

Literature Review: Follow Up after Mental Health Hospitalization

Introduction

A key quality improvement measure for Alameda County Care Connect is increasing patient attendance at follow-up appointments after mental health hospitalizations. The transition from inpatient to outpatient care poses a high risk for rapid re-hospitalization for individuals with SMI. Low attendance for follow-up outpatient appointments is heavily documented in the literature, with particular focus on individuals with serious mental illness and/or substance use disorder, individuals who are homeless, individuals with disabilities, and indigent populations or Medi-Cal beneficiaries (primarily due to the lack of availability of follow-up appointments within the 7-day or 30-day follow-up window after discharge).

Research Questions & Methodology

What are effective strategies for connecting vulnerable patients (especially patients with inconsistent phone or mailing addresses) to their follow up appointments after discharge from a mental health hospitalization?

To help answer this question, a review of academic literature and implementation research/models was completed, and key informant interviews were conducted with stakeholders in Los Angeles County's Department of Mental Health and San Francisco's Behavioral Health Unit.

Availability of Evidence-Based Care Transition Models

Care transitions strategies that effectively reduce hospitalizations are a significant area of study across the health care field. There is a large evidence base for effective care transitions models for patients transitioning from inpatient to outpatient care in general medical care settings. These models have primarily been designed and validated for use with older adults, adults with chronic medical conditions, and/or Medicare beneficiaries, who might face several barriers to managing their care, attending follow-up appointments, and preventing re-hospitalization.

Patients with mental health hospitalizations often experience higher barriers to continuity of care than other high utilizers of medical systems, including homelessness, lack of family and social supports, stigmatization, disorganized thoughts and behaviors, etc. Studies show that about 40% of patients with SMI do not attend any outpatient visits after discharge from a psychiatric hospital or inpatient mental health facility (Velligan et al). However, there are few evidence-based practices, models, or frameworks for care transitions for patients after mental health hospitalization. Common elements from traditional medical care transitions models are being applied and adapted to develop care transitions models that are appropriate for individuals with SMI and/or individuals with mental health hospitalization (Viggiano et al.; National Health Care for the Homeless Council 2012; Boutwell, et al.).

Overall, the literature suggests that improving follow-up appointments after mental health hospitalization require a significant investment in discharge planning and system navigation/support between the hospitalization and outpatient follow-up visits. Traditionally, psychiatric hospitals do not develop thorough discharge plans, and instead require patients to recall their outpatient care plans and follow-up appointments. Discharge models for patients with high risk of re-hospitalization require significant communication and planning during their initial presentation at a psychiatric hospital,

throughout any in-patient stay, while discharge planning, and immediately after discharge in community-based and in-home settings. The remaining findings in this document outline strategies and practices that can improve the patients' chance of attending follow-up appointments after discharge from psychiatric hospital stays.

Evidence-based care transitions models in general medical care

Model	Description
Coleman CTI Model	This model includes four key components, including 1) development of a patient-centered record (PHR) of their diagnoses, condition, and treatment needs after discharge, 2) Structured checklist of critical activities to empower patients pre-discharge, 3) Working with a Transitions Coach while in-patient around self-activation and management of medical care once they are discharged, and 4) Transitions Coach follow-up home visits and phone calls. Several RCTs have demonstrated significant reductions in hospital readmissions after working with a CTI Coach, i.e. 30% reduction in one study (Coleman, Parry, et al.); 36% reduction in another study funded by CMS (Voss et al).
Mary Naylor's Transitional Care Model (TCM)	Advance-practice-nurse (APN) leads comprehensive in-hospital planning for discharge, home follow-up, and care coordination (Viggiano et al). Beginning on the first day of admission, APN meets with patient every day to assess health conditions, behaviors, social determinants, and family supports. APN develops discharge plan with patient, and meets with the patient after discharge, including in-home visits (National Health Care for the Homeless Council 2012).
Bridge Model	Person-centered, social work-led care transitions intervention for older adults, which includes three key components: care coordination, case management and patient engagement. (Alvarez et al)
BOOST Model	Identifies high-risk patients at admission and provide targeted interventions that includes improved communication and information exchange between inpatient and outpatient providers (National Health Care for the Homeless Council 2012).
Project Re-Engineered Discharge (RED) Model	Boston University Medical Center-led initiative to develop strategies for improving hospital discharge and reducing rehospitalization. This model includes training and role delineation for all staff; delivery of patient education on their condition for the entire hospital stay; information sharing between hospital and PCP or outpatient provider; a health-literate discharge plan for the patient; and assignment of a Discharge Advocate (nurse, patient advocate, social worker, etc.) who coordinates the discharge and fills any necessary information or resource gaps to ensure follow up (National Health Care for the Homeless Council 2012).

Findings

Models for care transitions after mental health hospitalizations include eight common practices for preparing the patient for discharge: 1) patient and family/caregiver engagement and education; 2) patient-centered care plans; 3) "bridging" strategies that foster coordination between inpatient and outpatient providers; 4) transportation arrangements for the follow-up appointment; 5) connection to care coordinators or navigators who provide short-term case management until follow-up; 6) early post-acute follow-up call or visit within 3 days of discharge; 7) partner with community-based outreach models to increase touch-points with clients and improve follow-up; and 8) discuss housing status and placement options during discharge and care transitions planning.

Educate and Engage Patients and Family/Caregivers During Inpatient Stays

Evidence-based care transitions models use the opportunity of the inpatient stay to educate the patient and any caregivers/family members about their diagnoses/conditions, prescriptions, treatment options, and to provide motivational skills for health-care related activities (Viggiano et al.). Patients prefer to receive information about their conditions and participate in decision-making around their outpatient care (Decoux), and often need providers to communicate and support family/caregiver understanding and involvement in that plan (Boutwell et al).

Family/caregiver engagement has been noted as a critical gap in discharge planning for patients leaving psychiatric hospitals. Inpatient providers should develop standard procedures to ask patients about family members/caregivers, and to actively engage them in discharge planning.

Patient and family/caregiver education and engagement should be appropriate for individuals with low health literacy (Boutwell et al), e.g. use of visuals, colors, brief summative documents or bullet lists, and verbal repetition. Teach-back methods have been found to be particularly effective with patients with severe mental illness or complex care conditions (Project RED, Care Transitions Network). Teach-back methods involve patient education methods that ask patients to explain in their own words the details of their outpatient and/or self-care plan.

Co-develop a patient-centered care plan that is shared across care settings.

Discharge planning should include the development of a patient-centered care plan that is co-developed with the patient and shared across care settings (Viggiano et al). One example of a patient-centered care plan is the After-Hospital Care Plan (AHCP), which has clear medication instructions; information about their next follow-up appointment (arranged before discharge); and a clear, easy-to-understand care plan with the name and number they can call with any problems (Care Transitions Network). The plan should be “person-centered”, which includes client-identified, personally meaningful goals that are broken down into short-term action steps. The plan should include themes of hope for recovery, highlight a few patient strengths, and provide information that is aligned with patient-identified short-term/immediate needs (i.e. what do you need right now?). The patient should affirmatively agree with the discharge plan. One example of an After-Hospital Care Plan after psychiatric hospital stays is the [Wellness Recovery Action Plan](#) (WRAP).

Implement “bridging strategies” that coordinate care between inpatient and outpatient providers.

One study found that “three clinical interventions used during the hospital stay more than tripled the odds of successful linkage to outpatient care: communication about patients’ discharge plans between inpatient staff and outpatient clinicians, patients’ starting outpatient programs before discharge, and family involvement during the hospital stay” (Boyer et al.). The importance of family involvement is already discussed above, but the other two strategies primarily involve bridging the time between inpatient and outpatient care. Examples of bridging strategies include:

- Scheduling a follow-up appointment with aftercare mental health provider within 5 days of discharge (Boyer et al)
- Face-to-face meeting with receiving outpatient provider during inpatient stay (Care Transitions Network)
- Holding discharge planning meeting that include the patient, caregiver/family member,

- inpatient team, and outpatient provider (if possible)
- Identify and coordinate with existing community support services—e.g. ACT, Health Home, other Care Management, MCOs— that can connect the patient to aftercare (Care Transitions Network).
- Develop a standardized information exchange protocol and formal hand-off procedures between the transferring provider, receiving provider, and other community-based supports/case managers.

Arrange for transportation to follow-up appointments.

Many hospital patients—especially the homeless population—report that they do not have access to transportation to their follow-up appointments. Best practices in discharge planning assess patients' plans for traveling to their follow-up appointments, and arrange for transportation while the follow-up appointment is being scheduled. Patients should be informed of both the follow-up appointment and the transportation service that has been arranged at the same time. These problem-solving techniques help reduce the decision-making burden for patients with SMI or cognitive impairment (National Health Care for the Homeless Council 2012).

Connect patients to care coordinators or transition coaches while inpatient, who will assist with outpatient follow-up with needed services.

After stabilizing the individual, a key finding from the review of literature and key informant interviews was the need for care coordination models that support individuals to navigate through complex systems and access the needed services. Most care transitions models utilize care coordinators, patient navigators, transition coaches, or discharge specialists for short-term case management during and after the hospital stay until at least the first follow-up visit is completed. Several studies have found statistically significant improvements in attendance of follow-up appointments after psychiatric hospitalizations when care coordinators were utilized in discharge planning process from the inpatient setting (Orlosky et al; Batscha et al; Dixon et al).

The role of these care coordinators is to provide support and guidance throughout the continuum of care. Care coordinators help coordinate appointments, maintain communication, arrange transportation, and facilitate linkages for follow-up. Much of the literature points to early engagement of the patient care coordinator with the client; engagement prior to discharge from the hospital will establish a relationship and begin the process of building trust.

Care coordinators may be social workers, nurses, peer specialists, or other community-based partners. Social workers in hospital settings have not traditionally been utilized for discharge planning, however, case studies and research has documented that they have the skillset and knowledge to serve as care coordinators (Barber et al; Alvarez et al.).

Peer support models are effective in increasing client engagement and building trust. Given that trusted relationships are critical for maintaining communication and engagement with clients, utilizing peers who have gone through these systems and life circumstances can help facilitate improved relationships and engagement. An example of this model is a Peer Mentor Program in the hospital emergency room. This peer-based patient support program links frequent utilizers of the emergency room with peers who then engage them in a dialogue around their needs in order to begin building trust between the patient and the systems that serve them. In this model, an ongoing relationship is cultivated as the client is

released from the hospital and continues as he/she is stabilized. Los Angeles's Whole Person Care Model has developed a "Kin Through Peer" program that connects peer providers to patients who are disconnected from family.

Provide early post-acute follow-up within 3 days of discharge.

Care coordinators—or in their absence, inpatient provider who work with the patient—should follow up with the patient and/or caregiver within 72 hours after discharge (Care Transitions Network). This follow-up should be treated as a clinical intervention, and not used as simple reminder. Project RED has developed a five-pronged evidence-based approach for this 72-hour follow-up call: 1) assess clinical status, 2) review and confirm each medication, 3) review follow-up appointments, 4) assess for barriers to getting to appointment, problem-solve, and review what to do if another problem arises (including providing a phone number they can call), and 5) any needed follow-up actions that are patient-identified (Jack et al). The follow-up call should also just the teach-back method described earlier. An RCT study found statistically significant reductions in hospital utilization for patients who were connected to a care coordinator who conducted this 72-hour follow-up call (Jack et al).

One of Los Angeles's Whole Person Care pilot strategies for the Mental Health High-Risk target population is the Intensive Service Recipient Program—which provides 90-day short term case management for high utilizers of psychiatric services to navigate after-care transition planning, housing, and other concrete needs.

LA's WPC pilot has also defined a short-term (30 day) case management strategy for the Medically High-Risk target population, or high utilizers of inpatient stays at hospitals. In this strategy, a community health worker conducts the following activities (language is as described on the LA WPC pilot website):

- "Performs an assessment in partnership with the discharge team to determine patient's high-priority needs and develop a care plan that addresses the patient's needs to prevent future readmissions" (LA WPC Pilot)
- Conducts a "home visit within 72 hours of discharge to assist the patient with medication review, help fill needed prescriptions, schedule future appointments to primary care and specialty providers, arrange transportation as necessary, and address social service needs through referrals and linkages to social service organizations"
- "Accompanies the patient to their follow up primary care visit."

Partner with community-based outreach models to increase touch-points with clients and improve follow-up.

Community partnerships are emerging as one meaningful way for hospitals to successfully reduce readmissions. Collaboration with community agencies such a local NAMI group, faith based groups, targeted clinics, or other community organizations can help identify effective channels for promoting awareness on mental health resources, as well as increasing touch-points with client who may spend time in these places upon discharge. Examples of effective models include:

- *CMS Community-based Care Transitions Program (CCTP)*: This program represents a large, formal network of organized partnerships between acute-care hospitals and community-based organizations. The community organizations provide timely care transition services for patients after hospital discharge, monitor performance, and provide feedback to CMS.

- *Mobile Outreach:* Often times, upon hospital discharge, a client will need clothing, food, water, and hygiene items. A Mobile Outreach team can meet these basic needs and begin to establish trust and information sharing with the individual. This is also an opportunity to offer a hotline for clients to call for help or emergencies. This mobile clinic can have regular times directly outside the hospital to engage clients immediately after discharge, in addition to time spent in the community.
- *Memphis Congregational Health Network:* Initiatives involving congregations are another way to engage the community and leverage local support structures to better meet patients' needs. For example, the Memphis Congregational Health Network is a hospital-community partnership involving more than 500 area churches. It has reported significant reductions in readmission and mortality, as well as higher patient satisfaction scores.

Discuss housing status and placement options during discharge and care transitions interventions.

If the goal is to reduce recurrent hospitalizations, literature and interviews indicate that it is important to stabilize the individual through access to concrete supports, such as housing options, employment, and food security, prior to addressing the healthcare needs. Patients' housing status should be assessed during discharge planning, and options for placement should be provided if needed to allow for short-term follow-up from care coordinators or other community-based housing providers (National Health Care for the Homeless Council). This strategy also allows service providers to locate individuals and actively coordinate care.

Los Angeles has made significant investments in initiatives that provide coordinated housing and health interventions.

- *Corporation for Supportive Housing – Social Innovation Fund Initiative:* This program piloted implementation of an enhanced supportive housing model that included supportive housing, data driven targeting, assertive outreach and housing first, patient navigation/health care coordination, and clinical partnerships with health care providers. Key findings from a RCT emphasize that housing needs to come first, but must be linked with patient navigation/health care coordination and clinical partnerships with health care providers (Weitzman).
- *Los Angeles County Housing for Health Project:* HFH, a division within the Los Angeles County Department of Health Services, was established to provide supportive housing to DHS patients with complex medical and behavioral health issues who were experiencing homelessness. RAND conducted a formative evaluation that found a dramatic reduction in service use and cost reductions more than covered the year's worth of supportive housing costs (Hunter et al).
- *10th Decile Project:* This project works with hospitals to identify the 10 percent of homeless patients with the highest public and hospital costs and provide immediate services for placing these individuals into permanent supportive housing. Based on an evaluation done on this program, taking costs for housing subsidies and supportive services into account, every \$1 in local funds spent to house and support 10th decile patients is estimated to reduce public and hospital costs for the evaluation population that was housed by \$2 in the first year and \$6 in subsequent years (Lee).

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