



MFP/Pathways 2009-2011: Re-Institutionalization Root Cause Analysis Report Summary

Prepared by
The University of Illinois at Chicago
College of Nursing

Root Cause Analysis (RCA)

Presents information on participants who transitioned back to the community and were subsequently re-institutionalized.

Purpose is to identify and summarize:

- Demographic characteristics
- Utilization patterns
- Themes
- Behaviors


Covers 35 months: Feb. 2009 through Dec. 2011

51 of the 478 participants were re-institutionalized after transition, for an all-cause re-institutionalization rate of 11%.

Section I: Transition, Disenrollment & Re-institutionalization

Transition, Disenrollment, & Re-institutionalization

Total re-institutionalization as a cause for disenrollment was 58% (51/88).



Re-institutionalization by agency:

67% for DMH
participants
(24/36)

42% for DRS
participants
(5/12)

55% for IDoA
participants
(22/40)

Transition, Disenrollment, & Re-institutionalization

For all 51 participants that were re-institutionalized:

47% were transitioned within the DMH (24/51)

10% within the DRS (5/51)

43% within the IDoA (22/51).

Section II: Selected Information on Re-institutionalized Participants

Baseline Characteristics: Demographics

IDoA participants are approximately 10 to 20 years older than DMH or DRS participants who are re-institutionalized.

More males are re-institutionalized in the DMH (58%) and DRS (80%) than IDoA (32%).

Re-institutionalized participants lived in their current long term care facility approximately 2 years before transition, compared to 2.5 years for participants that were transitioned but were not re-institutionalized.

IDoA participants who were re-institutionalized were typically older than IDoA participants who were not re-institutionalized by approximately 4 years.



Baseline Characteristics: Housing Type

A majority of individuals moved into individual apartments (55%) and fewer into a Supportive Living Facility (SLF, 22%) or a house (20%). The exception was IDoA participants; 41% moved into a SLF at transition.

Among the 21 IDoA participants who were re-institutionalized, 41% resided in a SLF, 32% homes, 23% apartment, and 5% unknown housing.

There was a 17% difference in re-institutionalization rates between IDoA participants who transitioned to a SLF as opposed to IDoA participants who transitioned to other types of housing;

- 59% were not re-institutionalized and
- 42% were re-institutionalized.



Baseline Characteristics: Major Medical Health Conditions

The primary major medical conditions among those re-institutionalized were:

- Diabetes (51%),
- Heart disease (51%), and
- COPD (33%).

These conditions are fairly consistent across agency groups.

12% of all re-institutionalized participants had all 3 conditions (diabetes, heart disease and COPD).

The overall morbid obesity rate was 26%;

- For DRS participants the obesity rate was 40%;
- for DMH participants 33%; and
- for IDoA participants 14%.



Baseline Characteristics: Major Mental Health Conditions

71% of all participants had a major mental health diagnosis (depression, bipolar disorder, and/or schizophrenia).

Depression was the most prominent mental health diagnosis across all 3 agency groups.



Baseline Characteristics: Health Care Utilization

A majority of participants (60%) across all agencies had at least one emergency department (ED) visit in the 12 months *before* transition.

40% of DRS and IDoA participants had been hospitalized at least once in the 12 months before transition.

30% of all re-institutionalized had at least one ED visit and at least one hospital admission in the previous 12 months *before* transition.

DMH participants who were re-institutionalized had a higher rate of ED visits (62%) compared to DMH participants who were not re-institutionalized (41%).

Participants who were re-institutionalized after transition had higher ED rates (60%) compared to participants who were not re-institutionalized (45%).

Baseline Characteristics: Length of Time Lived in the Community

DMH participants lived in the community approximately 4 months longer than DRS or IDoA participants.

80% of DRS and 73% of IDoA participants lived in the community less than 6 months after transition compared to 38% of DMH participants.

A majority of DMH participants lived in the community between 6 and 12 months (54%)



Baseline Characteristics: Length of Time Lived in the Community

Six participants were re-institutionalized within approximately 30 days of transition (range: 2-38 days) .



- 1 DMH participant (17 days living in the community) was re-institutionalized by choice due to medication issues.
- 5 IDoA participants: All re-institutionalized because of deteriorating mental and/or physical health and an inability to self-manage.



Baseline Characteristics: Pre-transition Risks and Medications*

- A majority of re-institutionalized participants within the DRS (88%) and IDoA (51%) had 2 or more ADL/IADL limitations.
- A majority of all three participant groups had Medication-related risks at 90% or higher. The Average number of medications per participant was similar across all 3 agency groups.
- A majority of all three participant groups needed additional supports to live in the community.
- A majority of DMH participants (83%) were identified at risk for increased health care utilization at the time of transition.

*Based on pre-transition risk/medication documents completed by MFP Transition Coordinators.

Community Waiver and Demonstration Services*

- The demonstration service selected most often for all re-institutionalized participants was community transition services (70%; 35/51).
- The waiver service selected most was case management (56%; 28/51).

| | All | DMH | DRS | IDoA |
|-------------------------------------|-----|----------|----------|----------|
| N Participants Re-institutionalized | 51 | 24 | 5 | 22 |
| N Selected Services (%) | 169 | 51 (30%) | 30 (18%) | 88 (52%) |
| Average Services per Participant | 4 | 2 | 6 | 4 |

*Based on Transition Form C completed by MFP Transition Coordinators.

Community Waiver and Demonstration Services

Selected Services: DMH

- community transition services (54%),
- community support team (42%), and
- community support individual (38%).



Selected Services for all DRS re-inst participants

- community transition services,
- case management,
- personal assistant, and
- personal emergency home response (PEHR).



Selected Services: IDoA

- community transition services (81%),
- case management (71%),
- PEHR (52%), and
- homemaker (48%).



Post-transition Critical Incidents*

A Total of 153 Critical Incidents (CI) were reported or discovered among the 51 re-institutionalized participants:

- DMH participants experienced 85/153 (56%);
- DRS participants experienced 19/153 (12%);
- IDoA participants experienced 49/153 (32%).

*Based on incident reports completed by MFP Transition Coordinators and Recent Admissions Reports generated by the HFS Medicaid Data Warehouse.

Post-transition Critical Incidents

A majority of all re-institutionalized participants experienced at least one CI after transition

DRS participants had the highest average number of CIs (3.6) even though they experienced the least number of CIs of all re-institutionalized participants.

ED visits and Hospitalizations were the primary CIs experienced, and accounted for approximately 66% of all CIs reported.

Incident Review Action Plan Activities

Among DMH and DRS participants who were re-institutionalized, the following broad categories account for 68% of the recommendations UIC staff made during incident reviews:

- Follow-up appointments or referrals to providers,
- Care management planning, and
- Education/coaching (self-management skills, medication management, social support).

Among IDoA participants most action plan recommendations were for:

- Appointments or referrals to providers,
- Education/coaching, and
- Planned health service encounters following hospitalization or nursing home admission.

Post Transition Health Service Utilization

Health service utilization was very high for re-institutionalized participants.

A majority experienced one or more ED visits (71%) OR one or more hospitalizations (63%).

31% had 2 or more hospitalizations after transition. 41% of all hospitalizations (48/118) were psychiatric admissions.

A majority had one or more ED visits AND one or more hospital admissions (59%).

80% of re-institutionalized DRS participants experienced an ED visit or hospitalization within 2 weeks of transition (median days = 5).

The post transition health service utilization data may be under reported and not accurately reflect participants that have dual Medicaid and Medicare coverage.



Post-Transition Contacts

- At the time the case notes were abstracted from the MFP online system (“web app”), 7 re-institutionalized participants were either not in the web app or else they had no case notes to document post-transition contacts: 1 DMH participant, 2 DRS participants, and 4 IDoA participants.
- The average number of total contacts after transition and before re-institutionalization was 7.
 - DMH participants averaged 8 contacts,
 - DRS participants 11, and
 - IDoA participants 5.
- However, there were wide variations in contacts. DMH participant contacts ranged from 0 to 28, DRS participants 0 to 22, and IDoA participants 0 to 17.



Post Transition Contacts

44% of TC face-to-face contacts and 26% of CMHCW face-to-face contacts could not be documented for DMH participants. This does not mean that these participants did not have any TC or CMHCW contact after transition. It is more a reflection of how individual TCs and CMHCs enter notes/documentation of follow-up visits into the web application

The data primarily indicate that the notes section of the MFP Web Application does not allow a meaningful way of abstracting TC or CMHCW post transition contact information due to the way it is currently being used.

Contributing Factors to Re-institutionalization

The data indicate that factors contributing to re-institutionalization are complex, but 3 factors are significantly related. While in slightly different proportions, these factors are consistent across the 3 state agency participant groups:

mental health deterioration,

physical health deterioration, and

a recent hospitalization or multiple hospitalizations.

Section III: Significant Predictors of Re-institutionalization After Transition

Significant characteristics identified from literature that have been found to increase the risk of re-institutionalization include:

Advanced age

Male gender

Medical co-morbidity

SMI co-morbidity
(including a history of
alcohol and/or drug
abuse or dependence)

Poly-pharmacy
issues

Risk of social
isolation/lack of
family and peer
support group

Functional
disability
(ADL/IADL
limitations)

Multiple
hospitalizations

SIGNIFICANT PREDICTORS OF RE-INSTITUTIONALIZATION AFTER TRANSITION

- The variables that appear to increase the risk of re-institutionalization among MFP participants include:
 - *Diabetes* - appears to *increase* the risk by 16% compared to those participants who do not have a diagnosis of diabetes.
 - *Pre-Transition Medication Risks* - appears to *increase* the risk by 34% compared to those participants who do not have pre-transition medications risks.
 - *Additional Supports to Live in the Community* - appears to *increase* the risk by 15% compared to those participants who do not need additional support.
 - *Any Pre-Transition ED Visit/Hospitalization within 12 months of transition*- appears to *increase* the risk by 200% compared to participants who do not have any ED visits and/or hospitalizations 12 months prior to transition.
 - *Any Post Transition Hospitalization* - appears to *increase* the risk by 400% compared to participants who do not experience any hospitalization after transition.
 - *SLF Living Arrangements* - appears to *reduce* the risk by 34% compared to participants who move into other living arrangements.

Section IV: Recommendations



Pre-Transition Planning

- Conduct a functional assessment *prior to transition* so equipment and home service needs are fully evaluated and necessary supports are in place on the day of transition. Evaluate participants with ADL/IADL limitations by a nursing home PT *before transition*.
- Review participant's medication *prior to transition*, including their ability to understand and take medications on time. Ensure all medications and medication administration supplies are available on the day of transition, as well as a verified plan for getting refills and taking medications as prescribed. Include a plan to reconcile medications following all health care provider appointments.



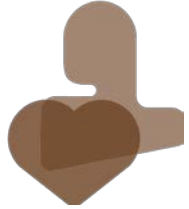
Pre-Transition Planning

- Arrange for a medication review by a pharmacist or primary care provider for participants with 5 or more prescription medications.
- Schedule initial appointments for all primary care, specialty care and psychiatrist providers *prior to transition* so they are set once the participant transitions.
- Arrange for rehabilitative, support programs to begin *prior to transition*, for participants who have a documented history of chronic, serious alcohol and/or substance abuse, and continue them into transition.



Pre-Transition Planning

- Involve nursing home staff early on in pre-transition planning. Meet with nursing home discharge staff on the day of transition, or shortly *before transition*, to verify arranged services will begin immediately upon transition.
- Arrange for an evaluation for by a mental health provider if the participant has a history of mental illness, depression or anxiety *before, or within seven days after transition*.



Care Management Intervention

- Arrange regular face-to-face contact between participants and their TC, especially in the first few weeks and months after transition. Take appropriate action and follow in place procedure when a regular schedule abruptly changes and no contact occurs for a given period of time. “No participant or caregiver contact” is not an appropriate action or response.
- Conduct face-to-face contacts in the participant’s home environment as much as possible. If a participant appears unsettled in the community, increase the number of visits until the participant begins to feel settled and better adapted to living in the community.



Care Management Intervention

- Schedule and conduct an initial contact by the TC to occur on the same day of transition and a face-to-face visit the same week.
- Schedule and conduct a review with UIC clinical staff as soon as possible after a hospitalization. Conduct a home visit with the participant and include in the review any medications changes and new recommendations.



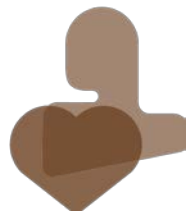
Care Management Intervention

- Assist participants in getting increased or improved health care/disease management services when multiple hospitalizations or health exacerbations occur. *An ED visit or hospitalization, especially within the first two weeks of transition, should be viewed as a red flag event. Complete a reevaluation of service needs following all hospitalizations.*



Care Management Intervention

- Accompany participants to health care provider appointments, especially during the first few weeks or months after transition, by the TC, CMHCS, or PA/caregiver. If the TC does not accompany the participant follow-up with the CMHCS or PA/caregiver. The TC documents the information in the MFP case notes.
- Assist participants in identify needed self management activities and follow-up to ensure they are being completed and reported to the participant's primary care provider. Provide participants with needed self management items: scale, blood pressure monitor, symptom/behavior logs, etc.



Care Management Intervention

- Stay up-to-date on a participant's provider visits and recommendations. Communication notebooks are an effective way to document changes, symptoms and recommendations, while keeping all those involved in the participant's care updated.
- Arrange for a home assessment from a home health nurse for participants who consistently miss medical or psychiatric appointments.



Procedural

- Develop a standardized format for documenting case notes that includes addressing recommendations from UIC, as well as addressing key components of the treatment plan or goals of the participant, what services and equipment are in place, and how successful each component of the plan is in meeting the participant's needs. This would also include specific formats for documenting:
 - Follow up home visits
 - Phone calls
 - Discussion with participant before/after provider visits
 - Satisfaction with home services
 - Confirmation that home services are meeting all medication management needs,
 - Effectiveness of assistive devices,
 - Ability to perform self management activities, etc.



Procedural

- Review and document all critical incidents with UIC clinical staff and the follow up status of the recommendations/action plan generated during the critical incident call.
- *Develop a system to track pre- and post-transition services.* Currently UIC does not receive any electronic format of community services received after transition. Therefore we cannot determine accurately what community services participants receive.