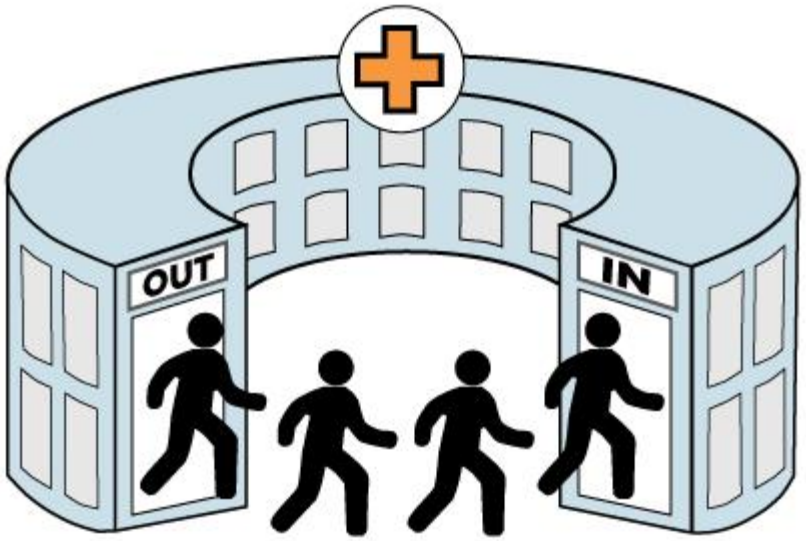
Behavioral Health & Readmissions in Massachusetts Acute Care Hospitals

November 17, 2016



CHIA.

Overview

- Introduction
- Why behavioral health?
- What are some of the key findings?
- What are some of the implications for practice and quality improvement?
- Questions & Answers

CHIA's All-Payer Readmission Analyses

- Medicare Fee-For-Service vs. all-payer population
- CHIA's adaptation of the Yale/CMS hospital-wide all cause unplanned readmission for the all-payer population – first public reporting in June 2015
- Statewide reports and hospital-specific readmissions profiles
- Expansion to include primary psychiatric discharges to look at behavioral health comorbidity

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Why Behavioral Health?

- One in four adults suffers from a behavioral health condition.
- One-third of all hospitalizations involved individuals with a comorbid behavioral health diagnosis.
- New discharge planning requirements to include behavioral health for all Medicare and Medicaid patients.
- First statewide, all-payer examination of the prevalence of behavioral health comorbidities and readmissions among hospitalized adults in Massachusetts acute care hospitals.

Counting “Eligible” Discharges (FY2014 #’s)

HDD Adult Discharges
677,379

Remove discharges that don’t make sense to include

- Missing/invalid SSN
- Transfers
- Deaths in hospital
- Against medical advice

Remove discharges for certain specialized types of care

- Obstetric
- Cancer
- Rehabilitation

Eligible Discharges
515,353

Unique Patients
347,747

Behavioral Health Comorbidity

Using a modified AHRQ methodology, both primary and secondary diagnoses across all discharges for patients within the one-year study period were used to classify patients into four mutually exclusive groups:

- Mental health disorders (MD) only
- Substance use disorders (SUD) only
- Both MD and SUD or co-occurring disorders (COD)
- No mention of MD or SUD (None)

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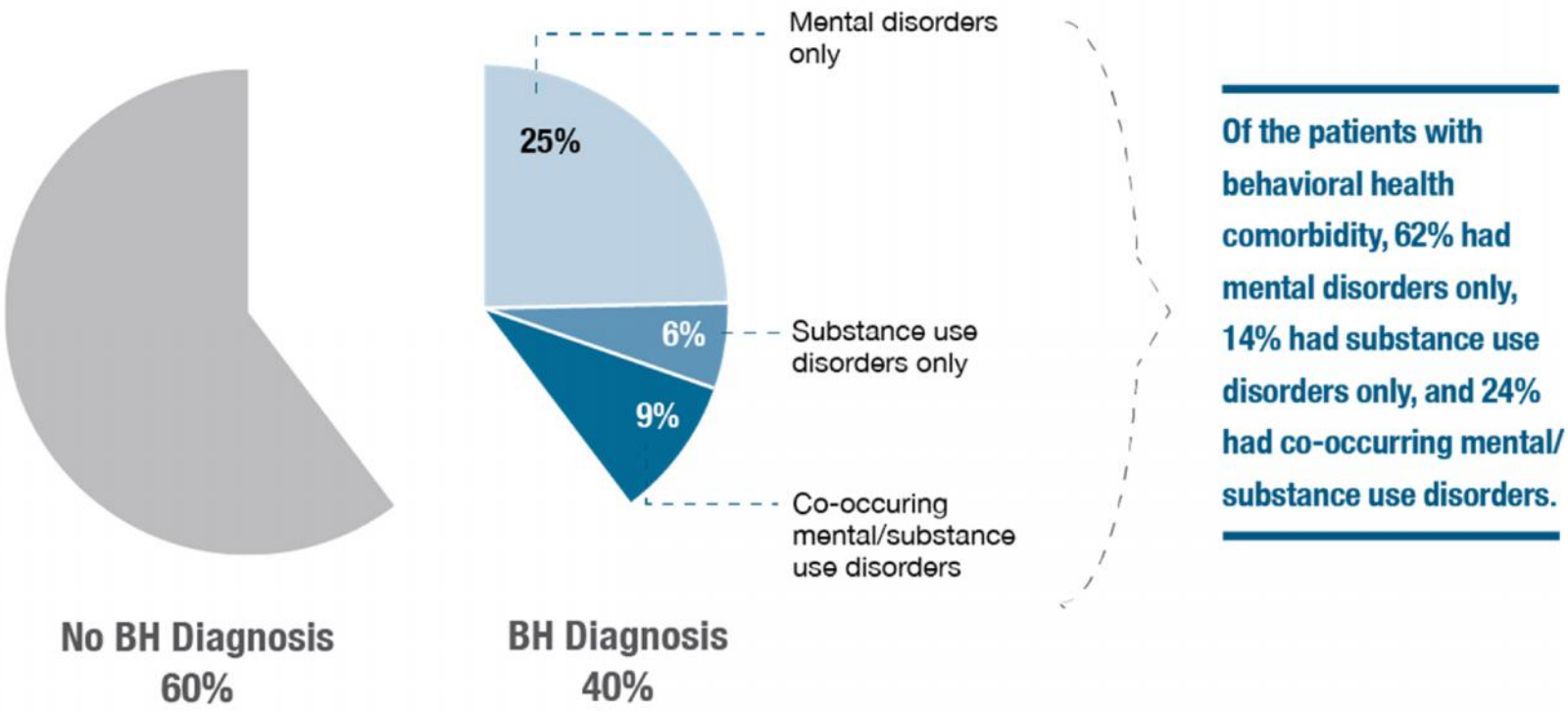
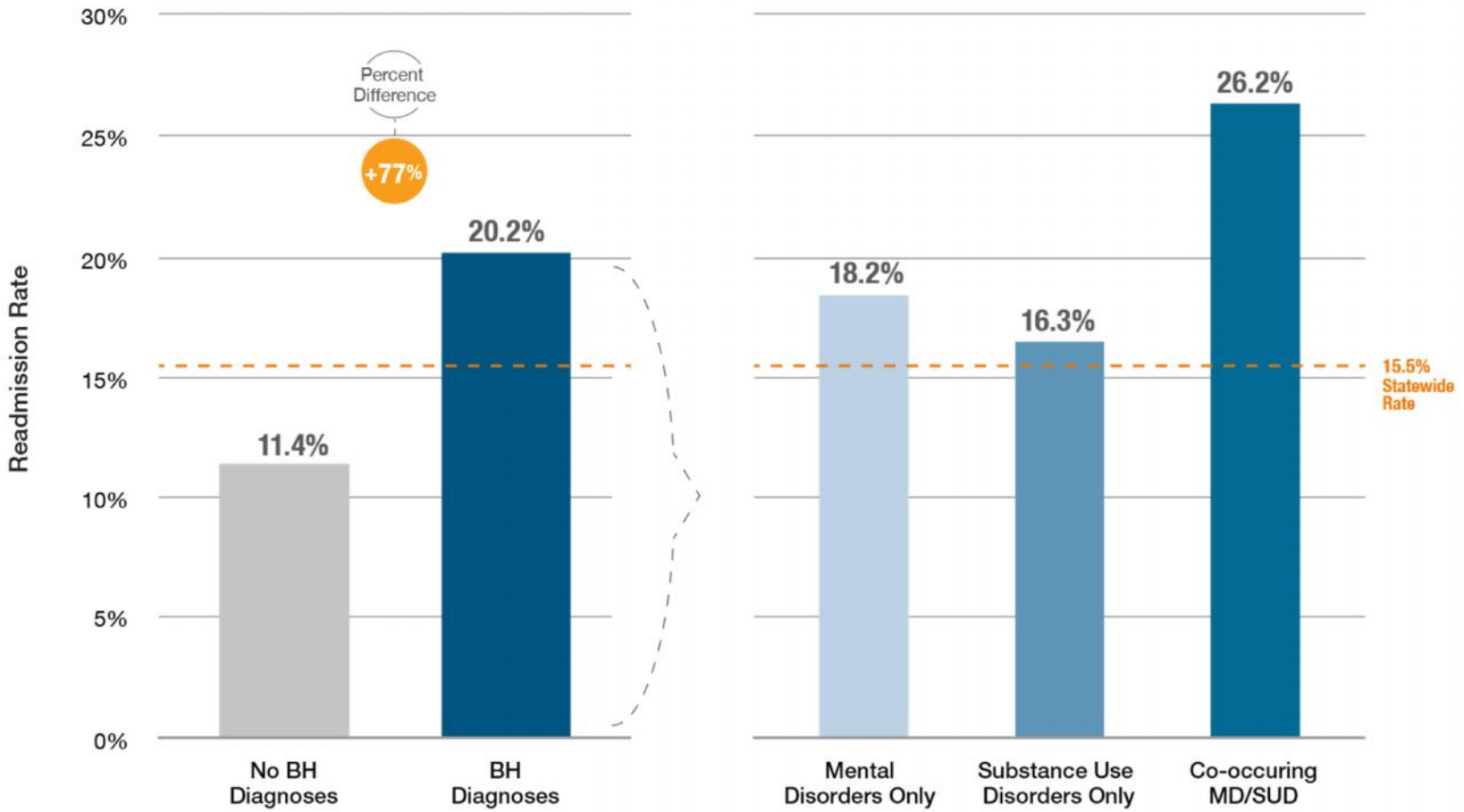
Statewide Prevalence of Behavioral Health Comorbidity among Patients in Acute Care Hospitals

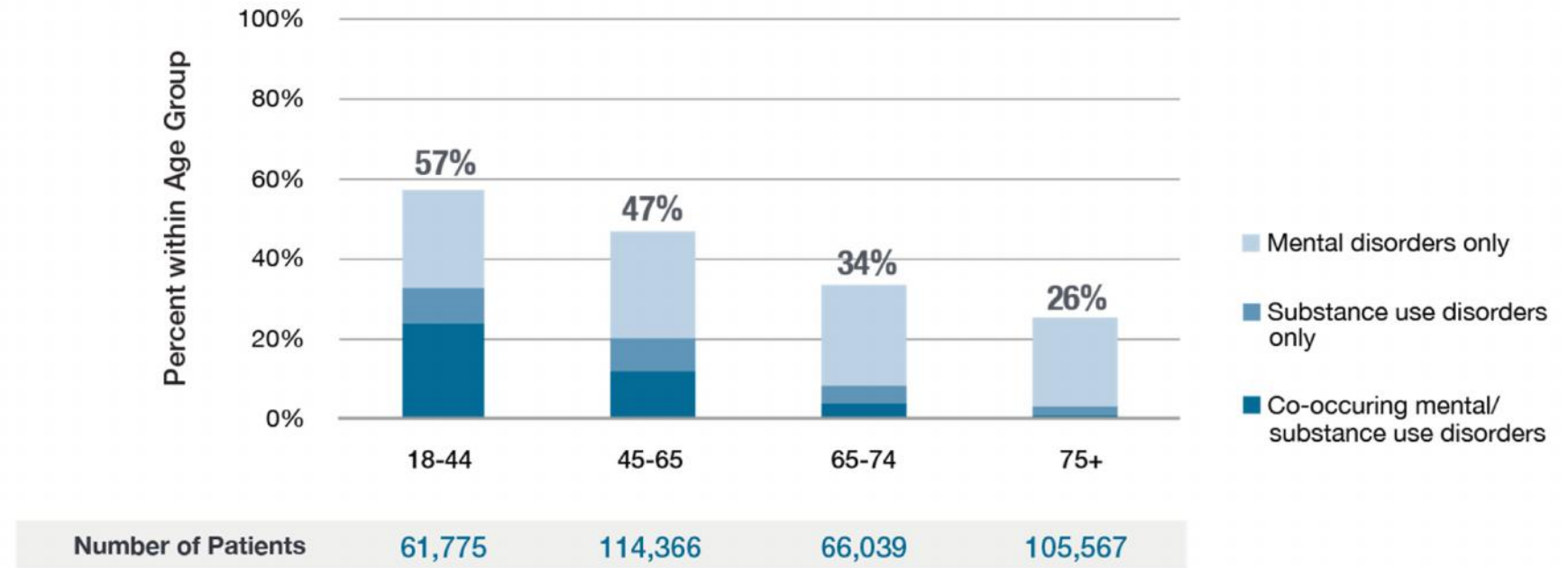


Of the patients with behavioral health comorbidity, 62% had mental disorders only, 14% had substance use disorders only, and 24% had co-occurring mental/ substance use disorders.

Statewide Readmission Rates and Behavioral Health Comorbidity

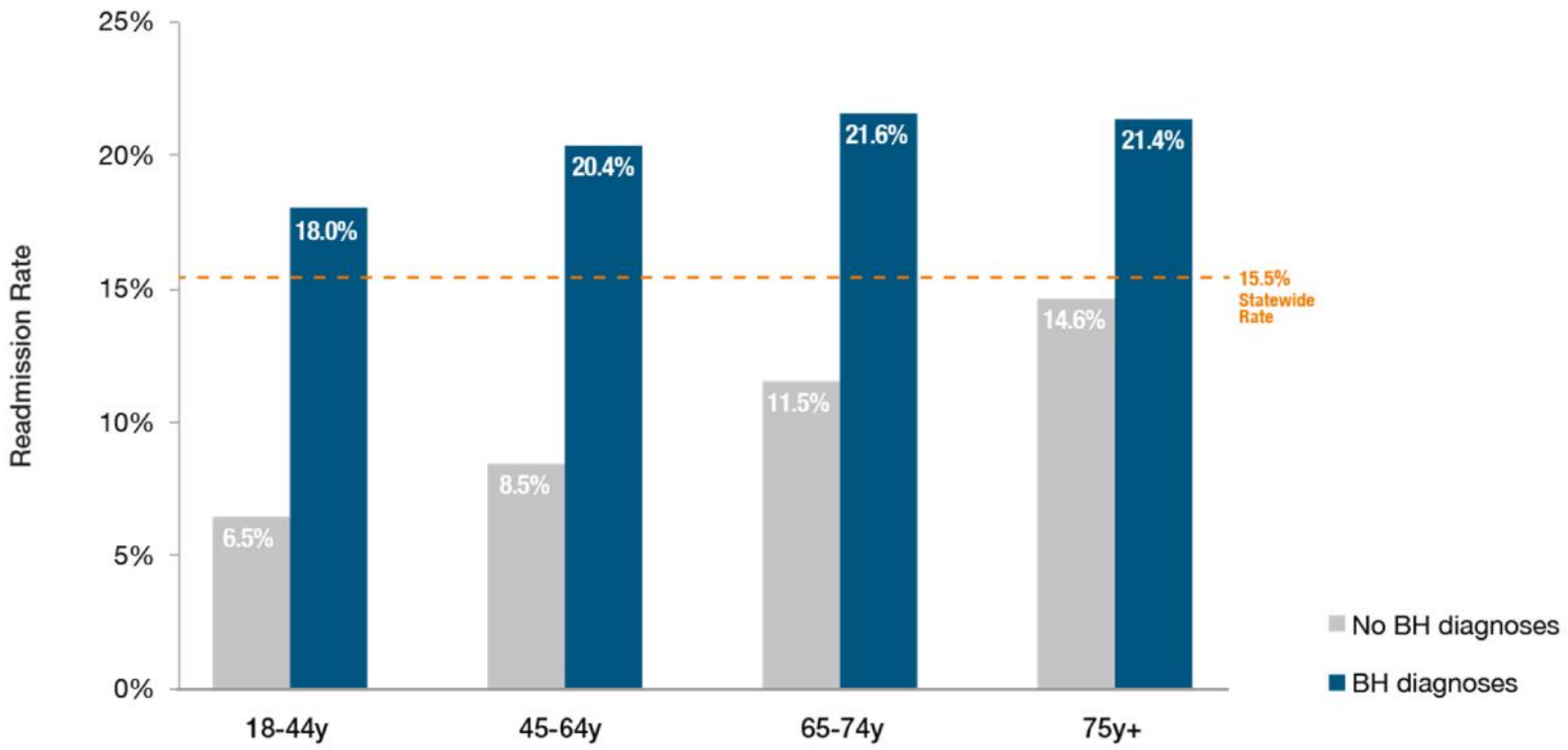


Prevalence of Behavioral Health Comorbidity by Age Group

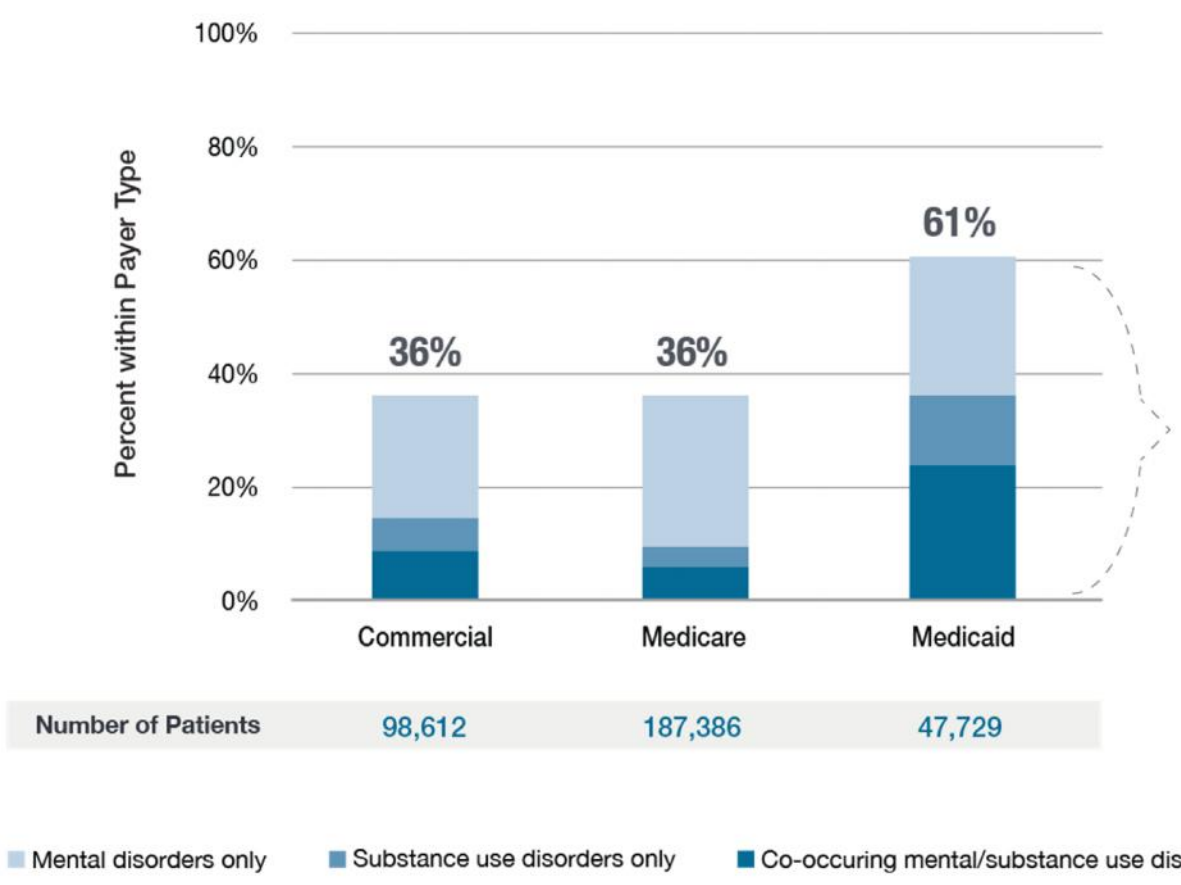


Number of Patients	61,775	114,366	66,039	105,567

Readmission Rates and Behavioral Health Comorbidity by Age Group

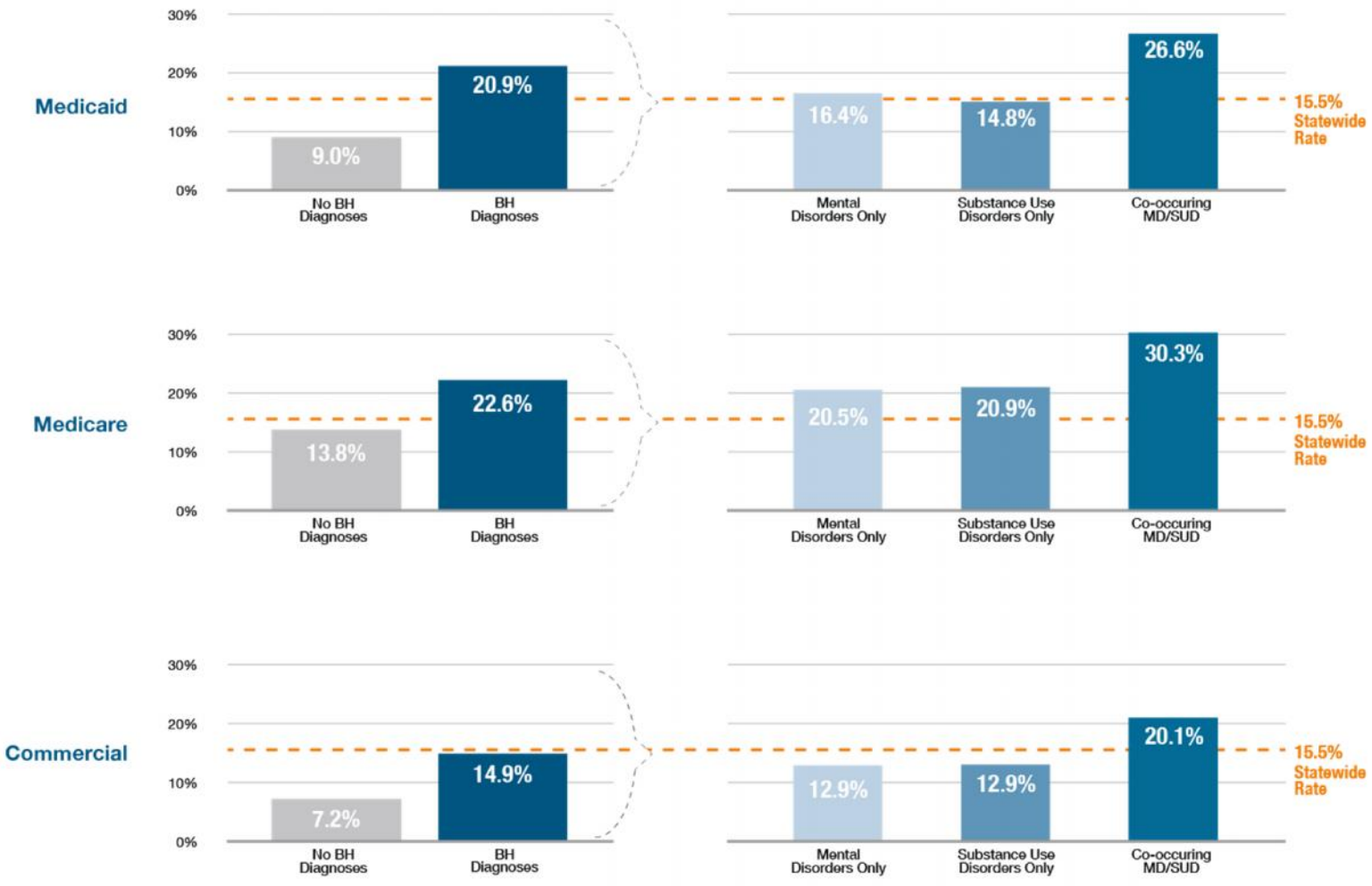


Prevalence of Behavioral Health Comorbidity by Payer Type

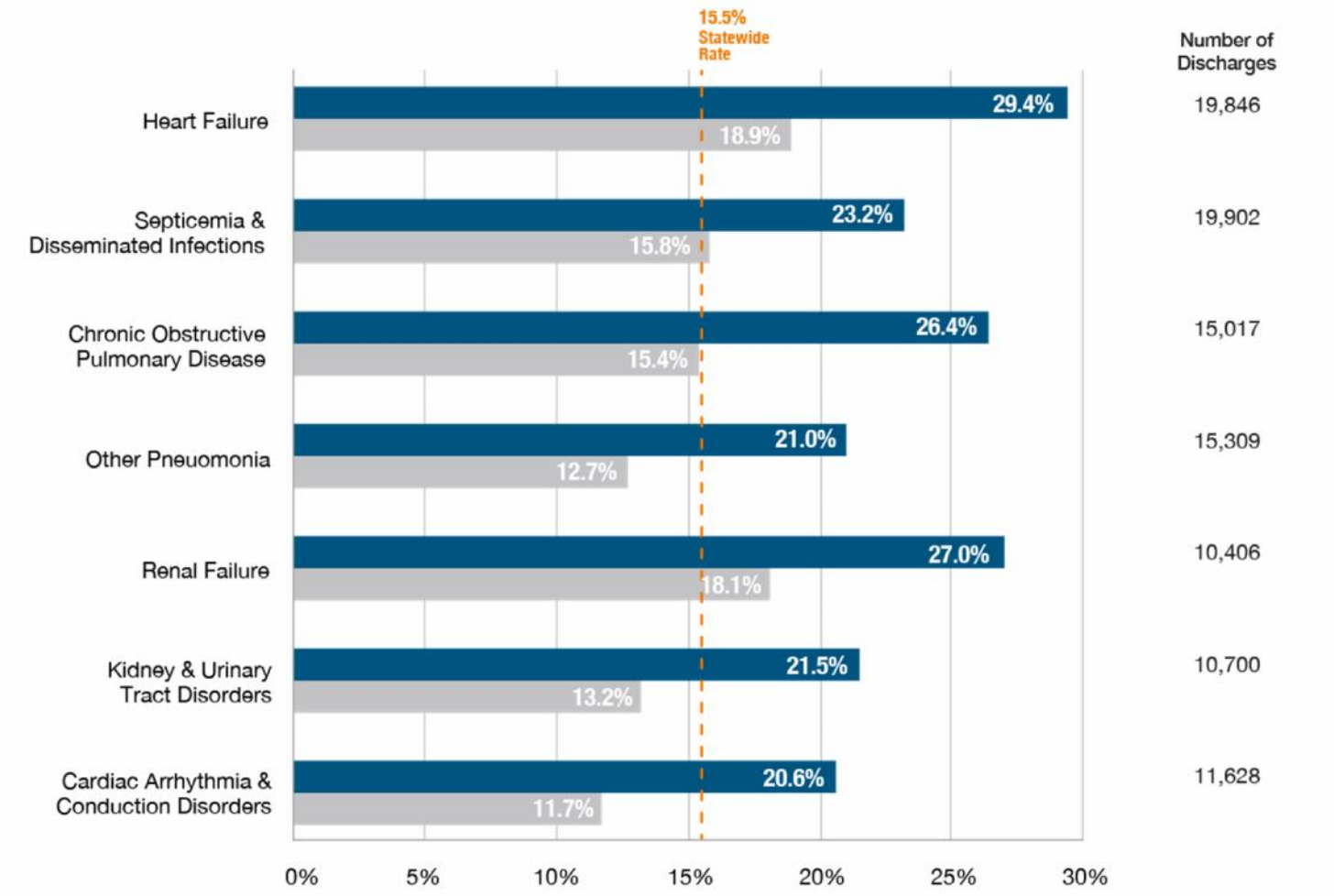


Of those Medicaid patients with behavioral health comorbidity, 41% had mental disorders only, 20% had substance use disorders only, and 39% had co-occurring mental/substance use disorders.

Readmission Rates and Behavioral Health Comorbidity by Payer Type



Readmission Rates and Behavioral Health Comorbidity by Common Discharge Diagnosis



Summary of Findings

- 40% of hospitalized patients had at least one comorbid behavioral health condition.
  - Patients with behavioral health comorbidity 77% more likely to be readmitted than those without any behavioral health comorbidity (20.2% vs. 11.4%).
- 61% of hospitalized Medicaid patients had a comorbid behavioral health condition.
  - Medicaid patients with comorbid co-occurring mental and substance use conditions were three times more likely to be readmitted than those without any behavioral health comorbidity (26.6% vs. 9.0%).
- Young adults (age 18-44) with a behavioral health comorbidity were nearly three times more likely to be readmitted than those without any behavioral health comorbidity (18.0% vs. 6.5%).
- Among patients discharged with heart failure, the presence of a behavioral health comorbidity was associated with a readmission rate that was 56% higher than those without any behavioral health comorbidity (29.4% vs. 18.9%).

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Implications for Practice & Quality Improvement

Amy E. Boutwell, MD, MPP

Why are these findings important?

61 man with 8 hospitalizations for shortness of breath.

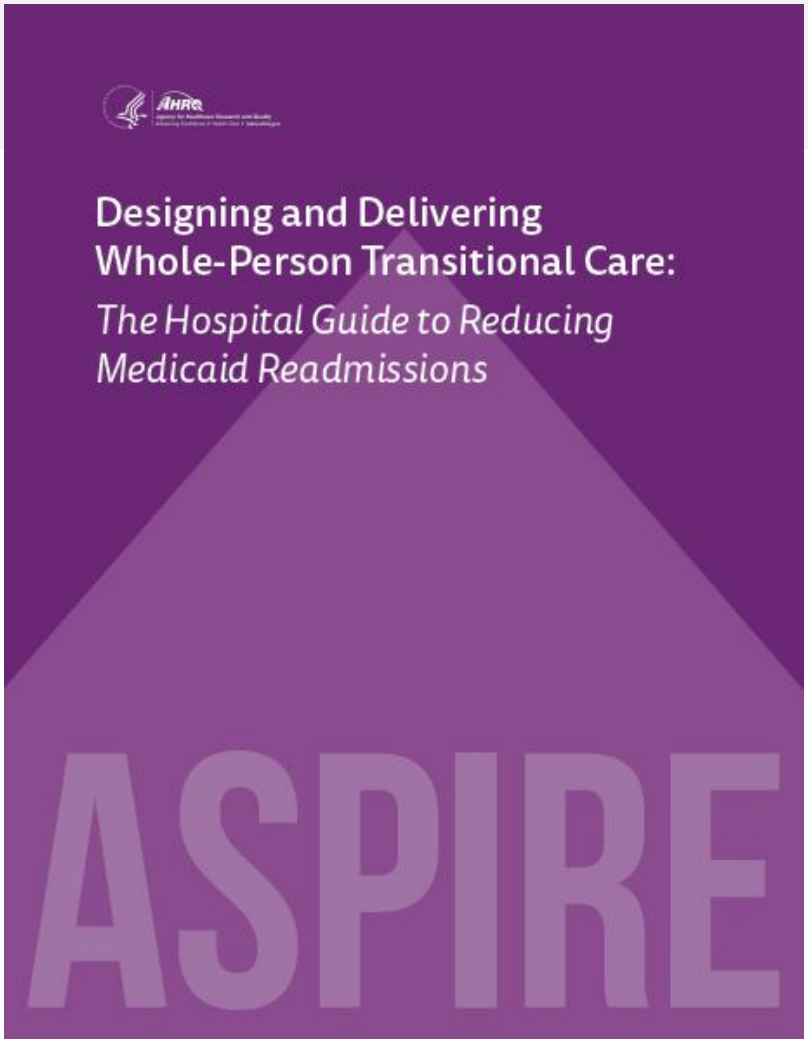
“Oh honey, I’m in here every couple of weeks and it always takes about 5 days to tune me up”

32M with lifetime of uncontrolled diabetes.

“I need housing, not a shelter. I need someone to help make sure I take my medicines. In a shelter they don’t do that and they kick you out every morning. I need a stable residence and no one is able to help with that."

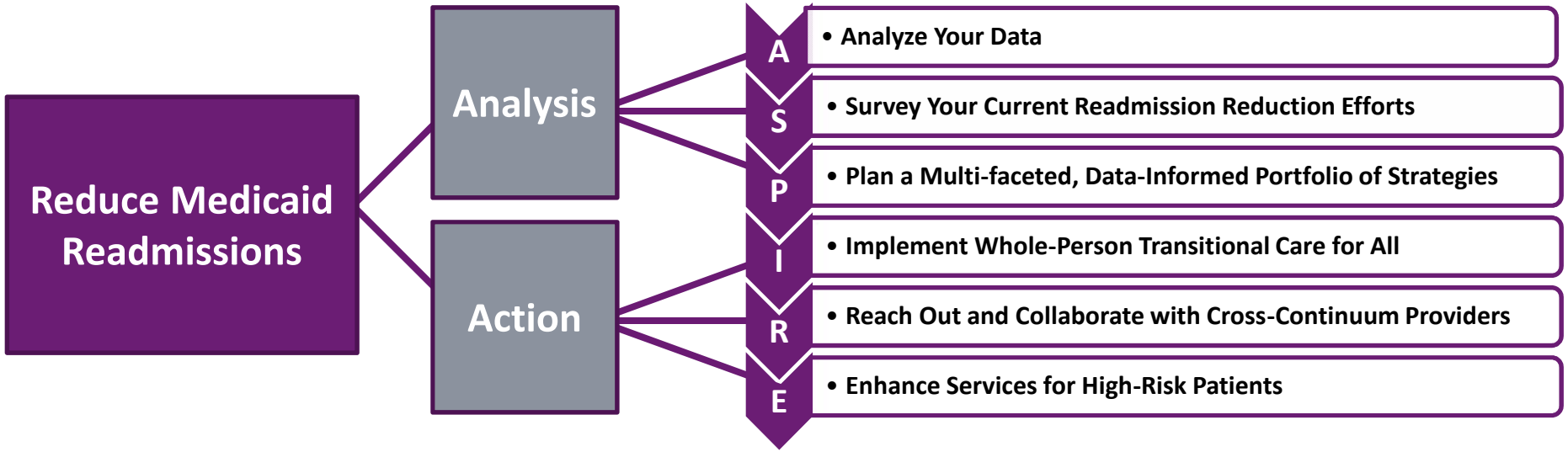
AHRQ Reducing Medicaid Readmissions Project

- Identify the similarities & differences in readmission patterns for Medicare v. Medicaid patients
- Explore whether the “best practices” to reduce readmissions apply to the Medicaid population as well
- Create a guide for hospitals to increase awareness of the unique issues in reducing Medicaid readmissions



The guide comes with 13 customizable tools to be used in hospital teams' day-to-day operations.

The ASPIRE Framework



Teams with Results

- Know their data –

  Analyze, trend, track, display, share, post

- Broad concept of “readmission risk”

  Way beyond case finding for diagnoses

- Multifaceted strategy

  Improve standard care, collaborate across settings, enhanced care

- Use technology to make this better, quicker, automated

  Automated notifications, implementation tracking, dashboards

Examples: Data-informed "Socially Complex" Criteria

- Adult, non-OB Medicaid patient
- Medicare <65
- Substance use disorder
- High utilization (4+ admissions/12 months)

- Whole-hospital readmission rate: **13%**
- "Socially complex" population readmission rate: **37%**

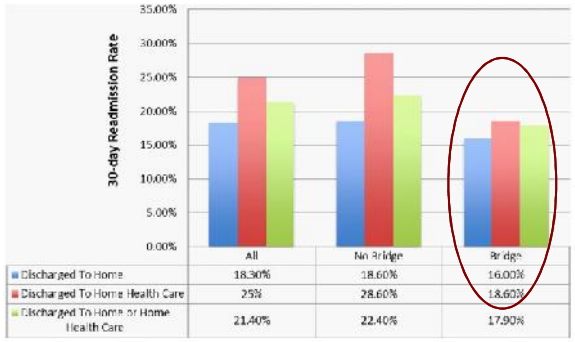
➢ **That's data-informed targeting!**

Designing Services for High Risk Target Populations

- There may be several target populations at high risk of readmission identified by your data analyses
- Consider the following high risk target populations:
  - Adults with behavioral health comorbidities;
  - Adults residing in group homes or other residential settings;
  - Adults with a personal history of repeated hospitalizations in the past year
- One “standard” transitional care model ***would not likely*** meet the needs and address the root causes of readmissions for all these populations
- Design “enhanced services” to ***meet the needs*** of each target population

Social Work-Provided Transitional Care

- Assess whole-person needs
- Anticipates needs will change over time
- Repeated assessments
- Customized interventions
- Link individuals to existing providers and services
- Provide psycho-therapeutic support
- Identify person-centered priorities and goals
- Advocate for timely services, patient preferences, etc.



- 20% reduction
- All hospital
- All cause
- At Scale (1500+)

Boutwell et at JAGS May 2016

In practice: Interdisciplinary Transitional Care Team

A large safety net hospital in California has an 8-member interdisciplinary transitional care team:

- Pharmacist
- COPD RN
- CHF RN
- Social worker
- 2 Community Health Outreach Workers
- Program Manager
- Data Analyst

The team serves patients admitted with COPD, CHF, or HIV. They actively screen for marginal housing and substance use disorder. They describe their work as "actively support" patients – accompany, support, touch base, follow-up. They hold "drop in" visits in an outpatient conference room on site at the hospital, during which hours patients can connect with the team, have specific questions or needs addressed. Notably, all clinical members of the team do home visits. The team states their success is due to working as an interdependent, highly collaborative team.

“Whole-Person” Adaptations to Transitional Care

- Navigating
- Hand-holding
- Arranging for….
- Providing with….
- Harm reduction
- Meet “where they are”
- Patient priorities first
- Relationship-based

Summary

- Know your data – use it as a powerful tool
- Constantly work to understand *why* patients return to the hospital
- Design services that will meet the needs of specific target populations
  - For people with behavioral health comorbidities, deploy care teams that actively "do for" – navigate, advocate, support
- Don't over-medicalize readmissions or hospital utilization
- It is possible to meaningfully improve care and reduce readmissions for people with behavioral health conditions!

THANK YOU!
Questions?

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