Driving Member Outcomes; Community of Care Creates post discharge Care Transition Workflow for Behavioral Health Patients

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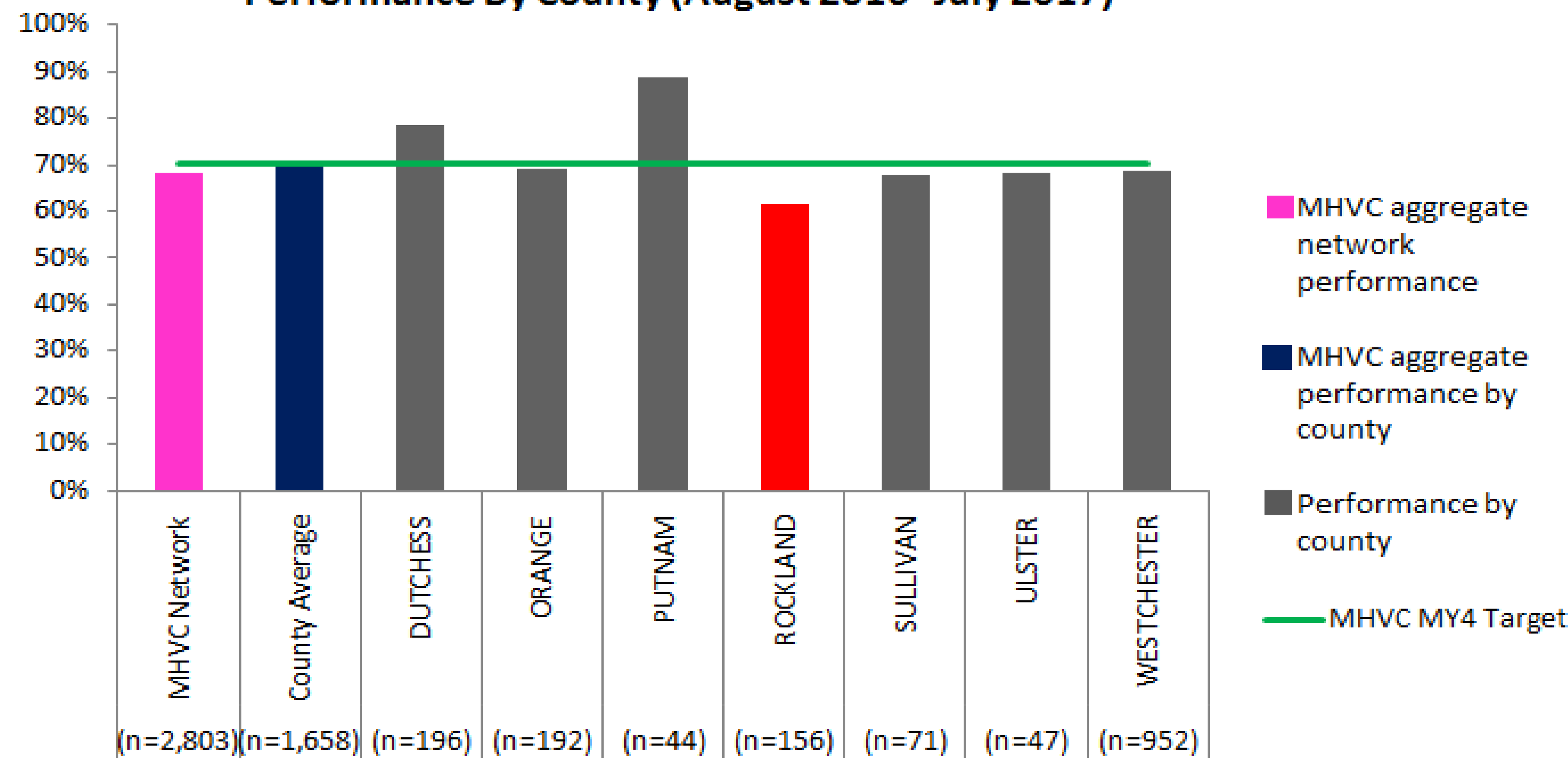
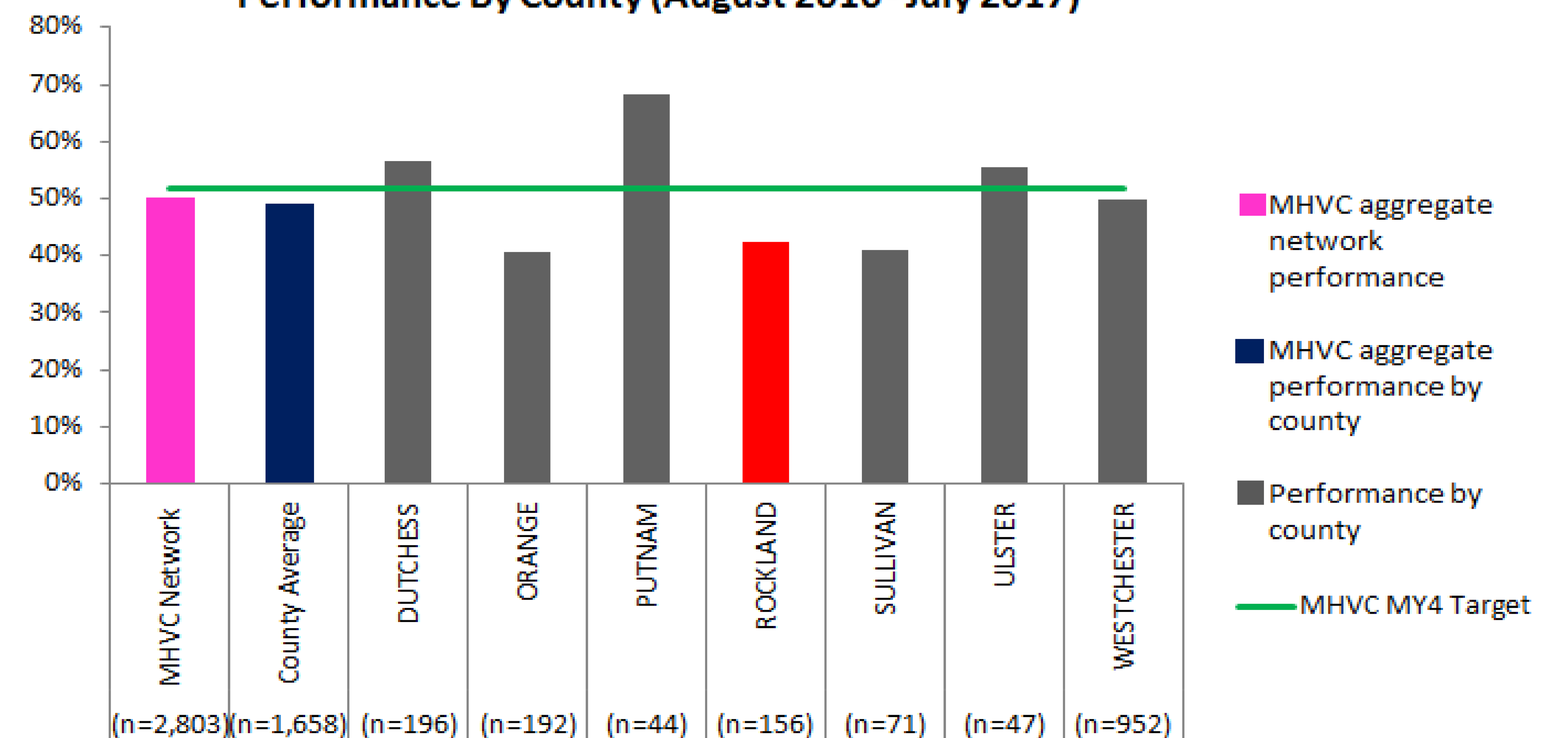
Background

A Community of Care (CoC) has been created encompassing Montefiore Hudson Valley Collaborative contracted partners in Rockland County. The CoC is intended to be a venue for partner engagement and collective performance improvement. Guided by data highlighting performance gaps, the Rockland CoC voiced a shared concern and commitment to address access to mental health treatment and performance on the DSRIP/HEDIS follow-up after a mental health inpatient hospitalization with outpatient mental health treatment.





**Data Source: New York State Salient Interactive Miner ; Data represents percentage of members who had a follow-up visit within the recommended timeframe and with an appropriate provider*

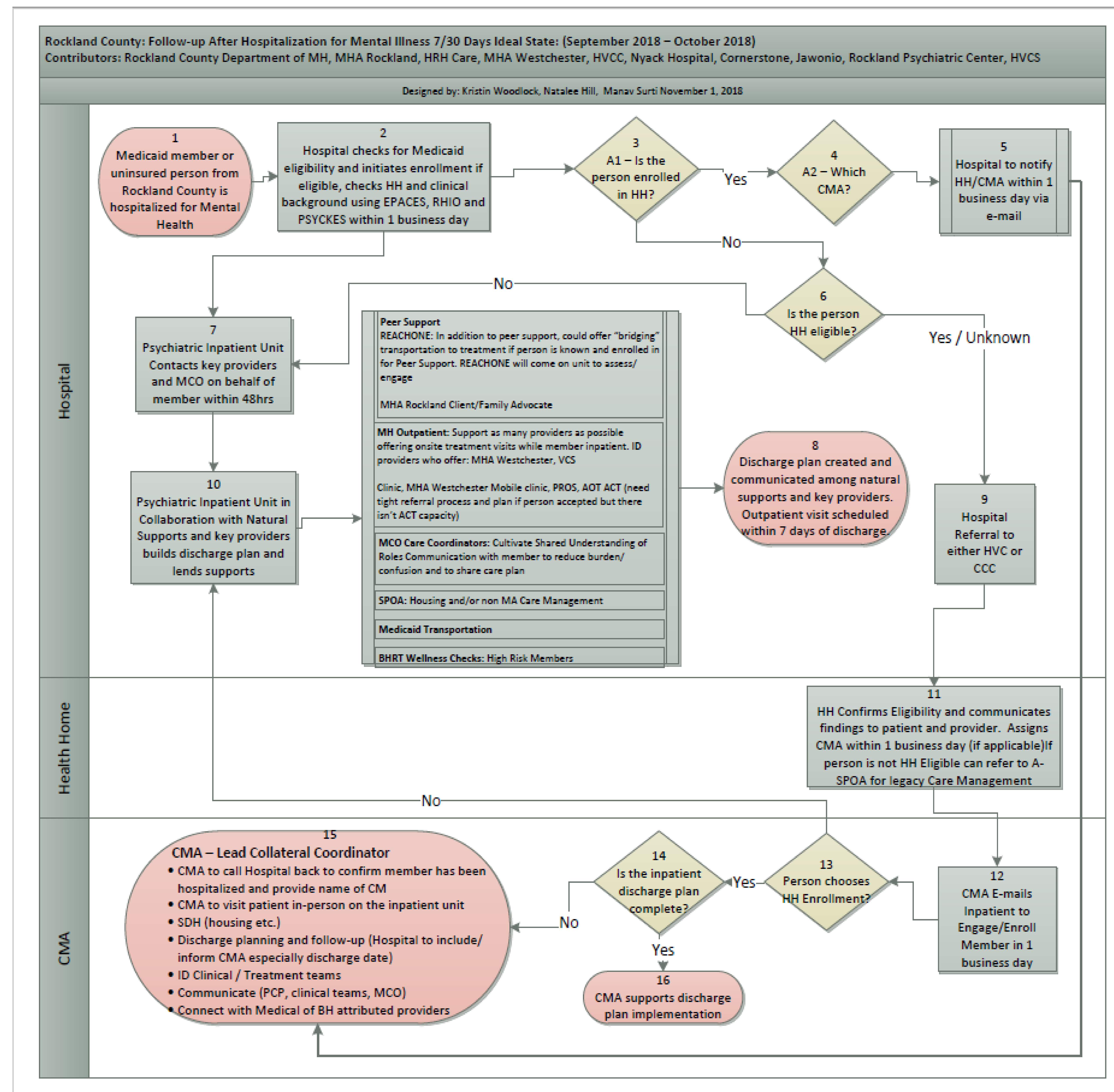
Key Discovery

There was a key lesson learned in this process: Multiple "helpers" reaching out with good intentions to engage the member who is hospitalized is overwhelming from the member's perspective. Our lack of a streamlined process, clear roles, and teamwork and accountability leads to an ineffective care transition process.

Intervention

This is a rapid process improvement project for members and contracted providers of MHVC. The project group is responsible for looking at data, identifying root causes of barriers to follow-up, understanding client needs, and developing provider-specific and CoC workflows. Working together, the group will develop an implementation plan to streamline a care transitions process post discharge following hospitalization for Mental illness. Solutions will address identified structural, performance, and policy and regulatory concerns.

The project team developed an efficient and effective "community" workflow to streamline the post-discharge follow-up process to connect members to eligible services and ensure continuity of care.



Workflow Summary

The project team developed an efficient and effective "community" workflow to streamline the post-discharge follow-up process to connect members to eligible services and ensure continuity of care.

The key steps in this workflow are:

All Patients:

- **Hospital staff to verify Medicaid eligibility using EPACES, RHIO, and PSYCKES and initiate enrollment, if applicable, at intake; Inpatient Psychiatric unit to contact key providers and MCO (within 2 business days) - *Workflow boxes 1-2, 7***
- **Hospital staff to refer eligible/unknown members to Health Home via e-mail (within 1 business day) - *Workflow boxes 3-6, 9***

Eligible/Enrolled Health Home Members:

- **Health Home to assign member to Care Management Agency (within 1 business day) - *Workflow box 11***
- **CMA to enroll/engage member during admission (within 1 business day) - *Workflow box 12***
- **CMA to support discharge plan if complete or assume the role of "Lead Collateral Coordinator" and visit patient in-person on the impatient unit - *Workflow boxes 14-16***

Ineligible/Not interested Members:

- **Psychiatric inpatient unit to build discharge plan including referrals to outpatient MH providers and appropriate CBOs - *Workflow box 10 and subsequent boxes including box 8***

Next Steps

Rockland County Follow-up after Hospitalization workflow is currently scheduled for implementation in Spring 2019.

The following Process & Outcomes metrics will be tracked to measure progress and success post implementation:

Hospital Process Measures:

- Time of admission to time of referral
- Number of referrals made to HH/CMA within 1 business day
- Number of ineligible patients connected to appropriate CBOs
- Number of pts. readmitted within 30 days for clinically related diagnosis

HH / CMA Process Measures:

- Number of HH eligible pts. referred from hospital
- Number of referred pts. outreached within 1 business day
- Number of outreached pts. enrolled in HH
- 3 month retention rate of enrolled pts.

Project Outcomes Measures:

- An increase in the rate of Follow-up appointments within 7/30 days post discharge from inpatient admission for mental illness