Readmission Prevention & Crisis Stabilization Programs: Service Innovation For A Managed Care Environment

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I. Emerging Markets Penalizing Hospitalizations & Readmissions

II. Changing Role of Crisis Stabilization & Readmission Prevention Programs

III. Current Programs Succeeding Around the Country

- David Covington, LPC, MBA, President & Chief Executive Officer, Crisis Access, LLC
- Lori Ashcraft, Ph.D., Executive Director, Recovery Opportunity Center/Recovery Innovations
- Jonathan Evans, President & Chief Executive Officer, Safe Harbor Behavioral Health

IV. Questions & Discussion
Emerging Markets Penalizing Hospitalizations & Readmissions
2012 National Health Care Spending $2.8 Trillion, Or $8,915 Per Person

- Hospital Care: 37%
- Physician & Clinical: 24%
- Other Professional: 5%
- Dental: 6%
- Other Health, Residential & Personal Care: 3%
- Prescription Drugs: 11%
- DME: 2%
- Other Medical Products: 2%
2012 National Health Expenditure By Major Sources of Funds – Total $2.8 trillion

- Private Health Insurance: 41%
- Medicare: 25%
- Medicaid: 19%
- Out-of-Pocket: 15%
Pressure To Reduce Readmission Rates

- CMS Hospital Readmissions Reduction Program was established as part of ACA requiring to reduce payments to acute care inpatient (IPPS) hospitals with excess readmissions.
- Congress enacted this program in 2010. Starting in fiscal year 2013 hospitals face penalties from a prior three-year period.
- All Medicare hospital fees reduced based on high 30-day readmission rates for patients with heart attack, heart failure or pneumonia.
  - Reduction capped at 1% of base inpatient payments in 2013
  - 2% in 2014
  - 3% in 2015 and thereafter
- During 2012, the 30-day, all-cause hospital readmission rate dropped to 18.4% from 19% among
- Decrease in readmission rate may be due to payment reform and other initiatives aimed at reducing avoidable readmissions and more beneficiaries receiving post-discharge care through ED, observational or other non-inpatient settings.
Hospital Readmission Penalties

- In August 2013, Medicare levied $227 million in fines against hospitals in every state but one. This is the second round of penalties issued to hospitals nationally.
- 2,225 hospitals were identified to have payments reduced beginning October 2013.
- 1,154 hospitals will not be penalized.
- The average penalty in FY13 is 0.42% whereas in FY14 the average reduced to 0.38%.
- Payment reductions impact all Medicare reimbursements for a patient stay made to hospitals:
  1. 18 hospitals will lose 2%
  2. 154 hospitals will lose 1%
Expansion Of Readmission Penalties

• Increased likelihood that CMS will expand the current readmission penalty program to more diagnostic groups
• As of October 1, 2013, the program includes Acute Care and Long–Term Care Hospitals.
• Medicare Payment Advisory Commission (MedPAC) recently endorsed penalties for home health under the Hospitals Readmissions Reduction Program.
  ◦ The MedPAC March 2014 report indicates that 29% of posthospital home health stays result in readmission.
Hospital Strategies To Reduce Excessive Readmissions

- Increased coordination with other providers to ease transition of discharged patients to the appropriate level of care
- Utilization of RNs, case managers and discharge planners to assess patients, identify needs and develop a plan for discharge
- Coordinating with community resources such as physicians, home health agencies, etc. after discharge
- Implementing policy and procedure notifying physicians of patient discharge, follow-up on test results and monitor patient progress
Changing Role of Crisis Stabilization & Readmission Prevention Programs
Emphasis On Crisis Intervention & Readmission Prevention Models

- Crisis stabilization programs provide 24-hour, short term residential care to prevent psychiatric hospitalization.
- Readmission prevention programs offer integrated treatment services like nursing, social workers and home care services to keep people in their home and avoid hospital readmission.
- Crisis Intervention Team (CIT) – community partnership, police respond to crisis calls and receive specialized training under supervision of mental health providers, family advocates and mental health consumer groups.
- Mental Health First Aid – an evidence-based training program teaches how to respond when individuals are experiencing crisis and non-crisis situations
- Multi-Systemic Therapy With Psychiatric Supports (MST-Psychiatric) – designed to treat youth who are at risk for out-of-home placement
- Assertive Community Treatment (ACT) – intensive highly integrated community mental health service delivery model designed to provide treatment, rehab and support services
Innovative Program Opportunity

- Partnership for Patients initiative sponsored by CMS encouraging hospitals to look beyond their walls and improve care coordination across providers to reduce readmissions.
- Community-based Care Transitions is a delivery model for improving care transitions from the hospital to other settings and reducing readmissions for high-risk Medicare beneficiaries.
- Up to $500 million available for 2011 through 2015 for community-based organizations.
- Focus on provision of care transition no later than 24 hours prior to discharge, timely and culturally competent post discharge education, patient-centered self management support and comprehensive medication review and management.
Current Programs Succeeding Around The Country
Featured Faculty

• David Covington, LPC, MBA, President & Chief Executive Officer, Crisis Access, LLC
• Lori Ashcraft, Ph.D., Executive Director, Recovery Opportunity Center/Recovery Innovations
• Jonathan Evans, President & Chief Executive Officer, Safe Harbor Behavioral Health
The Era for Crisis Services is NOW

DAVID COVINGTON, LPC, MBA—CRISIS ACCESS, LLC
“SB 82 [found] that 70% of people taken to ERs for psychiatric evaluation can be stabilized and transferred to a less intensive level of care.”
FOR IMMEDIATE RELEASE  Tuesday, October 19, 2010

Justice Department Obtains Comprehensive Agreement Regarding the State of Georgia’s Mental Health and Developmental Disability System

WASHINGTON - The Justice Department today announced that it has entered into a comprehensive settlement agreement that will transform the state of Georgia’s mental health and developmental disability system and resolve a lawsuit the United States brought against the state. The lawsuit alleged unlawful segregation of individuals with mental illness and developmental disabilities in the state’s psychiatric hospitals in violation of the Americans with Disabilities Act (ADA) and the Supreme Court’s landmark decision in Olmstead v. L.C.

The U.S. District Court for the Northern District of Georgia will retain jurisdiction to enforce today’s settlement agreement, which supersedes a 2008 agreement between the state and the Office for Civil Rights of the U.S. Department of Health and Human Services (HHS) concerning Georgia’s provision of community services for individuals with mental illness and developmental disabilities. In light of today’s agreement and the progress the state has made in complying with an earlier agreement regarding the conditions in the psychiatric hospitals, the United States has agreed to withdraw its motions to enforce that earlier agreement.

More than a decade ago, in Olmstead v. L.C., the Supreme Court found that one of Georgia’s state hospitals was impermissibly segregating two individuals with disabilities in that hospital when they could have been served in more integrated settings. The Supreme Court ordered states to serve individuals with disabilities in the most integrated settings appropriate to their needs.

“The Olmstead decision strongly affirmed that people with disabilities have a right to live and receive services in the most integrated setting appropriate for them as individuals,” said Thomas
Joint Effort in St. Louis

- Legislative response to shooting death of family members by person with mental illness
- Board of Directors four local CMHCs
Harris County MHMRA

- The NeuroPsychiatric Center (NPC)
- Psychiatric Emergency Services (PES)
- What happens when you come to the NPC?
- Paying for NPC Services
- Help Line
- Crisis Stabilization Unit (CSU)
- The NPC Pharmacy
- Crisis Residential Unit (CRU)
- Co-Occurring Disorders Unit
- Mobile Crisis Outreach Team (MCOT)
- Crisis Counseling Unit (CCU)
- Bristow Homeless Unit (PATH)
- Other Emergency Options
- U. T. Harris County Psychiatric Center (HCPC)
Statewide Crisis & Access Line

- Single Point of Entry concept led to GCAL
- Hurricane Katrina in 2005
- Scheduling, Dashboards and Analytics
Crisis Response Center Tucson

- 2006 community bond packages $54 million
- CPSA and University Physician’s Hospital
- Co-located Call Center, Stabilization and more
Phoenix’s Full Array of Services

- Peer Warm-line, Crisis Line & Mobile Crisis
- 24/7 Outpatient & Co-located Residential
- Detox, Crisis Stabilization & Psych Inpatient

Above, Community Bridges
- Level I Acute Inpatient Hospital (MIHS, St. Luke’s, Aurora, Banner)
- Level I Psychiatric Sub-Acute (UPC, RRC & CRU)
- Level I Sub-Acute Detoxification (CCARC & EVARC)
- 23-hr Crisis Stabilization - Psychiatric (UPC, RRC, BPC & St. Luke’s [C/A Only])
- 23-hr Crisis Stabilization – Substance Abuse (CCARC, EVARC & St. Luke’s [C/A Only])
- Level III Time-Limited Residential (CBI WV & EV Transition Point)
- 24/7 Walk-In Outpatient (CBI WV & EV Access Point)
- Mobile Crisis Teams (TERROS, Empact & MHW)
- Hospital Rapid Response (TERROS, CPR & MHW)
- CPS Rapid Response & Stabilization (TERROS & Empact)
- 24/7 Crisis Hotline (CRN)
- Crisis Transition Navigators (Peer) (Valle del Sol, Empact, NOVA & Comm. Bridges)
- Peer Operated Warm Line (Visions of Hope)
"Hospital hold" refers to a point where either of our psychiatric urgent care facilities reach their critical capacity and restricts the ability for hospitals to transfer individuals. The critical capacity limit is a point where the remaining bed availability must be reserved for walk-ins and police drop-offs. Though not ideal, hospital settings are considered a safer environment than the general community. Magellan recognizes that it is critical that individuals and their families have the services they need when they need them.

By early 2009, the hospital hold rate consistently reached a combined average over 75% with one facility reaching 98% hospital hold in the month of April. Starting in April, Magellan, and our network of crisis partners, made numerous changes and enhancements to the crisis system and implemented a system-wide capacity management initiative that has resulted in a drastic decrease in hospital hold.
Arcadia

CHOICES clinic about 5 miles due north of the Phoenix Airport. Serves more than 1,100 persons.

Trend

59%

Targets Met (Weighted)

9 of 17 (Goal 90%)

3311 North 44th Street,
Suite 100
Phoenix, AZ 85018

602-957-2220
7:30 am - 5:30 pm

www.choicesnetwork.org

ISP Current

ISP Quality 12

Customer Satisfaction

I. Clinical

Employment

Community

Complaints/1,000

Adverse/1,000

14%

41%

3.7

0.8

II. Recovery

Primary Care (COC2) Physician Follow-Up

Admissions/1,000

No 30d Readmit

Title XIX

79%

98%

33

88%

71%

III. Coordination

COT Adherence

Case Load Ratios

Staffing Physicians

Staffing Case Mgrs

 jurisdictions

100%

57%

110%

97%

IV. Accountability & Administrative

Encounters

96%
Keeping Individuals from Falling through the Cracks

Individuals walk out of an Emergency Department “Against Medical Advice,” for example, and crisis services shift their focus away to others.
If US airports settled for a 99.9% success rate for commercial flights, there would be 300 unsafe take-offs and/or landings... per day!
## Two Key Principles of Safety

| Goal #1: always know where the aircraft is and never lose contact; | Goal #2: verify the hand-off has occurred and the airplane is safely in the hands of another. |
Modifying the Milbank Continuum for Crisis Coordination

<table>
<thead>
<tr>
<th>Level 1</th>
<th>Level 2</th>
<th>Level 3</th>
<th>Level 4</th>
<th>Level 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>MINIMAL Agency Relationships</td>
<td>BASIC Shared MOU Protocols</td>
<td>BASIC Formal Partnerships</td>
<td>CLOSE Data Sharing (Not 24/7 nor Real Time)</td>
<td>CLOSE “Air Traffic Control” Connectivity</td>
</tr>
</tbody>
</table>

Crisis Access, LLC has modified the Milbank collaboration continuum (original citation Doherty, 1995) for the purposes of evaluating crisis system community coordination and collaboration (see table above).
The Five Components of a Level 5 Crisis System

For a crisis service system to provide Level 5 “Close and Fully Integrated” care, it must implement an integrated suite of software applications that employ online, real-time, and 24/7:

<table>
<thead>
<tr>
<th>Status Disposition for Intensive Referrals</th>
<th>24/7 Outpatient Scheduling for Urgent Apptmnts</th>
<th>Shared Bed Inventory Tracking</th>
<th>High-tech, GPS-enabled Mobile Crisis Dispatch</th>
<th>Real-time Performance Outcomes Dashboards</th>
</tr>
</thead>
</table>


Contact Us

Open Minds Planning & Innovations 2014

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Social Networking

http://davidwcovington.com
http://www.linkedin.com/in/davidwcovington
https://twitter.com/davidwcovington
https://www.facebook.com/david.covington
http://www.youtube.com/davidcovington
Opening Minds About Crisis Alternatives

www.recoveryinnovations.org
Recovery Innovations

- Founded in 1990 to serve Maricopa County
- Private not-for-profit
- Accredited by JCAHO since 1992
- Integrated professional and peer staff. 800 staff and 62% are peers providing peer support.
- World leader in recovery transformation that began in 2000 and has been our guiding vision
- 40,000 individuals served annually in five states and New Zealand in 22 locations.
- Recovery training in 32 states and five countries abroad.
No Force First


“There is no such thing as forced recovery.”

“The conditions that generate forced treatment are easily trumped by our seeming indifference to the massive use of force in the mental health culture…

“Let us commit to figuring out how to stop our mindless use of force. Let us use our best minds to figure out how to extricate our field from being society’s purveyors of force.”
During the period shown there were an average of 900 PRC admissions per month.

A reduction in hospitalization rate from 20% to 10% = 1,080 annual hospital admissions = $10 M + per year (($550 per hospital day with an average length of stay of 18 days in 2003).
Recovery Innovation’s
Recovery Symbol: Zero Restraint

PRC West Restraints

PRC Central Restraints
Getting to Zero; The Results

• No increase in staff injury.
• No increase in police events.
• No increase in chemical restraint.
• Today our Centers in CA, WA, NC, DE are licensed with no seclusion or restraint room.
No Force First – Peer Support

• Stop the violence
• Use lots of peer support
  – A minimum of 25%.
  – Today, 62% of Recovery Innovations direct service staff are Peer Specialists, 496 out of 800.
Results

• Of those receiving disability benefits at the time of employment, 59% went off benefits after becoming employed.
• 45% went off Medicaid.
• 16% discontinued a housing subsidy.
• 69% discontinued food stamps.
What Shows Up with Peers on the Team?

- The Peer Support Specialist’s own recovery is strengthened through service.
- Peer Support Specialists help others recover through engagement, hope, and mutual relationship/friendship.
  - Results; seclusion and restraint were eliminated in 8 months and in 15 months
  - Results; 180 bed County Hospital after one year reported a 36% reduction in seclusion and a 48% reduction in restraint.
- Peer Support Specialists help the organization recover.
Have a welcome sign on the door
Recovery Response Center Front Room
Jacksonville, NC
No Force First - Healing Spaces

• Institutional feeling replaced by “welcoming and friendly.” Spirit of hospitality.
• Use lots of light and open spaces.
  – No “us” and “them.” Take down the barriers.
  – Balance between privacy and community.
• Use warm colors with bright accents.
• Comfortable non-institutional furnishings.
• Label rooms using recovery language.
  – Front room, Retreat, Living Room.
  – Celebration suite, Room Hope, Learning Studio, etc.

© Recovery Innovations, Inc
No Force First – Create Alternatives
The Peer Living Room

• Offers a hospitality alternative to traditional psychiatric crisis services and hospitals.
• Staffed with Peer Support Specialists around the clock working alongside professionals.
• Following a “recovery partnership” and a “getting to know you” meeting, people may choose to be a guest in the Living Room.

What Happens in the Living Room?

• Peers share their stories of hope.
• Negotiate each person’s needs individually.
• Guests develop recovery plans.
• Make connections with the community
• Guests make plans for “next steps”
A New Language of Hope and Inspiration

- Crisis ➔ Opportunity
- Crisis Center ➔ Recovery Response Center
- Intake ➔ Recovery Partnership
- Assessment ➔ Getting to Know Each Other
- Staffing ➔ Mutual Planning Meeting
- Psycho-social history ➔ Telling My Story
- Treatment Plan ➔ Recovery Solutions
- Counseling ➔ Recovery Coaching
- Consumer ➔ Guest
No Force First – New Language

- Stop the violence
- Use lots of peer support
- Create a Healing Space
- Create non-hospital alternatives
  - Living Room, Restart, Peer Recovery Team
- Change the language
- Change the documentation.
  - Use the person’s name
  - Use ordinary language in the record
  - Include the person as a partner in the documentation process
Readmission Prevention & Crisis Stabilization for the Managed Care Environment

Jonathan Evans
President & CEO
Safe Harbor Behavioral Health
Safe Harbor Behavioral Health

• Founded in 1993 with focused mission to establish an intensive out patient clinic for patients with serious mental illness.
• Average LOS at the state hospital 8 to 10m years.
• Diagnosis of schizophrenia or Bi-Polar Mood Disorder with multiple treatment failures.
• 188 initial patients named to the project, with hospital diversions to follow.
Safe Harbor Behavioral Health

• Significant growth over the past 20 years with a continued focus on treatment of individuals with serious mental illness.
• Managed care environment the past seven years.
• Collaborative relationship with an openness to incentivizing innovative programming with a focus on management of chronic illness in the community.
C-SANDS

- Crisis Services Acute Need & Diversion Services
- 30 Day program providing timely access to psychiatric care and frequent therapy.
- Enhanced rate with BMHCO.
- Outcomes include reduction in ER, incarceration and impatient utilization.
- Cost savings for BMHCO.
Nurse Liaison Program

• Pay for performance contract with county funding and BMHCO.
• Nurse case management provided to patients pre-discharge from acute care settings.
• Nurse care manager has daily visits on the acute care units, meets with patients ready for discharge.
• Focus on engagement, importance of follow up, obtains records and reviews any impediments to care.
• Follow up post discharge including possible home visits.
The market intelligence to navigate.
The management expertise to succeed.

20+ years of market intelligence and management consulting
500+ years of collective team experience
40,000+ executive subscribers