Improving Transitions of Care from Inpatient to Outpatient Behavioral Health Settings

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TCPI Change Package: Drivers Addressed

1. Person and Family-Centered Care Design
   - 1.1 Patient and family engagement
   - 1.3 Population management
   - 1.4 Practice as a community partner
   - 1.5 Coordinated care delivery
   - 1.6 Organized, evidence-based care
   - 1.7 Enhanced access

2. Continuous, Data-Driven Quality Improvement
   - 2.1 Engaged and committed leadership

3. Sustainable Business Operations
   - 3.4 Efficiency of operation
Overview & Roadmap

1. Why transitions of care matter
2. Challenges to successful transitions of care
3. Interventions and strategies for improving care transitions
Why Focus on Transitions of Care?

• Transitions from points of care pose substantial obstacles to successful treatment outcomes
• Inpatient to outpatient transitions are particularly problematic from an individual, health system, and societal perspective
• Significant risks include care disengagement, symptom exacerbation, and hospital readmissions
Behavioral Health Readmissions

Statewide Perspective on Readmissions and Outpatient Appointments Kept

Readmission Rates
- 90 days
- 30 days

Post-Discharge Outpatient Appointments Kept
- 30 days
- 7 days
Collaborating with Managed Care Organizations

• Mutual interests between provider organizations and the MCOs
  • MCOs highly invested in the time period between inpatient and outpatient
  • MCOs now responsible for the larger spectrum of BH care

• Seeing MCOs as a resource
  • Bank of information on your patients’ histories of care
  • Increased number of people in Managed Care now = greater wealth of information held by the MCOs

• Moving to value-based payment means rethinking this relationship
  • MCOs expected to assess quality of providers based on outcomes and patterns rather than individual case utilization review
Barriers to Successful Transitions of Care

- Lack of client participation in creation of discharge plan
- Lack of client engagement in recovery process
- Confusion / disagreement about discharge plan
- Early stages of treatment acceptance
- Lack of family support/engagement in recovery
- Delay between discharge and appointment
- Logistical barriers to accessing services
- Difficulty reaching patient after discharge
- Stigma
Interventions to Improve Transitions of Care
Assessment

Inpatient Admission Assessment

• Identify readmissions / high utilizers
• Conduct in depth review
  • Why were they readmitted (root causes)?
  • What can we do differently this time?
  • What was the last discharge plan? How well did it work?
  • Review in treatment team meeting, cross department meetings (ER, inpatient, case workers, outpatient)
• Integrate dual diagnosis treatment: identify and treat, refer to providers of integrated treatment for aftercare
Family & Support

Involve Family & Support System

• Support evaluation
• Assess family needs
• Provide crisis intervention
• Psychoeducation and skill-building
  • “what do you think needs to happen to keep patient out of the hospital?”
Planning

Planning for Aftercare

• Follow-up appointment with aftercare mental health provider within 5 days of discharge

• Use higher-intensity outpatient services for hospital diversion and hospital step-down
  • Partial Hospitalization Program (PHP)
  • Some clinics developing Intensive Outpatient (IOP) level of care
  • Crisis Respite

• Identify and coordinate with existing community support services (ACT, Health Home, other Care Management, MCOs)
Discharge Plan

After Hospital Care Plan

• Develop and use After Hospital Care Plan
• Provide discharge instructions, including
  1. Clear medication instructions
  2. Follow-up appointments (arranged before discharge)
  3. Clear, easy-to-understand care plan with name and number to call with any problems
• Educate client and family using teach-back methods throughout inpatient stay
Person Centered Plan

Qualities of a Person Centered Plan

• Based on client-identified, personally meaningful goals
• Blends formal and informal supports
• Provides long term goals broken down into short term action steps

What makes a discharge plan successful

• Focuses on strengths and on hope for recovery
• Provides useful information that is responsive to what is important to the client
• Provides self care and self management support tools
• Patient agrees with discharge plan
Bridging and “Warm Hand-offs”

- Face to face meeting with receiving outpatient provider during inpatient stay or immediately upon discharge
  - Discharge planning meeting: outpatient provider, client, family, and inpatient team
  - Individual meeting/session: outpatient provider and client
- Build / practice / test skills that will help patient succeed in the next lower level of care
- Wellness Recovery Action Plan (WRAP)
Follow-Up

Follow-Up Phone Calls

• Follow-up phone call to client/caregiver within 72 hours
  • Clinical intervention / engagement (not just a reminder)
  • Use teach-back method

• Project RED Key Components
  1. Assess clinical status
  2. Review and confirm each medication
  3. Review follow-up appointments
  4. Assess for barriers, problem-solve, review what to do if problem arises
  5. After call: any needed follow-up actions

• Follow-up phone call to provider
Case Management

Short-Term Case Management

• May be provided by case manager, bridger, peer, etc. who can actively follow up on non-adherence to discharge plan

• Key principles
  • Assess client risk, adjust intensity and time frame accordingly
  • Address concrete needs, especially those that will pose barriers to accessing medication and aftercare services
  • Include home visits if necessary
  • Actively follow up on non-adherence (e.g. reschedule missed appointments)

• Some resources to consider: MCOs, Health Homes, etc.
Outpatient Management

- Identify and flag clients referred from inpatient
- Reminder phone calls before first post-hospital appointment
- Follow up on non-attendance
- Develop strategies for crisis management
  - *relapse prevention plans with monitoring for early warning signs*
  - *urgent care / walk-in appointments and on call availability*
- Develop crisis plan
- Offer specific resources for follow-up care other than the ER
  - Crisis Respite
Collaboration across the Continuum of Care

Community Partners

• Know/engage community partners across continuum of care
  • Standardize communication
  • Develop protocols for expedited referrals
  • Collaboration on treatment and discharge planning

• Develop a relationship with at least one pharmacy

• Real-time communication between inpatient & outpatient
Identify a portfolio of mutually reinforcing interventions across the care continuum, make ongoing incremental change

- Start with root cause analysis of readmissions
- Track clients, interventions, and outcomes over time (CQI)
- Develop committee on care transitions to facilitate collaboration and streamline processes
  - Buy-in / Motivation
  - Education
  - Resource Allocation
Thank you!

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