Readmission

- Psychiatric hospitals have faced a tsunami of change over the past 20 years that have significantly altered daily operations and shifted the role of the hospital within the mental health treatment community.
- First and foremost is the increased scrutiny paid to admission and readmission rates, as well as changes in the community standards of care that emphasize alternatives to hospitalization, including the individual’s right to self-determination and choice even within the hospital setting.
Role of Psychiatric Hospitals

- The introduction of new generation antipsychotic medications that are highly effective in remediating psychiatric symptoms for a large percentage of individuals and community-based alternatives to hospitalization, such as Assertive Community Treatment (ACT) teams also played a role in re-shaping the purpose of the psychiatric hospital as a short-stay setting for immediate stabilization rather than long term rehabilitation for most patients.
Nowhere has the scrutiny on the inpatient psychiatric hospital system been more acute than in the admission, discharge and readmission process.

The high cost of inpatient services, in particular, has focused the attention of Medicaid, Medicare, and managed care payers on establishing performance standards for readmission and routine monitoring for length of stay.
Financial Penalties

- Beginning in 2013, Medicare implemented financial penalties (reductions in per diem payments) for hospitals that exceeded inpatient re-admission standards and other quality metrics.
- Similarly, “transitions in care” (formerly known as “Discharge Planning”) has emerged as a sub-specialty area for quality and performance on its own.
- The typical inpatient Discharge Planning process resembles two ships passing in the night.
Ships in the Night

- Ship A, the hospital, controls the length of stay in the facility by discharging the person when they determine that hospital services are no longer medically necessary.
- At the same time the hospital needs to make sure that readmission is not likely to occur by ensuring that the person has sufficient stability and is referred to appropriate community services.
- Ship B, a community mental health service provider, may or may not be part of the discharge planning process.
The hospital needs to prevent readmissions by identifying the community services that are necessary to successfully support the person in the community, but they have no role in ensuring that the person is actually connected to the community resources.

Since the hospital does not control the community resources and the community providers do not have any authority in the hospital discharge planning process, there is often significant tension between these two discrete parts of the mental health system.
In addition, mental health service funding is allocated in silos in the United States.

Community providers cannot bill for services when the individual is in an inpatient setting and the hospital cannot bill when the person returns to the community.

These funding silos significantly inhibit coordination of care between these settings.
A study of more than 12 million Medicare recipients found that 24.6 percent of patients hospitalized for psychosis were re-hospitalized within 30 days of discharge, with 67 percent of the patients being readmitted for psychosis.
First Appointments

- Organizing discharge planning sessions where the hospital and community staff both participate can be challenging.
- Needless to say, gaps in services are common.
- One of the most important predictors of readmission is whether patients attend their first appointment with a community provider.
Are Connections Made

- It is not uncommon to find a 30% or greater rate of failure to appear for the first appointment.
- While some individuals eventually make a connection with their community providers, a sizable number fail to connect and, without ongoing treatment, remission is often inevitable.
- These individuals show up in emergency rooms, psychiatric inpatient settings, jails, in homeless shelters and, in some cases as mortalities.
Multiple Reasons for Readmission

- Factors in hospital readmissions have been closely studied across multiple states and payer systems.
- The available research indicates that the reasons for readmission include all of the following factors: the person may be discharged prematurely without achieving functional stability; the community resources needed to support the person are either not available, not sufficient or not responsive; the person doesn’t understand what they need to do to remain healthy; the person lacks capacity or desire to adhere to the discharge instructions upon leaving the more regimented inpatient setting; the person has an unaddressed or refuses to address a substance abuse issue; or the person’s living environment does not support recovery (Hemminger, 2012).
How are readmission outcomes measured?

- Follow-Up After Hospitalization for Mental Illness (FUH)

- The percentage of discharges for which the patient received follow-up within 30 days of discharge

- The percentage of discharges for which the patient received follow-up within 7 days of discharge.
Who has the highest probability of readmission.

- Rates of failure to attend a first outpatient appointment have ranged from 18 to 67 percent, with a median rate of 58 percent. Over time periods ranging from one to nine years, approximately 30 percent of patients disengage from mental health treatment services.

- In terms of clinical characteristics, individuals with a co-occurring serious mental illness and a substance use disorder have high rates of treatment disengagement, as do individuals with higher levels of psychopathology (Kreyenbuhl 2009).
Who has the highest probability of readmission

- Psychosis is one of the top five medical diagnoses for which patients are re-hospitalized (Jencks, Williams, & Coleman, 2009).

- As costs for psychiatric hospitalization can exceed $1,500 per day, interventions that reduce rates of re-hospitalization for patients with psychosis could yield significant savings to the health care system (Glazer, 2010).
Who have the highest probability of readmission.

- Younger age, male gender, ethnic minority background, and low social functioning have been consistently associated with disengagement from mental health treatment.
- Individuals with co-occurring psychiatric and substance use disorders, as well as those with early onset psychosis, are at particularly high risk of treatment dropout.
Who have the highest probability of readmission.

- Between 25 and 50 percent of patients who miss mental health appointments disengage from treatment entirely (Killaspy, 2007).

- Dropping out of treatment after a psychiatric hospitalization increases the likelihood of re-hospitalization from one in 10 to one in four (Mitchell & Selmes, 2007).
Disengagement from mental health services can be a significant problem that can lead to devastating consequences, including exacerbation of psychiatric symptoms, repeated hospitalizations, first episode or recurrent homelessness, violence against others, and suicide (Dixon 2009; Fischer 2008).
Positive Interventions

Emerging evidence suggests that brief, low-intensity case management interventions are effective in bridging the gap between inpatient and outpatient treatment (Dixon 2009).

Another factor that impacted readmissions was when there was a discussion about the discharge plan between the inpatient staff and outpatient clinicians.

Other strategies they found that increased attendance at appointments included having the patient meet with outpatient staff and visit the outpatient program prior to discharge (Boyer 2000).
One issue that comes into play is that people who are frequently readmitted often receive discharge plans that contain the exact same locations and services that have repeatedly failed to support them in the community.

Due to the rapid time frame in which the inpatient team must complete a discharge plan, the causative factors that drove the readmission are often not identified or considered when new discharge plan is developed.
Availability of Community Options

- Even when the reasons are obvious, the hospital often has few community options to choose from that are capable of addressing the issues.
- If the person needs to move to a more supportive environment, those settings are often not readily available.
- If an ACT Team is needed to support the person, there may be a wait list for the program.
Nevertheless, any approach to reduce readmissions and to support a successful community placement must address all of the factors that led to the person’s initial admission and any subsequent readmission.

- The problem of gaps in the service array needs to be addressed by the administrators of the system of care.
- That is slow
Inpatient hospitals and community providers need to unite to bring these gaps in care forward or the gaps and consequently high rates of readmission will continue to occur.

The discharge planning process often has a fundamental flaw in that the person is not just leaving one level of care, but entering another.

Rather than simply concluding a service, the person is transitioning between services.
Transitional Supports

- Research has shown that the most effective ways to reduce readmission is to provide education while the person resides in the inpatient setting, develop a transition plan that effectively deals with the factors in the prior readmissions and provide transitional support in the community to ensure that the discharge plan is followed and readjusted if needed (Forchuk, et al 2007).
- The goal is to connect the person with community services and supports necessary to succeed, and in each of these areas, peer services have been shown to play a beneficial role.
• Across the country many inpatient settings have begun to see the value of adding peer support and family support to their services; however, only a few have done it to the degree necessary to have the type of significant impact reported in the few randomized controlled trials that have been conducted.

• McGill and Patterson (1990) reported one of the earliest examples of peer support program in an inpatient setting.
Peer In Inpatient and Settings

- In this program, former patients were trained to be peer counselors in a large public sector acute psychiatric inpatient program.
- Due to their positive impact over a four-year period, staff that were originally skeptical changed their attitudes and began requesting that peer-run groups and services be expanded.
Several other studies have examined the role and outcomes of peers serving in inpatient settings (Chinman, et al, 2001, Lawn Smith and Hunter, 2008, Sledge, 2011).

The most promising target identified issues that are the most challenging within hospital environments: the need for rapid engagement into treatment during increasingly shorter lengths of stay, effective discharge and transition planning, and readmission prevention.
Peer Supports In Inpatient and Settings

- Others focus on education and support directed to assist the person and their family in caring through on treatment recommendations once they leave the hospital.
- Programs implemented to target these factors utilize peer staff that work with individuals while they are in the inpatient settings while others link the person with peer support upon discharge.
Another approach attempts to bridge the inpatient-community transition process by introducing peer support services while the person is in the hospital and continuing the service when the person returns to community.

Methods employed to test the effectiveness and outcomes of these interventions include randomly controlled trials, case studies, program reports and personal accounts by peer staff and persons receiving services.
In a study that examined peer support staff who were introduced after discharge, Chinman, Weingarten, Stayner and Davidson (2001) compared peer support outpatient programs with traditional care and found a 50% reduction in readmissions when compared to the programs where support services were not in place peer. The results support the conclusion that when individuals return to the community and receive peer support services it can reduce hospital readmissions.
Peer Supports in the Community

- Sledge, Lawless, Sells, Wieland, O'Connell, and Davidson (2011) found that individuals who were assigned a peer support staff member had fewer hospital admissions and hospital days over a nine-month period than patients who were not assigned a peer support staff member.

- The average length of stay for individuals who received inpatient peer support services was 10 days as opposed to 19 days for participants without peer support and hospital admissions for individuals that received outpatient peer support were 53% less than those without peer support.
Another group of studies examined peer supports who acted as “Bridger’s” between the hospital and the community.

Lawn, Smith and Hunter (2008) found that individuals who received peer support services in the hospital and when they returned to the community showed reduced admission rates and more stable community placements, fewer readmissions and reduced lengths of stay.
Peer Supports in the Community

- Individuals who took part in group peer support services had a readmission rate of only 17% compared with an expected rate of 30%.
- The data suggested that peer support staff are able to connect individuals with resources both inside and outside the hospital and provide the type of hopeful engagement that maximizes treatment returns.
The model strategically targets discharge planning issues and the gap between hospital and community services.

One of the most promising lines of research is the work of Cheryl Forchuk and her colleagues in Ontario, Canada who developed a Transitional Discharge Model (Transitional Discharge Model).

Known as the “Bridge to Discharge” program, her model addressed the traditional boundaries between hospital and community settings that impede care transitions by assigning an inpatient team of professional and peer support staff work with the individual while they are in the hospital and then remain with them in the community until a therapeutic relationship is formed with a community mental health provider.
Canada does not have the same funding silos that exist in the American system, allowing for more seamless care transitions.

Forchuk, Martin, Chan and Jensen (2005) reported that using peer support as part of the discharge process significantly reduced readmission rates and increased discharge rates.

The model was tested in a randomized clinical trial involving either peer support for one year, or ongoing support from hospital staff until a therapeutic relationship was established with a community care provider.
The peer group was discharged 116 days sooner than the traditional care group.

The study authors also reported that individuals who received peer support demonstrated improved social support, enhanced social skills and improved social functioning.

Forchuk and Brown (1989) based the Transitional Discharge Model model on early work on nurse-patient relationship that emphasized the importance of directed relationships in promoting health and healing (Peplau, 1952).
This research defined nursing as "a significant, therapeutic, interpersonal process that aims to promote a patient's health in the direction of creative, constructive, productive, personal, and community living".

Forchuk and Brown expanded on Peplau’s definition to include all professional staff involved with the person and then added peer support to the formulation.
Using the relationship as her framework, Forchuk, Martin, Jensen, Ouseley, Sealy, Beal, Reynolds, and Sharkey (2012) identified three essential elements that underlie the effectiveness of the Transitional Discharge Model model:

1. People heal in relationships (including staff and peer relationships);
2. Transitions in care are vulnerable periods for individuals with mental illness and services should be front-loaded to bridge the transition process; and
3. A network of relationships provided during transitional periods assists in sustained recovery.
Forchuk et al. (2012, p. 585) summarized their findings on design components that are key to the success of the Transitional Discharge Model approach: “... the availability of on-ward educational opportunities, presence of an accessible ‘champion’ for the intervention, perceived administrative support, belief in the usefulness of the intervention and in the ease of use of the intervention, and willingness to partner with outside groups.”
In general, active engagement and participation by staff throughout the process was critical.”

Implementing the Transitional Discharge Model involves a significant change in the relationship between hospital and community care providers as well as hospital operations.
Specific strategies that facilitated the implementation of Transitional Discharge Model within the inpatient environment include:

- (1) the use of educational modules for on-ward hospital staff training and peer training;
- (2) presence of on-site champions; and
- (3) supportive documentation systems. Issues identified as barriers to implementation included:
  - (1) feeling drowned, swamped and overwhelmed;
  - (2) death by process;
  - (3) team dynamics; and
  - (4) changes in champions. (Forchuk, Martin, Jenson, Ouseley, Beal, Reynolds, & Sharkey 2012).
In addition, they identified several actions that are critical to ensuring the person establishes a therapeutic relationship with a hospital clinical staff member before discharge and that hospital staff communicates properly, continuously and understands their roles in the discharge process.
To emphasize the foundational role of relationships during transition, Forchuk, Reynolds, Sharkey, Martin, and Jensen (2007a) changed the title of the Transitional Discharge Model (Transitional Discharge Model) to Transitional Relationship Model (TRM).

To Forchuk et al. (2007a, p. 80) “therapeutic relationships include not only the nurse–client relationship but also other staff relationships, family relationships, and peer relationships.
Each person needs a safety net of relationships because people are believed to heal in supportive relationships.

However, traditional models of care terminate relationships at the point of hospital discharge, which is a time of vulnerability for many clients.”

Forchuk, Reynolds, Sharkey, Martin, and Jensen (2007b) also studied the transferability of the model to a facility in Scotland. Reynolds et al.
(2004) implemented and evaluated the Transitional Discharge Model on acute care psychiatric wards there and reported that the group that did not participate in the Transitional Discharge Model model was more than two times as likely to be readmitted in the subsequent five months when compared to the Transitional Discharge Model discharge group.

Hanrahan, Solomon, and Hurford (2014) used an adapted version of the Transitional Discharge Model for older adults being released from acute care hospitals for patients with serious mental illness and medical co-morbidities.
The “Transitional Care Model” was delivered by a psychiatric nurse practitioner assigned within the acute setting who continued to see patients in the community. The study found that patients with immediate and pressing physical health problems were most receptive and actively utilized the service. A number of barriers were identified including communication and privacy issues making it difficult to remain engaged with persons in community mental health facilities.
While the nurse practitioner was accepted and valued in the physical health arena, the psychosocial needs and relationship issues were too demanding for a single staff.

The researchers concluded that a team approach including a social worker, peer provider, and consulting psychiatrist were needed for severely mentally ill patients being released from an acute physical health hospital (Solomon, Hanrahan, Hurford, DeCesaris, & Josey, 2014).
An interesting application of the peer support model was conducted by Vijayalakshmy, Smith, Schleifer, Steven, Morris, and McLennon (2006).

The study described a peer support intervention that specifically addressed individuals who were reluctant to return to the community.

The group utilized standard methods of rehabilitation and training with strong emphasis on validating individual needs and feelings using peer support.

After 18 months of the group intervention, five of the seven group members had achieved discharge and community success.
Similar models have been promoted in a number of locations. M-Power Advocates reported to the Massachusetts Inpatient Study Commission (2009) regarding the need to implement peer support programs designed to transition individuals from inpatient facilities.

Their report stated, “One type of support for individuals transitioning out of the hospital used very successfully in New York State is a Peer Bridger Project in which a trained peer specialist provides one-to-one support to a person ready to be discharged.”
This relationship begins several months before the discharge date and continues for several months after discharge. This is an excellent way to address the concerns and fears a person who has been in the hospital for months or years may have about being able to make it on the outside.

The Genesis Club in Worcester and the Lighthouse Clubhouse in Springfield run Peer Bridger projects under a DMH contract entitled "Peer Support in After Care.” Such programs need to be expanded throughout the state” (p.2).
Marc Community Resources CTP Program

Marc Community Resources has implemented a Community Transition Program utilizing trained peer support navigators to assist individuals who are being discharged from a community psychiatric inpatient setting.

The peer staff engages the individual while they are in the hospital and assist them while they transition to the community using a Critical Time Intervention model shortened to a 90 day period.

The results to date have been encouraging.
The Community Transition Program uses two evidence-based models in this program:

1) The first is Transitional Discharge model which treats discharges as transitions rather than terminations and

2) A truncated (90 days) Critical Time Intervention Model (CTI) that supports individuals in their recovery by assisting them with building their resiliency and titrating the assistance as independence or natural supports are obtained.
The goal of the Community Transition Program is to provide comprehensive supportive and stabilization services to participants who have challenges that lead to the frequent reoccurrence of in-patient psychiatric hospitalizations.

The Program aims to assist participants during the course of a 90 day period by coordinating stabilization efforts from the onset of their hospitalization through the transfer of care to their community-based clinical team.
Community Transition Program

- During this time Peer Transition Partners utilize interventions focused on evidence-based treatment, wellness and recovery, and person-centered supports to aid participants in achieving long-term community stability ultimately resulting in a reduction in hospital readmissions.

- The Program’s approach is centered on the collaboration among the individual, the hospital team, the community-based clinical team, Mercy Maricopa Integrated Care and the Community Transition Team, all of whom share the common goal of identifying and connecting participants to the natural and formal supports that leading to long-term community stabilization.
The Program’s highly individualized and flexible approach is specifically designed to help persons who are considered chronically prone to psychiatric hospitalization develop the hope and resilience necessary to live meaningfully in the community of their choice.
Community Transition Program

- Beginning in the hospital and continuing through their first few months in the community, participants are paired with Peer Transition Partners who walk alongside participants during the critical hospitalization and post-hospitalization phases of their recovery journey.
- Each Peer Transition Partner supports a dynamic list of 12-15 participants, and is supported by a dedicated program manager and a clinical staff member.
Demographic Overview:

- Total Referred: 310
- Total Accepted Enrollment: 265 (85% of referrals accepted program enrollment)
- Total Currently Enrolled: 102
Of those currently enrolled:

- Participants currently being treated at St. Luke’s and Banner Thunderbird: 10 (9.8%)
- Participants currently living in the community: 92 (90.1%)
- Participants who were homeless upon SLBHC/Banner admission: 46 (45.1%)
Of those currently enrolled:

- Participants newly designated as SMI while in-patient: 11.7%
- Participants discharged to temporary housing settings: 41 (40.1%)
- Participants with co-occurring substance abuse concerns: 140 (52.8%)
Readmission Data

- Participants who have been psychiatrically re-hospitalized within 30 days while enrolled: 39 (15%)
- Participants who have been re-hospitalized after >30 days: 10.
- Participants who went to UPC’s instead of hospitals: 10.
- A total of 59 individuals were readmitted including those greater than 30 days and to UPC’s. (22%)
• Other interesting information that has been obtained from this group is that approximately one-third of the re-admissions began with a medical hospitalization. In a significant number of cases the substance abuse challenges that were prominent reason for re-hospitalization.

• Approximately one-third experienced challenges with medication i.e. some people did not want to take their medication.
Community Transition Program

- Approximately one-third self-discharged from the hospital and went to motels or similarly unsupportive settings whereby they soon became homeless and symptomatic.
- In long-term psychiatric hospitals a small percentage of individuals resist discharge.
While the hospital staff were initially unsure how peer supports could be helpful, their attitude changed rapidly and they now see peer supports as a valuable resource.
CTP ENGAGEMENT PROTOCOLS
STANDARD ENGAGEMENT PROTOCOL:

• **Post-enrollment Inpatient phase typically lasts less than two weeks and should include:** Routine collaborative discharge planning with in-patient and PNO teams. Two F2F encounters in the first week and one F2F in the second week, or approximately 3 to 4 in-patient F2F encounters.

• **First 30 days in the community:** two F2F contacts weekly, one phone contact with participant weekly, one phone contact with PNO team
STANDARD ENGAGEMENT PROTOCOL:

- **Second 30 days in the community**: one weekly F2F contact, two weekly phone contacts with participant, one weekly phone contact with PNO team
- **Last 30 days in the community**: bi-weekly F2F contacts, bi-weekly phone contact with participant, bi-weekly phone contact with PNO team
The following profiles require standard engagement:

- **CLASSIC PROFILE**: This participant is closest to a “standard profile”. She has been connected with the system for a while and has ISP goals that relate to coping skills development and connecting to resources.

- This is the “easy case” that usually last the requisite 90 days and does not re-admit. Unfortunately, this profile only represents about 20% of our referrals.
The following profiles require Standard Engagement:

- **NEWLY DESIGNATED SMI PROFILE**: This person may or may not present many challenges beyond needing to connect to his new clinic team and become familiarized with the system in general.
- If co-present drug and housing challenges exist as well, these participants can present very tough circumstances.
The following profiles require Standard Engagement:

- **ADVOCACY PROFILE**: The participant may have been connected with their clinics for some time, and may already be aware of services and supports that they would like to connect with.

- However, these participants encounter significant barriers towards connecting to services or resources, whether due to issues with clinical team service delivery, counter-transference of service providers, difficulties with insurance/MMIC administrative factors, etc.
The following profiles require Standard Engagement:

- It is not uncommon for the "connecting" phase to last much longer than normal for this profile, which often results in the "testing" phase being very belated in timeframe.
• **In-patient phase could last up to or beyond 30 days (post-enrollment) and should include:** intensive collaborative discharge planning with in-patient and PNO teams. No fewer than two F2F encounters weekly, two phone contacts each with in-patient and PNO team weekly.

• **First 30 to 60 days in the community:** minimum of two F2F contacts weekly (or outreach attempts), minimum of two weekly phone contacts with participant, minimum of one phone contact with PNO team


INTENSIVE ENGAGEMENT PROTOCOL:

- *Next 30 to 60 days in the community:* one weekly F2F contact, two weekly phone contacts with participant, one weekly phone contact with PNO team
The following profiles require Intensive Engagement:

- **SUBSTANCE USE PROFILE:** This profile is obviously very challenging, especially if the person is not ready to stop using.
- Even when the person is in an active change phase scant resources (long waiting lists for treatment) make things difficult, especially if they are in a TLP with routine drug activity.
The following profiles require Intensive Engagement:

- **HOUSING PROFILE**: The individual is homeless and awaiting placement or needing assistance in applying. These participants frequently remain in the hospital while awaiting placement, which has taken up to 6-8 weeks in some circumstances.

- If they do not remain inpatient, and instead discharge to CASS, further challenges in remaining connected arise. While inpatient, few goals beyond that of general coping skills and/or assisting with obtaining necessary personal identification documents are able to be worked on.
The following profiles require Intensive Engagement:

- The individuals themselves often are very focused on their housing and defer working on other goals, or in general can learn about resources, but are unable to actually connect with these community services until they are discharged and placed.
The following profiles require Intensive Engagement:

- **POLY-CHALLENGED PROFILE**: This is our highest acuity participant as they have housing and drug challenges, and might also be estranged from their PNO team.

- Highly focused and collaborative discharge planning is required while in-patient and intensive post-discharge engagement often lasts far beyond the first 30 to 60 days of initial discharge. This person is at very high risk of a re-admit within the first 30 days after initial discharge.
KEY CHECKLIST ITEMS FOR INITIAL ENGAGEMENT:

- Review new medication regimen with participant (be aware of possible formulary incongruence). Provide medication education.
- If 72 hour post-discharge BMHP encounter doesn’t occur ensure that 7 day PNO encounter occurs.
- Immediately begin referrals for therapy (EMDR, CBT, DBT etc.) prior to discharge (CM needs to know and act).
KEY CHECKLIST ITEMS FOR INITIAL ENGAGEMENT:

- Immediately assist in initiating process for benefits (SSI/SSDI).
The program began in late December at St. Luke’s and expanded into the Banner Hospital System since that time the Peer Transition Partners have voluntarily enrolled 265 individuals.

Since they have been working with the individuals while they were/are in the hospital and when they return to the community, we thought it would be informative if we collected information that would shed some light on the discharge process with respect to what is working well and what barriers exist. While much of the information is probably suspected, it’s beneficial to confirm or deny our suspicions.
What’s Working:

- Hospital teams providing open access to units and to participants
- Hospital social work and psychiatric staff actively collaborating with Community Transition Program (CTP) team
- Referral and intakes completed quickly as a result of fluid communication and sharing of documentation between CTP and hospital teams (SLBHC/Banner Psych Evaluations)
What’s Working:

- Participants receive support from all of the Peer Transition Partners while inpatient (visiting each other’s assigned members) helps to make participant feel a part of the program. Also helps team members feel supported by the rest of the team.

- Frequent visits from Peer Transition Partners while participant is inpatient give the participant time to build trust with Peer Transition Partner, thus participant is more likely to actively engage after discharge.

- Assistance from MMIC staff, particularly Roni Siebels.
What’s Getting Better:

- CTP team now being invited to staffings at St. Luke’s by social worker, and to morning “flash sessions” by some psychiatrists. At Banner this aspect is being developed.
- Several PNO case-managers are now actively coordinating and collaborating with CTP team.
- Newly assigned co-located MMIC Utilization Management/RBHA Discharge Coordinator is actively engaged with CTP coordination efforts.
- PNO system (CM’s, CC’s, CD’s) beginning to better understand and accept the “reverse referral” process whereby St. Luke’s In-patient social worker and psychiatrist make referral directly to Community Transition Program and the Program makes the PNO outpatient team aware of the referral.
What Barriers Remain:

- Receiving PNO documents in a timely manner
- Participants leaving hospital often far beyond clinically established “discharge-ready” date which can lead to participant showing traits reflective of treatment regression
- Hospital social workers and CTP team frequently have difficulty getting in touch with PNO teams
- Some case-managers do not appear to fully understand the behavioral health housing landscape
What Barriers Remain:

- Families not involved in discharge planning
- Several participants have indicated that discharge planning process does not feel individualized (cookie cutter process)
- Several participants not wanting to return to certain clinics
- There have been several cases where a DC date was established and then suddenly the person was told they are leaving.
Four primary reasons people who engaged while inpatient went MIA upon discharge (in order)

- Engaged in illicit substance use immediately, or soon after, discharge
- Discharged to, or gravitated to, toxic environments and/or negative housing situations (TLP’s, wrong level of care, frequented old familiar negative areas)
- Discharged AMA often without medication and without the knowledge of PNO or CTP teams
- Non-adherence with prescribed medication regimen (often due to above-mentioned circumstances)
Other reasons for not being able to engage with individuals upon discharge

- Discharged without significant rapport with PNO team or CTP team (new to PNO, discharged before CTP built rapport)
- Many participants live in the moment, literally from crisis to crisis. If they are not in crisis they feel they don’t need us or their clinic. When a crisis erupts we hear from them
Other reasons for not being able to engage with individuals upon discharge

- Those with fewer supports tend to stay connected, while those with more natural/familial supports use those supports rather than formal (PNO and CTP) supports.
- Willingness to engage/participate often diminishes once individuals leave supportive therapeutic inpatient environment (sometimes even among those who stay committed to PNO and CTP services).
What can be done while participants are inpatient to help with substance abuse challenges

- Inpatient units should reach out to AA to allow for meetings at the hospital.
- Run a substance abuse groups focusing on trigger awareness and relapse prevention
- Use Motivational Interviewing techniques more actively during inpatient encounters when addressing substance use issues
Readmission Assessment
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<td>Provider: Appointment</td>
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<td>Time:</td>
<td></td>
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<tr>
<td>Previous DC Disposition: (Include living arrangements, recommended providers, and services):</td>
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<tr>
<td>Did client receive all services recommended by the treatment team at previous discharge:</td>
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<tr>
<td>Comments:</td>
<td></td>
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</table>
# Readmission Factors

## Reason for Readmission (Check All That Apply)

- □ Declined medication
- □ Supply of medication ran out prior to next available appointment
- □ Non-adherence due to relapse with Substance Abuse
- □ Did not engage in outpatient/community based services.
- □ Formulary incongruence.
### Readmission Factors

<table>
<thead>
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<th>Reason for Readmission (Check All That Apply)</th>
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<td>□ General non-adherence/did not take meds as prescribed.</td>
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<tr>
<td>□ Cognitive impairment (frequently forgets to take meds)</td>
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<tr>
<td>□ Refused to attend initial follow-up appointment</td>
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<tr>
<td>□ Refused to take medication</td>
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<tr>
<td>□ Treatment Adherence was not a factor in readmission</td>
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## Reason for Readmission (Check All That Apply)

- [ ] Other (must specify):

- [ ] Limited access to services (consumer needs more intensive services/supports than receiving)

### Treatment Adherence Comments:


## Access to Care

### REASON FOR READMISSION (CHECK ALL THAT APPLY)

- [□] Individual did not receive services recommended at previous discharge
- [□] Limited access to services (consumer needs more intensive services/supports than receiving)
- [□] Limited English impacted access to care
- [□] Need for adaptive equipment
<table>
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</tr>
</thead>
<tbody>
<tr>
<td>Need for skilled medical care</td>
<td>□</td>
</tr>
<tr>
<td>Benefits/Income not adequate to meet basic needs</td>
<td>□</td>
</tr>
<tr>
<td>Access to Care was not a factor in readmission</td>
<td>□</td>
</tr>
<tr>
<td>Previous care provided within another GSA</td>
<td>□</td>
</tr>
</tbody>
</table>

Access to Care Comments:
# Living Arrangements/ Supports

## REASON FOR READMISSION (CHECK ALL THAT APPLY)

- Choice of living arrangement at discharge not sustainable
- Disruption of placement – current medical need can no longer be met by current provider
- Disruption of placement – current psychiatric need can no longer be met by current provider
- Disruption of placement – disruptive / aggressive / threatening to peers, staff
### REASON FOR READMISSION (CHECK ALL THAT APPLY)

- □ Disruption of placement – family can no longer provide care
- □ Disruption of placement – no funding
- □ Transportation – Not knowledgeable about available resources for transportation
- □ Transportation – No access to transportation
<table>
<thead>
<tr>
<th>REASON FOR READMISSION (CHECK ALL THAT APPLY)</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Family has limited understanding of illness and treatment needs</td>
</tr>
<tr>
<td>□ Family conflict</td>
</tr>
<tr>
<td>□ Lack of primary/natural supports</td>
</tr>
<tr>
<td>□ Other (must specify):</td>
</tr>
<tr>
<td>Reason</td>
</tr>
<tr>
<td>----------------------------------------------------------------------</td>
</tr>
<tr>
<td>Did not complete Substance Abuse intensive program</td>
</tr>
<tr>
<td>Unable to access services or treatment for substance abuse</td>
</tr>
<tr>
<td>Other (must specify):</td>
</tr>
<tr>
<td>Substance Abuse not a factor in readmission</td>
</tr>
</tbody>
</table>

Substance Abuse Comments:
### Legal Issues:

**REASON FOR READMISSION (CHECK ALL THAT APPLY)**

- [ ] Failed to comply with COT order
- [ ] Unable to receive medication management while incarcerated
- [ ] Incarcerated after discharge
- [ ] Active or outstanding warrants
## REASON FOR READMISSION (CHECK ALL THAT APPLY)

<table>
<thead>
<tr>
<th></th>
<th>Probation/Parole</th>
<th>PO Name:</th>
<th>Offense:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Legal Issues not a factor in readmission</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>APS/CPS involvement</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Legal Issue Comments:
<table>
<thead>
<tr>
<th>Reason for Readmission</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Changes to outpatient medication regimen</td>
</tr>
<tr>
<td>□ Unable to administer own medication</td>
</tr>
<tr>
<td>□ Unable to communicate needs</td>
</tr>
<tr>
<td>□ Unable to complete activities of daily living</td>
</tr>
</tbody>
</table>
## REASON FOR READMISSION (CHECK ALL THAT APPLY)

- [ ] Unable to maintain personal safety
- [ ] Unable to access services or treatment for medical condition
- [ ] Other (must specify):
- [ ] No other factors precipitating readmission

**Other Comments:**

103
<table>
<thead>
<tr>
<th>Reason</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aggression/Combative</td>
</tr>
<tr>
<td>Agitation</td>
</tr>
<tr>
<td>Anxiety</td>
</tr>
<tr>
<td>Catatonia</td>
</tr>
<tr>
<td>Change in Sleep - Decreased</td>
</tr>
</tbody>
</table>
### Symptoms and Behaviors

**Precipitating Admission**

<table>
<thead>
<tr>
<th>Reason for Readmission (Check All That Apply)</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Change in Sleep - Increased</td>
</tr>
<tr>
<td>□ Confusion</td>
</tr>
<tr>
<td>□ Delusions (Describe Below)</td>
</tr>
<tr>
<td>□ Depression</td>
</tr>
<tr>
<td>□ Disorganized</td>
</tr>
</tbody>
</table>
### Symptoms and Behaviors Precipitating Admission

**REASON FOR READMISSION (CHECK ALL THAT APPLY)**

- ☐ Disorientation
- ☐ Flight of Ideas
- ☐ Grandiose
- ☐ Hallucinations (Describe Below)
- ☐ Homicidal Ideation/Threats
### Symptoms and Behaviors

**Precipitating Admission**

<table>
<thead>
<tr>
<th>Reason for Readmission (Check All That Apply)</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Hyper-verbal</td>
</tr>
<tr>
<td>□ Isolated/ Withdrawn</td>
</tr>
<tr>
<td>□ Looseness of Associations</td>
</tr>
<tr>
<td>□ Mania</td>
</tr>
<tr>
<td>□ Not Eating/ Poor Appetite</td>
</tr>
</tbody>
</table>
## Symptoms and Behaviors Precipitating Admission

<table>
<thead>
<tr>
<th>Reason for Readmission</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not Completing ADLs</td>
</tr>
<tr>
<td>Paranoia</td>
</tr>
<tr>
<td>Pica</td>
</tr>
<tr>
<td>Psychomotor Agitation</td>
</tr>
<tr>
<td>Selectively Mute</td>
</tr>
</tbody>
</table>
### Symptoms and Behaviors Precipitating Admission

<table>
<thead>
<tr>
<th>Reason for Readmission (Check all that apply)</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Self-Injurious Behavior</td>
</tr>
<tr>
<td>□ Sexually Inappropriate</td>
</tr>
<tr>
<td>□ Substance Abuse – Alcohol</td>
</tr>
<tr>
<td>□ Substance Abuse – Drugs</td>
</tr>
<tr>
<td>□ Substance Abuse Withdrawal</td>
</tr>
<tr>
<td>Reason for Readmission (Check All That Apply)</td>
</tr>
<tr>
<td>----------------------------------------------</td>
</tr>
<tr>
<td>□ Suicidal Ideation/Threats</td>
</tr>
<tr>
<td>□ Suicidal Gesture</td>
</tr>
<tr>
<td>□ Suicide Attempt</td>
</tr>
<tr>
<td>□ Tangential</td>
</tr>
<tr>
<td>□ Verbally Hostile/Threatening</td>
</tr>
</tbody>
</table>
• Weiden, et al. evaluated the relationship between medication adherence and risk of rehospitalization in a cohort of 4325 California Medicaid participants with schizophrenia who were prescribed antipsychotics between 1999 and 2001, and who were followed for 1 year.

• The probability of readmission was directly related to the longest gap (measured as days within 1 year) in antipsychotic medication. A gap of 30 days or more was associated with a rehospitalization rate of 22% (OR 3.96), compared with 6% for patients with no gap in therapy.
While the initial goal of antipsychotic therapy is to achieve symptomatic control while minimizing the adverse effects of treatment, medication alone is not sufficient to achieve functional recovery.

Psychoeducation, social support, and family services are also needed to maximize outcomes. It is important for social support services to be provided for people soon after diagnosis. Regardless of the attitude towards medications, this is an independent predictor of adherence and impacts overall outcome.
The Issue of Treatment Adherence

- Only about 50% of individuals receiving behavioral health services keep their first outpatient appointment after what may have been a very costly inpatient intervention. Adherence to a psychotropic medication regimen is even more problematic.

- Individuals who are no adherent often become so within 2 weeks of hospital discharge, with no adherence causes not necessarily directly related to the medication itself. Data on 100 consecutive admissions to a specialized early intervention services in Canada followed for 6 months showed that 45% were non adherent, defined as taking less than 75% of the prescribed doses of medication.
The Issue of Treatment Adherence

- Level of family and social support and early medication acceptance were significant predictors of adherence. Non adherent individuals were less likely to have good social support (P=.02), more likely to be single (P=.019); and more likely to have refused medication at the first offer of treatment (P=.001).

- One meta-analysis of trials comparing depot and oral administration demonstrated relative and absolute relapse risk reductions of 30% and 10%, respectively (RR 0.07, CI 0.57-0.87, NNT 10, CI 6-25, P=.0009).
In schizophrenia spectrum illness, adherence is a key factor in determining outcomes. Unfortunately, partial or no adherence is common; it has been estimated that 75% of individuals with schizophrenia become non adherent within 2 years of hospital discharge.

Both prescribers and individuals tend to overestimate adherence and underestimate non adherence. Bias with regard to reporting non adherence is well documented.

For example, literature reviews find an average of only 28% of individuals are adherent, while reports to their physicians indicate an adherence rate of 43%.
Partial adherence to antipsychotic therapy begins early after discharge from the hospital in individuals with schizophrenia, and the prevalence of partial or nonadherence increases over time. Even under closely monitored conditions (staff monitoring, pill counts, blood-level analysis), 25% of 68 individuals enrolled in a study were partially adherent within the 10-12 days to 2 weeks following discharge and before the first blood draw.

This trend continues after 1 year, when at least 50% of individuals will be partially or no adherent, increasing to 75% by 2 years following discharge.
The Issue of Treatment Adherence

- Strategies must also be devised to assist cognitively impaired and unmotivated individuals to adhere to medication schedules, such as using pill organizers arranged by day of the week, ensuring that medicines are kept in a place the person can remember, wristwatch or smartphone alarms, or establishing routines.

- Some commonly encountered risk factors for non adherence are those related to the medications themselves.