Reducing Mental Health & Substance Use Readmissions Within 30 Days Across Vancouver Coastal Health

Background/Context

A readmission is when a patient is admitted to hospital within 30 days of their initial discharge. Readmission rates are an important indicator of healthcare system performance.

High readmission rates:

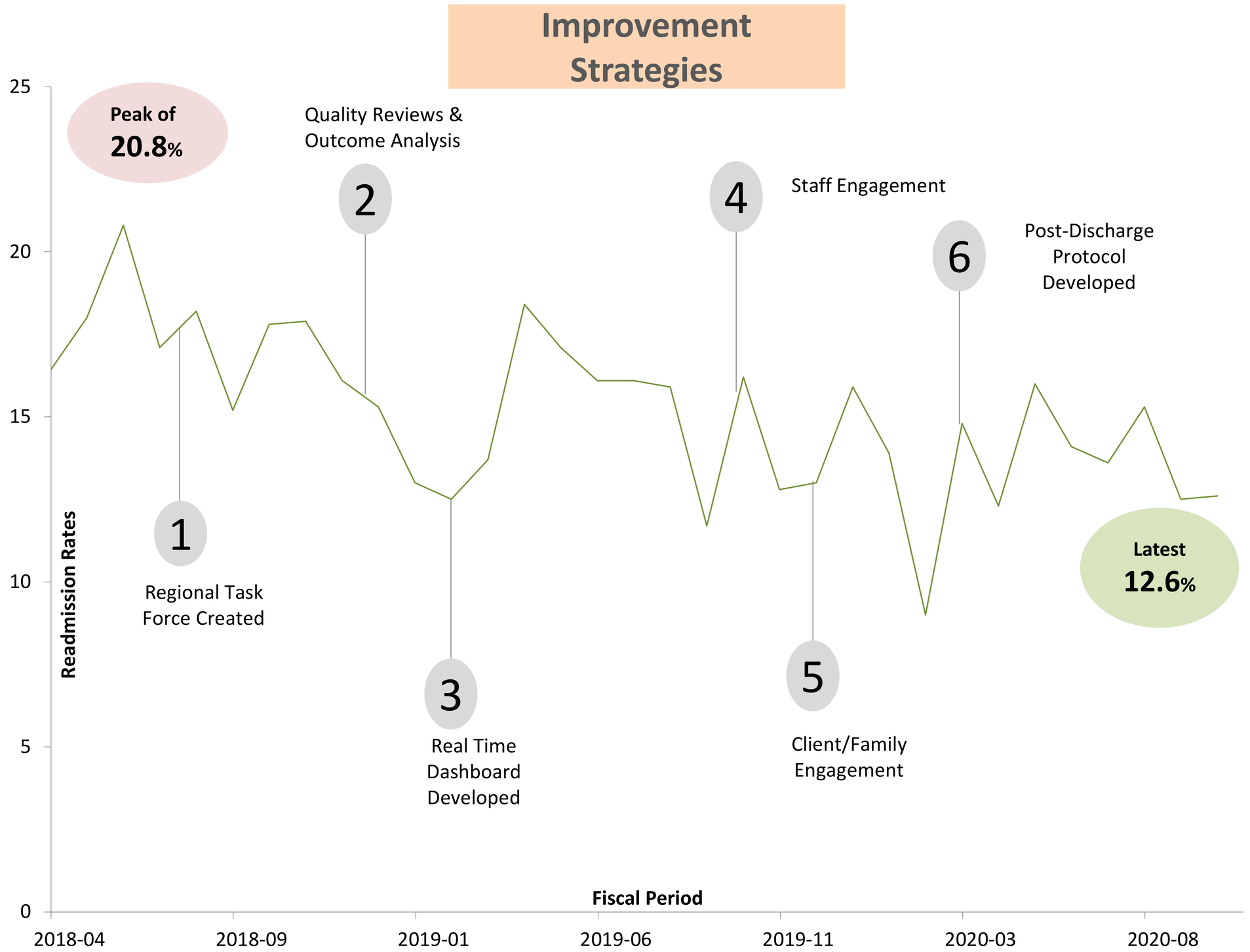
- Contribute to a higher cost to the healthcare system, and
- May indicate poor clinical outcomes for patients

Vancouver Coastal Health's (VCH) Mental Health and Substance Use (MHSU) program prioritized reducing MHSU readmission rates as an important area for quality improvement.

Aim

To reduce unplanned psychiatric readmissions across VCH.

Improvement Strategies



1 Regional Task Force Created

This committee was spearheaded by medical and operational leadership across the MHSU program and meets regularly.

2 Quality Reviews & Data Analysis

We used a combination of clinical and administrative data as a foundation for our strategy work.

Quality Reviews: Why are people being readmitted?

>100 Chart reviews across VCH

A planned appointment after discharge reduced readmission risk.

Stimulant use and psychosis is a prominent clinical feature in readmissions specifically in Vancouver.

Administrative Data Analysis: When and which individuals being readmitted?

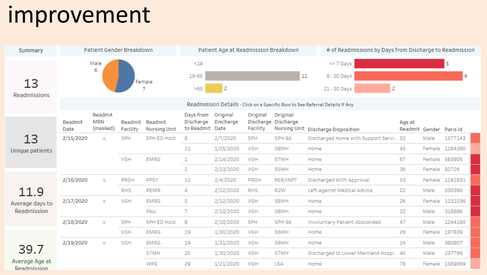
7 years of Historical Administrative Data

>40% of readmissions take place within 7 days!

68% of readmissions have a diagnosis related to Schizophrenia or Substance Use

3 Interactive Tableau Readmission Dashboard Developed

Real time data enabling quality improvement



4 Staff Engagement

Engaged in surveys and focus groups to gain staff perspectives.

"Offer evidence-based treatments for psychosis and stimulant use disorders in a timely way in the community."-Physician

5 Client and Family Engagement

3 Engagement Sessions

21 Participants

"I felt distorted and experienced a sense of loneliness after being discharged home - the intensive acute stay gave me structure"
– Client advisory member

6 Post-Discharge Protocol Developed

Protocol in development to ensure clients receive a follow-up contact (phone call, in person, text/video) within 2 days of their discharge date.

Results/Impact

Through our quality improvement work we now have 80% of all clients having a confirmed appointment with a community provider, within 28 days of discharge date.

Based on feedback from clients/families, we have begun to pilot contacting clients via phone/text/video within 2 days of their discharge date.

We are developing programs for clients with stimulant use who make up a very high proportion of readmissions.

Lessons Learned

Engagement from diverse stakeholders is important and should include: clinical, operational and medical leadership, as well clients and families.

Real-time monitoring enabled quality improvement by regularly tracking readmission rates down to the level of each hospital and nursing unit.

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