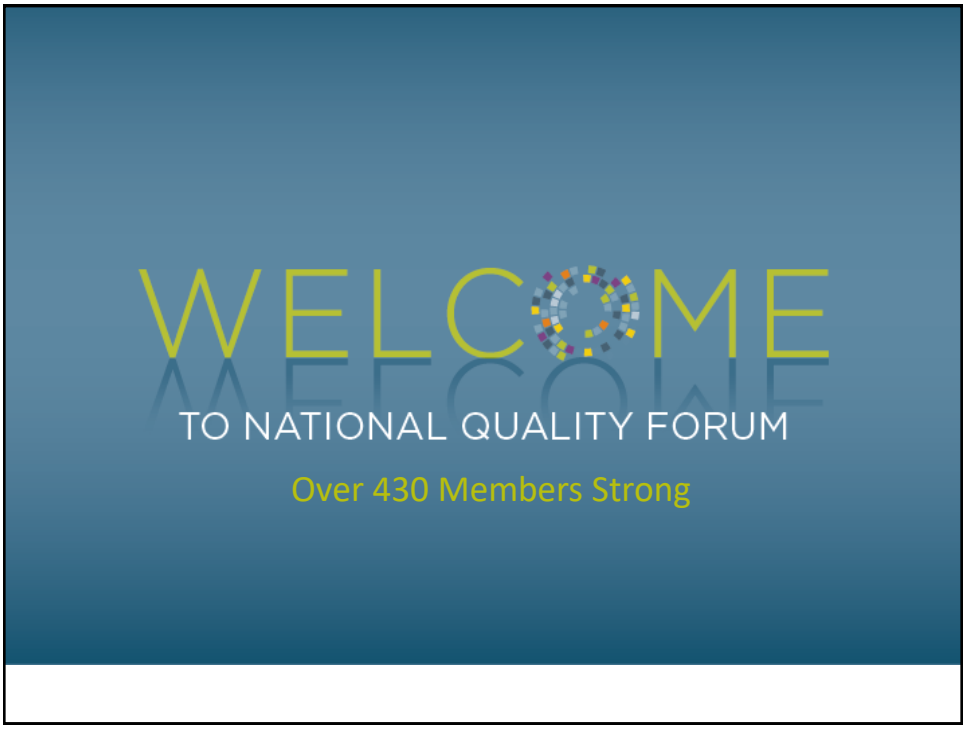
NATIONAL QUALITY FORUM

Member Education Summer Series: The Intersection of Hospital Readmissions and Behavioral Health

Part 2: The Provider/Payer Perspective

July 18, 2017



Reducing Behavioral Health Inpatient Readmissions

(a provider/payer perspective)

July 18, 2017

Agenda

1. Best Practice from Perspective of an Integrated Approach
   Michael Trangle, MD, Sr. Medical Director, HealthPartners
2. MN Behavioral Health (BH) RARE (Reducing Avoidable Readmissions Effectively)
   Tani Hemmila, MS, BSW, Consultant, Institute for Clinical Systems Improvement (ICSI)
3. Regions Hospital's Recent Efforts & Results
   Wendy Waddell, Director of Inpatient Mental Health, HealthPartners/Regions Hospital
4. Questions

Integration

Mary's Story

#1 Patient/Family Engagement & Activation

- Get release of information for family members and surrogates right away
- Appropriately engage them to help with establishing goals, treatment plan, assessing progress and discharge planning
- Utilize Teach Back method when appropriate
- Assist patient/families to connect with social service agencies, family support groups, financial-transportation-housing-vocational services as needed
- If patient struggles to manage their own care, connect with Case Management
- If patient has history of repeatedly failing as an outpatient, consider Assertive Community Treatment (ACT) Team

#2 Medication Management

1. Factor in cost/formulary/availability issues when choosing medication
2. Screen For Other Co-occurring Disorders
3. Medication Plan Communication
4. Special Population Considerations
   - Strategies to consider include: Eyes on meds, depot medications, involvement of case/care manager lethality/quantity of medications for suicidal patients

#3 Comprehensive Transition Planning

- Ensure that all the patients' needs/information is shared and understood by family and future caregivers
- Effective Transition Plan Components
  - Reason for hospitalization
  - Detailed medication information/instructions
  - Self-care activities such as exercise, diet, coping skills
  - Crisis Management: Condition-specific symptom recognition and management
  - All significant medical/physical needs are addressed in follow-up
  - Coordination and planning for follow-up appointments

#4 Care Transition

1. Helps the patient/family successfully transition from hospital to next providers
2. This is the most vulnerable time for patients and their families
3. Fragmentation often forces the patient/family to navigate a complicated system without adequate knowledge and support
4. Best Practice for Care Transition Includes:
   - Scheduled follow-up within 7 days or less with a psychiatric provider
   - All patients with mental illness and comorbid chronic or acute physical problems should have an appointment scheduled with their medical provider prior to discharge
   - Within 72 hours of transition a team member with knowledge of patient's history should contact the patient and review the Transition of Care Plan

#5 Transition Communication

1. All summaries should be received by the accepting facility within five business days (minimally before initial follow-up appointment)
2. When a patient transfers from one facility to another, direct verbal reports between nursing staff should occur
3. Determine if the patient has a county case manager, clinic care manager, or health plan case manager, if so disseminate information as appropriate
4. The transition communication responsibilities (including timelines) of the hospital physician, nursing, and medical records should be explicitly stated in policy and medical staff by-laws
5. Patient's providers including mental health, primary care, specialist, and families/significant others should be notified as soon as possible on admission and prior to transition out of the hospital

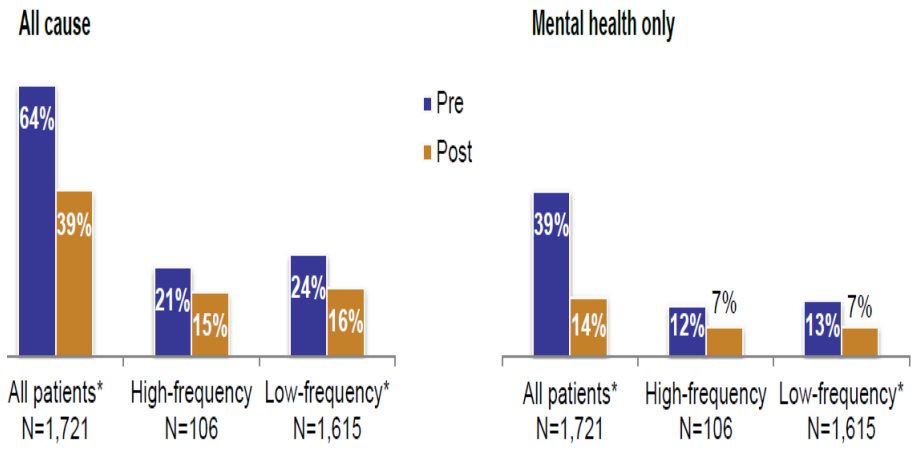
Mental Health Crisis Alliance

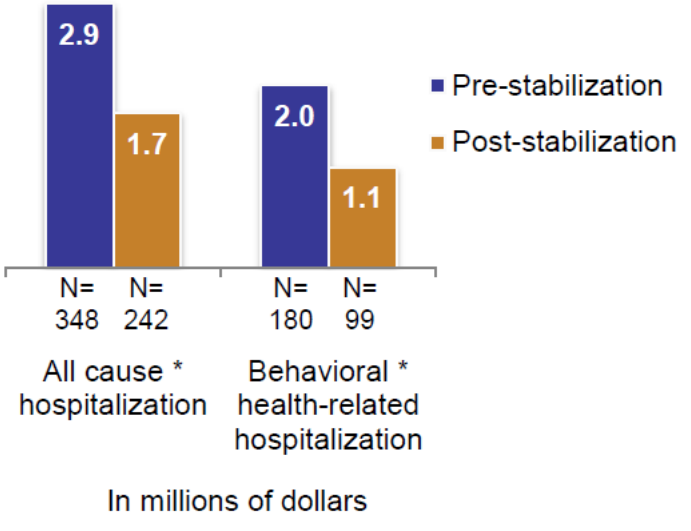
- Public/Private Alliance of:
  - 3 Counties
  - 3 Hospitals (with psychiatric units),
  - MN Department of Human Services
  - 3 Consumer Organizations,
  - 4 health plans
- Followed 1721 patients who utilized crisis stabilization services (with rapid access to psychiatric medications) 2008-2010
- Looked at utilization starting 6 months before involvement in crisis stabilization compared to the 6 months after crisis stabilization

Key Findings

- Emergency department utilization decreased significantly post-crisis stabilization for all patients including "high-frequency" patients
- Use of outpatient mental health services increased significantly for low-frequency patients following stabilization; no statistically significant change in utilization was observed for high-frequency patients
- All-cause inpatient hospitalization decreased significantly for all patients, including high-frequency patients. In addition, significant decreases in mental health-related admissions were observed for patients as well

Inpatient hospitalization: prior to and following crisis stabilization





Cost Implications

- Total costs for all-cause inpatient hospitalization decreased from $2.9 million prior to crisis stabilization to $1.7 million post-stabilization. This decrease was statistically significant
- Total costs for mental health hospitalization decreased from $2.0 million prior to stabilization to $1.1million post-stabilization. This decrease was statistically significant
- The net benefits for all cause hospitalization patients after receiving mental health crisis stabilization services is nearly $0.3 million, with a return of $2.16 dollars for every dollar invested. Patients with mental health related services generate a little over $0.3 million in net benefits with a return of $3.19 for every dollar invested

RARE Campaign: Maintaining patient health after a hospital stay…

Broad Community Support

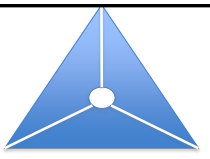
- Operating Partners:
  - Institute for Clinical Systems Improvement (ICSI)
  - Minnesota Hospital Association (MHA)
  - Stratis Health

ICSI Institute for Clinical Systems Improvement
Transforming health care, together

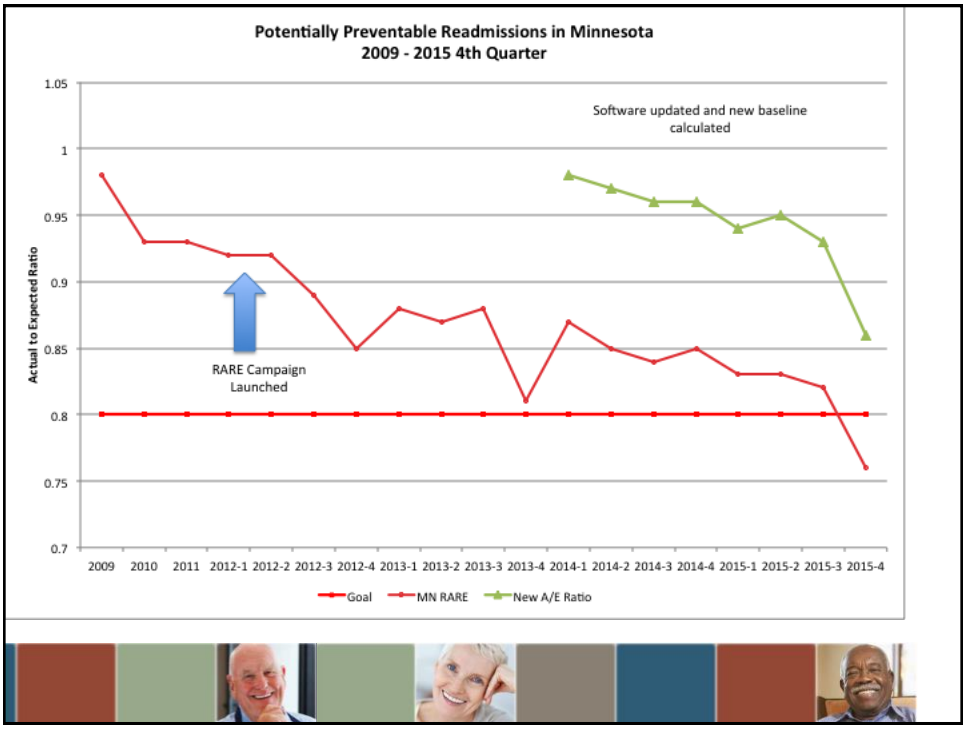
Minnesota Hospital Association

StratisHealth

Triple Aim Goals



- Population health
  - Prevent 6,000 avoidable readmissions within 30 days of discharge by the end of 2013
  - Reduce overall readmissions rate by 20% from the 2009 and maintain that reduction through 12/13/13.
- Care experience
  - Recapture 24,000 nights of patients' sleep in their own beds instead of in the hospital
- Affordability of care
  - Save millions of dollars in health care expenses

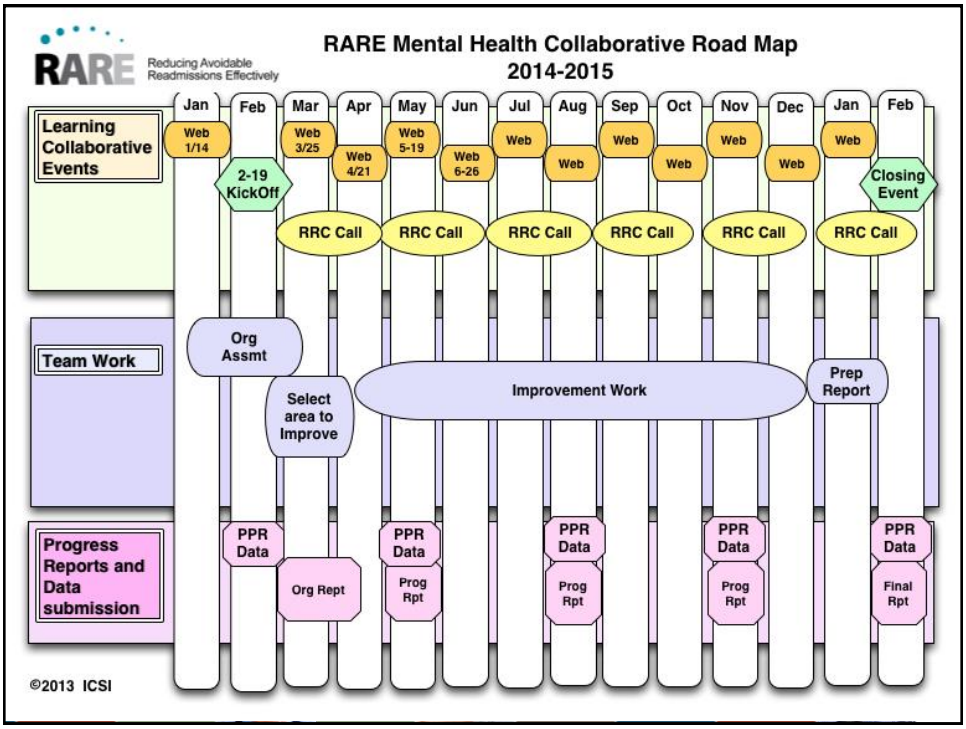

Potentially Preventable Readmissions in Minnesota
2009 - 2015 4th Quarter
Actual to Expected Ratio
1.05
1
0.95
0.9
0.85
0.8
0.75
0.7
Software updated and new baseline calculated
RARE Campaign Launched
2009 2010 2011 2012-1 2012-2 2012-3 2012-4 2013-1 2013-2 2013-3 2013-4 2014-1 2014-2 2014-3 2014-4 2015-1 2015-2 2015-3 2015-4
Goal
MN RARE
New A/E Ratio


RARE Campaign:
7,975 Readmissions Prevented
Each person represents 250 prevented readmissions, and 1,000 more nights of sleep in their own beds for Minnesotans
31,900 Nights of sleep at home

RARE Mental Health Collaborative

Aim:

- To improve care transitions between inpatient mental health units and the community
- To reduce avoidable readmissions



Five Focus Areas

Patient and Family Engagement

Comprehensive Discharge Plan

Transition Communication

Medication Management

Transition Support

Patient and Family Engagement Interventions by Participants

- Identifying a support person
- Recovery and Safety plan
- NAMI in the lobby
- Family education groups
- Teach back methodology
- Patient/Family Advisory Council for Mental Health

Medication Management Interventions by participants

- Teach back for medication education
- Involvement of pharmacist
- Pharmacists in the Emergency Department
- Fill prescriptions prior to discharge – compatible with outpatient formulary
- Long acting injectable clinic

Comprehensive Discharge Planning Interventions by Participants

- Identify support person prior to discharge and include them in discharge plan
- Include case management with family
- Process to communicate plans to other team members
- Preventive Care – referral to Primary Care

Care Transition Communication Interventions by participants

- Handoff communication to next care provider
- Developed relationships with community care providers
- Discharge summaries within 24 hours to next provider

Care Transition Support Interventions by participants

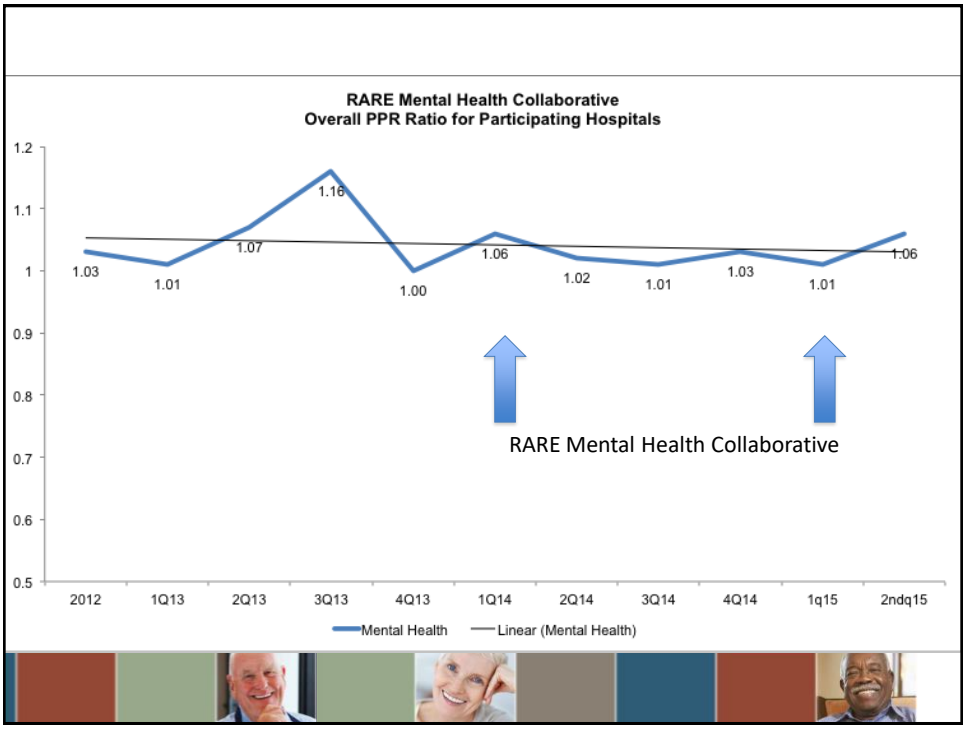
- Collaborated with community paramedics for home visit
- Follow-up phone calls to patient within 48 - 72 hours
- Case management
- Follow up appointments with mental health and primary care
- Walk in clinics

Care Changes Interventions by participants

- Risk stratification and social work plan based on assessment
- Individualized programing plans for patients
- Peer specialist
- One plan of care for complex care management – available for system (ED, inpatient and outpatient) (Integrated system)

Continuing Challenges

- Community linkages
- Care plan communication
- Meaningful real time data
- Social determinant factors for people with mental illness
- Cultural / time differences between mental health and health care



Regions Hospital Mental Health

- An eight-story, 115,000-square-foot, free-standing building opened in December 2012
- 100 private inpatient rooms
- A respectful recovery environment for patients including private rooms with private baths, activity space, outdoor patio area
- Family-friendly patient care space for behavioral health therapies and education

Multidisciplinary Effort

Readmissions team included:

- RNs
- Providers
- SW
- OT
- Pharmacy
- Consumer
- HUC

Focus Area and Collaborative Goal(s)

Transitions Communications

Goal: to decrease Regions Hospital inpatient MH 30 day all cause non-elective readmission rate to 10.4% by March 2015 using Regions calculations and data

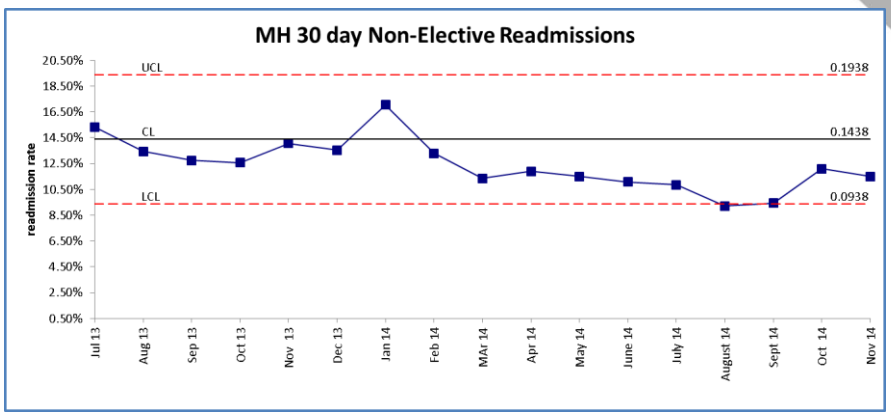
Interventions Then and Now

- Improved patient interview
- Focus on forwarding of information to next provider
- Peer Specialist/WRAP
- Increase patient/family presence in team meetings
- Care Planning

Interventions Then and Now

- InReach Case Management
- Community partnerships
- Long acting injectable clinic
- Phrazer Device usage
- ED provider model pilots

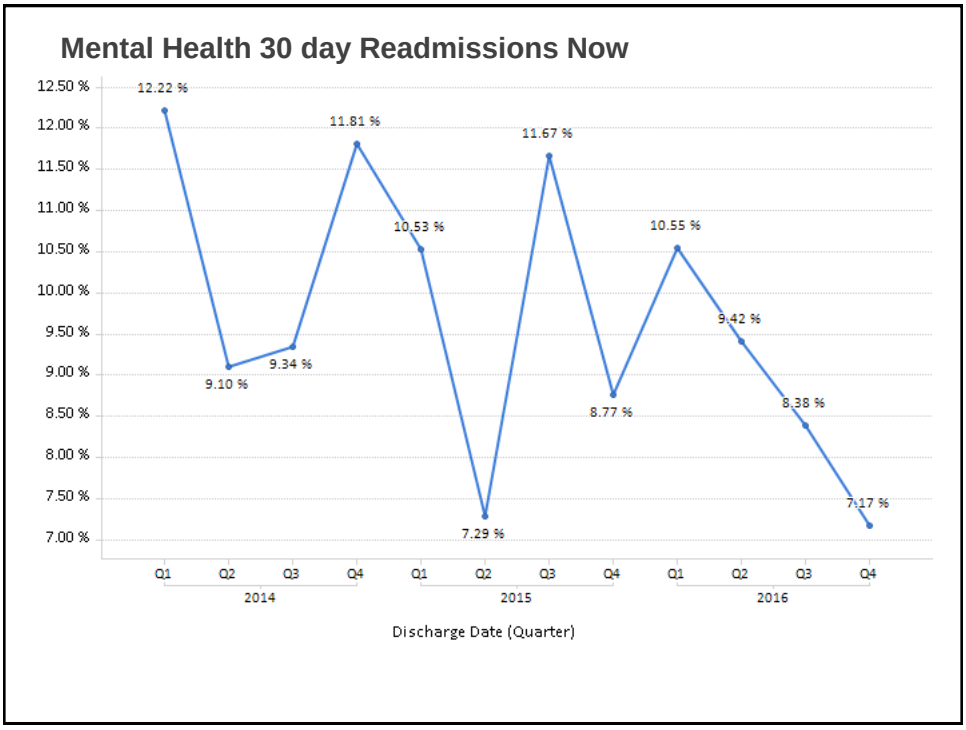
Data Results on Goal



Overall rate for RARE Initiative time period 11/50%

Lessons Learned

- No single intervention is magic
- Multidisciplinary approach
- Constant improvement work


Mental Health 30 day Readmissions Now
12.50 %
12.00 %
11.50 %
11.00 %
10.50 %
10.00 %
9.50 %
9.00 %
8.50 %
8.00 %
7.50 %
7.00 %
12.22 %
9.10 %
9.34 %
11.81 %
10.53 %
7.29 %
11.67 %
8.77 %
10.55 %
9.42 %
8.38 %
7.17 %
Q1
Q2
Q3
Q4
2014
2015
2016
Discharge Date (Quarter)

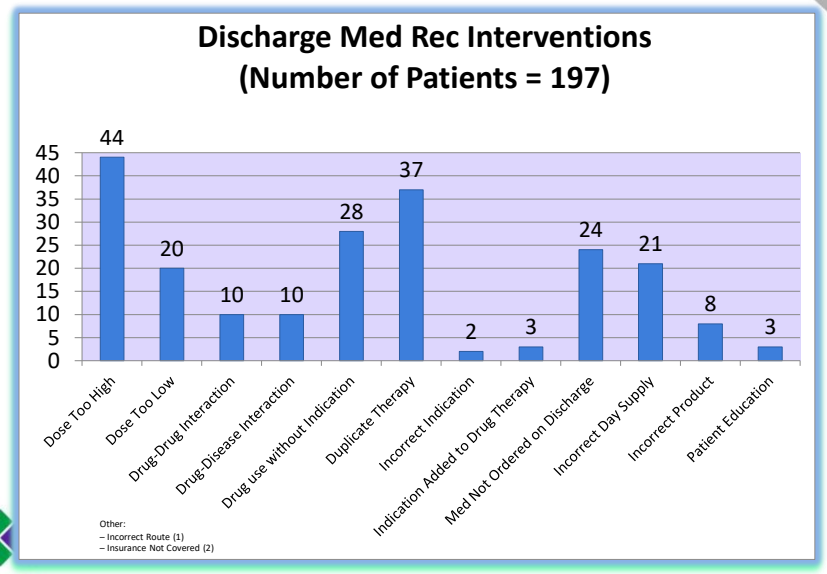

Regions Med Rec Pilot
A piece of the puzzle

Pilot Overview

- **Dates:** September 1, 2016 – January 31, 2017
- **Staff:** Two psychiatric pharmacists, pharmacy residents, pharmacy students
- **Hours:** Mon-Fri from 0700-1530
- **Population:** NE hospital, 100 beds, all discharges as workflow allowed, no patient stratification/prioritization
- **Documentation:** Patient specific documentation entered as an "i-Vent"

Pilot Summary: Psychiatry

- 168/168 (100%) pharmacist interventions were accepted and implemented prior to discharge
- We found need to treat 4 patients to detect and implement one intervention, with a total of 40 min of pharmacist time
- Due to resource constraints, we were able to perform discharge med rec on only 53% (695/1299) of discharges during the pilot
- Consistent with previously published literature, involving clinical pharmacists in the discharge medication reconciliation process reduced med errors and appeared to reduce 30 day readmissions



Readmission Rates*—30 Day

- Pilot
  - Sept 1, 2016-Jan 31, 2017
    - Pharmacist Discharge Med Rec: **4.17%**
    - Usual Care: 10.97%
- Historical Control
  - Sept 1, 2015-Jan 31, 2016
    - Usual Care: 11.29%

*Reported Annual Readmission Rates: 8.2-11.2%
Data provided by Nick Mattison. Statistical Analysis Pending.

QUESTIONS?