



## Reducing Behavioral Health Readmissions: Strategies and Lessons Learned

Key Strategies	Endorsed by*	Notes
<b>Emergency Room (ER)</b>		
<b>Identify high utilizers and potential readmissions</b> (those discharged from any hospital within past 30 days), and review overall utilization patterns (e.g. PSYCKES clinical summary, Regional Health Information Organization (RHIO)).	AHRQ, RQC	<b>RQC:</b> At high-performing hospitals, the ER often played a significant role. ERs using PSYCKES were able to identify high utilizers, and risk factors such as substance use. <b>AHRQ:</b> Use health exchange portals and other information to contextualize current ER presentation within longitudinal utilization history.
<b>Consultation before readmitting:</b> (1) If recently discharged from same hospital, member of most recent inpatient team comes to ER to conduct in-person evaluation before disposition. (Is client status the same as last discharge? Were prior admissions helpful?); (2) If recently discharged from other hospital, require collateral contact with current outpatient provider and/or most recent inpatient team before disposition; (3) Consultation or approval by chief of psychiatry prior to readmission.	AHRQ, RQC	<b>RQC:</b> ERs were better able to reduce readmissions among patients discharged from their own hospital. Some hospitals had “hard stop” on readmissions – i.e., no 30-day readmit without approval of chief of psychiatry; clients held in ER overnight pending approval. Second opinions can help to share risk with ER clinicians. Second opinions can also foster learning about reasons clients return after discharge leading to development of improved discharge protocols. <b>AHRQ:</b> Review history to discern acute from chronic symptoms.
<b>Care coordination and diversion planning during and after ER visit:</b> (1) Arrange follow-up appointments and detailed discharge plan; (2) identify and use higher intensity outpatient services to support diversion as needed (e.g. partial hospital, respite); (2) Ensure any current providers are aware of ER visit; (3) Make follow-up phone calls to verify adherence to treatment and medications, and to trouble-shoot; (4) identify & develop care co-ordination supports for after discharge e.g. mobile crisis, Assertive Community Treatment (ACT), Health Home.	AHRQ, RARE, RQC, STAAR	<b>RQC:</b> ER docs are more comfortable discharging to community if they are confident in the discharge and follow-up plan. <b>STAAR:</b> notify PCP of ER visits. <b>AHRQ:</b> Staff a dedicated readmission avoidance clinician in the ED to coordinate with outpatient providers and social services. <b>RARE:</b> a dedicated full time ER social worker to provide care coordination for high utilizers in the ER and for 60 days following visit, including home visits, is cost effective.
<b>On Admission / During Inpatient Stay</b>		
<b>Ensure access to medication post discharge:</b> 1) <b>Verify insurance formulary</b> before initiating medication; 2) <b>Obtain and verify prior authorization</b> for meds before discharge; 3) <b>Ideally, fill prescriptions at discharge:</b> patients leave with meds in hand (or are walked to the pharmacy by staff). Filled by hospital or outside retail pharmacy delivers.	RARE, RQC	<b>RQC:</b> 77% of hospitals endorsed verification of insurance to cover medication prior to discharge, and 74% of hospitals endorsed medication fill at discharge as critical or very important. Several high performing hospitals used this strategy; filling the prescription allowed them to test whether prior authorization was properly completed.
<b>“Warm Hand-Off:”</b> Whenever possible, face-to-face meeting with receiving outpatient provider (clinician, case/care manager and/or peer) during inpatient stay or immediately upon discharge. Ideally, outpatient provider participates in a discharge planning meeting with client, caregiver, inpatient team, and has an individual meeting with client.	STAAR, RARE, RQC, Transitions Project, CTI	<b>RQC:</b> most feasible for discharges to hospital affiliated outpatient provider, or for ACT/ Case Manager / Health Home worker. <b>Transition Project:</b> meeting (e.g. intake appointment) with new provider prior to discharge was associated with higher engagement and lower hospitalization on 6 month follow-up.
<b>Assertive outreach to families/caregivers;</b> and use caregiver meetings to support evaluation, assess family/caregiver needs, provide crisis intervention, and educate regarding after-hospital care plan.	RQC, CTI, STAAR, RED, RARE	<b>RQC:</b> 82% of participating hospitals identified family meeting focused on readmission reduction as very important or critical. Some high performing hospitals aggressively pursued family/ caregiver meetings for 100% of clients.

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<b>On Admission / During Inpatient Stay (cont'd)</b>		
<b>Provide discharge instructions modeled on Project RED After-Hospital Care Plan:</b> (1) Arrange behavioral health (BH) and medical follow-up appointments; (2) Provide clear, easy-to-understand care plan including medication instructions, schedule of appointments, and contact information	Project RED (key intervention), STAAR, RARE, AHRQ	<b>RED:</b> development and use of after hospital care plan is 1 of 2 most critical components in Project RED. <b>RQC:</b> Do not repeat the failed previous discharge plan. Readmission risk factors must be addressed in discharge plan.
<b>Use Teach-Back method</b> to educate patients and caregivers about the After Hospital Care Plan throughout the inpatient stay, to assess their understanding and ensure feasibility of plan. Provide anticipatory guidance: "what to watch for and what to do."	RED, AHRQ	<b>RED:</b> use teach-back to teach After Hospital Care Plan and assess understanding. <b>RQC:</b> Some high performing hospitals elected to train staff in motivational interviewing to engage patients and caregiver in plan.
<b>Integrated Dual Diagnosis Treatment: Identify &amp; Treat</b> co-occurring disorders e.g. screening at intake, PSYCKES review, 4-quadrant model of assessment, motivational interviewing, and referrals to providers of integrated treatment for aftercare.	RQC, (EBP for co-occurring disorders.)	Substance use is a driver of high utilization. <b>BHO Phase I:</b> case reviewers using PSYCKES reported that psych inpatient units were often unaware of substance history.
<b>Identify readmission/ high utilizers, and conduct in depth review or case conference:</b> What was the last discharge plan and how well did it work? Why were they readmitted (root causes)? What can we do differently this time? Include inpatient team, outside providers, care coordinator, residence, client and/or caregiver(s).	STAAR, AHRQ, RQC	<b>RQC:</b> 77% of participating providers identified case conferences of high utilizers/ readmissions as very important or critical. Some high performing hospitals conducted case conferences with client, caregiver, outside provider, residence, as well as interdisciplinary and cross department staff.
<b>After Discharge / Outpatient</b>		
<b>Follow-up phone call to client/caregiver</b> within 72 hours by someone known to the client (intensive call to assess clinical status, reinforce discharge plan, review medications, and trouble-shoot). Use teach-back method.	Project RED (key intervention), RARE, RQC, Transitions	<b>RED:</b> 1 of 2 most critical components. <b>RQC:</b> #1 highest endorsed component. Important for the call to be more than a reminder or attempt at contact.
<b>Follow-up phone call to provider:</b> Share information, verify attendance and follow up on non-attendance.	RARE, RQC, Transitions	<b>Transitions:</b> call to aftercare provider was associated with significantly higher client engagement on 6 month follow-up. <b>RQC:</b> 71% of hospitals using strategy endorsed as very important or critical.
<b>Active short-term case management</b> (according to need, different types and time frames may be effective) by bridger / case manager / enhanced Koskinas worker / home-based crisis intervention / peer bridger / other services. Include home visits if needed. Actively follow up on non-adherence to the plan. Follow until engaged in aftercare.	CTI, RARE, RQC, Transitions	<b>RQC:</b> Inpatient unit is responsible until patient is engaged in aftercare - one appointment is not sufficient. Develop protocol to <b>follow up on patient who does not attend aftercare appointment</b> , and follow-up until engaged. (e.g. mobile crisis, outreach). <b>CTI</b> is associated with improved community outcomes.
<b>Address concrete needs</b> , especially (but not exclusively) those that will pose barriers to accessing medication and aftercare services.	AHRQ, RQC	<b>AHRQ:</b> Developed a "whole person assessment tool." <b>RQC:</b> Clients discharged without Medicaid have almost 100% readmission rate.
<b>Build / practice / test skills</b> that will help the client succeed in the next lower level of care, e.g. filling pill boxes, keeping appointments.	CTI, Transitions Project	<b>Transition:</b> Practice keeping appointments was associated with decreased hospitalization on 6-month follow-up post discharge from ACT. High intensity services can promote dependence and may miss an opportunity to test and practice skills. <b>RQC:</b> some hospitals reported using practicing/ testing in inpatient setting.
<b>Increase Community Support:</b> Referrals to ACT/ Health Home / other Care Management.	RQC	<b>RQC:</b> 73% of hospitals using strategy endorsed as very important or critical.

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<b>Outpatient</b>		
“Warm hand-off:” see above.		
<b>Identify and flag clients referred from inpatient</b>	RQC	<b>RQC:</b> Clinic places all hospital referrals on high risk roster.
<b>Follow-up appointment with after care mental health provider within 3-5 days of discharge.</b>	RARE, RQC, Transitions	<b>Transitions:</b> Follow-up appointment within 30 days of discharge was associated with increased odds of higher engagement 6 months post discharge. <b>RQC:</b> Save slots for hospital referrals to ensure appointment within 5 days.
<b>Reminder Phone calls</b> before first post-hospital appointment, and follow up on non-attendance.	RQC	
<b>Develop strategies for crisis management</b> (e.g. monitoring for early warning signs, relapse prevention plans, urgent care appointments, on call, walk-in). Educate clients (and staff) not to use the ER for urgent care/ walk-in appointments.	Clinic CQI	<b>Clinic CQI: Health Promotion and BH Care Coordination:</b> This requires not only having systems in place at the clinic, but a culture change for staff and clients. <b>RQC:</b> Establish processes to monitor and follow-up on no shows (e.g. mobile crisis).
<b>Managing the Project</b>		
<b>No “silver bullet:”</b> No single intervention will solve the problem. Identify a portfolio of mutually reinforcing interventions across the care continuum, make ongoing incremental changes.	RED, STAAR, RARE, RQC, Transition.	<b>RQC:</b> Site visits to hospitals with high project impact indicate no one intervention is sufficient, but a core set of interventions can work synergistically together to support change.
<b>Know your data:</b> 1) <b>Start with a root cause analysis</b> of a sample of readmissions, including client/caregiver interviews; quantitative analysis (patient characteristics, setting discharged to, etc.); and staff input. 2) <b>Track clients, interventions and outcomes over time</b> , using continuous quality improvement methods.	RED, STAAR, AHRQ, RQC	<b>RQC:</b> exploring causes of readmission helps shift focus from client (e.g. patient was non-adherent), to systems and supports (e.g. why were they non-adherent? Barriers to access?) <b>RQC:</b> many high performing hospitals found tracking client level data critical for project management and success, including clients identified, delivery and outcome of interventions, post-discharge follow-up and 30-day outcomes, re-evaluation if readmitted.
<b>Systems of Care</b>		
<b>All relevant services within the hospital</b> play an essential role and should participate in the project. Develop a <b>committee on care transitions</b> to facilitate collaboration and streamline processes. Leverage health care IT to improve communication and tracking.	STAAR, RED, RQC	<b>RQC:</b> ER involvement is critical for preventing avoidable readmissions. Communication between inpatient, outpatient, and care managers is essential.
Develop and use <b>higher intensity outpatient services</b> for hospital diversion and hospital step-down	RQC	<b>RQC:</b> Developing levels of care immediately below inpatient is critical for diversion (e.g., ACT, partial hospitalization, mobile crisis, ambulatory detox, etc. were cited on hospital site visits).
Develop a <b>relationship with at least one pharmacy</b>	RQC	<b>RQC:</b> particularly important if no in-house retail pharmacy.
<b>Know and engage your community partners across the continuum of care</b> to standardize communication, develop protocols for expedited referrals, collaboration on treatment and discharge planning, cross-training. Must include: BH, medical, housing. Invite them to periodic meetings.	STAAR, AHRQ, RQC.	<b>RQC:</b> 79% of participating hospitals identify as very important or critical. Several successful hospitals had regular meetings of community providers and SPOA on-site at the hospital.
<b>Improved/real-time communication</b> between inpatient and outpatient BH providers and primary care physician (e.g., expedite transmission of discharge summary).	RED, STAAR, RARE	<b>RQC:</b> prior to inpatient admission, confirm need for admission with out-patient provider, coordinate treatment planning during admission, and ensure they have detailed after-hospital care plan.

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## References and Resources

### NYS OFFICE OF MENTAL HEALTH / NYS PSYCHIATRIC INSTITUTE / RESEARCH FOUNDATION FOR MENTAL HYGIENE (RFMH) PROJECTS

#### **ACT Transitions Project (Transitions, OMH / RFMH)**

The Transitions project adapted CTI to support discharge of long stay ACT clients and improve outcomes post discharge. The project evaluation examined the association between individual model components and outcomes on 6 month follow-up.

*Engagement with new provider at 6 month follow-up was associated with:*

- 1) Appointment with aftercare provider *prior* to discharge,
- 2) Appointment after discharge with aftercare provider within 30 days of discharge,
- 3) Follow-up calls post discharge with client/family,
- 4) Follow-up calls post discharge with aftercare provider (includes problem solving)

*Reduced hospitalization at 6 month follow-up was associated with:*

- 1) Appointment with aftercare provider *prior* to discharge,
- 2) Practice keeping on time appointments

#### **Behavioral Health Readmissions Quality Collaborative (RQC)**

The RQC is a collaborative effort between Greater New York Hospital Association, Healthcare Association of New York State, the Office of Mental Health (OMH), and participating hospitals to reduce behavioral health readmissions for adults. This collaborative, launched June 2012, was the first of its kind in the nation to address *behavioral health* readmissions. Phase 1 (with 45 participating hospitals) concluded in June 2014, and Phase 2 (with a total of 60 hospitals, state psychiatric centers and health homes participating) began in January 2015. The project adapted some practices from medicine (e.g. Project RED), and incorporated evidence-based and best practices from mental health to support improved post-discharge outcomes. Project activities, data analysis and outcomes measurement are ongoing.

Site visits were conducted at hospitals with high project impact (based on mid-project analysis of impact on Medicaid data measures at 1 year after project launch), and a survey was administered to all participating hospitals. Preliminary findings suggest that establishing a set of core clinical processes was critical for success. A key lesson learned is that a portfolio of mutually reinforcing interventions is needed to achieve project impact, and success depends more on robust implementation than on choice of any 1 intervention. Change is typically incremental, and continuing introduction of new process improvements often continues to bring down readmission rates, even among hospitals with relatively low readmissions rates. Project impact was best understood by looking at psychiatric and substance use data separately. Among practices being used by at least 10 participating hospitals, surveys identified those practices endorsed as very important or critical for reducing readmissions by >75% of the hospitals implementing them:

- 1) Follow-up phone call to client/caregiver post discharge
- 2) Readmission risk factors assessed and addressed in discharge plan
- 3) Family/caregiver meeting focused on readmission reduction during admission
- 4) Specific procedure for follow-up on clients not adherent to aftercare
- 5) Follow-up phone call to anyone: receiving provider / client / family / other / unspecified
- 6) Case conference review of each readmission: why were they readmitted, what can we do differently this time
- 7) Med fill at discharge
- 8) Improved communication and coordination between inpatient and outpatient
- 9) Verify insurance coverage for medication prior to discharge
- 10) Increase referrals to ACT/ Health Home / case management / other high-intensity services

Note: A number of high-performing hospitals used structured Motivational Interviewing interventions, including use of specific tools and fidelity assessments.



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#### Critical Time Interventions (CTI)

CTI is an empirically supported, time-limited case management model designed to prevent relapse/ recidivism and other adverse outcomes in people with mental illness following discharge from hospitals, shelters, prisons and other institutions. CTI was originally developed and tested by researchers and clinicians at Columbia University and New York State Psychiatric Institute with significant support from the National Institute of Mental Health and the New York State Office of Mental Health. CTI improves outcomes during vulnerable transition periods by: 1) strengthening the individual's long-term ties to services, family and friends, and 2) and by providing emotional and practical support during the critical time of transition. CTI workers establish a relationship with patients during their institutional stay. Post discharge work is organized in to three phases:

- 1) Transition: specialized support & implement transition plan - meet with caregivers, accompany client to providers, provide support, mediate conflicts
- 2) Try Out: facilitate and test clients problem solving skills – observe support network, modify supports as needed
- 3) Transfer of Care: terminate CTI services with support network safely in place – reaffirm roles of support network, develop and begin to set in motion long term goals, hold party/meetings to symbolize transfer of care.

<http://www.criticaltime.org/model-detail/>

#### OMH Continuous Quality Improvement Initiative for Health Promotion and Care Coordination (Clinic CQI)

The OMH Clinic CQI Initiative for Health Promotion and Care Coordination has engaged 302 clinics statewide (as of 12/2014) in a large-scale quality improvement project. Participating clinics choose one of two projects, both focusing on high utilization of inpatient and emergency services in the behavioral health population. The **Health Promotion and Coordination** project includes quality indicators that focus on ensuring that appropriate planning and coordination takes place for individuals at risk for high utilization of medical inpatient services and medical emergency room (ER) services as well as individuals who may be in need of appropriate laboratory monitoring/screening and outpatient medical visits. The **Behavioral Health Care Coordination** project includes indicators that focus on enhancing planning and coordination for individuals at risk for high utilization of inpatient and emergency room behavioral health services, as well as individuals with a diagnosis of schizophrenia, bipolar, or depression, who might have concerns related to adherence and discontinuation of certain medications. By mid-2014, some clinics showed statistically significant improvement in two quality measures based on Joinpoint analysis of the Medicaid data. The project is ongoing.



### References and Resources

#### OTHER NATIONAL INITIATIVES

##### **AHRQ (Agency for Healthcare Research and Quality) Reducing Medicaid Readmissions Project:**

AHRQ commissioned this guide to identify ways evidence-based strategies to reduce readmissions can be adapted or expanded to better address the transitional care needs of the adult Medicaid population. A critical lesson learned was that an important difference between Medicare readmissions and Medicaid readmissions is that for Medicaid the behavioral health population is predominant. The principal investigators, including Amy Boutwell, MD of Collaborative Healthcare Strategies, have identified an overall approach to reducing all cause readmissions:

- 1) Know your data
- 2) Inventory your existing readmission reduction efforts
- 3) Develop a portfolio of strategies (mix of strategies based on #1 and #2)
- 4) Improve standard hospital-based transitional care processes
- 5) Collaborate with cross-setting partners
- 6) Provide enhanced services to high-risk / high-utilizing populations.

<http://www.ahrq.gov/professionals/systems/hospital/medicaidreadmitguide/index.html>

##### **Project RED (Re-Engineered Discharge), Boston University**

Project Re-Engineered Discharge (Project RED) is a research group at Boston University Medical Center that develops and tests strategies to improve the hospital discharge process in a way that promotes patient safety and reduces re-hospitalization rates. The RED intervention is an evidence-based practice for reducing medical re-hospitalizations based on 12 mutually reinforcing components: linguistic assistance, schedule follow-up appointments prior to discharge, plan for follow-up of pending test results, organize post-discharge services and medical equipment, identify the correct medications and make a plan for how the patient

will obtain and take them, reconcile the discharge plan with national guidelines, teach a written discharge plan that the patient can understand, educate the patient about his/her diagnosis, assess the patient's understanding of the discharge plan, review with the patient what to do if a problem arises, expedite transmission of discharge summary to receiving providers, and provide telephone reinforcement of the discharge plan. The Project RED Team identifies 2 components as most critical:

- 1) In Hospital: Preparation & Education of written plan, including
  - a. Developing the After Hospital Care Plan (AHCP) with daily input from the care team (discharge begins on admission, involves the whole team, is summarized in a written document that is user friendly but comprehensive – AHCP forms are available for download in Project RED toolkit),
  - b. Teaching the AHCP to patient and family/caregivers using teach-back method (not passive education or presentation)
- 2) After Discharge – Reinforcement of the plan: Phone call within 72 hours after discharge
  - a. Assess clinical status
  - b. Review medications and appointments
  - c. Problem solving around obstacles

##### Project RED links:

Project RED Components: <https://www.bu.edu/fammed/projectred/components.html> ; Project RED Toolkit including After Care Hospital Care Plan form and guide to how to conduct a follow-up phone call: <https://www.bu.edu/fammed/projectred/toolkit.html>

Project RED presentation to RQC: [http://www.omh.ny.gov/omhweb/psyckes\\_medicaid/initiatives/hospital/learning\\_collaborative\\_2013/calls/BostonUniversity.pdf](http://www.omh.ny.gov/omhweb/psyckes_medicaid/initiatives/hospital/learning_collaborative_2013/calls/BostonUniversity.pdf)



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##### **RARE (Reducing Avoidable Readmissions Effectively)**

The RARE Campaign was conducted in Minnesota in 2011-2012 to reduce avoidable medical readmissions. They also developed a set of recommended actions for improved care transitions in the behavioral health population and plan to implement those in learning collaborative in 2014. Their recommendations are in the areas of: patient/caregiver engagement and activation; medication management; and care transition planning, support and communication.

[http://www.rarereadmissions.org/documents/Recommended\\_Actions\\_Mental\\_Health.pdf](http://www.rarereadmissions.org/documents/Recommended_Actions_Mental_Health.pdf)

##### **STAAR (State Action on Avoidable Readmissions)**

The Institute for Healthcare Improvement (IHI) focuses on identifying and testing new models of care and promoting adoption of best practices and effective innovations. In May 2009, IHI launched the State Action on Avoidable Rehospitalizations (STAAR) initiative to reduce medical readmissions.

They have identified the following process for developing projects to reduce medical readmissions:

- 1) Know your data (perform a root cause analysis)
- 2) Know your partners (engage the cross-continuum team, and work together)
- 3) Partner to improve shared transitional care processes for all patients, aligning efforts within and across organizations, including:
  - Medication management across settings
  - Timely communication between providers; notification of primary care physician of ED visit/ hospital admission
  - Consistent caregiver engagement in care plan
  - Warm handoffs
- 4) Know your high risk patients (identify proactively based on hospital or payer data), and collaborate to offer enhanced services to target population
- 5) Move from pilot to portfolio (don't delay)
  - Avoid looking for one single solution – develop portfolio
  - Don't over-plan – iterate as you go

STAAR recommends the following key clinical practices in “How to improve transitions from hospital to community settings to reduce readmissions”:

- 1) Partner with patient and caregiver to determine post-hospital needs
- 2) Provide effective teaching, using teach-back, to all learners (patient/family/caregivers), and assess understanding
- 3) Create and activate post-hospital follow-up care, including making timely appointments
- 4) Provide real-time handover communications, including patient-friendly care plan that includes medication, and critical information to receiving providers

<http://www.ihl.org/resources/Pages/Tools/HowtoGuideImprovingTransitionstoReduceAvoidableRehospitalizations.aspx>

STAAR home page: <http://www.ihl.org/engage/Initiatives/completed/STAAR/Pages/default.aspx>