

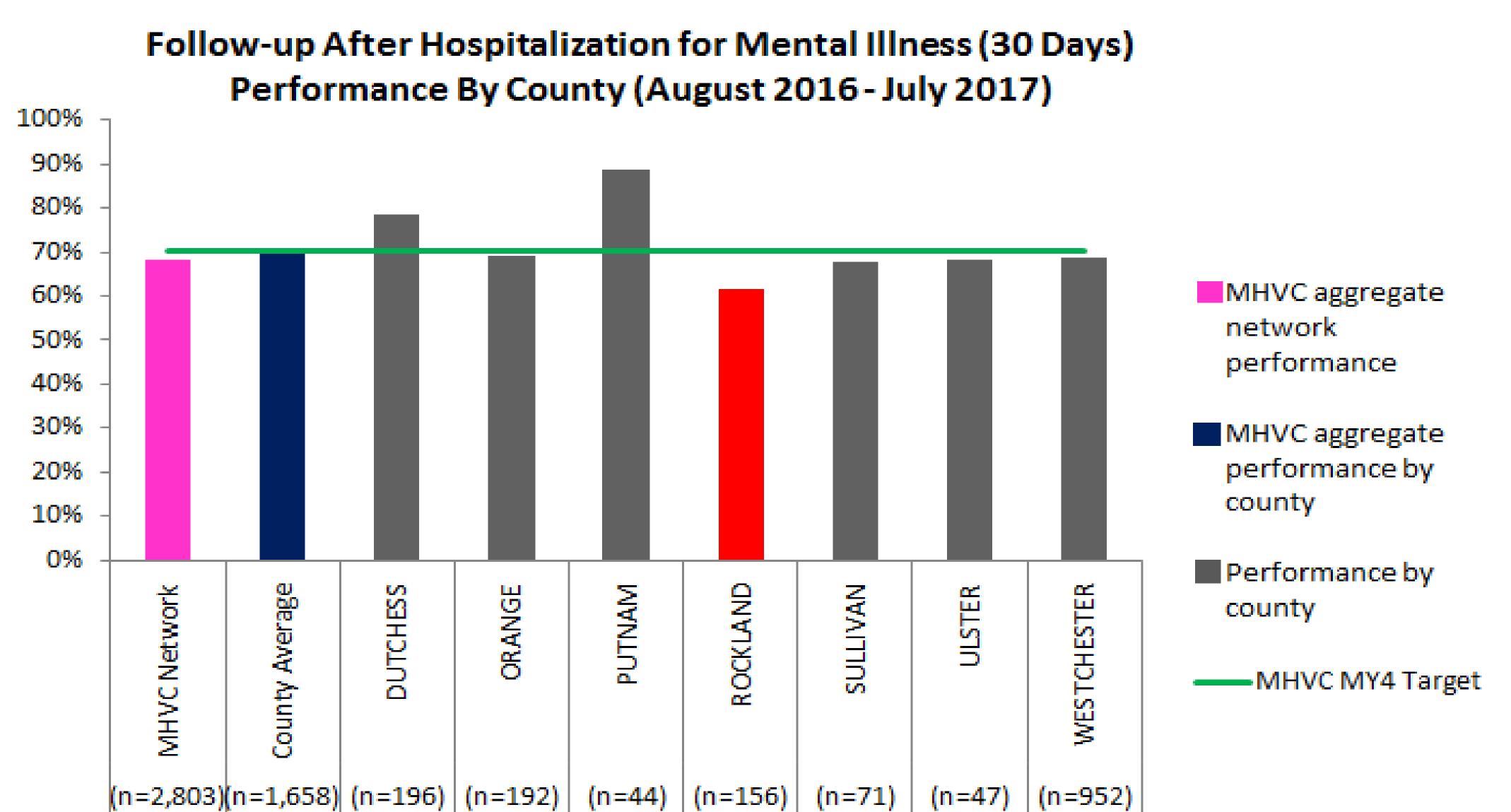
Driving Member Outcomes; Community of Care Creates post discharge Care Transition Workflow for Behavioral Health Patients

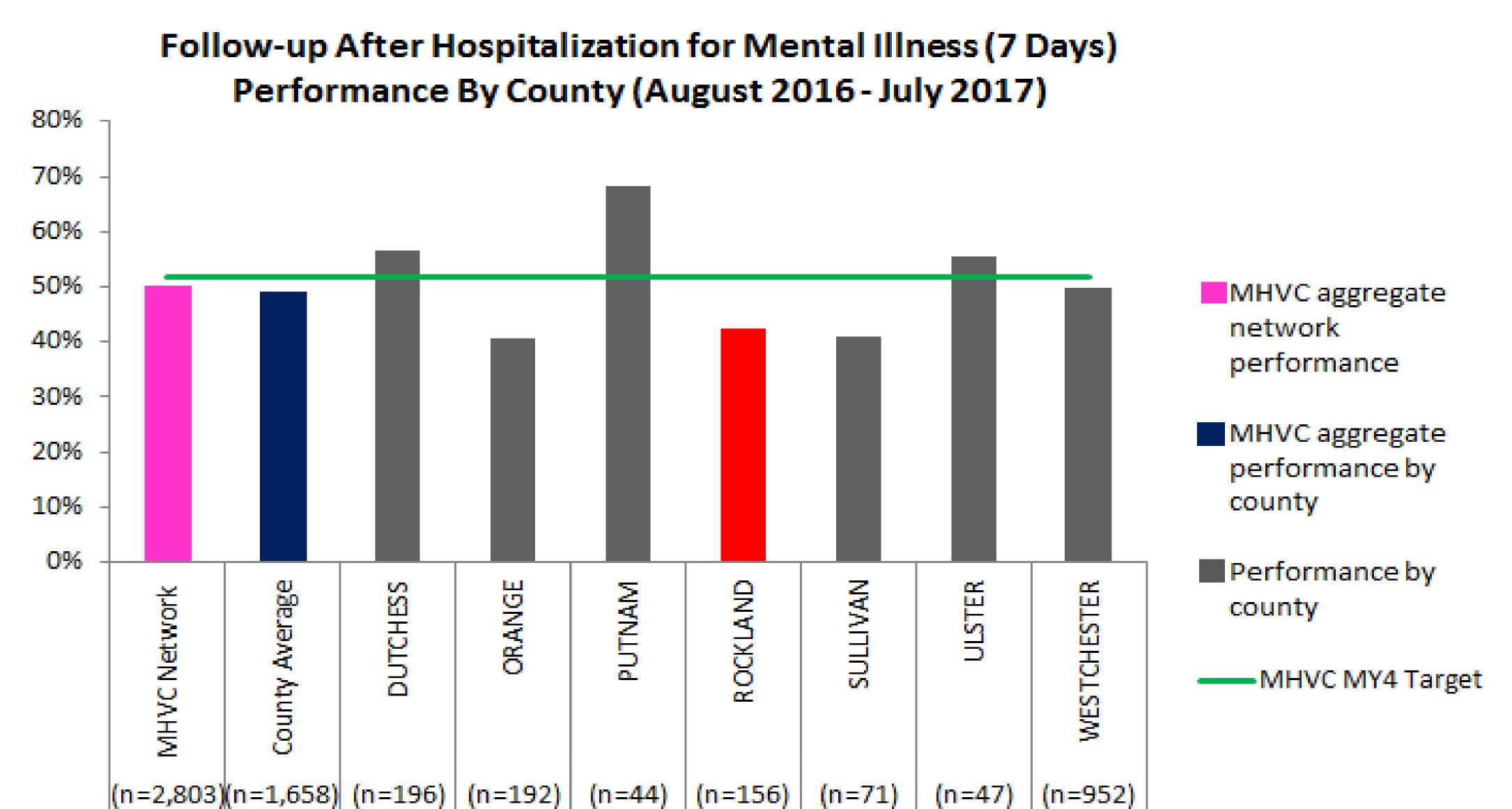
Kristin Woodlock RN, Natalee Hill MPA, Manav Surti MBA

Woodlock & Associates, Rockland County Department of MH, MHA Rockland, HRH Care, MHA Westchester, HVCC, Nyack Hospital, Cornerstone, Jawonio, Rockland Psychiatric Center, HVCS

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

Rockland County: Follow-up After Hospitalization for Mental Illness 7/30 Days Ideal State: (September 2018 - October 2018) Contributors: Rockland County Department of MH, MHA Rockland, HRH Care, MHA Westchester, HVCC, Nyack Hospital, Cornerstone, Jawonio, Rockland Psychiatric Center, HVCS Designed by: Kristin Woodlock, Natalee Hill, Manay Surti November 1, 2018 Hospital checks for Medicaid Medicaid member or A1 - Is the Hospital to notify eligibility and initiates enrollment A2 - Which uninsured person from person enrolled HH/CMA within 1 eligible, checks HH and clinical Rockland County is business day via background using EPACES, RHIO and hospitalized for Mental PSYCKES within 1 business day Is the person Yes / Unknown Psychiatric Inpatient Unit transportation to treatment if person is known and enrolled in for Peer Support. REACHONE will come on unit to assess/ Contacts key providers and MCO on behalf of member within 48hrs MHA Rockland Client/Family Advocate MH Outpatient: Support as many providers as possible offering onsite treatment visits while member inpatient. ID providers who offer: MHA Westchester, VCS Discharge plan created and communicated among natural Clinic, MHA Westchester Mobile clinic, PROS, AOT ACT (need supports and key providers. tight referral process and plan if person accepted but there Psychiatric Inpatient Unit in Outpatient visit scheduled Hospital Collaboration with Natural within 7 days of discharge Referral to Supports and key providers MCO Care Coordinators: Cultivate Shared Understanding of either HVC or builds discharge plan and Roles Communication with member to reduce burden/ lends supports confusion and to share care plan SPOA: Housing and/or non MA Care Management Medicaid Transportation BHRT Wellness Checks: High Risk Members HH Confirms Eligibility and communicates findings to patient and provider. Assigns CMA within 1 business day (if applicable)If person is not HH Eligible can refer to A-SPOA for legacy Care Management CMA – Lead Collateral Coordinator • CMA to call Hospital back to confirm member has been Is the inpatient Person chooses hospitalized and provide name of CM discharge pla CMA E-mails CMA to visit patient in-person on the inpatient unit Inpatient to SDH (housing etc.) Engage/Enroll Discharge planning and follow-up (Hospital to include/ Member in 1 inform CMA especially discharge date) business day • ID Clinical / Treatment teams Communicate (PCP, clinical teams, MCO) CMA supports discharge Connect with Medical of BH attributed providers plan implementation

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