# Bridging the Acute-to-Outpatient Care Gap in Mental Health: Developing and Implementing a Mental Health Transition Management Process in a Large Health System

David Geffen School of Medicine

Tina Kantaria, Pushpa Raja, MD, MSHPM[1], Germiniano Talag, RN[2], Jia Fan, MS[1], Filda Navarro, RN[2], Patrick Sonza, RN[2], Scott Fears, MD, PhD[1], Calvin Yang, MD, PhD[1], Jeffrey Balsam, PharmD, BCPS[3], Sharon Birman, PhD[1], Mona Lam, PhD[1], Barry Guze, MD[1]

## BACKGROUND

- Transitions from residential or inpatient mental health (MH) treatment to outpatient MH care are a time of higher risk for care attrition and re-admission
- VA performance metrics track MH encounters post-discharge, with national goals of 2 or more MH visits in the 30 days post-VA MH discharge

## OBJECTIVE

- To develop, pilot, and formatively evaluate a tele-mental health Transition Management Program (TMP) for patients discharged from residential MH care at VA Greater Los Angeles (VAGLA) to strengthen outpatient MH engagement

## METHODS

**Preparatory:**

- Developed a one-stop electronic Mental Health Post-Discharge Consult covering 25 outpatient referral settings

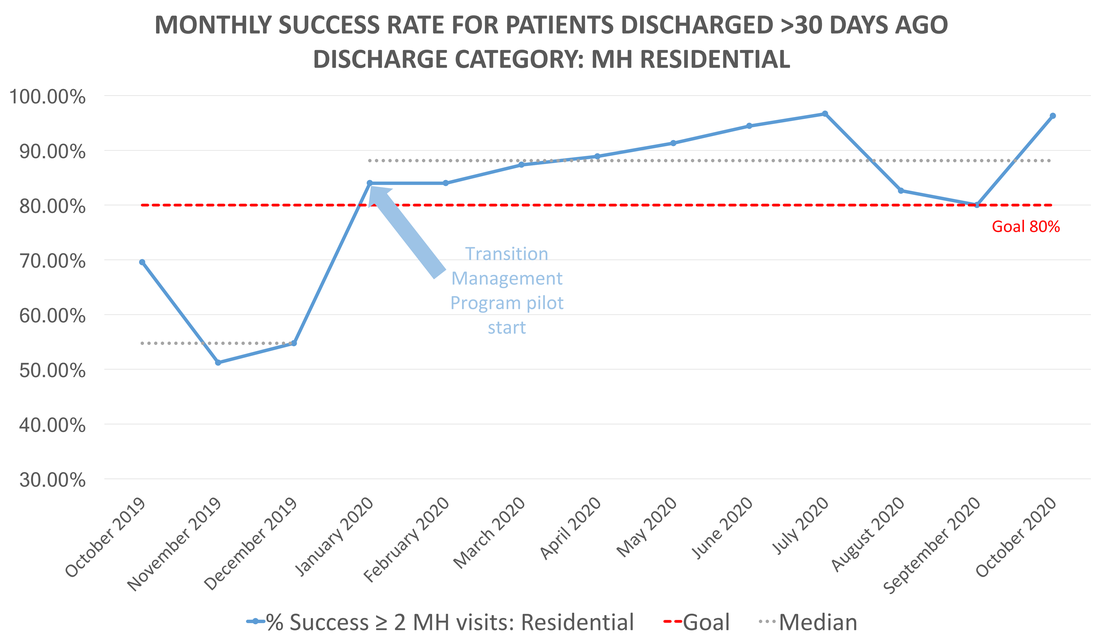
**Workflow:**

- Shifted 2 RNs from existing workforce to develop Transition Care Manager RN role, which included:
  - Receive and triage post-discharge consults
  - Liaise with outpatient clinics to rapidly schedule into appropriate MH programs
  - Engage patients via telephone before and after discharge to bridge the transition
  - Care manage for 30 days post-discharge – monitor appointment attendance, problem solve around missed appointments

**Monitoring:**

- Logged all consult uses during TMP deployment (e.g. number of consults placed, days between consult and discharge date), and all consult failures (e.g., discharge consult not placed)
- Logged patient no-show rates, success in connecting with 2 or more visits, and visit characteristics (e.g., monitoring to ensure majority of visits w/referral MH programs)
- Weekly huddles with RNs, data analyst, and MD to review data in tabular and chart form, adjust processes iteratively

## RESULTS




Pilot phase data (Jan – July 2020)

| | 28-Week Transition Management Program Pilot (Jan-Jul 2020) |
|---|---|
| Number of post-discharge consults placed for regularly discharged* MH residential patients | 220 |
| Average number of weekly consults | 8 |
| Number of days between consult placement and discharge date | 3.2 |
| % of regular discharges without post-discharge consult placed | 2% |
| % of total post-discharge MH visits within 30d completed by Transition Management team** | 19% |
| Number of MH referral programs with ≥1 completed post-discharge visit | 22 |

*Irregular discharges (ie, against medical advice) discharges were not included in pilot program; this cohort was added following pilot period
**Tracked to ensure majority of contacts were with referral MH programs, rather than solely with RN Transition Management team

| | 12-week Pre-Pilot Baseline (Oct-Dec 2020) | 28-week TMP Pilot (Jan-Jul 2020) |
|---|---|---|
| Average success rate (per 2-week period) in connecting patients with ≥2 MH visits | 53% (range 43-83%) | 88% (range 76-100%) |

During weekly huddles, the Transition Management team reviewed data to identify additional needed clinical outreach and make targeted process improvements (eg, identifying clinics with longer delays scheduling post-discharge visits and collaboratively problem solving with stakeholders)

## NEXT STEPS

- The TMP program moved from pilot to sustained implementation phase in July 2020
- In August 2020, the TMP process was adapted for Inpatient MH discharges:
  - With 10 weeks of post-30d data, for 111 patients: average 83% weekly success rate in connecting discharges with goal ≥3 MH visits within 30 days, versus average of 61% in 20 weeks pre-TMP

## IMPLICATIONS & CONCLUSIONS

MH care transitions, like medical care transitions, are a complex process and a period of vulnerability for individuals

- A **MH Transition Management Program** staffed by RNs offers an approach to:
  - Bridge the transition through "warm touches" pre- and post-discharge
  - Facilitate priority scheduling
  - Liaise between residential/inpatient and varied outpatient MH settings
  - Monitor post-discharge patient engagement
  - Quickly identify and problem solve around barriers to engagement
  - Improve post-discharge MH engagement
- Adds particular value in large, complex, disperse healthcare systems, especially with increase in tele-health due to COVID

Use of PDSA cycles to refine process flow, and integrating up-to-date data into clinical huddles, are critical to sustaining improvement