



Office of
Mental Health

Project Interventions by Setting

Readmissions Quality Collaborative Phase 2 Kick-Off Conference

Note: these slides have been re-formatted but are identical to those shown and distributed at the conference

Molly Finnerty, MD
NYS Office of Mental Health
January 30th, 2015

Project Goal



Office of
Mental Health

Project Goal

Goal: Reduce 30-day readmissions for any reason, after discharge from inpatient behavioral health treatment.

- Discharge from behavioral health
 - Psychiatry
 - Detox
 - Rehab
- Readmission to any behavioral health or medical inpatient service at any institution



Guiding Principles

- ❖ Collaborate across the continuum of care
 - All service types: Psychiatry, substance abuse, medical, primary care, health homes, discharge planning, etc.
 - All settings: Emergency, inpatient, outpatient
 - External partners: managed care/ Health and Recovery Plans (HARPs), health homes, Performing Provider Systems (PPSs), community providers.
- ❖ Focus on care transitions: Patient is followed until he/she has made a successful transition
- ❖ “No silver bullet” - Implement a set of mutually reinforcing interventions, tailored to your hospital
- ❖ Standardize existing processes



Emergency Department

- ❖ Identify and flag potential readmissions (patients discharged from behavioral health inpatient within the past 30 days)
- ❖ Consultation / “2nd Opinion” before readmitting
 - If discharged from your hospital, inpatient discharging team comes to emergency department before disposition
 - If from another hospital: consult with their discharging team and/or patient’s community provider
 - Review what worked / didn’t work in previous discharge plan
- ❖ Care coordination in the Emergency Department for high-need patients
 - Refer to alternate levels of care
 - Address concrete needs
 - Follow up call to check on medication access and plan



Inpatient Setting

- ❖ Standardize specific elements of developing and teaching the discharge plan
 - Clear and easy to understand (like Project Re-Engineered Discharge (RED) format)
 - Medications: purpose, how to take, ensure access – i.e., obtain pre-certification
 - Appointments: *first behavioral health (BH) appointment within 3-5 days*, include both medical and BH, plan transportation
 - If a readmission, what will you do different this time?
 - Number to call for questions / problems: phone # of a provider who knows the plan and is *known to the patient*
 - Educate patient and caregiver re: plan, medication adherence, what to do / whom to call if a problem or question arises
 - Use structured teach-back tool to assess understanding
- ❖ Warm hand-off, whenever feasible
- ❖ Medication fill at discharge (BH and medical)



Post Discharge: Hospitals or Community Partners

- ❖ In-depth follow-up phone call within 72 hours
 - Intervention, not only a reminder (Project RED style)
 - Reinforce the plan
 - Review medications
 - Problem-solve

- ❖ Communicate plan to outpatient providers
 - Include detailed medication information, e.g., dates and dosages of Long-acting Injectable administration
 - Verify appointment is kept

- ❖ Follow up if appointment missed: new appointment

- ❖ For highest-need, highest-utilizing patients, provide active short-term case management
 - Intensity/duration determined by need



Health Home / Care Management

- ❖ Warm hand-off: Meet with the patient in the hospital before discharge

- ❖ Expedite discharge plan to
 - Behavioral health aftercare providers
 - Medical and primary care providers

- ❖ Post-discharge case management
 - In-depth follow-up phone call within 72 hours (as above)
 - Make appointment reminders
 - Follow up on missed appointments



Outpatient

- ❖ Warm hand-off, whenever feasible
- ❖ First post-discharge appointment within 3-5 days
- ❖ Identify and flag clients discharged to you from any behavioral health inpatient, and for these clients:
 - Make reminder calls before
 - First post-discharge appointment
 - First post-discharge prescriber appointment
- ❖ Follow up on non-adherence / non-admission
 - Track no-shows, canceled appointments, and whether they are admitted to the program
 - Call to inform the referrer if the client misses appointments or is non-admitted to the program



Recommended Structure for Cross-Setting Communication

Develop a care transitions committee that includes all behavioral health settings and medical representation, and community partners, including managed care organizations, receiving providers, residences, and other partners

- ❖ Meet monthly
- ❖ Invite community partners to participate on a quarterly basis
- ❖ Review readmissions / other sub-optimal transitions to identify opportunities for improvement
- ❖ Develop new / improved processes for care transitions and communication/ documentation

