Advancing St. Mark's Mission Statement Through Improved Mental Health Services

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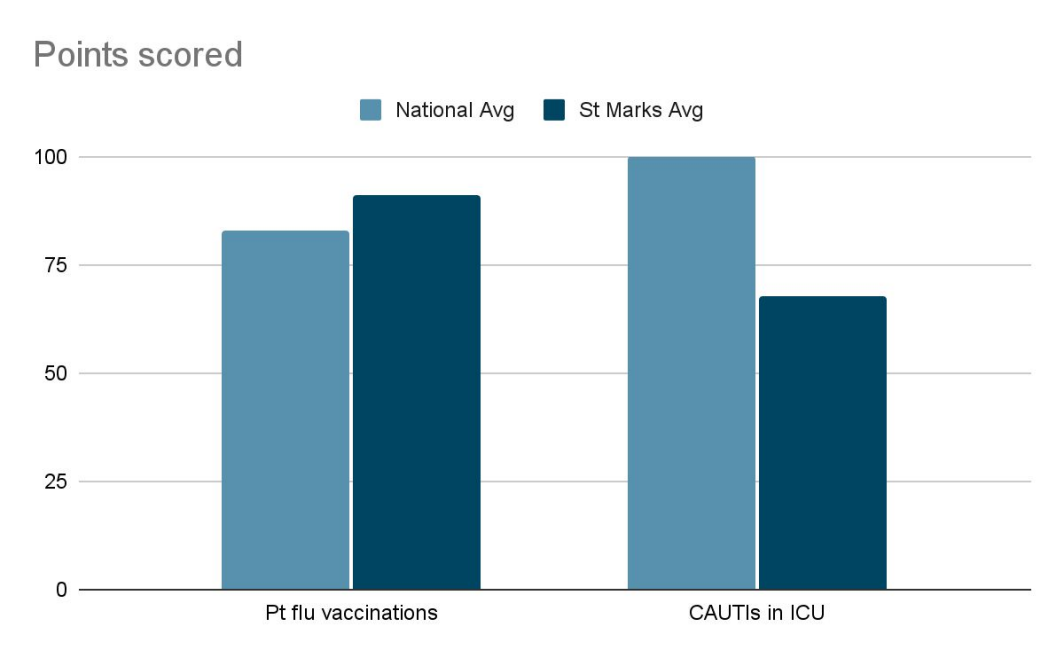
Strengths of St Mark's Hospital



2.4 Billion

Gross Patient Revenue

(Medicare, n.d.)

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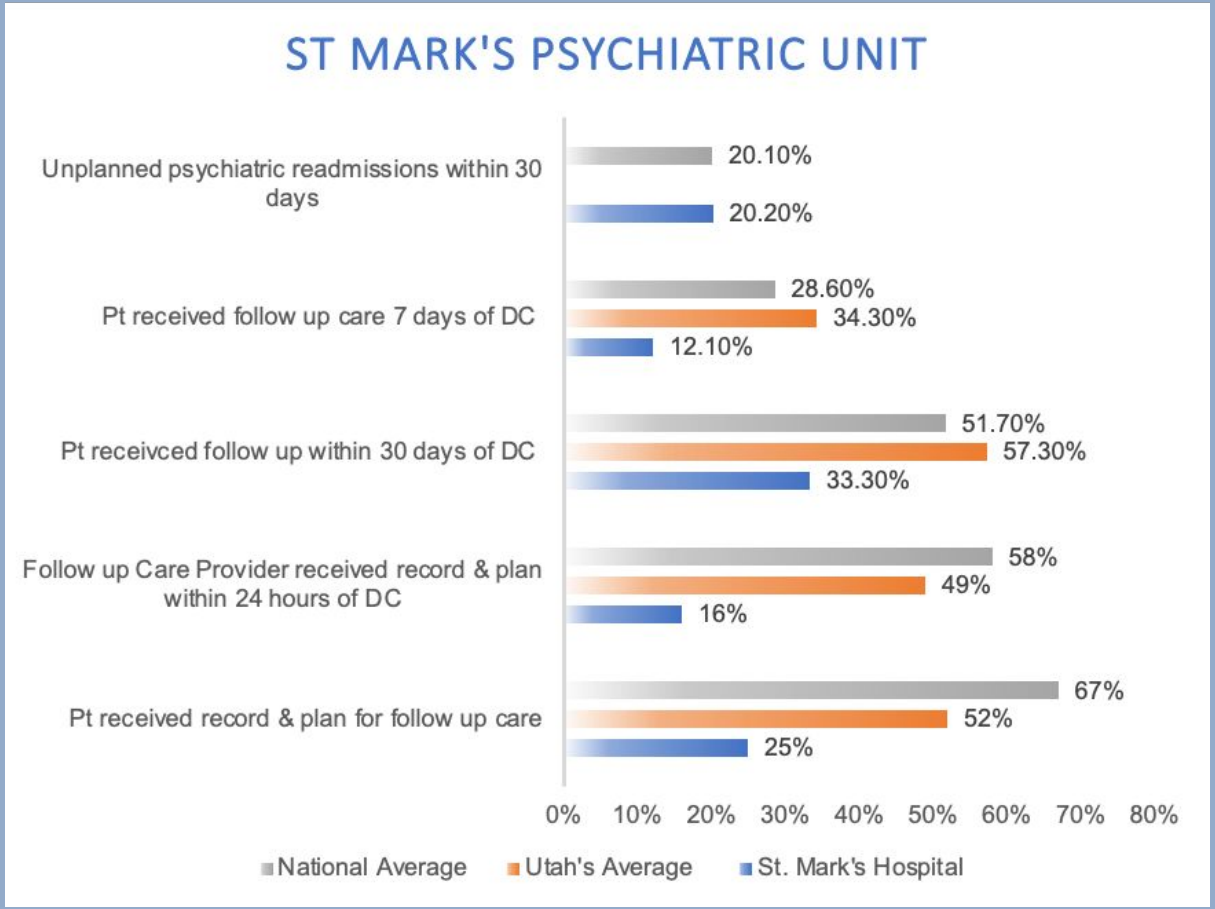
Opportunities for Growth

Mental Health



(Medicare, n.d.)

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Mental Health Trends

Study

USA, 2012-2018
Ages: 4-17

Prevalence

34.6% increase in mental health diagnoses

Disorders

Attention deficit/hyperactivity, conduct disorders, anxiety, and depression

Medical Costs

Control: $1,629
Mental Illness: $6,055

(Tkacz & Brady, 2021)

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Mental Health Trends in Utah

Suicide	Self-inflicted injuries	ED Visits	Hospitalizations
Leading cause of death in 2020 for ages 10-24	70/day in 2019	15,875 in 2019	9,456 in 2019

(Utah Department of Health & Human Services, n.d.)

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Evidence Based Solutions and Outcomes

A

TRANSITION CARE COORDINATORS

Long-term health management

B

ORGANIZATIONAL CHANGE MODEL

Improved quality of care and growth

C

INCREASE COMMUNITY TRUST

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Evidence Based Solution A

A

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VANDERBILT UNIVERSITY MEDICAL CENTER CASE STUDY

GOAL

Reduce readmissions to decrease overall hospital penalties and costs

IMPLEMENTATION

- Intervention addressed diagnoses that incur readmission penalties
- Diagnoses included:
  - congestive heart failure
  - COPD
  - pneumonia

RESULTS

Provides a comparison between no transition of care provided, a partial implementation of transition between care, and full implementation of care transitioning

(Kripalani et al., 2020)

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Transition Care Coordinators

01

Structured Needs Assessment

02

Medication Reconciliation

03

Patient Education

04

Post-Discharge Guidance and Contingency Plan

05

Facilitated Follow-up

(Kripalani et al., 2020)

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Transition Care Coordinators Readmission Rates

30 Day Readmission

Usual care: 18.8%
TCC care: 9.4%

90 Day Readmission

Usual care: 31.5%
TCC care: 19.8%

(Kripalani et al., 2020)

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Transition Care Coordinators Overall Cost Reduction

30 day readmission

Estimated usual care/patient: **$7601**

Estimated care per patient with TCCs: **$3632**

Difference: **$3969**

90 day readmission

Estimated usual care per patient: **$15,123**

Estimated care per patient with TCCs: **$9439**

Difference: **$5684**

(Kripalani et al., 2020)

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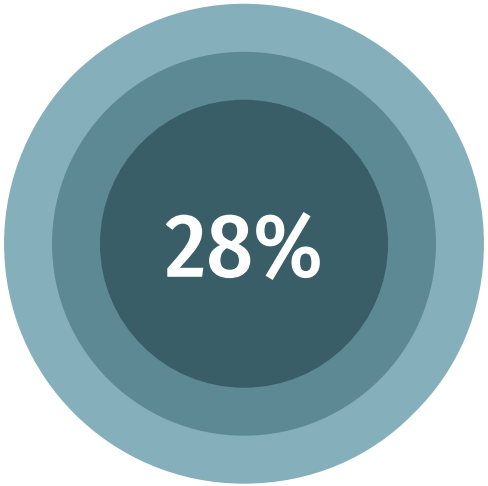
HOW DOES THIS STUDY RELATE TO MENTAL HEALTH READMISSIONS?



28% of patients received a mental health diagnosis within the 12 months leading up to their physical health concern and corresponding admission

Patients who have comorbid mental health concerns are 28-56% more likely within 30 days after discharge to be readmitted compared to their counterparts who have no mental illness

(Benjenk & Chen, 2018)

Evidence Based Solution B

A

TRANSITION CARE COORDINATORS

Long-term health management

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ORGANIZATIONAL CHANGE MODEL CASE STUDY

GOAL

Reduce 30-day psychiatric inpatient readmissions

IMPLEMENTATION

Performed in Wisconsin involving 23 out of the 72 total counties, or 61% of residential admissions in the state

IMPORTANCE

9% to 48% of inpatient readmissions can be effectively prevented

(Molfenter et al., 2016)

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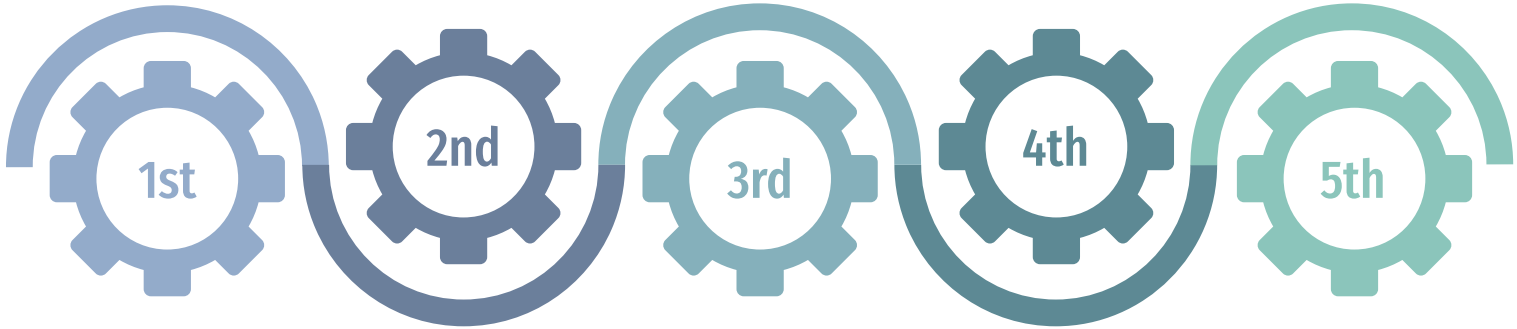
5 Specific Elements Implemented with the Organizational Change Model

Scheduling a post-discharge meeting between a crisis manager and the patient

Police officer training on who to contact during a crisis and how to manage the situation



Discharge meeting with social worker to review appointments, crisis plan, medications, and community resources

Patient engagement in postdischarge outpatient therapy

Inclusion of of crisis beds to divert patients that would become inpatient admissions

(Molfenter et al., 2016)

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The Results

30-day readmission rates:

	Before plan	Rate decrease
Counties with the plan implemented	12.4%	4.3%
No implementation of the plan	7.53%	0.53%

(Molfenter et al., 2016)

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Outcome C

A

TRANSITION CARE COORDINATORS

Long-term health management

B

ORGANIZATIONAL CHANGE MODEL

Improved quality of care and growth

C

INCREASE COMMUNITY TRUST

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References

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Questions?
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Main Entrance
Entrance 1
Entrances 5 - 7
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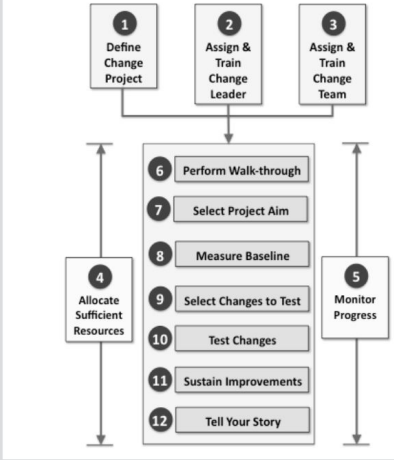
	Usual Care N= 6,276	TCC Care N=762	TCC (Full) N=460	TCC (Partial) N=302	P-value (Usual Care vs. TCC Care)
Readmissions					
30-day	1,182 (18.8%)	72 (9.4%)	41 (8.9%)	31 (10.3%)	<0.001
90-day	1,975 (31.5%)	151(19.8%)	86 (18.7%)	65 (21.5%)	<0.001

Figure 1. NIATx Organizational Change Model



Appendix

Table 1. Strategies to Prevent Psychiatric Hospital Readmissions

Treatment Phase	Practices
During Stay	Apply evidence-based practices to increase engagement (eg, motivational interviewing, contingency management).
	Develop a crisis plan.
	Use multidisciplinary case conferences to review high acute cases and determine post-discharge needs.
	Develop discharge objectives at admission.
Discharge Process	In the discharge session, patient meets with the social worker and nurse to review appointments, crisis plan, community resources, and medications.
	Warm hand-off to outpatient services.
Post-discharge	Case manager meets with patient 24 hours after discharge or phone follow-up within 48 hours of discharge.
	Reduce wait time to outpatient services.
Pre-readmission (For Patients Seeking Care)	Utilize sub-acute crisis beds for observation and assessment.
	Implement crisis line.
	Develop process where patients presenting to emergency department with mental health issues can been seen by mental health providers the next day.
	Give crisis response team member a smart phone to reduce the time needed to respond to police officer calls and to create a single point of entry.

Transition Care Coordinators Overall Cost Reduction

30 day	Usual Care	TCC Care (Overall)	Difference	TCC (Full)	TCC (Partial)	Difference
Percent with cost >0	70.8%	67.7%	2.9%	67.3%	68.4%	−1.1%
Estimated Total Cost given cost > 0	$10074	$4999	$5075	$5859	$4200	$1659
Estimated Total Cost	$7601	$3632	**$3969** ($2589, $5099)	$4236	$3078	**$1158** (−$690, $3268)
90 day						
Percent with cost >0	79.3%	76.0%	3.3%	74.7%	78.4%	−3.7%
Estimated Total Cost given cost > 0	$18033	$11653	$6380	$11595	$11703	−$108
Estimated Total Cost	$15123	$9439	**$5684** ($3627, $7602)	$9250	$9716	**−$466** (−$3636, $3079)

Kripalani et al., 2020

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Community Trust: Bringing it all Together

Transition Care Coordinators

- Structured assessment of social determinants to health
- Follow-ups prove to patients that they are not just cared for while in the hospital
    - We are treating people, not simply the diagnosis that someone walks in with
- Patient education allows patients to “own” the process and find meaning to what they are expected to accomplish
    - The patient is a part of the care team and is crucial in making care plan decisions

Organizational Change Model

- Improvement of collaboration between hospitals and community resources
    - Cohesiveness amongst different community centers
    - Trust between
- Patients feel seen by mental health providers rather than being pushed to the side and viewed as unimportant
- Training all sectors of the community to understand mental health and the treatment thereof

Kripalani et al., 2019 **and** Molfenter et al., 2016

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