

*Sandhills Center LME,
Therapeutic Alternatives, Inc.
and
Mental Health Association in N.C., Inc.*

Sandhills Center Hospital Transition Team

*Mental Health Leadership Academy
Capstone Project
August 2008*

Sandhills Center Hospital Transition Team

Needs Analysis:

- Need to Reduce Readmissions to State & Community Hospitals
- Need to Insure Consumers Exiting Hospital Settings are Safely Integrated into Community Care System (e.g. psychiatric care, medication, housing, etc.)
- Approximately 40% of Hospitalized Consumers are New to the Community System
- Re-Hospitalized Consumers Become High Cost/High Risk and sometimes Lose their Provider
- Need to Increase Accountability for Consumer Care
- Create Financial Incentives in contracting model to get the Best Outcomes for Consumers

Sandhills Center Hospital Transition Team

Program Description:

- Sandhills Hospital Transition Team is a group of individuals contracted by Sandhills Center to provide linkage and assist with access to continued services of the consumer's choosing post discharge from a psychiatric hospital or substance abuse treatment facility.
- This program is designed to assist with prevention, recovery and reintegration into the community with identified providers based on an individual assessment of consumer needs.
- Two strong Providers within Sandhills Center's eight county catchment area were selected to partner this innovative concept.
 - Therapeutic Alternatives
 - Mental Health Association of North Carolina
- The program was implemented January of 2008.
- This service is provided for the first 30 to 45 days post discharge with an expectation of initial contact being made while the consumer is inpatient.
- Provides essential recovery/reintegration element in the Sandhills Crisis Continuum.

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Service Elements:

- Make Initial Contact in Hospital Setting via LME Hospital Liaison referral
- Coordinate with LME Hospital Liaisons on Discharge Planning
- Address Transition Issues
- Connect with Existing Providers
- Conduct Necessary Assessments and Develop Initial Person Centered Plan
- Make Appropriate Treatment Referrals
- Support Consumer Choice
- Weekly consumer updates by HTT to LME Hospital Liaison
- Monthly HTT and LME meeting to identify and resolve problem areas

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Program Goals:

- Increased Accountability for Consumer Care
- Increased % of Consumers with 30-day Post-Discharge Treatment Contact
- Reduction in State and Community Hospital Readmissions
- Improved Transition to Community Care for Consumers
- Improved consumer compliance with aftercare appointments post hospital discharge

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Funding Model:

- Initial Funding Commitment = \$250,000
- Need to address Essential Unfunded Activities (e.g. travel, transportation & in-hospital contacts)
- Pay Provider's Actual Cost – Actual Revenues (State/Medicaid Patient Fees)
- Use of Single Stream Funding Flexibility for Non-unit Cost Reimbursements
- Assumed 50% State Dollar/Medicaid Reimbursement

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Jan-June 2008 Results:

- # of Consumers Served = 247
- Total Project Expenses = \$177,333 (Estimated revenues = 40%)
- Cost Per Case = \$717.94
- 48.2% of Consumers served has at least one prior hospitalization (high cost/high risk)
- Cost Benefit Model: Reduction in Hospital Bed Days
 - 1 day = \$0.91 : \$1
 - 3 days = \$2.72 : \$1
 - 5 days = \$4.53 : \$1

Note: Assumes \$650 per day hospital/physician costs
- “Soft Benefits”:
 - Improved relationships with State/Community Hospitals
 - Improved consumers access to community services
 - On-going Needs Assessment Activities
 - Reduced Emergency Room and Law Enforcement Costs
 - Address needs of high cost/high risk consumers
 - Improved quality of life for consumers/long term recovery

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Critical Factors:

- Daily communication between LME Hospital Liaisons and HT Team
- Ability and willingness of hospital administrators and staff to support the program
- Provider's knowledge of community resources
- Accuracy of information (e.g. current address, telephone numbers and current providers)
- Single Stream Funding-Creation of an appropriate funding mechanism and incentives
- Strong public/private partnership