First International Congress in management of secure care transition

Hospital Vila Franca de Xira
Portugal

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

Viggiano T et al. **Care transition intervention in mental health**. Current Opinion in Psychiatry. 2012, 25: 551-558

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

Canadian Institute for Health Information and Statistics Canada. **Health Indicators 2011**. CIHI, 2011; --- Hermann RC, Mattke S, Somekh D, Silfverhielm H, Goldner E, Glover G, et al. **Quality indicators for international benchmarking of mental health care**. Int J Qual Health Care 2006; 18 (suppl 1): 31–8; --- Rumball-Smith J, Hider P. **The validity of readmission rate as a marker of the quality of hospital care, and a recommendation for its definition**. N Z Med J 2009; 122: 63–70.

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

Jencks SF, Williams MV, Coleman EA. **Rehospitalizations among patients in the Medicare fee-for-service program.** N Engl J Med 2009; 360:1418–1428.

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

Canadian Institute for Health Information and Statistics Canada. **Health Indicators 2011**. CIHI, 2011; --- Leslie DL, Rosenheck RA. **Comparing quality of mental health care for public sector and privately insured populations**. Psychiatr Serv 2000; 51: 650–5; --- National Association of State Mental Health Program Directors Research Institute. **30-day Readmission Rates. National Association of State Mental Health Program Directors Research Institute**, 2012; --- Commission for Health Improvement. Psychiatric Readmissions (Adults of Working Age). **Commission for Health Improvement**, 2003

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

National Committee for Quality Assurance. **The state of healthcare quality 2011**. Washington, DC: National Committee for Quality Assurance; 2011.

- 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

  Lien L. Are readmission rates influenced by how psychiatric services are organized? Nord J Psychiatry 2002; 56:23–28.

- Early psychiatric readmission does not reflect only the quality of in-patient care[a,b] but also

- The continuity of care with other parts in the mental health system[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[a]

a) Canadian Institute for Health Information and Statistics Canada. **Health Indicators 2011**. CIHI, 2011; --- b) Zhang J, Harvey C, Andrew C. **Factors associated with length of stay and the risk of readmission in an acute psychiatric inpatient facility: a retrospective study**. Aust N Z J Psychiatry 2011; 45: 578–85; --- c)Durbin J, Lin E, Layne C, Teed M. **Is readmission a valid indicator of the quality of inpatient psychiatric care**? J Behav Health Serv Res 2007; 34:137–50.

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

Berenson RA, Paulus RA, Kalman NS. **Medicare's readmissions- reduction program: a positive alternative.** N Engl J Med 2011; 366:1364–1366.

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

Nelson EA, Maruish ME, Axler JL. **Effects of discharge planning and compliance with outpatient appointments on readmission rates**. Psych Serv 2000; 51:885–889.s

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

Laxmisan A, Hakimzada F, Sayan OR, et al. **The multitasking clinician: decision-making and cognitive demand during and after team handoffs in emergency care**. Int J Med Inform 2007; 26:801–811.

Arora V, Johnson J. **A model for building a standardized hand-off protocol**. Jt Comm J Qual Patient Saf 2006; 32:646–655.

REVIEW

Care transition interventions in mental health

Theresa Viggiano[a], *Harold A. Pincus*[b], *and Stephen Crystal*[a]

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

Model	Reference
Care Transitions Interventions (**CTI**) From Coleman et al.	www.caretransitions.org
Transitional Care Model (**TCM**) Based on the work of Mary Naylor	www.transitionalcare.org
Minnesota's Reducing Avoidable Readmissions Effectively (**RARE**) campaign	www.transitionalcare.org

Better Outcomes for Older Adults through Safe Transitions (**BOOST**) from the Society of Hospital Medicine	(http://www.hospitalmedicine.org/AM/Template.cfm?Section=Home&TEMPLATE=/CM/HTMLDisplay.cfm&CONTENTID=27659)
The Geriatric Resources for Assessment and Care of Elders (**GRACE**)	Counsell SR, Callahan CM, Buttar AB, et al. **Geriatric Resources for Assess- ment and Care for Elders (GRACE): a new model of care for low-income elders**. J Am Geriatr Soc 2006; 54:1136–1141.
The Guided Care Model (**GCM**) based at Johns Hopkins	Leff B, Novak T. It takes a team: **Affordable Care Act policy makers mine the potential of the Guided Care Model**. Generations 2011; 35:60–63.
The Bridge Model. Created by the Illinois Transitional Care Consortium.	www.transitionalcare.org/the-bridge-model
Project Re-Engineered Discharge (**RED**) From the Boston University Medical Center	www.bu.edu/fammed/projectred/components.html

ORIGINAL INVESTIGATION

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

REVIEW

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

Sunil Kripalani, MD, MSc[1]
Amy T. Jackson, PharmD[2]
Jeffrey L. Schnipper, MD, MPH[3]
Eric A. Coleman, MD, MPH[4]

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 1. Care Transitions Intervention Activities by Pillar and by Stage of Intervention

	Four Pillars			
Stage of Intervention	Medication Self-management	Patient-Centered Record	Follow-up	Red Flags
Goal	Patient is knowledgeable about medications and has medication management system	Patient understands and uses PHR to facilitate communication and to ensure continuity of care plan across providers and settings; patient manages PHR	Patient schedules and completes follow-up visit with primary care provider or specialist and is prepared to be an active participant in interactions	Patient is knowledgeable about indications that condition is worsening and how to respond
Hospital visit	Discuss importance of knowing medications and having a system in place to ensure adherence to regimen	Explain PHR	Recommend primary care provider follow-up visit	Discuss symptoms and drug reactions
Home visit	Reconcile prehospitalization and posthospitalization medication lists Identify and correct discrepancies	Review and update PHR Review discharge summary Encourage patient to update and share PHR with primary care provider or specialist at follow-up visits	Emphasize importance of follow-up visit and need to provide primary care provider with recent hospitalization information Practice and role-play questions for primary care provider	Assess condition Discuss symptoms and adverse effects of medications
Follow-up telephone calls	Answer remaining medication questions	Remind patient to share PHR with primary care provider or specialist Discuss outcome of visit with primary care provider or specialist	Provide advocacy in getting appointment, if necessary	Reinforce when primary care provider should be telephoned

*Abbreviation: PHR, personal health record.

Table 3. Utilization Outcomes*

Variable	Intervention Group (n = 379)	Control Group (n = 371)	2-Sided *P* Value†		OR (95% CI)
			Unadjusted	Adjusted‡	
Rehospitalization					
Within 30 d	8.3	11.9	.11	.048	0.59 (0.35-1.00)
Within 90 d	16.7	22.5	.05	.04	0.64 (0.42-0.99)
Within 180 d	25.6	30.7	.15	.28	0.80 (0.54-1.19)
Rehospitalization for same diagnosis as index hospitalization					
Within 30 d	2.8	4.6	.21	.18	0.56 (0.24-1.31)
Within 90 d	5.3	9.8	.03	.04	0.50 (0.26-0.96)
Within 180 d	8.6	13.9	.045	.046	0.55 (0.30-0.99)

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, χ^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*

Nonelective Hospital Costs	Intervention Group (n = 379)	Control Group (n = 371)	2-Sided *P* Value†	
			Unadjusted	Log Transformed
At 30 d	784 (3916)	918 (2971)	.048	.06
At 90 d	1519 (4914)	2016 (4872)	.02	.02
At 180 d	2058 (5452)	2546 (5466)	.04	.049

*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

The Availability, Responsiveness, and Continuity (**ARC**) model	Glisson C, Schoenwald SK. **The ARC organizational and community intervention strategy for implementing evidence-based children's mental health treatments**. Ment Health Serv Res 2005; 7:243–259.
Transition Access Program (**TAP**). 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	www.coaccess.com
A program coordinated by the health plan Amerigroup Florida	http://www.ahipresearch.org/pdfs/innovations2010.pdf;http://innovations.ahrq.gov/content.aspx?id=3082
The Offices of Mental Health and Alcoholism and Substance Abuse Services in the state of New York	http://www.omh.ny.gov/omhweb/bho/
Minnesota's Reducing Avoidable Readmissions Effectively (**RARE**) for mental illness	www.transitionalcare.org

RARE Reducing Avoidable Readmissions Effectively

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

BJPsych | The British Journal of Psychiatry (2013)
202, 187–194. doi: 10.1192/bjp.bp.112.115030

Review article

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

Vigod S et al. **Transitional interventions to reduce early psychiatric readmissions in adults: systematic review.** The British Journal of Psychiatry. 2013. 202, 187-194

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)
- Medication education/reconciliation (Shaw H, et al, Int J Pharm Pract . 2000)

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)

- Telephone follow-up (Kasprow WJ et al., Psych Serv ,2007, Forchuk C et al, J Psychiatr Mental Health Nurs, 2005)

- 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 at 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)

Amilcar 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 a adesão do doente"

Lisboa, 11 de Novembro de 2016

Pela Comissão organizadora

Maria José Lourenço
Diretora de Enfermagem
Hospital Vila Franca de Xira