Preventing Avoidable Inpatient Admissions

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April 22, 2013
Goal of the NYS Care Management Training

To provide education, training, and ongoing support to care managers who are in transition of their workforce responsibilities in a way that utilizes their existing knowledge, skills and strengths so that individuals with complex needs can improve their health and wellness and realize their full potential.
Today’s Webinar Objectives

As a result of today’s webinar, HH CM will:

- Be familiar with key factors contributing to readmission rates
- Be familiar with best practice models which reduce readmission rates
- Connect key care management skills with reducing readmission rates
What Can We Do To Reduce Hospital Readmissions?

Scope of the Problem
Review of Literature
GNYA/HANYS/OMH Quality Collaborative
Summary of Findings
Reducing Readmissions: A National Quality Focus

Hospital readmissions are common and costly

- 19.6% of Medicare beneficiaries discharged were re-hospitalized within 30 days; cost to Medicare of unplanned readmissions estimated at $17.4 billion (Jencks, 2009)
- Up to 79% of readmissions are likely to be preventable (van Walraven, 2011)
- Medicaid enrollees aged 21-64 had 10.7% 30-day readmission rate (Healthcare Cost and Utilization Project (HCUP) Statistical Brief #89, 2010)
### 30-Day Readmission Rates by Major Diagnostic Category at Initial Hospital Stay for Medicaid Recipients Age 21-64, 2007

<table>
<thead>
<tr>
<th>MDC at 1st admission</th>
<th>Readmission rate</th>
<th>% of all non-obstetric readmissions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Circulatory System</td>
<td>10.4%</td>
<td>15.0</td>
</tr>
<tr>
<td>Mental</td>
<td>11.8%</td>
<td>12.0</td>
</tr>
<tr>
<td>Respiratory System</td>
<td>11.4%</td>
<td>10.7</td>
</tr>
<tr>
<td>Digestive</td>
<td>10.3%</td>
<td>9.6</td>
</tr>
<tr>
<td>Alcohol/Substance Abuse</td>
<td>13.0%</td>
<td>8.4</td>
</tr>
</tbody>
</table>

Among 15 states, behavioral health discharges ranked among the top 5 diagnostic categories for 30-day readmissions.

Agency for Healthcare Research and Quality (AHRQ) Health Care Utilization Project Statistical Brief #89, 2010
# Potentially Preventable Readmissions (PPR), NYS Medicaid Program (2007)

<table>
<thead>
<tr>
<th>Recipient Health Condition</th>
<th>PPR Rate</th>
<th>Total PPR Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental Health</td>
<td>8.0</td>
<td>$202,842,118</td>
</tr>
<tr>
<td>Substance Abuse</td>
<td>10.3</td>
<td>$90,714,989</td>
</tr>
<tr>
<td>Mental Health and Substance Abuse</td>
<td>17.9</td>
<td>$370,272,653</td>
</tr>
<tr>
<td>All Others</td>
<td>4.8</td>
<td>$149,116,486</td>
</tr>
<tr>
<td>Total</td>
<td>9.4</td>
<td>$812,946,246</td>
</tr>
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New York State (NYS) Dept. of Health, Division of Quality and Evaluation, Office of Health Insurance Programs, Statistical Brief #3
# Reasons for Admission for WRBHO Complex Cases

<table>
<thead>
<tr>
<th>Reason for Admission</th>
<th>All Complex Cases (231 reasons offered for 183 cases in Total)</th>
<th>Complex Readmission Cases (121 reasons offered for 86 cases in total)</th>
<th>Variance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Substance Use (For both SUD as well as MH admissions)</td>
<td>28%</td>
<td>24%</td>
<td>+4%</td>
</tr>
<tr>
<td>Medication Non-Adherence</td>
<td>19%</td>
<td>14%</td>
<td>+5%</td>
</tr>
<tr>
<td>Lack of Engagement with Outpatient Provider</td>
<td>18%</td>
<td>21%</td>
<td>-3%</td>
</tr>
<tr>
<td>Increased Symptomatology without Precipitant Noted</td>
<td>12%</td>
<td>16%</td>
<td>-4%</td>
</tr>
<tr>
<td>Homeless</td>
<td>5%</td>
<td>7%</td>
<td>-2%</td>
</tr>
<tr>
<td>Legal Issues</td>
<td>3%</td>
<td>6%</td>
<td>-3%</td>
</tr>
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</table>
Index stays for BH were most likely to be followed by readmission.

- More than 21% of patients admitted with a BH diagnosis were readmitted within 30 days
- Diagnosis of schizophrenia had a 23% readmission rate
- Diagnosis of Bipolar had a 20% readmission rate
- Diagnosis of MDD/other psychosis had a 18% readmission rate
- Diagnosis of Opioid dependence/abuse had a 26% readmission rate
Review of the Literature

1. Enhanced care and support during transitions
2. Improved patient education and self management support
3. Multidisciplinary team management
1a. Improved Discharge Processes: Transitions

- Project RED
- Care Transitions Interventions
- Transitions Navigator
- Transitional Care Model
Project RED
(Re-Engineered Discharge)

- Assignment of a nurse discharge advocate
- Works during hospitalization to do patient education, arrange post-acute follow up, medication reconciliation, prepare individualized discharge instruction booklet
- Call from pharmacist 2-4 days post discharge
- Reduced subsequent hospitalizations (ED/admission) within 30d 30%

Project RED: Key Activities

- Educate patient about diagnosis throughout the stay
- Organize post-discharge services, make all appointments
- Confirm medication plan, reconcile with guidelines
- Give patient written discharge plan
- Assess patient’s understanding of the plan
- Review what to do if a problem arises
- Expedite transmission of discharge summary to outpatient providers
- Call two to three days post discharge to reinforce plan, problem-solve
Care Transitions Interventions

- Care Transition Coach teaches patients with complex conditions
  - how to manage their medications
  - how to set up and prepare for follow-up appointment
  - how to respond if their illness worsens
  - how to ask questions about their illness

- Reduced 30 day readmission by 30%
Transitions Navigator

- Transitions Navigator
  - Coordinated any needed outpatient care
  - Followed up with patient’s outpatient provider
  - Assured that the patient and family understood the diagnosis, treatment and discharge plan

- 30-day readmission rate was 23% less than the hospital’s overall readmission rate (11.5% vs. 15%)

University of Utah Health Care
Transitional Care Model

- Transitional Care Nurses work as nurse, case manager and patient advocate
- Provides comprehensive in-hospital planning and home follow-up for high risk adults
Successful Transitions

Characteristics

- Communication tools
- Patient activation
- Nurse-led coaching
- One-hour education sessions
- Telephone outreach
- Comprehensive discharge planning
- Home follow-up visits

(Chiu 2007)
Enhanced Communication between inpatient and outpatient services

- User-friendly discharge form shared with patient and sent electronically to outpatient office nurse who called to review plan
- Outpatient physician modified the plan as needed


Use of Peer Advocates

- Inpatient psychiatric staff continue to work with a patient until working relationship with an outpatient provider was established
- Reduced readmission within 5 mo by 50%

1b. Early Post-Discharge Follow-up

A high percentage of re-hospitalizations occur in the days to weeks following discharge

- Crucial time period is first 2-3 weeks (Anderson 1999)
- 35% of patients had at least one re-hospitalization within 2-14 weeks (Li 2004)
- National Medicare study found 50% of patients discharged who were readmitted within 30 days had no outpatient visit (Jencks 2009)
Follow Up Reduces Re-Hospitalization

Reviewed 18 studies covering 3000 patients

- All studies included “comprehensive discharge planning” (medication review and anticipatory guidance on discharge)
- Other elements included: single home visit, frequent phone follow up or both

These interventions reduced re-hospitalization by 25% overall

1c. Patients with Medical Conditions

Benefit from:

- Front-loaded home care visits
- Remote monitoring
- Enhanced patient education
- Home visit by pharmacist
2a. Patient Education & Self-Management Support

Educational interventions included

- A variety of modalities and services
- Provided across a variety of settings, but generally inpatient
- Ranged from encouraging active self-management to symptom education

Among individuals with schizophrenia, symptom education was associated with a reduction in 90-d readmission from 36% to 22%  
Prince 2006
2b. Case Management

Evercare Intervention

- Medicare patients were segmented into 4 risk strata with different levels of intensity of NP follow up
- Each NP had a case load of 100 within a geographic area
- 2004 analysis found a significantly lower average number of hospital admissions/100 enrollees

Kane 2004

Showed ICM was associated with statistically significant reductions in hospitalizations for patients with serious mental illness over a 1-year follow up

Most Effective Interventions

- Enhancing patient self-care
- Telephone contact
- Patient education
- Proactive review of care needs
Western Regional Behavioral Health Organization Experience

Primary system level barriers to care coordination
Primary System Level Barriers to Care Coordination

In answering this question, we reviewed:

- WRBHO performance data
- Feedback from stakeholders during past BEST Meetings
- Conversations now taking place with facility leadership (Case Conference Conversations)

Categories of Barriers:

- System Level Culture & Values
- Communication across the System
- Resources
Primary System Level Barriers to Care Coordination

Barrier Category- System Level Culture & Values:

- Not believing in **recovery** as a real goal or opportunity for the individual.
- Not believing that addressing the **needs of the whole person** is their job.
  - In only 48% of the time did the provider follow up when a PH need was identified
  - When asked, staff indicate that they do not believe it to be their job
- Tendency to **stereotype** people after multiple admissions and not thinking outside of the box for a new solution.
  - Observed in the lack of change in discharge plan from one admission to the next for those with multiple readmissions
- Reliance on State Psych Beds when **community-based solutions** should be considered.
  - Q4- 22% if the Long Stay Cases were awaiting a State Psychiatric bed
  - State plans to down-size State psychiatric hospital system
Primary System Level Barriers to Care Coordination

Barrier Category- Communication across the System:

- Lack of effective systems for cross-systems linkages specific to those dually diagnosed: MH and SUD and well as MH and OPWDD.
  - Stakeholders routinely share this concern during BEST Meetings as well as during case reviews

- Lack of communication between the inpatient and outpatient programs including MD, discharge planners, and others.
  - Feedback shared during BEST Meeting small group conversations tied to improving access to and acceptance of after care supports.

- Changing medications as the individual moves from an outpatient to inpatient service and not having effective process for communicating the with individual (as well as their outpatient provider) the reasons for the change.
  - Seen as root cause for medication management issues identified by individuals
Primary System Level Barriers to Care Coordination

Barrier Category - Resources:

- Lack of resources to move the individual to the next level of care
  - 31% of the WRBHO Long Stay Cases in Q4 resulted from waiting for residential services
- Lack of Peer Transition Coach resources
  - Feedback from those organizations positioned to provide Peer Transition Coach resources indicate lack of funding to do so.
- Lack of stable housing
  - 45% of the individuals homeless at admission did not see an improvement in their housing status at the time of discharge
GNYHA/ HANYS/ OMH Quality Collaborative: Reducing Behavioral Health Hospital Readmissions

Molly Finnerty, MD
Edith Kealey, MSW
Kate M. Sherman, LCSW
The Learning Collaborative Model

Hospitals work together toward a common goal

• Conduct continuous quality improvement project
• Identify and share successful strategies
• Promotes rapid adoption of best practices

Background

• Institute for Healthcare Improvement (IHI) model
• HANYS/ GNYHA have used in medical/surgical areas
• First behavioral health collaborative last year
Hospital Activities: Form Quality Improvement Team

- Leadership / medical “champion” is key
- Project leads from relevant programs
- Interdisciplinary
- Data manager – crucial for monitoring / reporting
Hospital Activities: Continuous Quality Improvement (CQI)

Select program(s) to participate

• Flexible, but inpatient participation recommended
• Inpatient, outpatient, emergency
• Psychiatry, detoxification, substance abuse rehabilitation

Select one or more strategies

• Maximum flexibility
• May be different for different programs, but coordinated effort is more manageable
• Should support key indicator: inpatient readmissions
Hospitals Report Monthly

All hospitals report on inpatient admissions:
- Number of inpatient admissions
- Number of these known to be a readmission (based on their own data)

Number of clients screened for high risk
- Number of clients on census at high risk of readmission
- Interventions delivered

All Hospitals report on implementation milestones:
- CQI team established
- PSYCKES access for staff
- Settings selected (e.g. inpatient units, ER, outpatient)
- Strategies selected
- Core activities implemented (screening, etc.)
CQI Project: Implement Core Activities

Identifying clients individuals risk factors for readmission
- Screening tool
- PSYCKES
- BHO data

Addressing readmission risk factors

Improving transitions in care
- Inpatient/Emergency Department (ED): optimizing discharge planning process
- Checklist in development
- For outpatient: referrals, coordination of care
## Select Capacity Building Goals/Strategies

### Goal 1: Improve medication practices.

<table>
<thead>
<tr>
<th>Medication Practice</th>
<th>Emergency</th>
<th>In-patient</th>
<th>Out-patient</th>
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<tbody>
<tr>
<td>Increase use of depot medications</td>
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<td>√</td>
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<tr>
<td>Increase use of clozapine</td>
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<td>√</td>
<td>√</td>
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<tr>
<td>Clinical interventions to improve adherence</td>
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### Goal 2: Improve engagement in outpatient care.

<table>
<thead>
<tr>
<th>Engagement Method</th>
<th>Emergency</th>
<th>In-patient</th>
<th>Out-patient</th>
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</thead>
<tbody>
<tr>
<td>Case Management, Assertive Community Treatment, Assisted Outpatient Treatment, Health Home</td>
<td>√</td>
<td>√</td>
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<tr>
<td>Peer services</td>
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<tr>
<td>Clinical interventions to improve adherence</td>
<td>√</td>
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### Goal 3: Improve delivery of integrated treatment for psychiatric and substance use disorders.

<table>
<thead>
<tr>
<th>Integrated Treatment</th>
<th>Emergency</th>
<th>In-patient</th>
<th>Out-patient</th>
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</thead>
<tbody>
<tr>
<td>“Focus on Integrated Treatment”</td>
<td>√</td>
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</table>
Factors Predicting Readmission
A Conceptual Model for Examining Readmissions

Figure 1 Conceptual model of the determinants of preventable readmissions.

Vest et al., 2010
Research on BH Readmissions: Challenges

• No standard definition of time period: as long as two years

• Varying populations and treatment settings: few studies done for youth, co-morbid mental health and substance use

• Varying methods: matched control, prospective cohort, retrospective review of administrative data

• Unclear how previous research applies in evolving healthcare environment
Key Factors in BH Readmissions: Previous Hospitalizations

Multiple studies have found an association between previous inpatient admission and readmission

- Prospective cohort study of 262 adult inpatients with schizophrenia found those readmitted within three months more likely to have had four or more previous hospitalizations (Olfson et al., 1999).

- Retrospective study of 1,481 patients found number of previous admissions predicted readmission within six months (Thompson et al., 2003).

- Prospective cohort study of 319 adult inpatients found number of previous psychiatric hospitalizations predicted readmission during eighteen-month follow-up (Klinkenberg & Calsyn, 1998).

- Prospective cohort study of 233 high utilizing psychiatric inpatients found number of inpatient days in previous year predicted readmission within two years (Bowersox et al., 2012).
Key Factors: Medication Non-Adherence

- Cohort study of 477 patients with schizophrenia found those readmitted to inpatient within six months had an average of 2.7 medication refills compared to 6.8 refills in those not re-hospitalized. (Laan, 2010)

- Retrospective analysis of Medicaid claims for 4,325 outpatients with schizophrenia found any gap in antipsychotic medication was associated with increased risk of hospitalization, with gaps as small as one to ten days associated with an Odds Ratio of 1.98 and gaps greater than 30 days with an Odds Ratio of 3.96. (Weiden, 2004)
Key Factors : Engagement in Outpatient Services

• Retrospective review of 3,113 inpatients found that those without an outpatient appointment after discharge were twice as likely to be re-hospitalized in the same year compared to those with at least one outpatient appointment (Nelson, 2000)

• Retrospective analysis of 22,054 people in three states found those who attended two or more appointments after inpatient detoxification were less likely to be readmitted within twelve months and had longer time until second inpatient detoxification (Mark, 2008)
Key Factors:
Substance Use

• Prospective cohort study of 262 adult inpatients with schizophrenia found those readmitted within three months were significantly more likely to have comorbid substance use disorder. (Olfson et al., 1999)

• A study of 50 Medicaid inpatients at high risk for readmission identified substance use or related conditions as the most common reason for admission. (Raven et al., 2008)
Strategies to Reduce Behavioral Health Re-admissions
Priority Goals for Re-admissions Quality Collaborative

1. Improve medication practices
2. Improve engagement in outpatient care
3. Improve delivery of integrated treatment for co-occurring psychiatric and substance use disorders
Goal 1: Improving Medication Practices
Strategies to Improve Medication Practices

• Increase use of depot medications

• Increase use of clozapine (not planning to discuss today)

• Increase medication-assisted alcohol treatment

• Facilitate medication fill upon discharge

• Implement clinical interventions to increase treatment adherence
Use of Depot Medications

- Systematic review of ten studies with 1,700 participants found that significantly fewer on depot antipsychotics relapsed relative to oral medication (Risk Ratio=0.70, 95% Confidence Interval (CI) = 0.57-0.87). (Leucht et al., 2011)

- Retrospective analysis of 2,588 patients with schizophrenia in Finland found the risk of rehospitalization among those receiving depot antipsychotics was one-third (Adjusted Hazard Ratio=0.36, 95%, CI=0.17-0.75) compared to patients on oral medication. (Tiihonen, 2012)
Medication-Assisted Alcohol Treatment

• Secondary data analysis of claims for 20,752 patients found use of a Food and Drug Administration (FDA) approved medication for alcohol dependence is associated with reduced readmissions and cost. (Baser, 2011)

• Secondary analysis of claims data for 11,515 individuals with Alcohol Use Disorder (AUD) found those on Naltrexone XL (n=211) had lower non-pharmacy costs and utilization of acute services compared to Acamprosate, Disulfiram, oral Natrexone and psychosocial treatment. (Bryson, 2011)
Other Clinical Interventions

Retrospective analysis of secondary data for 861 individuals with first hospitalization for schizophrenia or schizoaffective disorder (DO) found that individuals without a fill of antipsychotics within one week post-discharge were 75% more likely to have a readmission within 28 days (Boden et al., 2011), suggesting opportunity for improvement by providing medications on discharge.
Goal 2: Improving Engagement in Outpatient Care
Strategies to Improve Engagement in Outpatient Care

- Determine whether clients at risk are assigned to care management or other intensive services, connect those with existing services, and refer those who are not

- Implement peer services that contribute to reducing readmissions

- Implement clinical interventions to increase treatment adherence
Assertive Community Treatment (ACT)

• Cochrane Review (1998) found that ACT clients were less likely to be admitted to the hospital than those receiving standard community care (Odds Ratio=0.59, 99%CI 0.41-0.85).

• In a prospective trial with 144 people, clients receiving ACT team care had a significantly reduced rate of re-hospitalizations (Salkever, 1999)
Intensive Case Management

- Cochrane Review (2010) concludes intensive case management reduces hospitalizations and increases engagement in outpatient care compared to standard care and non-intensive case management, particularly for individuals with high levels of hospitalization.

- Retrospective secondary data analysis of 164 clients found that clients assigned to Intensive Case Management (ICM) had fewer periods of hospitalization (longer community tenure) than those assigned to Case Management (CM). (Kuno et al., 1999)
Assisted Outpatient Treatment (AOT)

- Consumers who received court orders for AOT appeared to experience a number of improved outcomes: reduced hospitalization and length of stay, increased receipt of psychotropic medication and intensive case management services, and greater engagement in outpatient services. (Swartz, 2010)

- Increased medication adherence and reduced readmissions continued after the end of the AOT order if it was for at least seven months. (Van Dorn, 2010)
Peer to Peer Services

- In a randomized trial of peer mentor versus usual care for individuals currently hospitalized with major mental illness and three or more hospitalizations in previous eighteen months, those randomized to peer mentorship (n=38) had fewer re-hospitalizations and fewer hospital days than those in usual care (n=36) at 9-month follow-up post-discharge. (Sledge, 2011)

- Longitudinal comparison group study of people with co-occurring Substance Use Disorder (SUD) and Mental Illness (MI) found those who participated in a peer support program (n=106) had lower dropout rates and readmissions than the treatment as usual group (n=378) (Min, 2007)
Other Clinical Interventions

- Randomized trial of 121 psychiatric inpatients showed that adding a one hour motivational interview prior to discharge was significantly associated with attendance at first outpatient appointment compared to Treatment as Usual (Swanson, 1999)

- Cognitive behavioral group therapy was introduced on an inpatient unit, with subsequent significant reductions in readmissions from 38% to 24% for patients with schizophrenia and bipolar disorder (Veltro, 2008)
Goal 3: Improving Delivery of Integrated Treatment for Psychiatric and Substance Use Disorders
IDDT Examples

• Randomized control trial of 129 clients with severe psychotic or affective disorders and drug dependence found those enrolled in a six month intervention including motivational interviewing and social skills training had lower rates of re-hospitalization vs. manualized control. (Bellack, 2006)

• Retrospective pilot study of 44 clients receiving 24 weeks of integrated dual-diagnosis treatment found a 60% reduction in inpatient days in the year after treatment compared to the previous year. People with schizophrenia had a 74% reduction in hospital days. (Granholm, 2003)
## Strategies by Settings

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<thead>
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| Goal 2: Improve engagement in outpatient care. | | | |
| CM, ACT, AOT and/or Health Home | √ | √ | √ |
| Peer services | | | √ |
| Clinical interventions to improve adherence | √ | √ | √ |

| Goal 3: Improve delivery of integrated treatment for psychiatric and substance use disorders. | | | |
| “Focus on Integrated Treatment” | √ | √ | √ |
Core Project Activities

- **Case finding:** Implement admission protocol to identify clients at risk of readmission, using Screening Tool and/or PSYCKES data.

- **Identify and address risk factors:** Assess for risk factors and implement policy that identified risks for readmission are addressed explicitly on treatment plan and discharge plan.

- **Optimize discharge process:** Implement a protocol or checklist to ensure best practices in discharge planning, including procedures for bridging time between discharge and first outpatient session. Coordinate discharge planning efforts with the Behavioral Health Organizations (BHOs).
Using Technology to Support Improved Client Outcomes

mPower Project-Loyola
- mPOWER: Mobile Patient Opportunities for Wellness, Empowerment and recovery
- Bundled, evidence based care and integration strategy combining cutting edge technology in, smartphone recovery support, pharmacological recovery support, trauma support and peer support.

MyChart-URMC/Strong
- A secure patient portal to outpatient information stored in eRecord.
- It is not the patient’s legal medical record, and is considered a convenience.
- Piloted in May 2011 and launched for all patients May 2012.
- Currently utilized by 46,000 patients.
Summary of 5 Interventions found at 4 Hospitals

- Invest in quality first: care for patients correctly and readmission rates fall
- Use HIT to improve quality and integrate care across settings
- Begin care management and discharge planning early, target high-risk patients and ensure frequent communication across the care team
Summary

- Educate patients and their families in managing conditions. Teach at a level appropriate to patients and ensure they understand and can teach back key instructions.
- Maintain a “lifeline” with high-risk patients after discharge through telephone calls, other practices.
- Improve medication practices.
- Improve engagement in outpatient care.
- Improve delivery of integrated treatment for co-occurring psychiatric and substance use disorders.
Health Home Care Management: Managing Transitions

Starting at admission, the care manager collaborates with inpatient staff to optimize the transition.
Effectiveness of care transitions…

The presence of a single clinician/care manager who is taking responsibility for coordination across the continuum of the person’s overall healthcare, regardless of setting.
Easing anxiety/concern during transitions…

- An understanding of (and preparation for) the self-care role in the next setting
- **Consistent advice** from all care providers
- A sense of safety/support attributable to the ability to contact an appropriate healthcare practitioner for guidance as necessary

***Caregiver’s strong regard for the preferences of the person/family being served. Seeing these preferences in the discharge plan***
“Patient Activation” and Promoting Self Management

Empowerment-providing tools and tips that will help the person understand and manage his/her conditions

Happens when folks are sharing experiences with others and providing support
What could benefit the person you are serving?

- Skills to deal with frustration, fatigue, pain, isolation, insomnia, anger-symptoms that go across many disease processes
- Activity/exercise
- Using medications as prescribed
- Communication skills (how to speak with health care providers, family, social supports)
- Being open to trying new interventions
"The best way to predict the future is to create it."
-Peter Drucker
As the plan is developed...

Question to ask yourself:

Is this plan supported by best practices?
Best Practice: Engagement

Think about how you begin the relationship…do you start with a consultation that leaves the person in a passive role—thus, compromising engagement?

What influences your engagement in a new situation and whether you will return?

- *Desire or goals*: what are you looking for
- *Importance*: how much of a priority is it
- *Positivity*: do you feel good about the experience? Do you feel welcomed, valued and respected?
- *Expectations*: What do you think will happen and does it happen?
- *Hope*: Do you believe that it will help you?
Best Practice: Person Centered Thinking

**Important “To” the person**
Things that resonate with the person regarding:
- Values and ideals
- Personal preferences
- Interests
- Talents
- Dreams and aspirations

**Important “For” the person**
Things that must be kept in mind regarding issues of:
- Health and safety
- What is needed to be a valued member of his or her community of choice
Best Practice: Motivational Interviewing

Conversations about Change
- Guide, Follow, Direct

The Spirit of MI
- Partnership
- Acceptance—absolute worth, accurate empathy, autonomy support and affirmation
- Compassion
- Evocation—“that which is already present” not “installing what is missing"

The Method of MI:
- Asking open-ended questions, Affirming, Reflecting, Summarizing
- In addition: Providing information and advice with permission
Remember: MI and Discord

- In MI discord is viewed as a relationship issue (it is not ‘blamed” on the person being served)
- It is about how we engage the person in dialogue, the words we choose, the spirit in which we approach the relationship
Best Practice: Illness Recovery

- Test results
- Services that were provided during inpatient stay
- Discharge medications
- Any pending information such as test results that are not yet available at time of admission
- Information/education that has been provided to the person/family
- The wellness/recovery activities for which the person/family will be responsible after discharge
Best Practice: Care Manager Transitions

- Focus on the coaching role during the transition
- Coach the service recipient and family and/or social supports in self management
- Value and promote collaboration with other care providers
Best Practice: Focus on Discharge Outcomes

- The ability of the service recipient and his/her social supports to manage medication
- A comprehensive record of care that is available to all providers of care…that belongs to the service recipient
- The service recipient getting to **timely** outpatient appointments following discharge from inpatient
- Knowing the “red flags” that indicate worsening of conditions—knowing how to respond!!
What else?

- Visiting the person in his/her own home/temporary housing and assessing current status (whenever possible, within 24-48 hours of discharge)
- Collaborating with pharmacy, specialty services etc
- Managing care across conditions, providers, sites of care (face to face, telephone, Email, text)
- Promoting disease management
- Promoting self management
- Promoting wellness activities
- Supporting lifestyle modification (we will talk about this later…Motivational Interviewing)
- Engaging family/friends/chosen social support system in the process
- Social service assistance
- Adequate nutrition (cost, availability-check the kitchen!)
- Social activities
- Transportation
Effective Negotiation: Why do we want to focus on this topic?

- Cost effective
- Efficient
- Improves care
- Creates more satisfying work
Negotiation Requires…

- Purposeful information sharing
- Joint responsibility for services (care) and outcomes

It is helpful to remember that even one encounter with another care provider can leave a lasting impression.
Effective Negotiation/Collaboration

- Occurs both face to face and electronically
- Involves an exchange of ideas/approaches
- Benefits from mutual respect
- Requires trust and persistence
- Can be difficult

AND

- Results in better outcomes for the person served and supports personal growth for the clinicians
What can you do to enhance effectiveness of collaboration?

1. Demonstrate professional maturity: keep learning, seek to understand best practice, keep skills current

2. Understand the perspective of others: value the other perspective…then our solutions will be more creative; understand the values and motivations of other clinicians
Burn out interferes with negotiation

Avoid “burn-out”:

Recognize what can happen when we get close to the suffering of others, utilize self-care strategies
Negotiation Requires

Intentional team-building:

- Development of a shared meaning
- Building of trust
- Engaging in respectful negotiation
- Management of disagreement
- Mentoring each other/ being a role model
- Being assertive
Next Steps

- Please share your feedback via the webinar survey.
- Log on to the NYS Care Management Training Initiative website to review additional resources at www.healthhometraining.com
- Have conversations with your supervisor and co-workers regarding common practices described in today’s webinar.
Questions