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The Consult

network health
Collaborating with providers for the best quality care

Follow-Up After Hospitalization for Mental Illness (FUH)

One in five adults experience mental illness. Mental and/or substance use disorders are ranked among the top-five diagnoses for hospitalized adults ages 18-44.

Additionally, 1 in 6 youths, aged 6-17, experience mental illness. One study showed mental illness accounted for 18.7% of pediatric admissions, with a 30-day readmission rate of 8.0%.

Patients hospitalized for mental health issues are vulnerable after their discharge, making timely follow-up care by trained mental health clinicians critical for their health and well-being. Mental health clinicians are specifically qualified to identify potential reactions to medication changes made during hospitalization, as well as coping difficulties patients are experiencing while transitioning back to school, work and home.

Follow-Up After Hospitalization for Mental Illness (FUH) is a HEDIS measure that assesses the percentage of adults and children 6 years of age and older, who were hospitalized for treatment of mental health disorders and had a follow-up visit with a mental health practitioner within 7 days of discharge and a second visit within 30 days of discharge. Timely follow-up care after hospitalization for mental illness decreases the likelihood of readmission, promotes better continuity of care and results in improved outcomes.

This measure requires a follow-up visit to be with a mental health provider due to their specific qualifications to identify challenges for this population.

How can health care providers impact follow-up care?

- Educate patients on the importance of following up with a mental health provider after hospitalization
- Promote early patient and family engagement in discharge planning
    - Schedule follow-up appointments prior to discharge, utilizing telehealth services to bridge access gaps when appropriate
    - Provide appointment details such as date, time, provider name and address
    - Provide culturally competent care - a patient's culture and belief system can influence if they will seek help, what type of help, what coping styles and supports they have and what treatments might prove to be successful.
    - Identify barriers to care such as transportation and financial concerns
    - Identify resources including community health resources
- Improve communication between inpatient and outpatient resources to ensure smooth transitions

How Network Health can help

- Connect patient to Network Health Case Management if not already established: 920-720-1602 or 866-709-0019
- Network Health Behavioral Health Care Managers Support Patients in Need
    - If your patient has recently been discharged from an inpatient behavioral health unit, they should have a follow up appointment with a behavioral health provider within seven days of discharge for optimum stability of symptoms.
    - Finding the right behavioral health provider for your patient can make all the difference in the counseling experience. It can be challenging to find the right fit.
    - Does your patient need a psychiatrist for medication management, a psychologist for neuropsychological testing or a therapist for talk therapy?
    - Would they prefer a male or female therapist? Does the therapist have special interest and training in the issue your patient wants to address?
    - Referring your patients to a Network Health care manager is like giving them a personal GPS to navigate the health care system, find providers, explore patients' benefits and offer supportive phone calls between appointments. If patients agree, care managers will collaborate with their primary care doctors and specialists for optimum coordination of their care.
    - It is key for members to connect with the right providers for treatment plans that best serve members' needs. The care managers stress to

members the importance of follow-up appointments with their providers, encourage members to follow through with treatment plans and help members find additional resources within the community.
    - Network Health care managers may be reached at: 920-720-1602 or 1-866-709-0019.

Screening Needs for Patients Prescribed Antipsychotic Medications

Patients with schizophrenia and affective disorders have 1.5 to two times higher rates of diabetes and obesity when compared with the general population, this translates into increased mortality rates due to Cardiovascular disease (CVD). The use of certain psychotropics results in metabolic sequelae, such as obesity, dyslipidemia, glucose dysregulation and the metabolic syndrome. These sequelae exacerbate the already elevated risk of CVD and diabetes in this group of people. Therefore, the use of psychotropic agents that result in, for example, excessive weight gain not only add another complication for physicians managing a patient with schizophrenia but also may have serious prognostic and cost implications with respect to treatment-related diabetes and coronary disease incidence. Obesity, ethnic background, family history and certain medications increase these individual's risk of developing type 2 diabetes[1].

Second generation or "atypical" antipsychotics (SGAs) pose varying risks of metabolic effects, requiring the need to monitor weight, glucose and lipids. Clozapine and olanzapine carry a high risk; risperidone and quetiapine carry a moderate risk; and aripiprazole and ziprasidone are associated with lower risk, although their side effects are not yet as well documented as older medications.

Baseline monitoring measures should be obtained before or, as soon as clinically possible, after the initiation of any antipsychotic medication\.

- Personal and family history of obesity, diabetes, dyslipidemia, hypertension or cardiovascular disease
- Height, weight and BMI calculation
- Fasting plasma glucose
- Fasting lipid profile

Coordination with appropriate health care professionals may include the following.

- Nutrition and physical activity counseling for overweight or obese patients
- If appropriate, a weight management program addressing psychosocial needs
- Patient, family/caregiver education regarding treatment with SGAs and potential risks

Monitoring recommendations for individuals taking SGAs[2].

	Weight	**Glucose**	**Lipids**
Baseline	X	X	X
At four weeks	X		
At eight weeks	X		
At 12 weeks	X	X	X
At four months		X	
Quarterly	X		
Annually		X	
Every two - five years			X

*More frequent assessment may be warranted based on clinical status.

The HEDIS measure *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)* focuses on individuals 18-64 years of age with schizophrenia, schizoaffective disorder or bipolar disorder, who were dispensed an antipsychotic medication and had an annual diabetes screening test (glucose or HbA1c meet requirement).

[1] Hinds, Coutler, Hudson & Seaton. (2015). *Screening for diabetes in patients receiving second-generation atypical antipsychotics.* American Journal of Health-System Pharmacy. 2015; 72: S70-3.
[2] PL Detail-Document, Comparison of Atypical Antipschotics. Pharmacist's Letter/Prescriber's Letter. October 2012.

BMD Screening with PRN Home Health

Helping your patients receive the right care at the right time is what drives a great practice, especially after a fall that results in a bone fracture. Did you know that Medicare recommends women 67-85 years old who have experienced a fracture, to have a bone mineral density test (BMD) within six months of the fall? BMD screening is not always completed after a fall due to difficulty getting to the clinic or fear of COVID exposure.

Network Health has a solution. We partnered with PRN Home Health, a local agency, to meet members within their own home for a complimentary BMD screening. The results will be given to the member as well as sent to the personal doctor. This screening provides the opportunity to further discuss fall prevention and maintaining bone health.

The referral process is simple, just email the member details to Network Health at qi@networkhealth.com and we will schedule this free service with the member. Network Health is driving innovation to meet member's needs, so they receive the right care at the right time.

Using the STEADI Program to Assist with Fall Prevention

The STEADI program was developed by the CDC as an on-going effort to educate health care teams about falls in adults aged 65 and older. The goal of the program is to provide health care workers with steps to prevent falls within their practice. This free continuing education program can be utilized by any physicians, nurses, pharmacists, therapists and anyone else on the healthcare team. You can access this training by registering at CDC Training and Continuing Education , searching for course number WB4310 and completing the evaluation.
The PowerPoint STEADI Our Staff for Fall Prevention reviews the STEADI initiative to prevent falls including the following.

- Falls not being a priority to the patient or provider due to other medical issues being addressed
- Frequency of falls in older adults aged 65 and over
- Cost of fall recovery
- Risk factors and barriers for falls
- Prevention

The CDC also offers tools that can be used in the health system practice to assist in implementation of a successful fall prevention program.

- Developing an easy-to-use falls screening tool
- Assessment of risk factors for falling
- Intervention examples
- Patient follow-up
- Implementation of falls program
- STEADI guides for health care providers
- Patient education materials on falls prevention and safety checklists
- Fact sheets
- Wall charts

As healthcare providers, you play a vital role in the promotion of fall prevention in our older population. With the right screening, interventions, education and follow-up, you will have the ability to assist our members to remain free from falls, stay healthy and remain independent.

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