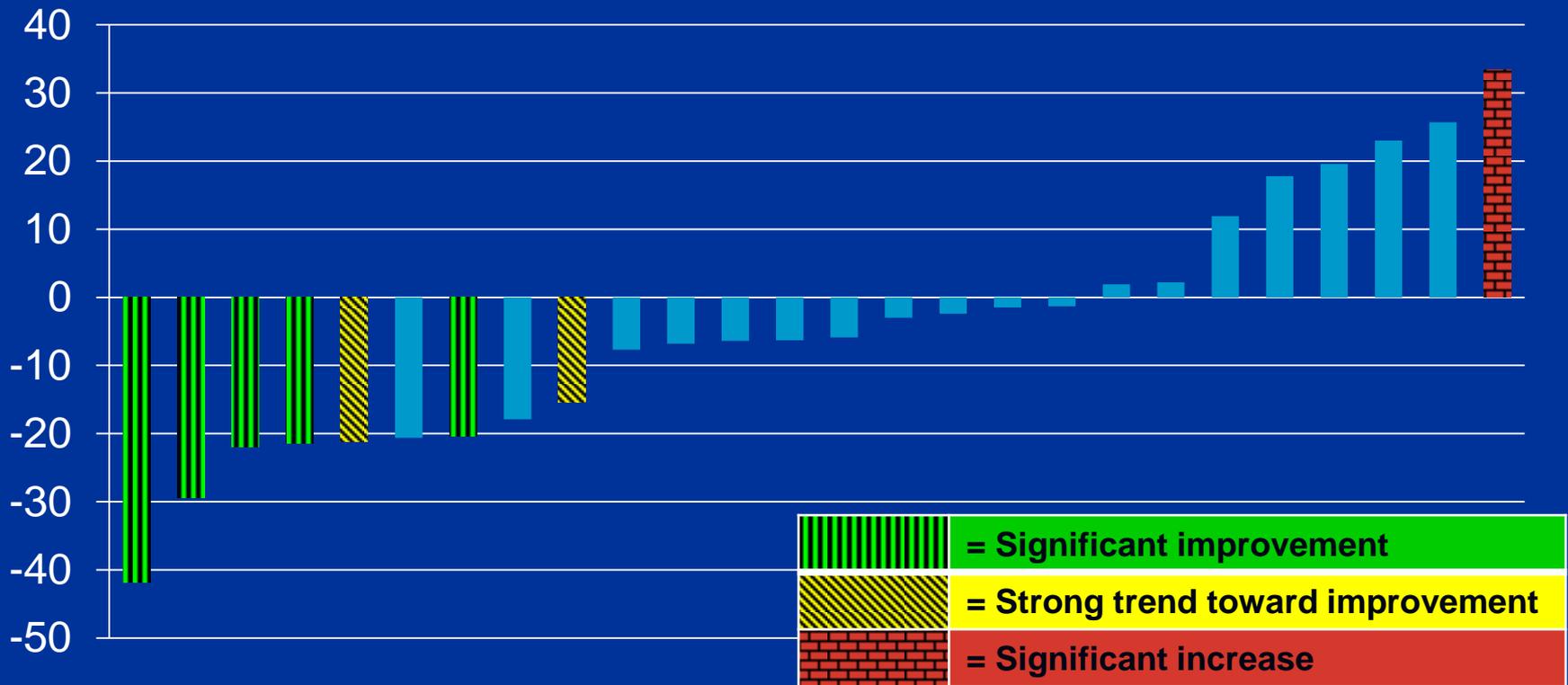
Project Data: Emergency Departments (ED)

Psychiatric ED visits by individuals with a Psychiatric Inpatient stay in the prior 30 days, and disposition:

Aggregate data for all participating hospitals

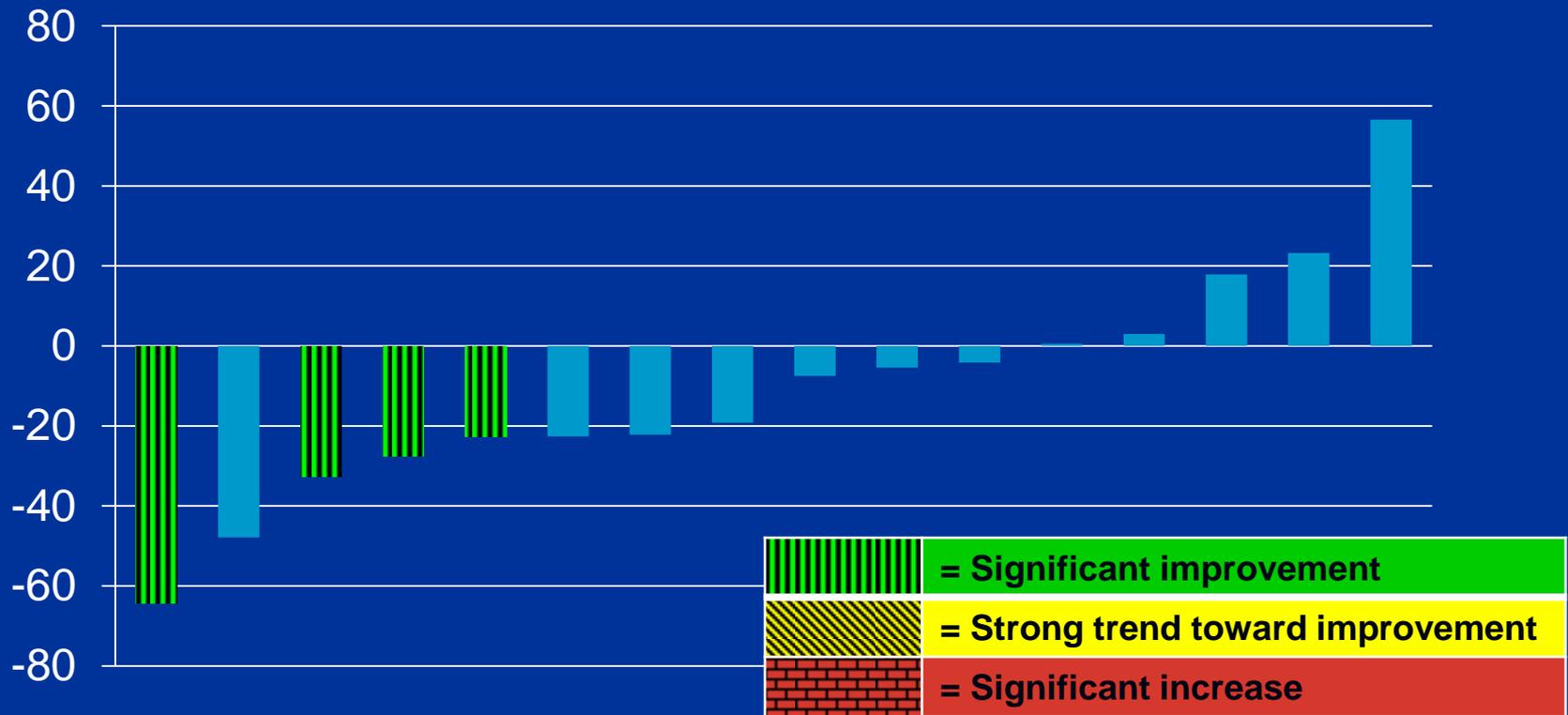
	Baseline (June 2012) ED visits	Baseline rate of Readmissions in ED		Most recent (Sep 2013) ED visits	Most recent rate of Readmissions in ED		Average Annual Percent Change	AAPC 95% CI		Statistically Significant Trend? (P-Value <0.05)
	(N)	(n)	%	(N)	(n)	%		Low	High	
ED visits with Psychiatric Inpatient stay at <u>any</u> hospital in prior 30 days	824	444	54%	914	454	50%	-4.2	-8.3	0.1	No
ED visits with Psychiatric Inpatient stay at the <u>same</u> hospital in prior 30 days	413	223	54%	473	220	47%	-7.6	-12.9	-1.9	Yes

Psychiatric ED visits by individuals with a Psychiatric Inpatient stay at any hospital in the prior 30 days, and disposition: Average Annual Percent Change, by hospital



Shown: hospitals with an average of at least 10 patients per month in the denominator.

Psychiatric ED visits by individuals with a Psychiatric Inpatient stay at the same hospital in the prior 30 days, and disposition: Average Annual Percent Change, by hospital



Shown: hospitals with an average of at least 10 patients per month in the denominator.

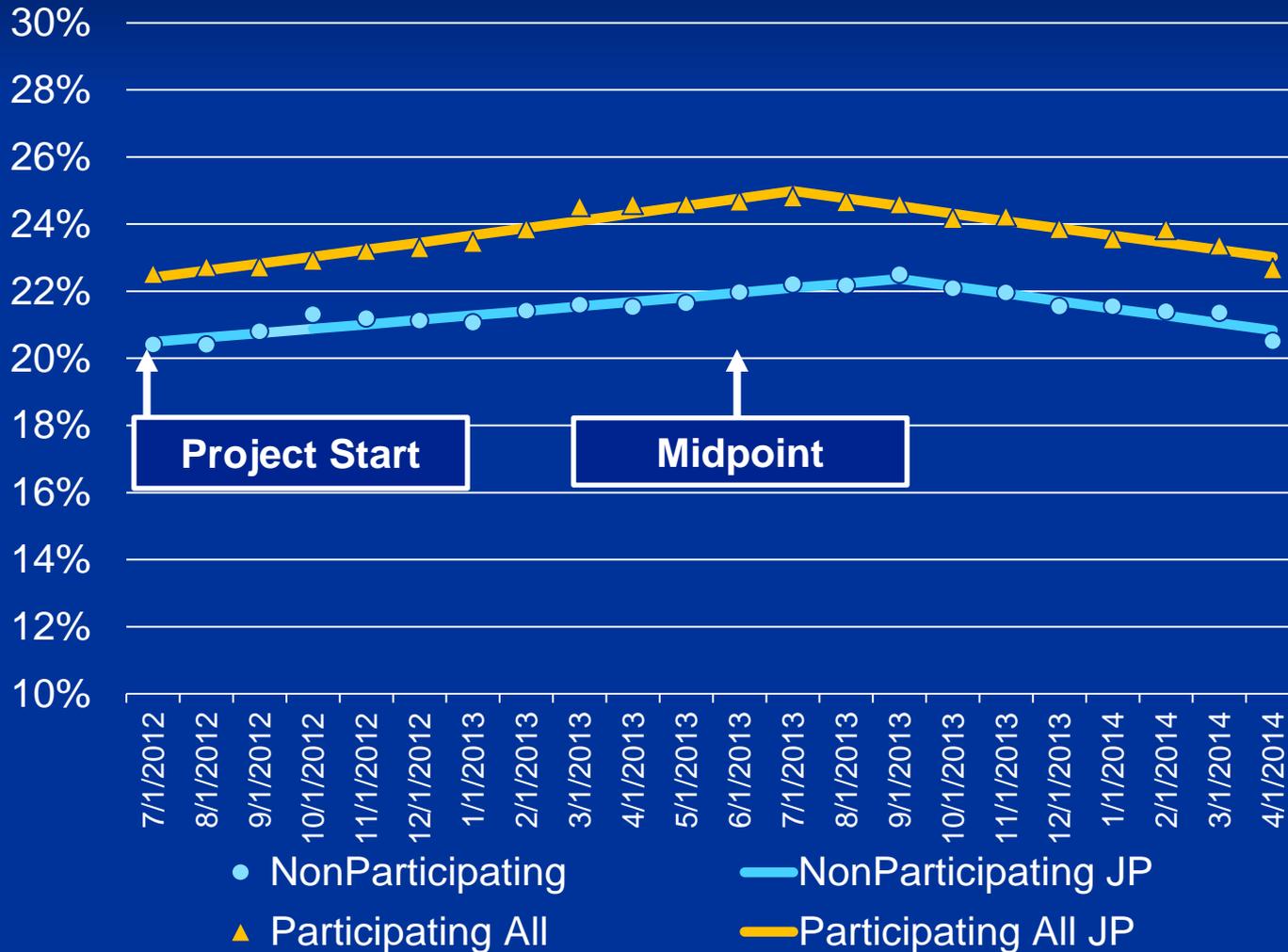
**Project Data:
Behavioral Health (BH)
Readmissions among
Outpatient Mental Health (MH)
Service Recipients**

30-Day BH Readmissions (Any Hospital) among Mental Health Outpatients

- The Psychiatric Services and Clinical Knowledge Enhancement System (PYSCKES) “All Behavioral Health” 30-day Readmissions Indicator
 - **Denominator:**
Individuals in the outpatient population at specified hospital(s) who had a behavioral health hospitalization (MH or SUD, at any institution) within the past year.
 - **Numerator:**
Among those hospitalized, those with a behavioral health readmission (MH or SUD, at any institution) within 30 days of discharge, in the past year.
- **Filtered for Outpatient Mental Health Population:**
 - Individuals who have received any mental health outpatient service in the past 9 months at the specified hospital(s)

30-Day BH Readmissions (Any Hospital) among Mental Health Outpatients

PSYCKES Indicator: 12-month look-back



Average Annual Percent Change
7/1/2013 to 4/1/2014

Participating:
-10.4

Non-Participating:
-7.5

Both statistically significant

Includes individuals of all ages

30-Day BH Readmissions among MH Outpatients at Participating Hospitals Average Annual Percent Change 7/2013-4/2014 by Hospital



Measurement Challenges

- Defining hospitalization/readmission (length of stay, same service type)
- Data maturity: need to wait 6 months to see both index admission and readmission appear in claims/encounter data
- PSYCKES Readmissions indicator specifications use a 12-month look-back: clinically useful but less sensitive to change
- Focused on Readmission indicators but not on other potential measures of change (e.g. engagement in outpatient services, medication adherence)
- Confounding trends and variation:
 - Seasonal fluctuations
 - Super-storm Sandy
 - Health home and other systems transformation initiatives
- Limited baseline data
- Exploring alternative statistical methods (e.g., recurrent event analysis)

Midpoint Survey Data

Most Critical to Success

Shown: Top 14, cited by at least 70% of hospitals implementing the strategy

Excludes: Strategies being implemented by fewer than 10 hospitals

Strategies and Interventions to Reduce Readmissions	Among those implementing, number and percent who rated it a 4 (very important) or 5 (critical to success)	
	n	%
Follow-up phone call to client/family	17	89%
Staff training	11	85%
Readmission risk factors addressed in discharge plan	19	83%
Family meetings focusing on reducing readmission	26	81%
Follow-up on clients not adherent to aftercare	13	81%
Follow-up phone call of any kind	21	81%
Special case conference for high-risk clients	20	80%
Med fill at discharge	19	79%
Closer communication inpatient-to-outpatient re high risk clients	19	79%
Verify insurance coverage for medication	24	77%
Increase referrals to case management / health homes / etc.	22	76%
Bridger	9	75%
Structured discharge interview with checklist or teach-back	13	72%
Follow-up phone call to provider	12	71%

Clinical/Counseling Interventions

Clinical/counseling Interventions to Reduce Readmissions	Number and percent implementing the intervention (n=43)		Among those implementing, number and percent who rated it a 4 (very important) or 5 (critical to success)	
	N	%	N	%
Family meetings focusing on reducing readmission	32	74%	26	81%
Group treatment focusing on discharge planning / relapse prevention	28	65%	19	68%
Integrated treatment for co-occurring MH and SUD	24	56%	15	63%
Counseling for adherence	32	74%	18	56%
Peer services during inpatient stay	13	30%	7	54%

Question and Answer