Strategies for Reducing Readmissions to the Inpatient Psychiatric Setting

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Objectives

- Identify elements of a comprehensive strategy for reducing all cause readmissions and an organizational assessment.
- Identify resources and innovative approaches to address process gaps contributing to your readmission rate.
- Discuss available community resources that improve behavioral health outcomes
Readmissions from the Inpatient Psychiatric Setting

- National: ~21.50 percent
- Lake Superior Quality Innovation Network (LSQIN) region (MI, MN, WI): 21.29 percent
- Discharge diagnoses with highest readmission rates:
  - Schizophrenia and other psychotic disorders: 22.85 percent
  - Substance-related disorders: 22.60 percent
  - Personality disorders: 22.48 percent
  - Mood disorders: 21.73 percent
  - Alcohol-related disorders: 21.67 percent

All-cause 30 day readmissions, based on Medicare FFS claims data, Q4 2015-Q3 2016

Key Areas Identified as Focus for Improvement

- Client/Family Engagement and Activation
- Medication Management
- Comprehensive Transition Planning
- Care Transition Support
- Transition Communication

^ RARE Recommendation actions for improved care transitions: Mental Illness and SUD 2014
Identify High Utilizers or Readmissions

- In-depth review – case conference
  - What was the last discharge plan
  - How well did it work
  - Why were they readmitted (root cause analysis)
  - What can be done differently the next time
- Analysis should included inpatient team, outpatient providers, care coordinator, residence, client and/or caregivers

RARE – resources for organizational assessment, interviews, population analysis; STAAR, AHRI, RQC

Where to Start

- Quality Improvement process
  - Engage all relevant services within hospital/system – inpatient, outpatient, ED
  - Include community partners across continuum of care
- Root cause analysis
  - Sample of readmissions, including client/caregiver interview
  - Quantitative analysis (Patient characteristics, setting discharged to, etc)
  - Staff input
  - RESOURCE: RARE 2014
- Track clients, interventions and outcomes over time
- No ‘silver bullet’ – need mutually reinforcing interventions across continuum of care

Assessment Tools – See Resources
Patient/Family Engagement and Activation

Patient/Family Engagement and Activation: Why Is It Important?

- No one gets through a serious illness by themselves
- No one should be discharged from the hospital without someone with them to hear the directions and ask questions
- No one manages their illness well if they don’t understand their illness or the treatment plan and if they weren’t involved in developing their treatment plan

Additional Sources:  RQC, CTI, STAAR, RED, RARE
NAMI Survey: Patients

- Get well cards – 25%
- Visits from family – 86%
- Visits from friends – 45%
- Have an easy time staying connected – 34%
- Involve family and friends in recovery – 35%
- Involve in treatment plan – 25%

Additional Sources: RQC, CTI, STAAR, RED, RARE

NAMI Survey: Patients

- Have someone with me at discharge – 27 percent
- Encouraged to sign a privacy release – 27 percent
- Provided me with info about my illness – 39 percent
- Provided me with info about my meds and side effects – 43 percent
- Had input into my treatment plan – 41 percent
- Was listened to – 45 percent
- Offered hopeful words about recovery – 40 percent
NAMI Survey: Patients

- “I would have liked to have more information on my new medication when I first started on it, instead of getting it from Target Pharmacy after I got out.”
- “Treat me like a patient with an illness, not like I am incapable of making good decisions.”
- “Due to my mental illness, physical symptoms were disregarded as figments of my imagination.”

NAMI Survey: Families

- Sign a privacy release – 38%
- Provided information on illness – 27%
- Info on meds and side effects – 26%
- Taught me what to do to help – 11%
- Had input into treatment plan – 31 percent
- Showed empathy – 40%
- Hopeful words – 34%
NAMI Survey: Families

- "We had to ask if they had a video or something to read to help us when our 18yr old son was hospitalized while he had been in college - there was no support for us as parents. We had to find that on our own and in our own community."
- "They could have included me, consulted with me, and not dismissed me."

NAMI Survey: Families

- "Parents who are obviously the ONLY other contact of patient should be included in treatment/care/discharge."
- "More descriptions of the unit, rules, population, etc. It was my son's first time in an adult unit."
- "Staff could have treated me like a caring parent - just like they would for a child with cancer."
Recognize the Importance of Families & Friends

*Family is not an important thing, It’s everything*
- Michael J. Fox

**What Families Provide**

- Social support - improves physical health, helps with resilience and better quality of life
- Practical help - transportation, housing, food, finding and keeping jobs, money, make appointments, fill medications, monitor stress
- Advice, knowledge and encouragement
What Families Provide

- Recognition of early warning signs
- Record keepers
- Understand person’s strengths, talents and preferences
- Advocacy for person – in the hospital and with the insurance company, county, etc.

What Families Need

- Encouragement to maintain hope
- Validation of worries/difficulties
- Respect and empathy
- Honest and caring communication
What Families Need

- Resources and information
- To learn and ask questions
- Access to education and support
- Information about the mental health system

Why Families Want Information

- Reduce anxiety and confusion
- Determine appropriate expectation for their loved one
- Learn how to motivate their relative
- Find out about mental illnesses
- Assure accessibility to a professional during a crisis
Why Families Want Information

- Understand the diagnosis and prognosis
- Understand symptoms, medications and side effects
- Get specific suggestions for coping with symptoms
- Deal with practical issues
- Make contact with peer support groups

True Family Engagement

- Include families in discharge and treatment planning
- Seek information from families about the history, background of their relative’s illness
- Inform families of shifts in treatment strategies and changes in medications
True Family Engagement

- Give timely reports on how things are going
- Consult with and inform families about possibilities for improving their relatives condition
- Establish clear open channels for family complaints and grievances

True Family Engagement

- Listen to their concerns
- Assess the strengths & limitations of the family
- Address feelings of loss
- Help improve communication among family members
- Encourage expanded support networks
HIPAA versus Families

- Families perceived as overprotective or unengaged
- Families don’t want access to medical records but to information
- They want to provide information to you and obtain information to help their loved one in the community

HIPAA v. Families

- Family Involvement Law
- HIPAA allows professional judgment
- Ask questions and involve families in the beginning – ED evaluation
- Ask questions and involve families at the end – discharge planning
HIPAA v. Families

- Proactively ask for privacy releases
- Ask more than once
- Ask if you can share certain information
- Provide general information
- Can assume consent if patient in room and allows you to discuss situation

Patient Engagement

- Identify support network
- Teach them about their illness
- Teach them about the treatment plan
- Involve them in changes in medication
Patient Engagement

- Partnering and decision making
- Reflecting on pros and cons
- Need enough information in order to made decisions
- How do they want others involved in the decision making

Patient & Family Engagement

If everyone is on the same page, it’s easier to move forward.
Medication Management

- Access to medication at discharge
  - Verify insurance formulary before initiating medication
  - Obtain and verify prior authorization before discharge
  - Ideally – fill prescriptions at discharge – walk out with meds in hand (or walk to pharmacy by staff to get meds)
- Check Medicaid status – enroll if eligible/needed
- Provide full, written information about medications
  - Reason, dose, schedule for the day, etc.
  - Side effects, what to watch for
- Be sure discharge medication lists are consistent and clear

SOURCE: RQC, RARE,
Factors Related to Acceptance & Adherence to Medications

- Limited insight about their condition and need for medication (anosognosia)
  - Is part of the condition
  - Tendency to ‘blame the patient’

- Negative attitudes about medication because of past experiences
  - Side effects – esp. TD, weight gain, sleepiness
  - Didn’t help with symptoms

- Cognitive challenges

- Address factors related to acceptance and adherence
  - Staff education
  - Use of motivational interviewing
  - Use Teach-back method

Comprehensive Transition Planning
Comprehensive Transition Planning

- Assess readmission risk factors at time of admission and throughout ¹
  - In care planning with team and client
  - In meetings with family & caregivers

- Use Teach-back method with client and family throughout the stay ¹,²,³

- After Hospital Care Plan² - e.g. Project RED format
  - Easy to understand, plain language (avoid medical jargon, health literacy)

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1. RQC – from NY-OMH Reducing Behavioral health readmissions. 2. RARE Recommended Actions 2014 3. NY-BHC

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Comprehensive ‘with’ client/family -- not ‘for’ them

- Address²,³
  - Medications - clear instructions, patient understanding, Teach-back
  - Crisis Management – condition specific symptom recognition, management; red flags – urgency of issue, who to contact and how; emergency; after clinic hours
  - Coordination & planning for
    - Appointments – made before transition
    - Coordinate with patient and family – address barriers to getting there and keeping the appointment

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Focus on Recovery

- Eight dimensions of wellness
- Four dimensions for recovery
  - Health
  - Home – stable, safe place to live
  - Purpose – meaningful daily activities, independence, income & resources to participate in society
  - Community – having relationships and social networks that provide support, friendship, love and hope

Understanding Discharge Plans

- Are they realistic? Understandable?
- Do they address the patient’s goals? or the team’s goals for the patient?
- Who can do what in terms of transportation, in-home services, checking medicine cabinet, obtaining new prescriptions, etc.
- Teach-back – include family if possible
Patient Engagement - TRIP MAP

- Think about problems, pressures, people & priorities
- Research facts and possible solutions
- Identify options
- Weigh the Pluses and
- Minuses for each option
- Action planning
- Ponder the results of the decisions

Care Transition Support
Care Transition Support: Client & Family

- Brief teaching to prepare the patient for their follow-up visit
- Have a follow-up appointment with provider of MH services – within 7 days or sooner
  - New referrals – facilitate connection between patient and agency
  - Receiving MH provider – should have system to accommodate availability
  - Should have appointment scheduled BEFORE they leave the hospital

Community Resources

- Family psycho-education classes
- Support groups for the person with a mental health condition and family members
- Written resources
- Advocates

You are not alone.
Care Transition: Other Strategies

- Case or care manager contact (internal or outpatient clinic)
- Coach to help client and family develop skills and confidence and ensure needs are met (Care Transitions Intervention® - Dr. Eric Coleman)
- Assertive Community treatment (ACT) intervention – PACT, CSP
- Active short-term case management until engaged in aftercare
  - Bridger-case manager
  - Peer-bridger
  - Critical Time Intervention – a time limited case management model
Transition Communication

- Starts on admission
  - Patient’s providers should be notified of the admission and prior to transition out of the hospital
  - Determine if patient has a case worker/care manager, contact them, involve them in care plan and changes in care plan
- Family and caregivers – must know who is responsible for care (during stay and after)
- Use a brief video for patient/family/caregivers that addresses
  - The need for transitions
  - Preparation for outpatient care (both mental health and primary care)

Bridging and “Warm Hand-offs’

- Face to Face meeting with receiving outpatient provider during inpatient stay or soon after. Ideally:
  - Discharge planning meeting: outpatient provider, client, family, inpatient team
  - Individual meeting: outpatient provider & client
- Real-time communication between inpatient and outpatient providers
  - Expedite transmission of discharge summary

^ RQC Other Sources: STAAR, RARE, RQC, Transitions Project, CTI
Outpatient Care That Affects Readmission Risk

- **Client**
  - Follow-up appointments within three to five days of discharge
    - Reminder phone calls before appointment, follow-up on non-attendance
    - On-time appointments
  - Follow-up appointment - Address strategies for crisis management:
    - Monitoring for early warning signs, relapse prevention plan, use of urgent care or walk-in appointments
    - Education on use of ER

- **Providers:**
  - Follow-up calls post discharge between inpatient – aftercare providers for information and problem solving

1. RQC 2. ACT Transition Project

Other Source: RARE

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Aftercare

- **Use of higher-intensity outpatient services – hospital diversion, step-down**
  - Partial Hospitalization Program (PHP)
  - Intensive Outpatient (IOP) level of care
  - Identification of and coordination with existing services such as ACT

Source: RARE, RQC, Transitions
Follow-up Phone Calls

- Follow-up phone call to client/family
  - Within 72 hours
  - Clinical intervention, intensive (not just a reminder call)
    - Address concrete needs especially those that pose barriers to access to medication, aftercare services, housing, food
  - Use Teach-back method (don’t read the med list)
  - Ideally by staff known to client
  - Not “discharged” until attends first outpatient appointment

- Follow-up phone call to provider
  - Share information, problem solving
  - Verify attendance, follow-up on non-attendance,

Source(s): NY Project RED (key component), RARE, RQC, Transitions

Key Points:
Client/Family engagement

**Client/Family Engagement**
- Family (natural support system) involvement and support
- Use Teach-back method
- Health literacy
- Releases of information

**Medication Management**
- Medication reconciliation
- Patient medication list
- Medication availability (through insurance, pharmacy)
- Patient agreement and understanding
Key Points:
Transition Communication

Comprehensive Plan
• Transition Plan
• Recovery Model
• Collaboration with patient & family

Transition Communication
• Hand off communication
• Discharge summary – expedited to aftercare providers

Key Points:
Care Transition Support

- Follow-up appointment – schedule before discharged: within three to five days
  (or use alternate bridging connections until appointment)
- Community resources for peer and family education and support
- Follow-up phone calls
  - Patient within 72 hours
  - Behavioral health
  - Medical Health
REMEMBER

- There is no ‘silver bullet’.
Thank you for all the work you do to care for our loved ones!

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RESOURCES

- AHRQ - Reducing Medicaid Readmissions Project

- RARE – Reducing Avoidable Readmissions Effectively (Minnesota)
  - [http://www.rarereadmissions.org/](http://www.rarereadmissions.org/)
  - Mental Health - [http://www.rarereadmissions.org/documents/Recommended_Actions_Mental_Health.pdf](http://www.rarereadmissions.org/documents/Recommended_Actions_Mental_Health.pdf)

- RED – Project RED (Re-Engineered Discharge)
  - [https://www.bu.edu/fammed/projectred/components.html](https://www.bu.edu/fammed/projectred/components.html)
  - Conducting follow-up phone call: [https://www.bu.edu/fammed/projectred/toolkit.html](https://www.bu.edu/fammed/projectred/toolkit.html)

- RQC – Behavioral Health Readmissions Quality Collaborative (NY)
RESOURCES

- STAAR - State Action on Avoidable Readmissions  
  http://www.ihi.org/engage/Initiatives/completed/STAAR/Pages/default.aspx
- Care Transitions Intervention (CTI) Coleman – http://www.caretransitions.org
- ACT Transitions Project - http://www.namihelps.org/assets/PDFs/fact-sheets/General/Assertive-Community-Treatment.pdf
- Teach-back method
  - Always Use Teach-back: http://www.teachbacktraining.org/

Additional References


ASSESSMENT TOOLS

RQC - https://www.omh.ny.gov/omhweb/psyckes_medicaid/initiatives/hospital/project_tools/
Community Resources: NAMI – National Alliance on Mental Illness

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