Patient care transition in psychiatry and mental health
(Transição entre níveis de cuidados e a adesão do doente)

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Avoidable hospital readmissions

- are a worldwide problem
- represent reduced quality of health care
- increase health costs

Early readmission

- Within 90 days of discharge
- Represents negative clinical outcome for the patients
- Visits to Emergency Department Units, and in-patient psychiatric treatment are expensive
- Governments are implementing strategies to reduce early readmissions

- According to a 2009 study, 20% of Medicare beneficiaries from the USA were rehospitalized within 30 days after discharge.
- Annual cost of $17 billion


- In high income countries, 13% of psychiatric patient are readmitted shortly after discharge from an acute psychiatric unit

About 50% of all discharged psychiatric patients from a psychiatric hospital will be readmitted within 1 year

Bridge JA, Barbe RP. *Reducing hospital readmission in depression and schizophrenia: current evidence*. Curr Opin Psychiatry 2004; 17:505–511;

Madi N, Zhao H, Li JF. *Hospital readmissions for patients with mental illness in Canada*. Healthc Q 2007; 10:30–32.

In the USA fewer than a half of discharged patients are connected with outpatient care within 7 days

Care transition between hospital and the community is a challenge worldwide:

In the Netherlands, 1 year after compulsory admission to a psychiatric hospital more than 1/3 of psychiatric patients were readmitted

Wierdsma AI, van Baars AW, Mulder CL. Psychiatric past history and healthcare after compulsory admission. Care use as an indicator of the quality of care for patients in compulsory care in Rotterdam. Tijdschr Psychiatr 2006;48:81–93

To reduce readmission in Norway:

- Longer stays in ward
- Appropriate discharge planning
- Follow-up visits after discharge

Early psychiatric readmission does not reflect only the quality of in-patient care\textsuperscript{a,b} but also

The continuity of care with other parts in the mental health system\textsuperscript{c}

Particularly the ability of mental health systems to coordinate care and support as patient move from hospital to less intensive types of ambulatory care\textsuperscript{a}

Causes of avoidable hospital readmissions

- Patients released without being stabilized
- Lack of coordination and reconciliation of medication after discharge
- Inadequate communication among hospital staff, patients, family and primary care providers
- Inadequate planning for care transitions

In psychiatry and mental health settings, inadequate transitions among care providers are particularly problematic and increase the risk of hospital readmission and symptoms exacerbation.

Systematic protocols and communication procedures for managing transitions have been shown to be effective in managing handoffs.


There is a lack of research on interventions to address the care transitions in psychiatry
# Models and initiatives tested in the area of general medical care

<table>
<thead>
<tr>
<th>Model</th>
<th>Reference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Care Transitions Interventions (<strong>CTI</strong>)</td>
<td><a href="http://www.caretransitions.org">www.caretransitions.org</a></td>
</tr>
<tr>
<td>From Coleman et al.</td>
<td></td>
</tr>
<tr>
<td>Transitional Care Model (<strong>TCM</strong>)</td>
<td><a href="http://www.transitionalcare.org">www.transitionalcare.org</a></td>
</tr>
<tr>
<td>Based on the work of Mary Naylor</td>
<td></td>
</tr>
<tr>
<td>Minnesota’s Reducing Avoidable Readmissions Effectively (<strong>RARE</strong>) campaign</td>
<td><a href="http://www.transitionalcare.org">www.transitionalcare.org</a></td>
</tr>
<tr>
<td>Better Outcomes for Older Adults through Safe Transitions (BOOST) from the Society of Hospital Medicine</td>
<td><a href="http://www.hospitalmedicine.org/AM/Template.cfm?Section=Home&amp;TEMPLATE=/CM/HTMLDisplay.cfm&amp;CONTENTID=27659">http://www.hospitalmedicine.org/AM/Template.cfm?Section=Home&amp;TEMPLATE=/CM/HTMLDisplay.cfm&amp;CONTENTID=27659</a></td>
</tr>
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<tr>
<td>The Bridge Model. Created by the Illinois Transitional Care Consortium.</td>
<td><a href="http://www.transitionalcare.org/the-bridge-model">www.transitionalcare.org/the-bridge-model</a></td>
</tr>
<tr>
<td>Project Re-Engineered Discharge (RED) From the Boston University Medical Center</td>
<td><a href="http://www.bu.edu/fammed/projectred/components.html">www.bu.edu/fammed/projectred/components.html</a></td>
</tr>
</tbody>
</table>
The Care Transitions Intervention

Results of a Randomized Controlled Trial

Eric A. Coleman, MD, MPH; Carla Parry, PhD, MSW; Sandra Chalmers, MPH; Sung-joon Min, PhD

Promoting Effective Transitions of Care at Hospital Discharge: A Review of Key Issues for Hospitalists

Sunil Kripalani, MD, MSc
Amy T. Jackson, PharmD
Jeffrey L. Schnipper, MD, MPH
Eric A. Coleman, MD, MPH

The period following discharge from the hospital is a vulnerable time for patients. About half of adults experience a medical error after hospital discharge, and 19%-23% suffer an adverse event, most commonly an adverse drug event. This article reviews several important challenges to providing high-quality care as patients leave the hospital. These include the discontinuity between hospitalists
<table>
<thead>
<tr>
<th>Stage of Intervention</th>
<th>Four Pillars</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Medication Self-management</td>
</tr>
<tr>
<td>Goal</td>
<td>Patient is knowledgeable about medications and has medication management system</td>
</tr>
<tr>
<td>Hospital visit</td>
<td>Discuss importance of knowing medications and having a system in place to ensure adherence to regimen</td>
</tr>
<tr>
<td>Home visit</td>
<td>Reconcile prehospitalization and posthospitalization medication lists; identify and correct discrepancies</td>
</tr>
<tr>
<td>Follow-up telephone calls</td>
<td>Answer remaining medication questions</td>
</tr>
</tbody>
</table>

*Abbreviation: PHR, personal health record.*
### Table 3. Utilization Outcomes*

<table>
<thead>
<tr>
<th>Variable</th>
<th>Intervention Group (n = 379)</th>
<th>Control Group (n = 371)</th>
<th>2-Sided $P$ Value†</th>
<th>OR (95% CI)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Unadjusted</td>
<td>Adjusted‡</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rehospitalization</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Within 30 d</td>
<td>8.3</td>
<td>11.9</td>
<td>.11</td>
<td>.048</td>
</tr>
<tr>
<td>Within 90 d</td>
<td>16.7</td>
<td>22.5</td>
<td>.05</td>
<td>.04</td>
</tr>
<tr>
<td>Within 180 d</td>
<td>25.6</td>
<td>30.7</td>
<td>.15</td>
<td>.28</td>
</tr>
<tr>
<td>Rehospitalization for same diagnosis as index hospitalization</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Within 30 d</td>
<td>2.8</td>
<td>4.6</td>
<td>.21</td>
<td>.18</td>
</tr>
<tr>
<td>Within 90 d</td>
<td>5.3</td>
<td>9.8</td>
<td>.03</td>
<td>.04</td>
</tr>
<tr>
<td>Within 180 d</td>
<td>8.6</td>
<td>13.9</td>
<td>.045</td>
<td>.046</td>
</tr>
</tbody>
</table>

Abbreviations: CI, confidence interval; OR, odds ratio.
*Data are given as percentages unless otherwise indicated.
†To test statistical significance between the intervention and control groups, $\chi^2$ test was used for unadjusted utilization outcomes, and logistic regression analysis was used for adjusted use outcomes.
‡Adjusted for age, sex, education, race/ethnicity, self-reported health status, chronic disease score, prior hospitalization and emergency department utilization, and discharge diagnosis.

### Table 4. Nonelective Hospital Cost Outcomes*

<table>
<thead>
<tr>
<th>Nonelective Hospital Costs</th>
<th>Intervention Group (n = 379)</th>
<th>Control Group (n = 371)</th>
<th>2-Sided $P$ Value†</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Unadjusted</td>
<td>Log Transformed</td>
<td></td>
</tr>
<tr>
<td>At 30 d</td>
<td>784 (3916)</td>
<td></td>
<td>.048</td>
</tr>
<tr>
<td>At 90 d</td>
<td>1519 (4914)</td>
<td></td>
<td>.02</td>
</tr>
<tr>
<td>At 180 d</td>
<td>2058 (5452)</td>
<td></td>
<td>.04</td>
</tr>
</tbody>
</table>

*Data are given as mean (SD) US dollars unless otherwise indicated.
†To test statistical significance between the intervention and control groups, median test was used for unadjusted cost outcomes and $t$ test (or Behrens-Fisher test for unequal variances) was used for unadjusted log-transformed cost outcomes.
## Models and initiatives tested in the area of Psychiatry

<table>
<thead>
<tr>
<th>Initiative/Program</th>
<th>Description</th>
<th>Source/Website</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Transition Access Program (TAP).</strong></td>
<td>A behavioral health organization in Colorado (USA) has begun testing a Coleman-based patient-centered intervention model designed to improve continuity of care between settings, improve member safety, improve member outcomes and decrease hospital admissions</td>
<td><a href="http://www.coaccess.com">www.coaccess.com</a></td>
</tr>
<tr>
<td><strong>The Offices of Mental Health and Alcoholism and Substance Abuse Services in the state of New York</strong></td>
<td></td>
<td><a href="http://www.omh.ny.gov/omhweb/bho/">http://www.omh.ny.gov/omhweb/bho/</a></td>
</tr>
<tr>
<td><strong>Minnesota’s Reducing Avoidable Readmissions Effectively (RARE) for mental illness</strong></td>
<td></td>
<td>www-transitionalcare.org</td>
</tr>
</tbody>
</table>
Recommended Actions for Improved Care Transitions: Mental Illnesses and/or Substance Use Disorders

The Five Key Areas

The issues that influence avoidable readmissions are many and complex. Improvement work needs to be done in each care setting and across care settings to make an impact. In analyzing the literature, local and national programs, five areas have been identified as a focus for quality improvement efforts.

#1 Patient/Family Engagement and Activation
#2 Medication Management
#3 Comprehensive Transition Planning
#4 Care Transition Support
#5 Transition Communication

www-transitionalcare.org
Transitional interventions to reduce early psychiatric readmissions in adults: systematic review

Simone N. Vigod, Paul A. Kurdyak, Cindy-Lee Dennis, Talia Leszcz, Valerie H. Taylor, Daniel M. Blumberger and Dallas P. Seitz

Intervention effect on readmission

- Pre-discharge interventions
- Post-discharge interventions
- Bridging Interventions

Pre-discharge interventions

- Two studies about *psychoeducation* in the inpatient setting (Wirshing DA et al., Sch Res, 2006; Xiang Y-T et al, Br J Psych, 2007)

- Structured pre-discharge *needs assessment* (Kasprow WJ et al., Psych Serv, 2007)


What does not work: only scheduling a follow-up appointment prior to discharge (Cuffel BJ et al., Psych Serv, 2002)
Post-discharge interventions

- Post-discharge psychoeducation (Prince JD et al., J Nerv Ment Dis, 2006; Karniel-Lauer E et al., Can J Psych, 2000; Kasprow WJ et al., 2007)


- Both interventions included a transition manager (bridging intervention)

- Structured post-discharge needs assessment (Schmidt-Kraepelin C et al., Eur Arch Psychiatry Clin Neurosci, 2009)
Bridging Interventions

- **Transition manager**
  
  (Kasprow WJ et al., 2007, Forchuk C et al., 2005)

- **Timely communication of the discharge plan to the out-patient provider**
  
  (Shaw H et al., 2000)
Care transition interventions at the Psychiatry Department of Hospital Vila Franca de Xira

- Adult psychiatry
  - Project K
    - Psychoeducation
    - Communication with primary care
- Child and adolescent psychiatry
  - Meetings with teachers and school psychologists
  - Bridging with teams of Social Security responsible for children and adolescents
  - Meetings with psychologist from primary care units
Conclusions

- Avoidable hospital readmissions are a worldwide problem
  - represent reduced quality of health care
  - increase health costs

- Contrarily to the general medical care, there is a lack of research on interventions to address the care transitions in psychiatry

- However, the few studies available have shown some effective approaches to reduce early admissions:
  - Pre-discharge interventions
  - Post-discharge interventions
  - Bridging Interventions
CERTIFICADO

Certifica-se que o(a) Exmo(a). Senhor(a)
Amílcar Santos

Participou no I Congresso Internacional de Gestão da Transição Segura realizado nos dias 09, 10 e 11 de Novembro de 2016, na qualidade de Palestrante na mesa A pessoa com doença mental com o tema "Transição entre níveis de cuidados e adesão do doente"

Lisboa, 11 de Novembro de 2016
Pela Comissão organizadora

Maria José Lourenço
Diretora de Enfermagem
Hospital Vila Franca de Xira