

HealthierHere

The Accountable Community for Health of King County

# Project Workgroup: Transitional Care – Mental Illness/Substance Use

May 7, 2018



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# Care Transitions from Psychiatric Facilities

## Project Goal

**Immediate:** Implement the Peer Bridger and Transition Support Program care transitions models, demonstrated by real time identification of patients at high risk of readmissions, early notification of patient and partners of planned discharge, provision of written transition plan, timely completion of the discharge summary, and initiation of a 30-day transition of care period with the behavioral health specialist and PCP that includes updates post hospitalization for individuals transitioning from inpatient psychiatric settings.

**Long-term:** Reduce potentially preventable emergency room visits and potentially preventable readmissions.

## Focus Populations

Medicaid beneficiaries with serious mental illness or substance use disorder discharged from inpatient care, including psychiatric inpatient facilities and psychiatric units in hospitals who are at high risk of readmission.

## Interventions

The Peer Bridger Program is a community/home-based outreach service which is designed to provide short term community support for King County residents (over 18 years of age). This program provides services to individuals to support their recovery as they transition from inpatient psychiatric services back into the community and reduce future readmissions in collaboration with partners cross the continuum of care. All services are provided under the direction of an MHP (Mental Health Professionals) and include Recovery Navigators and Peer Recovery Coaches.

The Peer Bridger Program services are based in recovery principles and focus on the values of hope, choice, empowerment, and wellness.

- Training in the Peer Bridger model and in trauma-informed care, crisis intervention, and motivational interviewing provider to Peer Support/Recovery Coach staff.
- Peer Bridgers are sited within the hospital setting.
- Peer Bridgers work collaboratively within the clinical teams with the goal of utilizing the same Peer Bridger to work with participants both in the hospital and post discharge.
- Peer Bridgers work with people up to 90 days post discharge.
- Peer Bridger staff have access to a “slush fund” for basic services and essential needs such as bus passes, cell phones, clothing, food, engagement activities, etc.

Once discharge takes place, the range of services provided by Peer Bridgers is customized to the individualized need of the participant and could include temporary case management until the participant is successfully connected with outpatient services.

Peer Bridges will:

- Assist participants to feel like someone is truly on their side, who will advocate for them and help them overcome overwhelming stressors in their lives.
- Learn how to observe limits with themselves and other people.
- Demonstrate that recovery is possible for clinical staff through their own success stories and professionalism –increasing the adoption of recovery principles across the disciplines Model compassionate, open relationships that inspire hope.
- Bring the participant perspective to the team and help to communicate and explain clinical strategies back to the participant.
- Advocate for the participant and challenge staff to consider alternative perspectives.
- Assist with the discharge planning process.
- Focus first on the crisis needs –hope begins to emerge as overwhelming tasks begin to be systematically addressed.
- Sit in on intake sessions with case managers and psychiatrists.
- Help people:
    - Connect with, (and successfully utilize) their outpatient services
    - Recognize their own strengths and develop personal goals
    - Learn about their medications (obtaining and effective use)
    - Develop and utilize natural supports
    - Learn time management skills
    - Navigate complex social service systems
    - Obtain housing
    - Follow-up with obtaining and understand their benefits
    - Connect with recovery communities (12-step, CD treatment, etc.)
    - Cope with life changes (diagnosis, loss, homelessness, etc.)
    - Learn to tolerate challenging living situations (shelters, streets, families, etc.)
    - Practice skills learned while in the hospital (DBT, CBT, WRAP, etc.)
    - Learn self-advocacy
    - Learn and start to practice recovery principles

Providers and Hospitals will be responsible to:

- Inpatient Psychiatric Providers (including hospitals and Evaluation and Treatment facilities):
    - Identify high risk patients to reduce potentially preventable readmissions and emergency room visits.
    - Ensure engagement/reengagement in behavioral health treatment.
- Hospitals:
    - Establish relationships and partnerships with community providers that employ trained Peer Bridgers.
    - Ensure appropriate Peer Bridger staff are included in discharge planning and transitional care services.
    - Identify community-based providers, including health homes, as partners in providing transitional care to high risk patients. Medicaid patients will be considered high risk and receive the 90-day transition support if they meet any or all of the high-risk criteria:
        - Readmitted within 30-days of a previous psychiatric hospitalization.

        - History of 2 or more psychiatric hospitalizations (inpatient or observation) in the past 12 months.
        - Any chronic medical condition comorbidity.
        - Unmet social needs identified via a social needs screen within 24 hours of admission.
    - Notify patients and Peer Bridger providers of planned discharge no later than 48 hours in advance.
    - Identify high risk patients early and provide early notification of planned discharge to avoid adverse events upon discharge.
    - Assist patients in obtaining a primary care provider and a behavioral health provider (if they don't have one) prior to discharge, preferably by the patient's care team.
    - Allow the Peer Bridger provider to visit the patient prior to discharge to provide care transition services (If approved and properly credentialed/onboarded by the hospital).
    - Provide patient with a written TOC plan prior to discharge that includes a reconciled medication list, follow up appointment, and patient self-education (written at an appropriate health literacy level).
    - Complete the discharge summary within 48 hours of discharge and transmit or otherwise made available to all outpatient treatment members, including the behavioral health provider and the PCP as described in the TOC Model.

## Metrics

**Patient Engagement Metric**

*The number of participating patients who receive discharge instructions that include patient self-education, medication reconciliation, and follow-up appointments, prior to discharge.*

**Clinical Metrics**

- All-Cause Readmission Rate (30 Days)
    - Among Medicaid beneficiaries age 18-64 years old, the percent of acute inpatient stays during the measurement year that were followed by an unplanned acute readmission within 30 days.
- Inpatient Hospital Utilization
    - For members 18 years and older, the risk-adjusted ratio of observed to expected acute inpatient discharges during the measurement year.
- Follow-up After Emergency Department Visit for Alcohol or Other Drug Dependence
    - The percent of discharges for members 18 years and older who had a visit to the ED with a primary diagnosis of alcohol or other drug dependence during the measurement year AND who had a follow-up visit with any provider with a corresponding primary diagnosis of alcohol or other drug dependence, reported separately for follow-up within 7 and 30 days after discharge.
- Follow-up After Emergency Department Visit for Mental Health
    - The percent of discharges for members 18 years and older who had a visit to the ED with a primary diagnosis of mental health during the measurement year AND who had a follow-up visit with any provider with a corresponding primary diagnosis of mental health, reported separately for follow-up within 7 and 30 days after discharge.

- Follow-up after hospitalization for Mental Illness
    - The percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental illness diagnoses and who had an outpatient visit, an intensive outpatient encounter or partial hospitalization with a mental health practitioner, reported separately for follow-up within 7 and 30 days of discharge.
- All Cause Emergency Department Visits per 1000 Member Months
    - The rate of Medicaid beneficiary visits to emergency department per 1000 member months, including visits related to mental health and substance use disorder, reported for three age groups: 10-17 years, 18-64 years, and 65 years and older.
- Percent Homeless (Narrow Definition)
    - The percentage of Medicaid enrollees who were homeless in at least one month in the measurement year. Excludes "homeless with housing" living arrangement code within the DSHS database ACES, reported for three age groups: 0-17, 18-64, and 65 and older.
- *30-day Psychiatric Inpatient Readmissions
    - For members 18 years of age and older, the number of acute inpatient psychiatric stays that were followed by an acute readmission for a psychiatric diagnosis within 30 days.
- *Substance Use Disorder Treatment Penetration
    - The percentage of members with a substance use disorder treatment need who received substance use disorder treatment in the measurement year. Separate reporting for three age groups: 12-17 years, 18-64 years, and 65 years and older.
- *Mental Health Treatment Penetration (Broad Version)
    - The percentage of members with a mental health service need who received mental health services in the measurement year. Separate reporting for three age groups: 6-17 years, 18-64 years, and 65 years and older.

*Metrics in addition to Healthier Washington pay for performance metrics for this project

# Evidence-Based Approaches: Transitional Care

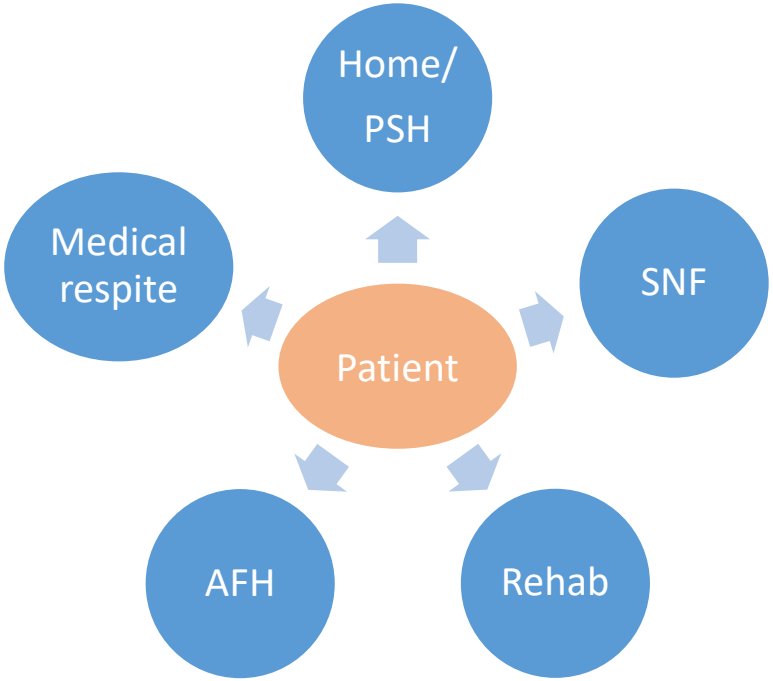
| Evidence Based Approach | Model Target Population | Model Description |
|---|---|---|
| **A Best Practice Approach to Community Re-entry from Jails for Inmates with Co-occurring Disorders (APIC)** | Target Population #: 1<br>Medicaid members returning to the community from **prison or jail.** | Set of critical elements (Assess, Plan, Identify, Coordinate) that are likely to improve outcomes for person with co-occurring disorders who are released from jail. |
| **Peer Bridger Program** | Target Population #2:<br>Medicaid members with **serious mental illness or substance use disorder** discharged from inpatient care, including psychiatric inpatient facilities and psychiatric units in hospitals. | Peer Bridger is a community/home-based outreach service designed to be short term community support. Peers are state-certified Peer Support Specialists who have lived with mental illness or substance use and are in recovery. |
| **Care Transitions Intervention/Coleman Model** | Target Population #3:<br>Adults and people with disabilities **transitioning from inpatient care and long-term care facilities** who could benefit from the Care Transitions Intervention, also known as the Coleman Model. | The Care Transitions Intervention® is also known as the Coleman Model® and is a 4-week program where patients, with complex care needs, and family caregivers receive specific tools and work with a Transition Coach to learn self-management skills that will ensure their needs are met during the transition from hospital to home. |

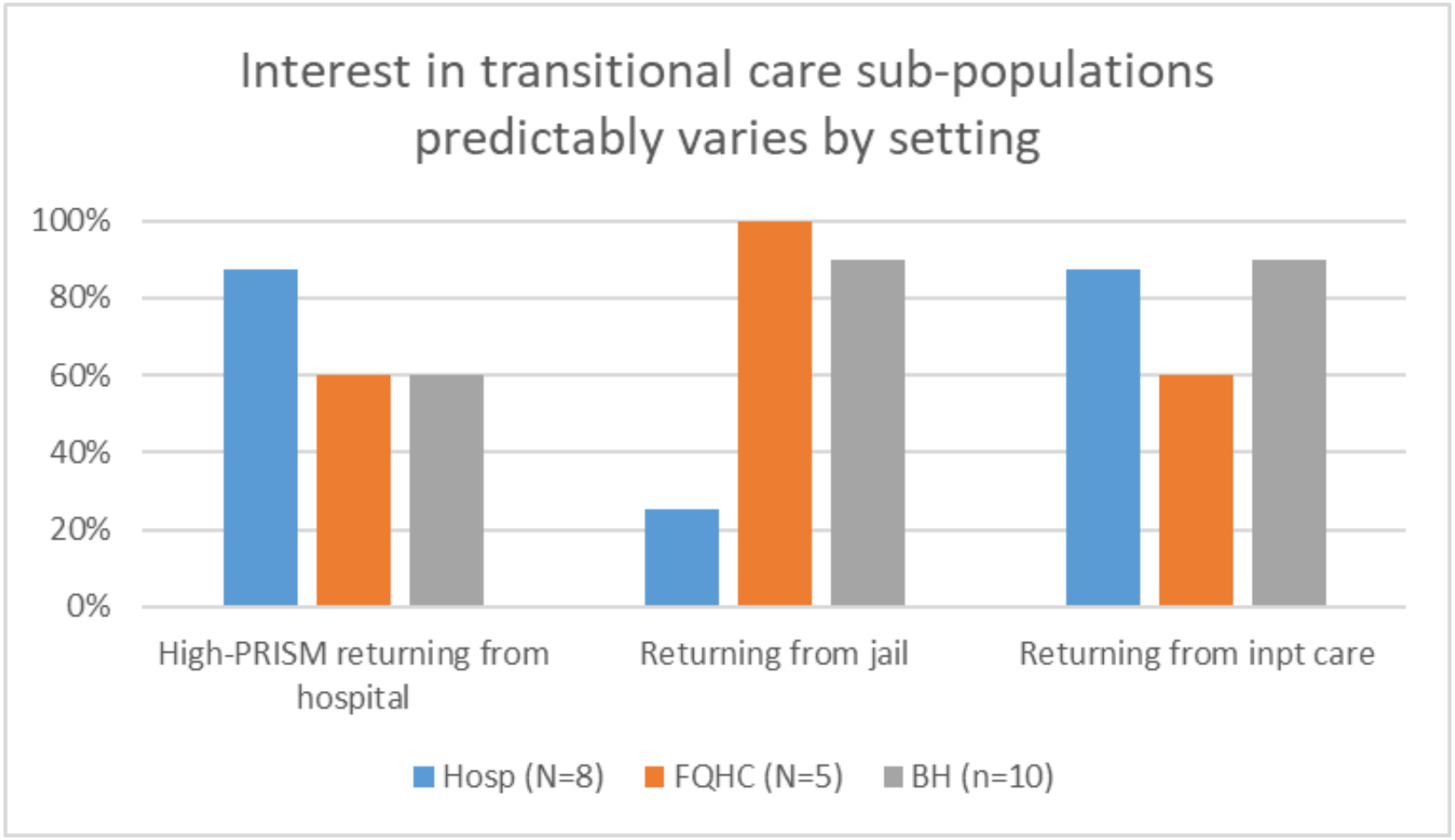
# Transitional Care Approaches: Peer Bridger Program

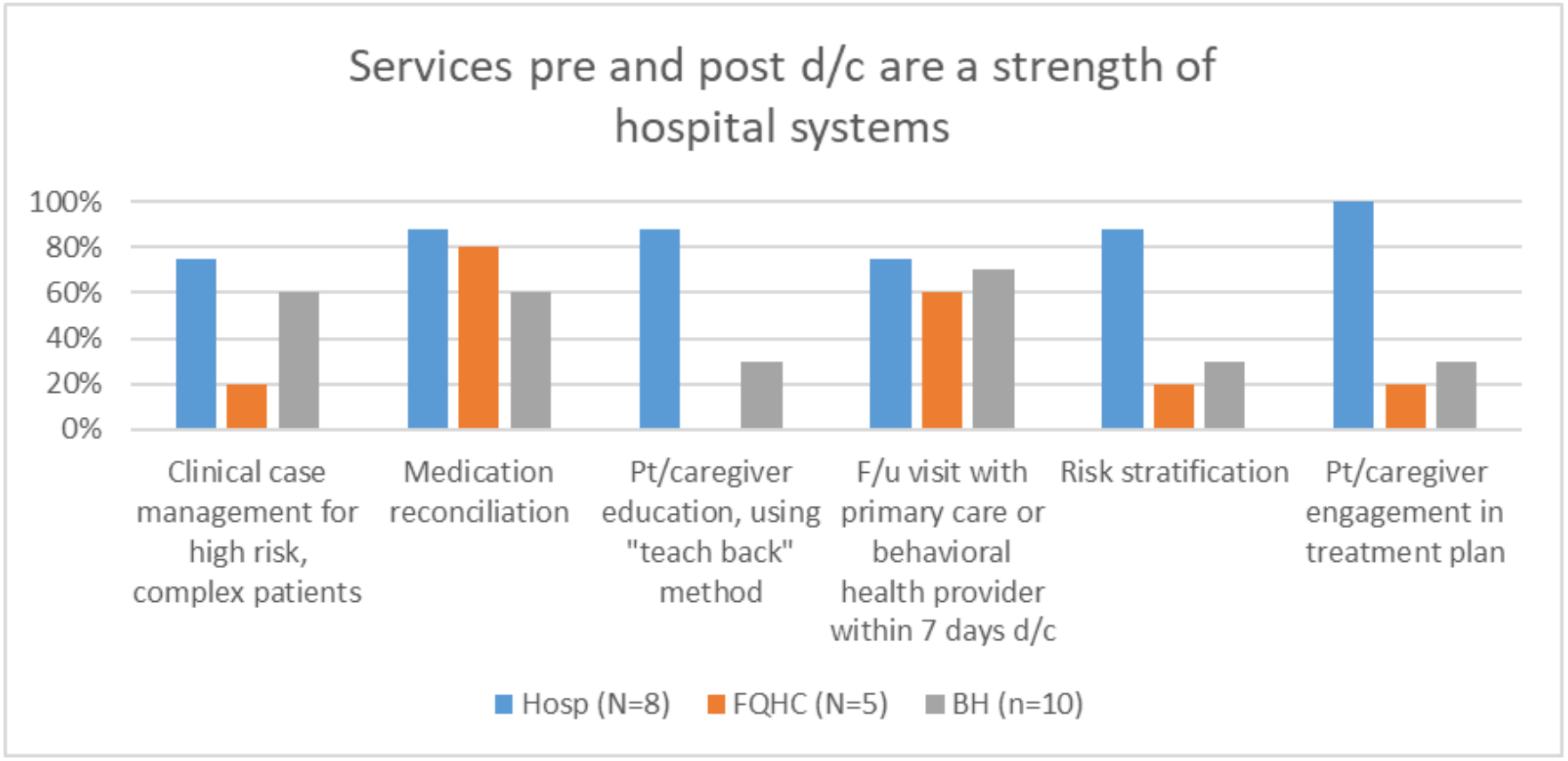
Peer Bridger is a community/home-based outreach service designed to be short term community support.

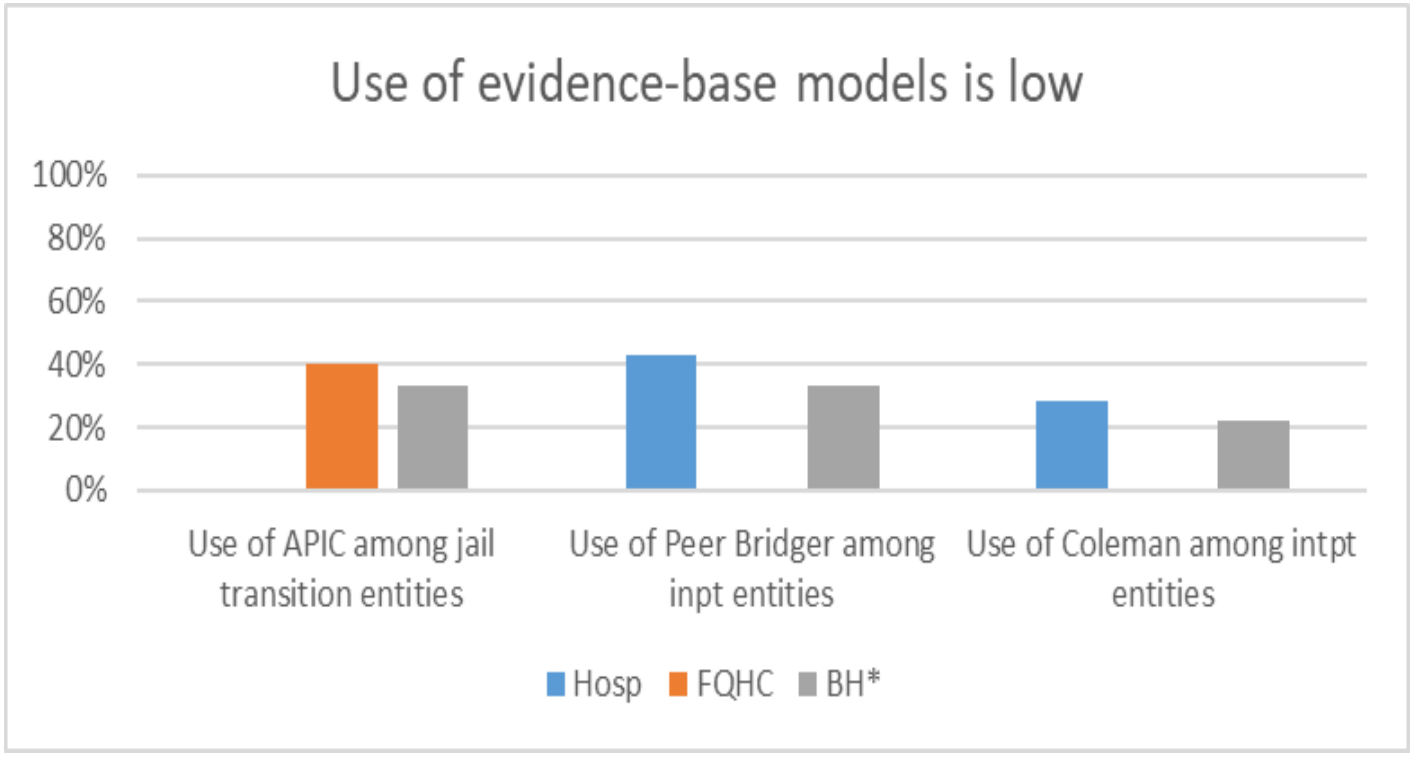
- Peers are state-certified Peer Support Specialists who have lived with mental illness or substance use and are in recovery. Because of their own experience, Peers have a unique understanding of the challenges of receiving services and recovery.
- The Peer Bridger Program services are based in recovery principles and focus on the values of hope, choice, empowerment, and wellness.
- Provides services to individuals to support their recovery as they transition from inpatient services back into the community.
- All services are provided under the direction of an MHP (Mental Health Professionals) and include Recovery Navigators and Peer Recovery Coaches.

# Transitional Care: Project-specific Current State Assessment Results




Interest in transitional care sub-populations predictably varies by setting
100%
80%
60%
40%
20%
0%
High-PRISM returning from hospital
Returning from jail
Returning from inpt care
Hosp (N=8)
FQHC (N=5)
BH (n=10)


Services pre and post d/c are a strength of hospital systems
100%
80%
60%
40%
20%
0%
Clinical case management for high risk, complex patients
Medication reconciliation
Pt/caregiver education, using "teach back" method
F/u visit with primary care or behavioral health provider within 7 days d/c
Risk stratification
Pt/caregiver engagement in treatment plan
Hosp (N=8)
FQHC (N=5)
BH (n=10)




"Other" models

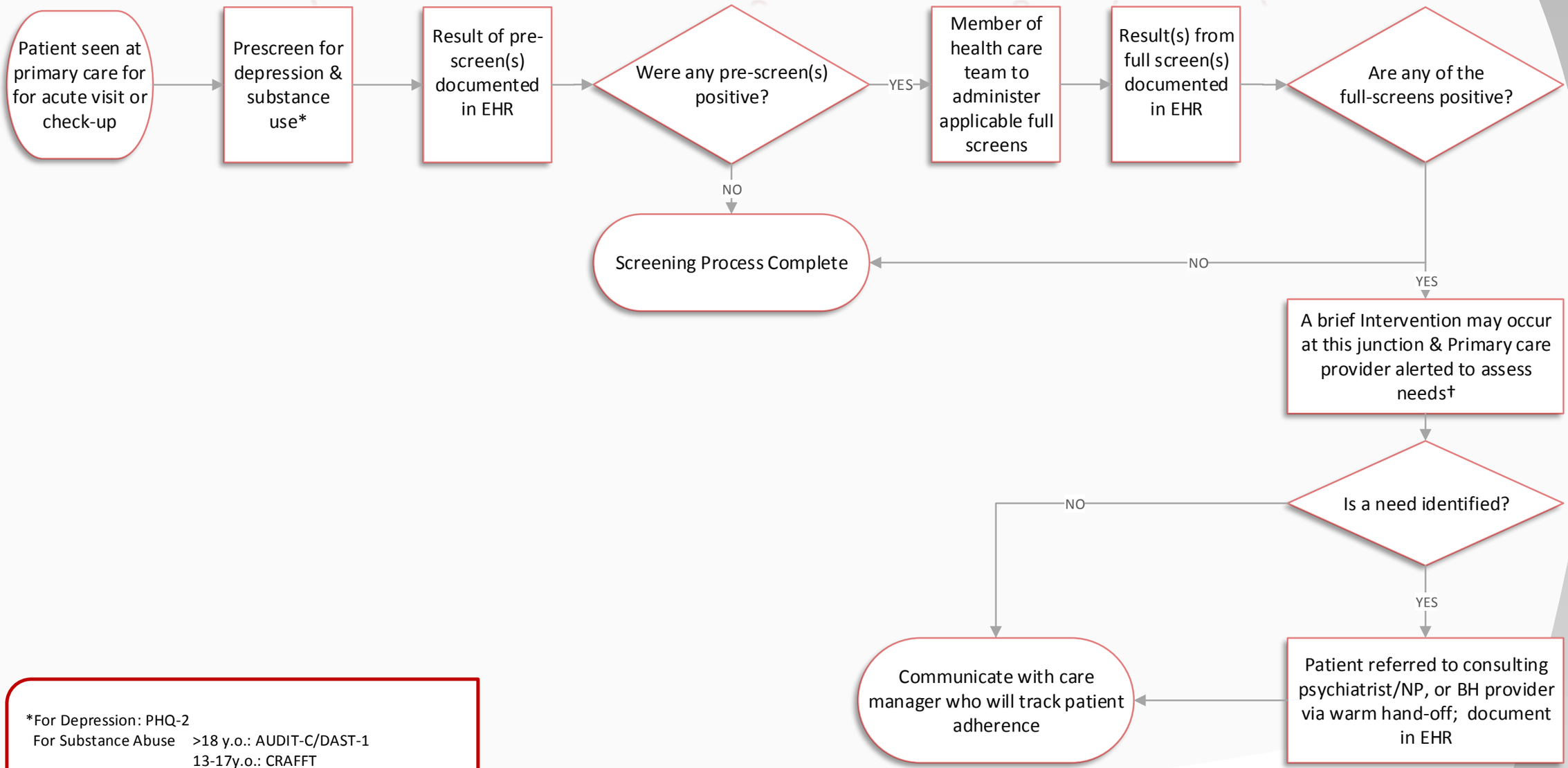
**Jail transition**: forensic steering committee, intensive case management with LEAD; components of APIC

**Hospital transition**: care coordination; assertive outreach; Coleman; peers; PACT; REACH; language-specific CM

# Barriers for Transitional Care

- Housing
- Communication/collaboration; d/c info sharing
- Timely access to MH/SUD treatment, specialty care, clinics
- Funding – for outreach, CHWs, longer PCP appts.
- Staffing
- SNF and AFH funding models, beds, willingness to accept pts.

# Primary & Behavioral Health Integrated Care Program (Model 3) Flow Chart




*For Depression: PHQ-2
For Substance Abuse >18 y.o.: AUDIT-C/DAST-1
13-17y.o.: CRAFFT

†Brief Interventions if performed following a substance use screening may be billable if required criteria met

Suffolk Care Collaborative