

## Introduction

Health & Medicine Policy Research Group launched its Behavioral Health-Primary Care Integration Learning Collaborative in 2015. After establishing consensus criteria for integration and examining the strengths and weaknesses of the existing delivery system, the Learning Collaborative set up a Hospital Transitional Care Workgroup to focus on the potential to improve outcomes for individuals returning to the community after inpatient behavioral health hospital admissions. After many in-depth discussions of Learning Collaborative members' own interventions and the barriers and opportunities to those efforts, the Workgroup began collecting data on hospital transitions. This data collection project concentrated attention on the processes of transitional care, where they breakdown, and how they may be improved. This paper summarizes the Workgroup's conclusions. Key takeaways are:

- **Transitional care requires integration because social determinants of health are drivers of breakdowns in transitions to the community**
- **Housing and employment are priority areas for improvement, and resources need to be identified early—at admission, not at discharge**
- **Ad hoc interventions by hospital systems and their community partners alone cannot avoid the breakdowns in communication and coordination that interfere with stabilization in the community**
- **Integrated Health Homes, a new program being launched in Illinois in 2019, must be implemented cautiously, with protocols in place for how community providers work with hospitals to engage patients in plans for post-discharge services. Those plans must include social supports for housing, employment, and other identified needs, as well as primary care and outpatient behavioral health follow-up**

## Focus of the Hospital Transitional Care Workgroup

Health & Medicine Policy Research Group's Behavioral Health-Primary Care Integration Learning Collaborative created a Hospital Transitional Care Workgroup to focus attention on the challenge of connecting individuals with behavioral health conditions to follow-up outpatient services after a hospitalization. During early discussions, Learning Collaborative members identified transitions from the hospital to the community as a key pivot point for integrated care. A hospital admission can interrupt attempts to implement a community-based plan for integrated behavioral and physical health care if the chance for timely follow-up to address the cause of the hospitalization is missed. On the other hand, a successful transition can help consolidate the integrated care plan around the key concerns of the individual and strengthen his or her recovery.

Coordination of hospital care and community-based behavioral health and social services is still relatively novel. Social needs like housing and food security are often important underlying causes of hospital admissions and readmissions, but identifying and addressing social needs does not fit seamlessly into hospitals' workflow. Many hospitals, including those involved in this study, have created partnerships with community-based providers to identify resources that help individuals access stable housing, employment, and social supports to maintain their recovery in the community. Yet it is frequently unclear, even when those hospital-community partnerships exist, who is primarily responsible for the complex role of coordinating community-based resources for post-hospital transitions, and breakdowns in communication are common.

The Hospital Transitional Care Workgroup investigated the process of hospital-to-community transitions among its own members by collecting data from Learning Collaborative member Blue Cross Blue Shield of Illinois (BCBS). Workgroup members defined the scope of the data collection project, creating a list of questions related to (1) assessment of primary care status at admission; (2) communication between hospital, community primary care providers, community behavioral health providers, and payers, including actual transmission of relevant discharge information; and (3) successful primary care appointment attendance after discharge. Working with BCBS, the Workgroup arrived at a set of questions that could be answered from claims data and BCBS's Medical Management Platform.

The Workgroup had identified additional data points that would have revealed more qualitative aspects of the transition process and highlighted the role of social determinants of health in hospital utilization. These included the barriers to communication and follow-up outpatient care observed by hospital discharge staff and measures of housing instability. However, surveying hospital staff was beyond the scope of this project, and social determinants data is still largely missing from medical records collected by hospitals, community physicians, or payers. Therefore, the Workgroup chose to focus on the HEDIS metrics for seven and 30-day outpatient follow-up and 30-day hospital readmissions, along with process measures from the BCBS Medical Management Platform. Those process measures tracked how often hospital staff were scheduling appointments, coordinating with family members, and communicating with BCBS, and whether patients were actively engaged in their care plan after discharge.

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Throughout this process, Workgroup members were conscious of the distinction between data collection for the purpose of collaborative learning—in this case to gain insight into the breakdowns that occur so often in hospital transitions—and data collection for drawing conclusions about effectiveness of an intervention. No member of the Workgroup claimed to have solved the problem of transitions from behavioral health inpatient hospital stays to ongoing recovery in the community. The Workgroup was not testing an intervention or evaluating performance on transitional care, but they relied on tools designed for quality measurement, such as HEDIS measures. Their goal was to draw into sharper focus this major challenge to integrated care in order to better articulate the key pitfalls in the existing delivery system and potential solutions, as well as ideas for broader reform.

Through BCBS, the Workgroup collected data for 20 unique Medicaid managed care patients admitted to one of two hospitals for inpatient mental health services between January 1, 2018 and March 30, 2018. Half the patients were enrolled in the Integrated Care Program, a Medicaid-only managed care program for Seniors and People with Disabilities (SPD) that was implemented in metropolitan areas of Illinois from 2011 to 2017, and half were Medicaid Family Health Plan members. Dually-eligible Medicare-Medicaid enrollees and individuals enrolled in intensive care coordination programs were excluded. The Workgroup deliberated for many months to assemble meaningful data for the purpose of collaborative learning, but it is important to note that the sample size is very small, patients were not randomized—in fact they were deliberately selected

for moderate- to high-risk status—and there was no control group for comparison. Again, this data was not intended for formal evaluation or hypothesis testing, but for collaborative learning purposes. As discussed in the Learning Collaborative Playbook, sharing performance data, even internally with a team committed to the same goal of improving integrated care, involves a level of risk and vulnerability to the providers and payers involved. Furthermore, the most readily available data on transitional care is very hospital-centric, yet a motivating principle of integrated transitional care is that hospitals alone cannot optimize transitions to the community. It is with these caveats in mind that we discuss the results of the Hospital Transitional Care Workgroup’s data collection project.

## Preliminary Results

The results of this preliminary, exploratory data collection project confirm that transitions are a major challenge for integrated care and that a better bridge from hospitals and medical stabilization to communities and social stabilization is needed. This is no surprise. Illinois as a state has not been meeting goals for HEDIS metrics on readmission and behavioral health follow-up after hospitalization, and its managed care programs have struggled to meet benchmarks for those measures as well. The 2017 national median percentage of patients who receive seven-day follow-up care is 41.9%, compared to Illinois’ 27.4%. For 30-day follow-up, the 2017 national median is 61.4%, while Illinois only reaches 43.8%.<sup>1</sup> Follow-up after hospitalization for mental illness (FUH) for Medicaid managed care enrollees has been a priority measure for the Illinois Department of Healthcare and Family Services, which set a pay-for-performance benchmark at the national Medicaid 75th percentile. The national Medicaid 75th percentile is 59.1% for seven-day outpatient behavioral health care follow-up and 71.6% for 30-day follow-up.<sup>2</sup> Even with a financial incentive, in addition to the intrinsic motivation to improve on transitional care, only one Integrated Care Program plan met the benchmark in 2016 and no plans met the benchmark for ACA/Family Health Plan members.<sup>3</sup> Our small, non-scientific sample of 20 individuals mirrors these national and state-level results—not enough people with behavioral health conditions are receiving optimal services and supports to safely and successfully transition to their communities.

The providers in the Learning Collaborative have been deeply involved in behavioral health integration initiatives, and the Hospital Transitional Care Workgroup has been active for over three years. If post-hospital care coordination was amenable to straightforward internal process changes at hospitals, then the topic would not have justified their interest and energy. But thus far the efforts of individual providers have been largely ad-hoc interventions that are difficult to systematize, sustain, and embed in the routines of both inpatient and outpatient delivery systems. The data the Workgroup collected, while not surprising, did focus members’ attention on the kind of problem transitional care presents, and the need for systemic solutions. Providers that put their full weight behind improving hospital-community partnerships still cannot patch the holes in what should be an integrated medical-behavioral-social support system. What is needed is not a ‘magic bullet’ to fix a dysfunctional transitional care system, but rather a flexible set of protocols and operational processes that allow for the level of communication and personalized assessment necessary to tailor each admission and discharge to the unique circumstances of each individual.

In Illinois, the Integrated Health Home (IHH) model has been proposed as a way to build the bridge between medical, behavioral health, and social services. IHHs would provide a structure that was missing in hospital transitions—hospital staff would know exactly which entity is responsible for post-discharge social stabilization and medical/behavioral health follow-up for moderate- to high-risk patients. But introducing this new entity, the IHH, will not ensure that community-based providers will work hand-in-hand with the hospital to manage complex transitions. There are multiple points of potential breakdown in the process of transitioning from hospital to community. Providers can mitigate that risk by formalizing a methodology for IHH-hospital coordination, from sharing assessments, records, and care plans and tracking housing stability, employment status, and family support to providing community-based organizations access to patients on the inpatient unit. Actually implementing such protocols effectively will depend on the expansion of health

information exchange infrastructure in Illinois, which must have the capacity to give real-time hospital admission, discharge, or transfer alerts to Health Homes. The State role must also include a recognition that siloed grant programs and infighting between departments interfere with providing people the resources they need to stabilize their lives and their medical and behavioral health conditions. The system as whole needs to

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develop ways to blend and braid funding to maximize available resources while minimizing administrative costs to search for and connect to funds for housing, vocational training, and other social supports. IHHs will need to interact with the full ecosystem of providers, and the more transparent and efficient that ecosystem is, the more likely IHHs are to succeed.

Research and the practical experience of Learning Collaborative members indicate that social determinants of health are key factors in the success of a transition from a behavioral health hospital admission. Process improvement within hospitals can ensure that discharge planning begins at admission and all staff

are trained to engage patients and their families in care plans and to collect and transmit necessary information to payers and community partners. However, the hospital-community partnership itself requires further protocolization to define the basic principles for behavioral health transitions and clarify the roles of hospitals, outpatient primary care practices, including FQHCs, community-based behavioral health providers, community-based social services providers, payers, and government agencies. Across the transition process, all of these entities need to recognize that individuals in behavioral health inpatient units may look similar on paper but are not starting from the same place when they exit the hospital. Identifying family and other supports, housing status, and employment status, and connecting to community resources that can fill unmet needs, is crucial to understand each person's unique situation and their potential trajectory toward recovery. Integrated Health Homes provide a missing piece in the process—an entity that is clearly responsible for the coordination of medical-behavioral-social services post-discharge.

But just as patients differ from one another, every hospital and every community in Illinois—a diverse state which is just now expanding Medicaid managed care to every county—is starting with different challenges, experience, and resources to meet the needs for primary care, behavioral health, acute care, and social supports. Providing integrated behavioral health care at the point of service will depend upon statewide coordination of available resources to support capacity for primary care, behavioral health, and social services, especially supported housing and employment. Collaborative learning projects, such as the Hospital Transitional Care Workgroup, are often stymied by shortages of those resources or difficulty locating which services are available, through what funding mechanism, and in what area of the state. The more transparently and efficiently IHHs and their partners can identify and access necessary services, the more likely transitions to the community will be successful, which would bring us one step closer to the vision of integrated behavioral health and primary care.

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<sup>1</sup> Medicaid.gov. "Performance on the Adult Core Set Measures, FFY 2017, Table FUH-AD," Available for download from: <https://www.medicaid.gov/medicaid/quality-of-care/performance-measurement/adult-core-set/index.html>, accessed December 21, 2018.

<sup>2</sup> Centers for Medicare & Medicaid Services. "Quality of Care for Adults in Medicaid: Findings from the 2017 Adult Core Set: Chart Pack," September 2018, page 53. <https://www.medicaid.gov/medicaid/quality-of-care/downloads/performance-measurement/2018-adult-chart-pack.pdf>

<sup>3</sup> Illinois Department of Healthcare and Family Services. "Calendar Year (CY) 2016 HEDIS 2017 Medicaid Rates." <https://www.illinois.gov/hfs/SiteCollectionDocuments/HEDIS2016Report.pdf>

### **About Health & Medicine Policy Research Group**

Health & Medicine is a Chicago based non-profit working to improve the health of all people in Illinois by promoting health equity. Founded in 1981 by Dr. Quentin Young, it was formed as an action-oriented policy center—nimble, independent, and focused on regional health issues. Health & Medicine’s mission is to promote social justice and challenge inequities in health and health care. It conducts research, educates and collaborates with other groups to advocate policies and impact health systems to improve the health status of all people. Health & Medicine has successfully developed health policy recommendations and implementation strategies for different public and private entities, earning the trust of the legislature, advocates, the media, researchers and policymakers at all levels of government in Illinois to become the region’s “honest broker” on healthcare policy matters. Learn more at [www.hmprg.org](http://www.hmprg.org).

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