

## Mental Health Readmissions

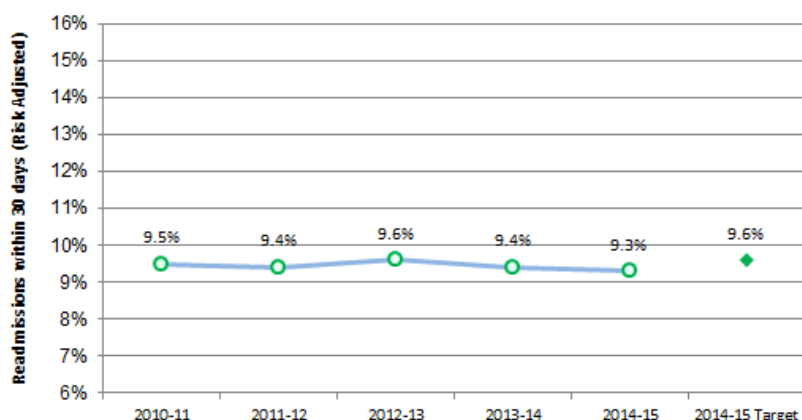
### Measure Definition

The percentage of patients who have mental health disorders with unplanned readmission to hospital within 30 days of leaving hospital. Excludes patients who have mental health disorders who require scheduled follow-up care.

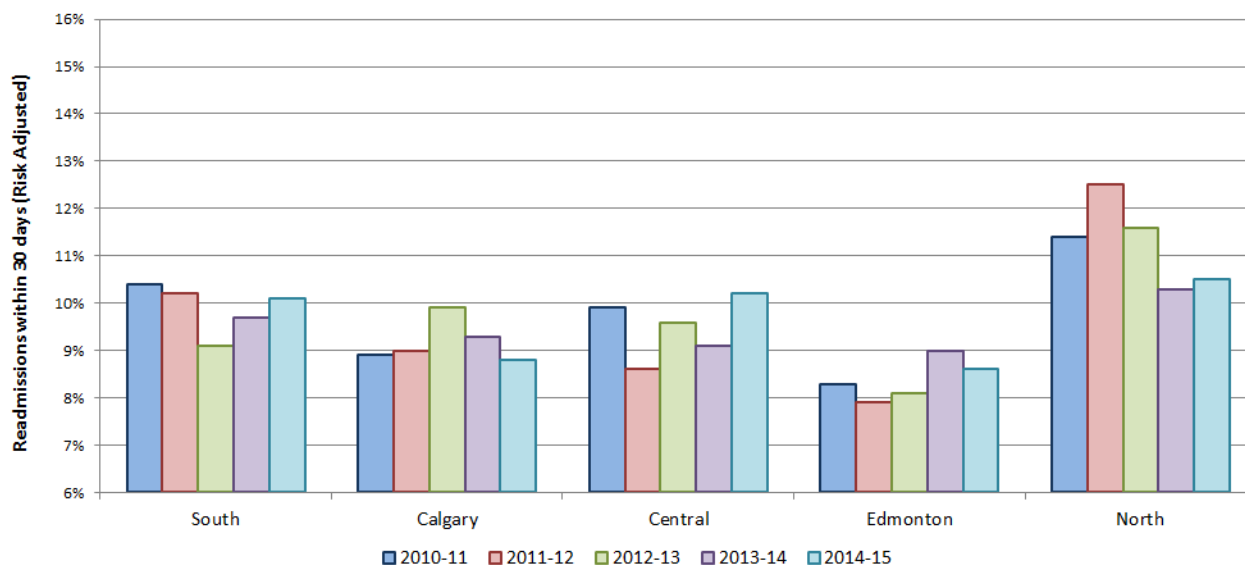
### Understanding this Measure

Hospital care for people diagnosed with a mental illness typically aims to stabilize acute symptoms. Once stabilized, the individual can be discharged, and subsequent care and support are ideally provided through primary care, outpatient and community programs in order to prevent relapse or complications. While not all readmissions can be avoided, monitoring readmissions can assist in monitoring of appropriateness of discharge and follow-up care.

Mental Health Readmissions - Annual



Mental Health Readmissions - by Zone



## Mental Health Readmissions – Actions

<b>Provincial/ Strategic Clinical Network (SCN)</b>	<ul style="list-style-type: none"> <li>Work continues by the Addiction &amp; Mental Health SCN to explore emergency medical services (EMS) use of “test and treat” protocols for complex, high needs mental health patients who frequent emergency departments.</li> </ul>
<b>South</b>	<ul style="list-style-type: none"> <li>Develop case management approaches for complex needs patients with Primary Care Networks.</li> <li>Collaborating with psychiatrists to readmission rates and to develop a plan to address higher rates.</li> </ul>
<b>Calgary</b>	<ul style="list-style-type: none"> <li>Patients contacted within seven days of discharge to provide post-discharge support and reinforcement of discharge recommendations.</li> <li>Initiate Community Treatment Orders as appropriate.</li> <li>Evaluate 30-day Readmission Rates.</li> </ul>
<b>Central</b>	<ul style="list-style-type: none"> <li>Discharge Continuity Project continues to link together inpatient and community services, and addresses suicide risk management policy.</li> <li>Enhanced mental health liaisons to support rural facilities, EDs, and other agencies.</li> <li>Enhanced discharge planning/transition occurring via Centennial Centre for persons with Development Disabilities.</li> <li>Advocate for additional supports and partner with Child and Family Services for community living.</li> <li>Enhanced linkages/referrals with continuing care in multiple zones for complex clients.</li> </ul>
<b>Edmonton</b>	<ul style="list-style-type: none"> <li>Consolidated and expanded existing community addiction and mental health services into new outpatient clinic in Leduc in June 2015.</li> <li>Implemented integrated electronic health record (eClinician) in approximately 100 clinical departments, across 50 sites, with 1,100 staff and physician users. Ongoing maintenance and optimization moved into operations.</li> <li>Concurrent Disorders Capable Treatment Continuum Project underway with Alberta Infrastructure. Business case, functional programming and project charter complete.</li> </ul>
<b>North</b>	<ul style="list-style-type: none"> <li>Begin implementation of Addiction and Mental Health Strategic and Operational Plan.</li> <li>Continue implementation of the Triple Aim project in Grande Prairie.</li> <li>Began implementation of Aboriginal Mental Health Strategy and action plan.</li> </ul>

### IN SUMMARY

While not all readmissions can be prevented, the rate can often be reduced through better follow-up and coordination of care for patients after discharge. Tracking the readmission rate helps us understand the effectiveness of hospital care, and how well we support patients after they leave the hospital.

### DID YOU KNOW

*Five percent of Alberta’s population is using services that account for 66% of costs associated with inpatient, emergency and urgent care, general practitioner and specialty physician care. This **complex high needs patient (CHNP)** has almost 1.8 times more actual than expected costs, with 70% of the cost distribution related to chronic disease. Understanding unique clinical profile and utilization patterns will aid AHS in providing appropriate care to Albertans.*

## Mental Health Readmissions – Zone Details

The percentage of patients who have mental health disorders with unplanned readmission to hospital within 30 days of leaving hospital. Excludes patients who have mental health disorders who require scheduled follow-up care.

Mental Health Readmissions within 30 days (Risk Adjusted)	2011-12	2012-13	2013-14	Q4 YTD		Trend *	2014-15 Target
				2013-14 Last Year	2014-15 Current		
<b>Provincial</b>	<b>9.4%</b>	<b>9.6%</b>	<b>9.4%</b>	<b>9.4%</b>	<b>9.3%</b>	<b>↑</b>	<b>9.6%</b>
South Zone	10.2%	9.1%	9.7%	9.7%	10.3%	↓	9.1%
Calgary Zone	9.0%	9.9%	9.3%	9.3%	8.9%	↑	9.9%
Central Zone	8.6%	9.6%	9.1%	9.1%	9.8%	↓	9.6%
Edmonton Zone	7.9%	8.1%	9.0%	9.0%	8.6%	↑	8.1%
North Zone	12.5%	11.6%	10.3%	10.3%	10.1%	↑	11.4%

\*Trend: ↑ Improvement → Stability ↓ Area requires additional focus

Mental Health Discharges (Index)*	2011-12	2012-13	2013-14	Q4 YTD	
				2013-14 Last Year	2014-15 Current
<b>Provincial</b>	<b>12,309</b>	<b>12,780</b>	<b>13,508</b>	<b>13,508</b>	<b>13,922</b>
South Zone	1,535	1,509	1,507	1,507	1,492
Calgary Zone	4,254	4,340	4,753	4,753	5,121
Central Zone	1,537	1,539	1,483	1,483	1,629
Edmonton Zone	3,099	3,292	3,444	3,444	3,410
North Zone	1,884	2,100	2,321	2,321	2,270

\* Total number of hospital stays for select Mental Health diagnoses.