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Clinical Summary
Psychiatric Care Transitions from Hospital Settings

Goal

Immediate: Implement an integrated whole person model of care that ensures safe and successful transitions from psychiatric hospitals back into community settings, such as, home or skilled nursing facilities.

Long-term: Reduce preventable emergency department (ED) visits and hospital readmissions due to behavioral health disorders. Ensure continuity of care.

Focus Populations

Medicaid members who live with serious mental illness and/or substance use disorder discharged from inpatient psychiatric settings or ED holds who meet a minimum of 3 of the following criteria:

- Two or more chronic conditions
- Active mental health issue and/or substance use disorder
- Four or more prescribed medications
- Two or more hospitalizations and/or four ED visits in the past 12 months
- Low health literacy
- Limited English proficiency
- Limited engagement with primary care (no primary care visit in the last six months)
- Limited engagement and/or disengaged from behavioral health care
- Homeless or housing instability
- Limited community supports, ineligible for other programs such as Health Homes.

Alternatively, a clinical provider's determination of high risk for readmission is acceptable without regard to the above criteria.

Key Project Elements

The following interventions are recommended for participating provider organizations. Pursuing the recommended strategies as appropriate for specific focus populations is likely to help Practice Partners achieve their goals related to HealthierHere's 2019 pay for progress incentives.

HealthierHere is taking a broad, portfolio approach to inform King County's transformation efforts. The evidence-based models identified by the Health Care (e.g., Bree Collaborative Model, Coleman Model, Collaborative Care Model, APIC, and the Chronic Care Model), have congruent underlying principles that are foundational to system and service delivery transformation.

Based upon the Peer Bridger Program and Transition Support Program (TSP), implementing organizations are encouraged to utilize the following key strategies.

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Utilize Population Health Management Tools:

- Use electronic health records and registries to identify individuals and services that are needed, share integrated care plans and other Continuity of Care Documents, as appropriate and allowed by law, with primary care providers (PCPs), behavioral health providers, social service providers (e.g., supportive housing), individuals, and their caregivers.
- Measure and monitor against a defined set of indicators to track progress.
- Conduct routine quality assurance and improvement reviews of panels of high-risk individuals.

Assess Whole Person Care Needs:

- Whole person care needs include the following: physical health, substance use, behavioral health, oral health, and the social determinants of health. Partners will determine their standard assessments and/or adopt HealthierHere's recommended assessments which have yet to be determined.
- Hospital staff will screen individuals before discharge to identify those at high risk for readmission based on the criteria above.
- Increase the completion of POLST forms and other advance care planning documents at your organization.

Implement Team-based Care:

- Form a person-centered, multi-disciplinary, integrated care team. Composition of the team should be based on an individual's needs and risk stratification, and members could include PCP, behavioral health provider, and community support specialists.
- Assist individuals in obtaining a PCP and/or a behavioral health provider (if they don't have one) prior to discharge.
- Assign individuals at high risk for complications to a member of the team who can provide care coordination.
- Notify individual, caregivers, and community partners of planned discharge at least 48 hours in advance.
- Refer individual to community support specialist (e.g., peer bridgers, peer support specialists), as appropriate.
    - Community support specialists serving this focus population should:
        - Receive training in trauma-informed care, crisis intervention, and motivational interviewing.
        - Work collaboratively with clinical teams towards the goal of utilizing the same community support specialist to work with individuals both in the hospital and post-discharge.
        - Have access to a fund for basic services and essential needs such as bus passes, cell phones, clothing, food, engagement activities, etc.
        - Have a caseload of 8 – 14 patients.
        - Collaborate with hospital discharge planners during the discharge process.
        - Sit in on care team meetings while the individual is still in the hospital.
        - Sit in on intake sessions with case managers and psychiatrists, as able and if the individual is willing.
        - Aim for ongoing engagement/reengagement in behavioral health treatment by the individual.
        - Meet the patient where they are and share their own successful recovery stories to offer hope.

Develop Integrated Care Planning:

- Create individually tailored, culturally appropriate transition and treatment plans that support patient engagement with the care team. Language needs, including interpretation and translation, must be incorporated in the care planning and delivery.
- High-risk individuals, caregivers, and community support specialists must be notified of planned discharge no later than 48 hours in advance to avoid adverse events upon discharge.
- Transition and treatment plans should include the following information:
    - Assigned community behavioral health specialist and PCP that includes post-hospitalization discharge notes.
    - An updated and reconciled medication list.
    - Next steps, including follow up appointments with specialist, as needed.
- Aftercare appointments must be scheduled in coordination with the community support specialist.
- Ensure that the plan is available to all team members serving the individual's needs.
- Community support specialists will meet with individuals and their family caregivers before hospital discharge to develop individually tailored transition plans that:
    - Are based upon an assessment of needed community services and supports.
    - Emphasize productive interactions between the care team and the individual.
    - Include a reconciled medication list, follow-up appointment, and patient self-education (written at an appropriate health literacy level and in the individual's language).
- The individual must have an adequate supply of their medications upon discharge.

Provide Self-Management Support:

- All focus population individuals should receive self-management support by a member of the health care team. Establish an individually tailored self-management goal, which should be reviewed at each visit.
- After discharge, the community support specialist will conduct in-person meeting(s) such as home visits and follow-up by phone and/or telehealth options in service of the following goals:
    a. Increase self-management skills
    b. Ensure personal goals are congruent with individual's self-efficacy
    c. Improve continuity of care with primary care follow-up
    d. Ensure medication management and reconciliation with PCPs or other providers including pharmacists
    e. Practice advocacy by identifying key questions for PCPs/specialists
    f. Educate on health system navigation
    g. Ensure patient can "teach back" expectations from physical and behavioral health appointments, including what medications are needed and why.

Link to Community Resources:

- As needed or desired, the care team will refer individuals to community resources.
- To address the social determinants of health, the integrated care team will connect individual with appropriate resources, social services agencies and community based organizations depending on the individual's needs (e.g., transportation, food, shelter). For applicable individuals, the integrated care team will work with the individual and community support specialists to support selected activities. In such cases, the community support specialist will communicate with PCP and/or specialist(s) regarding the individual's treatment and progress.

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Pay for Performance Metrics

Incentive payments for ACHs and partnering provider organizations are dependent on improvement in project-specific Pay for Performance metrics selected by the Health Care Authority. Partnering provider organizations participating in the Transitional Care project will agree to help HealthierHere improve the following set of metrics.

Metric	Definition
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.
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 years, 18-64 years, and 65 years and older.

References/Guidelines

Viggiano, T., Pincus, H. A., & Crystal, S. (2012). "Care transition interventions in mental health." Current Opinion in Psychiatry, 25(6), 551-558.
https://www.integration.samhsa.gov/Care_transition_interventions_in_mental_health.pdf

"King County Peer Bridger Program – Supporting Successful Transitions,"
https://ncc.expoplanner.com/files/15/SessionFilesHandouts/10_Jerome_1.pdf

"Program Helps Individuals Stay out of Hospitals, On to Stability," Sound Mental Health.
https://www.sound.health/program-helps-individuals-stay-out-of-hospitals-on-to-stability/

"What is the Peer Bridger Program?" https://riinternational.com/our-services/washington/peer-bridger-program/