Best Practices Guideline
Follow-Up After Hospitalization for Mental Illness

Definition
Healthcare Effectiveness Data and Information Set (HEDIS) defines this metric as the percentage of youth (6 years of age and older) who were hospitalized for treatment of selected mental illness or intentional self-harm diagnoses and who had a follow-up visit with a mental health provider within seven days of discharge.[i]

Rationale
Timely follow-up care with a qualified mental health provider can improve patient outcomes, decrease the likelihood of hospital readmissions and decrease the overall cost of care.[ii] [iii] [iv] The three months following psychiatric hospitalization carries a 100-fold increase in the risk of suicide. Research indicates that youth who meet this metric have a 56% reduction in their risk of death by suicide in days eight through 180 post-discharge.[v]

Partners For Kids Best Practices [vi]

1. Develop a process to educate providers, practice staff and caregivers on the reasoning and importance of this metric:

    a. Only half of patients with a psychiatric hospitalization complete a follow-up visit with an outpatient behavioral health provider within seven days of discharge.
    b. There is a 100-fold increase in the risk of suicide in the first three months following inpatient psychiatric hospitalization.
    c. Youth with an outpatient mental health visit within seven days after discharge from psychiatric hospitalization have a 56% reduction in risk of suicide during the six months following hospitalization.

2. Use health information exchange technology to identify patients who are currently admitted or recently discharged from inpatient psychiatric units in need of a follow-up appointment in seven days.

3. Perform a chart review of non-compliant patients to understand systemic reasons for non-compliance and implement process adjustments when appropriate.

4. Maintain a list of direct contacts for area pediatric inpatient psychiatric units to improve communication regarding discharging patients.

5. Develop a standardized process for coordination of follow-up appointments within seven days for patients transitioning care from hospitalization. Identify a designated staff person to coordinate care during this transition.

6. Contact the patient/family before the visit to address barriers such as transportation and reiterate the visit's importance.

7. Create daily reminder and recall reports to identify all patients with scheduled follow-up visits and appointments who have missed or cancelled. Identify a specific staff person responsible for reviewing the list to ensure appointment reminders or rescheduling occurs in a timely manner.

8. Identify patients eligible for care coordination services through OhioRISE and work to link them to this service.

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[i] https://www.ncqa.org/hedis/measures/follow-up-after-hospitalization-for-mental-illness/
[ii] Barekatain M, Maracy MR, Rajabi F, Baratian H. (2014). Aftercare services for patients with severe mental disorder: A randomized controlled trial. J Res Med Sci. 19(3):240-5.
[iii] Luxton DD, June JD, Comtois KA. (2013). Can post-discharge follow-up contacts prevent suicide and suicidal behavior? A review of the evidence. Crisis. 34(1):32-41. doi: 10.1027/0227-5910/a000158.
[iv] Glazer, W. (2010). Tackling adherence in the real world. Behavioral Healthcare, 30(3), 28-30.
[v] Fontanella, CA, et al (2020). Association of Timely Outpatient Mental Health Services for Youths After psychiatric Hospitalization With Risk of Death by Suicide. JAMA Network Open. 3(8);2012887. Doi: 10.1001
[vi] Arizona Health Care Cost Containment System (AHCCCS). Best Practice Audit Guide: Follow-up After Hospitalization for Mental Illness 9FUH). Targeted investments Program Quality Improvement Collaborative.

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