Welcome to the New England QIN-QIO Care Transitions Webinar!

Thank you for joining. Our presentation will begin shortly.

If you haven’t already, please dial in to the audio line:
888-895-6448 Passcode: 519-6001
Butler Hospital - Bridging the Divide: 
An Inpatient Psychiatric Hospital's 
Approach to Improving Transitions of 
Care 

New England QIN-QIO

Moderator: Kathy Calandra – New England QIN-QIO
Speakers include:
- Diane Ferreira, RN, MHA
- Ana Tuya Fulton, MD
- Lisa Shea, MD
- Carolyn Walsh, LICSW

June 23, 2016 | 11:00am – 12:00pm
Learning Objectives

☑ Understand the challenges of and evidence around transitions work in the behavioral health arena;

☑ Explore Butler’s experience and key “lessons learned”

☑ Identify strategies for potential application to your own environment, and

☑ Connect with others doing this work.
Connection Tool - Chat In...

Introduce yourself in chat and let us know how you are improving the transitions of care for patients with behavioral health conditions...
Today’s Speakers

Diane Ferreira, RN, MHA
Director of Care Management & Social Services
Butler Hospital

Lisa Shea, MD
Medical Director
Butler Hospital

Ana Tuya Fulton, MD
Chief of Internal Medicine
Butler Hospital

Chief of Geriatrics,
Care New England Health Systems

Carolyn Walsh, LICSW
Social Services Systems Administrator
Butler Hospital
Butler Hospital’s Approach to Understanding and Addressing Readmissions

Ana Tuya Fulton, MD, FACP
Carolyn Walsh, LICSW
Diane Ferreira, RN, MHA
Lisa Shea, MD
Disclosures

• Ana Tuya Fulton, MD – faculty on and receives funding from – Rhode Island Geriatrics Workforce Enhancement Program (#U1QHP28737 from the US Health Resources and Services Administration)

• Lisa Shea, MD – Rhode Island Blue Cross Professional Advisory and Credentials Committee
Objectives

• Understand the challenges of and evidence around transitions work in the behavioral health arena
• Review the experience of Butler Hospital team and “lessons learned”
• Take home strategies for potential application to other sites and systems
Transition Interventions: Mental Health
Background

• Transitions of Care

  Refers to the actions involved in coordinating care for patients as they move through various settings in the health care system

  • “Good” transitions help reduce adverse events, reduce readmissions and improve patient satisfaction and reduce costs.

  • Target populations for our work – older adults with dementia and patients with psychiatric illness
Rehospitalizations among Patients in the Medicare Fee-for-Service Program

Stephen F. Jencks, M.D., M.P.H., Mark V. Williams, M.D., and Eric A. Coleman, M.D., M.P.H.

ABSTRACT

BACKGROUND
Reducing rates of rehospitalization has attracted attention from policymakers as a way to improve quality of care and reduce costs. However, we have limited information on the frequency and patterns of rehospitalization in the United States to aid in planning the necessary changes.
### Table 2. Highest Rates of Rehospitalization and Most Frequent Reasons for Rehospitalization, According to Condition at

<table>
<thead>
<tr>
<th>Condition at Index Discharge</th>
<th>30-Day Rehospitalization Rate</th>
<th>Proportion of All Rehospitalizations</th>
<th>Most Frequent</th>
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<td>Drug toxicity (1.9)</td>
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<td>GI problems</td>
<td>19.2</td>
<td>3.1</td>
<td>GI problems (21.1)</td>
<td>Nutrition-related or metabolic issues (4.9)</td>
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</table>
Viggiano: 2013 Systematic Review

• “This review of intervention models identified multiple models, trials and initiatives for care transition interventions for general medical populations, but few targeted specifically for mental health populations.”

Vigod, et al 2013:

- Identified 15 studies evaluating 15 intervention components
- Statistically significant impact on readmission in 7 of the studies
- Effective components:
  - psychoeducation interventions targeting disease management and living skills,
  - structured assessments of patients’ discharge needs,
  - pre-discharge medication education/reconciliation,
  - post-discharge telephone follow-up,
  - efforts to ensure timely follow-up appointments,
  - home visits,
  - peer support, and
  - the bridging components of transition manager and timely communication by in-patient staff with an out-patient care or community service provider during the transition.
May 2015 – AHRQ Brief

• “Hospital readmission within 30 days of discharge usually represents a negative clinical outcome for patients with mental disorders and may be due to factors such as poor access to adequate community-based aftercare and challenges in psychiatric medication adherence and self-care. “

AHRQ Brief – Scope of the Issue

• Top 10 Most Common Medicaid 30-Day Readmissions (with Total Cost) for Medicaid Patients Aged 18-64, 2011

1. Mood disorders
2. Schizophrenia and other psychotic disorders
3. Diabetes mellitus with complications
4. Other complications of pregnancy
5. Alcohol-related disorders
6. Early or threatened labor
7. Congestive heart failure
8. Septicemia (except in labor)
9. Chronic obstructive pulmonary disease and bronchiectasis
10. Substance-related disorders

AHRQ – Management Strategies

• “Little known about effectiveness of different LOS for these patients, support services after DC, alternatives to hospitalization, or long term approaches to reduce hospitalizations”

• Other than ACT – Assertive Community Treatment – demonstrated key interventions/impact

• Need to measure well being and function rather than LOS and readmission

Transitions Committee History
Development

• Personal research interest – 2006
• Geriatric unit collaborations - 2008
• Working group formation
• Participation in Providence and Kent Community Transitions Coalitions – 1/2012
• Formation of the Transitions of Care Committee – Charter approved 5/2012; First meeting 6/15/12
Composition

- Medicine/Geriatrics
- Geriatric Psychiatry
- Chief Medical Officer
- Med Director & Quality
- SW
- OT
- Care Management
- Quality & Regulation
- Performance Improvement
- Admissions RN and MD leads
- Patient experience lead

- Medical Records/Billing
- Compliance
- Pharmacy
- Nursing leadership – geriatric, addictions, intensive treatment units
- QIO (Healthcentric Advisors)
- Health system – quality
- Health system – VNA
- Kent hospital psych unit team
- Providence center partners
- Local payers
<table>
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<tr>
<th>Full Name</th>
<th>Last Name</th>
<th>First Name</th>
<th>Type</th>
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<td>Charles</td>
<td>Core</td>
<td>Butler Hospital</td>
<td>Director Quality and Regulation</td>
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<td>Kevin Ball, MD</td>
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<td>Chief, Intensive Treatment Unit</td>
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<td>David Boscia, LICSW</td>
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<td>Quarterly</td>
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<td>Manager, Community Outreach Programs</td>
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<td>Cliff Cabral, LMHC, NCC, CCMHC, CBIS</td>
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<td>Hospital Liasson/Case Manager</td>
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**TOCC Members as of 5/20/16**
Projects Completed

• Uniform, streamlined packets for internal/external transfers
• RN-RN form
• ER communications meetings – quarterly
• Readmissions data deep dive
• Psychosocial assessment revision
• Collaborations with payers, outpatient providers, State – Medicaid and BHDDH
• Research projects – pilots done
Community Outreach
Coalition Model Adaptation

• Several members of Butler’s committee were participating in the QIO (Healthcentric Advisors) community coalitions

• Adapted the model – invited CMHC’s, home care agencies, private providers to join
Results of Collaborations

• Communication Improvement
  • Discharge summary CQI project
  • Medication list improvements
  • Clarification of HIPPA and 42 CFR issues
• Easing follow up appointments upon discharge
  • Agreement around “higher” risk patients to prioritize
  • PCP appointments effort
• Ideas for closer collaboration
Readmission Rates
30-day Readmission Rates
FY 2014-FY 2015

• Overall 30 day readmission rate:
  • Butler Inpatient 16.0%
    • (FY 11-12 16.5%; 12-13 18.3%; FY 13-14 16.7%)
  • Kent Unit at Butler 20.7%
    • (FY 11-12 29.1%; 12-13 24.2%; FY 13-14 21.2%)

• By diagnosis – 30 day readmission range 4.8%-25.0%
  • Substance use 16.9%
  • Bipolar disorder 19.0%
  • Depressive disorder 16.7%
  • Schizophrenia 18.9%
FY 2015-2016 TD

• Overall 30 day readmission rates:
  – Butler inpatient units 13.9% (compared to last year TD 16.0%)
  – Kent inpatient units 19.4% (compared to last year TD 20.7%)

• Best practice – Quality metric of “closest local similar organization”
  – 10% readmission rate
Addressing Readmissions

- Reasons for Readmission Category added to psychosocial assessment - FY15
- Rounding Template – FY16
- Complex Care Rounds – FY16
- Utilization Review Committee meets twice a month - FY16
- Embedding Readmission Assessment Tool as well as HealthPath and Integra tools into the Psychosocial Assessment
- Shifted some SW hours for increased weekend coverage
- Working with CNE on patient education initiative around admissions
Morning Rounding Template

- Primary Diagnosis
- Patient’s current condition
- Symptoms requiring continued inpatient stay and short term treatment goals
- *If this is a readmission within 30 days, what needs to be addressed differently?*
- Plan for Medication Adjustments and other change in plans of care
- *Barriers in Transition Planning*
- Caregiver concerns
- *Is this an ACO or HealthPath patient? Is it a readmission?*
- Estimated Length of Stay
- Insurance
- Last Covered Night and Next Review Date
# Readmission Assessment Tool

<table>
<thead>
<tr>
<th>POINTS</th>
<th>Score all that apply below</th>
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</thead>
<tbody>
<tr>
<td>IP readmission within 30 Days (excludes medical send outs) (14 pts)</td>
<td></td>
</tr>
<tr>
<td>Current admission + 1 additional IP readmission or more in last 6 months (8 pts)</td>
<td></td>
</tr>
<tr>
<td>If the patient meets one of the readmission criteria above then continue with scoring of tool below</td>
<td></td>
</tr>
<tr>
<td>Pt has Chronic Medical Disease and has no PCP or not currently following up w/ PCP in the community (2 pts)</td>
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<tr>
<td>If this is a readmission within 6 months, has the patient been non-adherent with medications? (4 pts)</td>
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<tr>
<td>Hx of Poor Engagement: Failure to keep MH and/or SA follow up appts (4 pts)</td>
<td></td>
</tr>
<tr>
<td>Psychosocial Risk factors: __ homelessness or unstable housing, __no or low income/SSI, __lack of transportation, __poor social supports, __language/literacy barriers (2 pts each max 6 pts)</td>
<td></td>
</tr>
<tr>
<td>Substance abuse: actively using prior to admission or newly sober (4 pts)</td>
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<tr>
<td><strong>Total Score</strong></td>
<td><strong>14 pts or greater= High Risk for readmission</strong></td>
</tr>
</tbody>
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For High Risk patients offer follow up according to High Risk algorithm
## Reasons for Readmission by Percentage FY15

<table>
<thead>
<tr>
<th>Reason for Readmission</th>
<th>Within 7 days</th>
<th>Within 30 days</th>
<th>Within 90 days</th>
<th>Greater than 90 days</th>
<th>Missing Readmission Category</th>
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<tr>
<td>Worsening/Exacerbation of Symptoms</td>
<td>25.5</td>
<td>20.8</td>
<td>19.3</td>
<td>24.8</td>
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<td>Relapse</td>
<td>18.8</td>
<td>19.9</td>
<td>21.0</td>
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<td>18.6</td>
</tr>
<tr>
<td>Medication Non-Adherence</td>
<td>10.3</td>
<td>13.9</td>
<td>16.3</td>
<td>19.1</td>
<td>18.0</td>
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<tr>
<td>Inability To Maintain Sobriety</td>
<td>12.7</td>
<td>15.8</td>
<td>16.1</td>
<td>14.8</td>
<td>20.0</td>
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<tr>
<td>Failed To Keep Appointments</td>
<td>15.6</td>
<td>13.5</td>
<td>12.3</td>
<td>8.6</td>
<td>11.8</td>
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<tr>
<td>Homelessness</td>
<td>10.1</td>
<td>9.4</td>
<td>6.9</td>
<td>5.1</td>
<td>5.3</td>
</tr>
<tr>
<td>Access To Medication</td>
<td>1.0</td>
<td>2.5</td>
<td>2.4</td>
<td>3.4</td>
<td>3.2</td>
</tr>
<tr>
<td>Decline In Functioning</td>
<td>2.6</td>
<td>2.5</td>
<td>2.7</td>
<td>2.0</td>
<td>0.3</td>
</tr>
<tr>
<td>Refused Aftercare Appointments</td>
<td>2.4</td>
<td>1.0</td>
<td>1.8</td>
<td>1.2</td>
<td>1.6</td>
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<tr>
<td>Lack Of Social Supports</td>
<td>1.0</td>
<td>0.6</td>
<td>1.2</td>
<td>2.1</td>
<td>0.1</td>
</tr>
</tbody>
</table>
## Reasons for Readmission by Percentage FY16

<table>
<thead>
<tr>
<th>Reason for Readmission</th>
<th>FY 16 YTD</th>
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<tbody>
<tr>
<td></td>
<td>Within 7 days</td>
</tr>
<tr>
<td>Worsening/Exacerbation/Decline of Symptoms or Functioning</td>
<td>35.9</td>
</tr>
<tr>
<td>Inability to Maintain Sobriety/Relapse</td>
<td>20.0</td>
</tr>
<tr>
<td>Medication Non-Adherence</td>
<td>10.9</td>
</tr>
<tr>
<td>Failed to Keep Appointments</td>
<td>9.8</td>
</tr>
<tr>
<td>Homelessness</td>
<td>6.5</td>
</tr>
<tr>
<td>Access to Medication</td>
<td>1.8</td>
</tr>
<tr>
<td>Return after Medical Clearance</td>
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<tr>
<td>Refused Aftercare Appointments</td>
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<tr>
<td>Lack of Social Supports</td>
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</tr>
<tr>
<td>Medication Issues</td>
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<td>Transportation</td>
<td>0.4</td>
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</tbody>
</table>

* Data through May 2016/ Patients may have one or more reasons for readmission.
BlueCross and BlueShield of RI, Care New England, Butler Hospital and The Providence Center have come together, in partnership, with the objective of driving the State of RI and its more than 1 million residents closer toward the Triple Aim.

- Guided by a desire to create an open, honest partnership that delivers health solutions that are a win for our patients, our partners and our communities and ourselves
- Align incentives to support improved individual and public health and wellness outcomes
- Strive for highest quality of care, by using best practices and supported clinical and administrative solutions.
What is HealthPath?

• The nation’s first health home program for BCBSRI commercially insured and Medicare adults

• Clinical approach based on Assertive Community Treatment model

• Bundled monthly payment covers all services – including supportive services which have not traditionally been paid for on the commercial insurance side

• All enrollees are pre-approved for one year – with services from the program expected to last for 9-12 months
Model of Care

• Team-based treatment model that provides multidisciplinary, flexible treatment and support to people with mental illness 24/7.

• Care coordination & Wrap around services including psychiatry, case management, nursing, therapy, peer support, transportation, coordination with primary care and other medical specialties as needed.
Outcomes

**DLA Score Improvement**
- 53% significant improvement
- 31% improvement
- 16% no change

**Total Cost of Care**
- 8% Reduction in Behavioral Health Costs for HealthPath members
- Medical admissions increased

**ALOS & Readmission rates**
- Trending positively: slight decrease in ALOS for opt ins & Readmission rates were significantly lower for opt ins
ACO – Integra Community Care Network, LLC
Integra Behavioral Health Home Team

- Located on Butler Hospital grounds and began
- Run by Providence Center Staff
- Prescribing through Butler staff
- Work with ACO: Medicare Shared Savings Program (MSSP – Dual eligible) and Accountable Entity Patients (Managed Medicaid SPMI and Non-SPMI)
- Provide complete wrap around services to include: Therapy, Nursing, Psychiatry, Case Managers, Recovery Specialists, collaboration with Primary Care through Affinity
Integra Behavioral Health Home

• Daily ACO list for eligibility
• Integra screening tool done by SW and referral made to liaison
• HH team meets with patient while still inpatient for seamless transition
• As of June 10th: 48 active patients, 5 referrals pending, 3 inpatient readmissions
• Continued education planning for staff around ACO eligibility and referrals
Integra Chronic Care Management

• Multidisciplinary team providing care to high risk patients
• Weekly meeting with PC and Geriatrics
• Focus on advance care planning
• NP home visit program – extension of the primary care office
  • Prescribing power
Patient Story

- 65 year old man with chronic hepatitis C, cirrhosis, CHF, COPD living alone with minimal supports with chronic opioid overuse, chronic pain and depression.
- 8 episodes of care at Butler in 2 years
- Socially isolated, ongoing substance use
- Integra outreach – NCM, NP
Patient Story

• Discharged from Butler in March 2016
• No further ER or PAS episodes
• SW, NCM, NP in the home
• Transportation via the ACO to PCP, Suboxone provider and support services
Quality & Measures

• Publically Reported Quality Measures
  • Transition Record
  • 30 day all-cause re-admission (Medicare)

• Pay for Performance
  • Transition Record
  • 30 day all-cause re-admission (commercial payer)
  • HEDIS Follow-up 7 day and 30 day post-discharge

• Internal
  • HBIPS Transitions of Care

• Future
Quality & Measures

• Internal
  • CurrentCare (RI HIE) enrollment
  • Identification of PCP

• Future
  • Medication Reconciliation
  • Medication Adherence post-discharge
  • Outcome
  • Value Based Purchasing
Challenges

- Long stay patients – in/out from group home
- Need for transitional program to group home/community
- Limited community providers – Suboxone, geriatric psychiatry, child & adolescent psychiatry
Challenges

• Prior authorization requirements
• Statewide lack of transportation infrastructure
• Better treatment/recognition of BH issues in primary care and clear directory of services statewide so that primary care docs know who to call
  • they often say they don't screen because they don't know who to call for help when screen is positive).
Next Steps

• Patient & Family members
• Ongoing efforts in the community to “marry” home based services, BH services and primary care
Lessons Learned & Recommendations

• Involve community partners
References (additional)

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Mark Your Calendar
September 22nd

There’s No Place Like Home

Long Term Service and Supports (LTSS)
key partners enhancing transitions of care & enabling patients to stay in home of choice

Details will be share in Aug and posted on our website: http://www.healthcarefornewengland.org/