It Starts Before Discharge!

Improving Follow-Up After Hospitalization for Mental Illness

Proper follow-up care with a mental health practitioner after a hospitalization helps patients:

- Increase medication adherence
- Reduce risks of readmission
- Get their needs met for everyday activities

The Follow-Up After Hospitalization for Mental Illness (FUH) Healthcare Effectiveness Data and Information Set (HEDIS®) measure looks at the number of discharged patients following hospitalization for treatment of selected mental illness diagnoses or intentional self-harm who had a follow-up visit with a mental health practitioner. It is split into two rates: 7-day follow-up and 30-day follow-up.

The Michigan Department of Health and Human Services (MDHHS) instituted a statewide Quality Improvement Project focused around improving FUH. MeridianComplete and Southwest Michigan Behavioral Health (SWMBH) are implementing interventions to improve members' quality of care through the post-discharge care transition.

A recent study found that patients who do not receive early interventions, such as discharge planning and connection to community-based services after discharge, were **2.83 times more likely to be readmitted to the hospital** within 30 days of an inpatient discharge for mental illness.[1]

Engaging patients in appropriate follow-up care starts before discharge. You can help support this project by engaging in the following best practices:

Notifying SWMBH of an inpatient admission while member is still inpatient and also upon discharge

- SWMBH helps coordinate behavioral healthcare services for patients and works with MeridianComplete to help align with necessary medical healthcare services

- Please share the patient's phone number and address with SWMBH for ongoing contact with the patient after discharge
- For any behavioral health inpatient admission after business hours, contact SWMBH at **800-676-0423** the morning of the next business day
- Provide discharge documentation to SWMBH **via fax at 269-441-1234 within *24 hours* of patient's discharge**

[1]Shaffer, S.L., Hutchison, S.L., Ayers, A.M., Goldberg, R.W., Herman, D., Duch, D.A., . . . Terhost, L. (2015). Brief critical time intervention to reduce psychiatric rehospitalization. Psychiatric Services: A Journal of the American Psychiatric Association, 66 (11), 1155-1161. https://doi.org/10.1176/appi.ps.201400362

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Communicate with the SWMBH utilization case manager during the discharge planning process to develop the most appropriate plan

- Integrated Healthcare Specialists are on staff to assist with discharge planning for complex cases and to provide support as needed

Schedule follow-up outpatient appointments to occur within seven days before the patient leaves the hospital

- There is a greater likelihood that patients will attend appointments if they are already scheduled
- It can be difficult to reach patients for appointment scheduling after they leave the hospital
- The appropriate provider type for Follow-Up After Hospitalization for Mental Illness is Mental Health Practitioner
- If unable to schedule a follow-up outpatient appointment within seven days, focus on helping the member make and keep a follow-up outpatient appointment before 30 days post-discharge
- Be sure to include the appointment provider, date and time in the discharge instructions
- SWMBH has a utilization case manager for discharge planning questions, available at **800-676-0423**

Assess for social determinants of health needs, such as transportation and housing

- Patients may not know how to access resources that will help support them after discharge and assist them in getting to future appointments and needed care
- Help connect the patient with any needed community supports and notify SWMBH of needs to help continue to support