Hennepin Health
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Focus Study: Barriers to 30 Day Follow-Up After Hospitalization for Mental Illness

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Description

In health care, continuity of care is a crucial element, especially for patients in the field of psychiatry who have recently been discharged from a hospital. The shift from inpatient to outpatient care poses challenges for patients and healthcare providers, including openness to treatment, competing priorities, financial insecurity concerns and dilemmas faced by patients regarding their post-hospitalization life after improvements in symptoms, lack of social support, poor patient-doctor relationships, lack of insight, and stigma associated with mental illness. Therefore, it is vital to employ effective strategies to ensure patients receive the required care and support during this transition.

The transition from hospital admission to outpatient care is a crucial phase in psychiatric treatment for people with mental illnesses, emphasizing the necessity of continuity of care for effective management. This continuity post-hospitalization is essential for minimizing relapses and re-admission risk, making it a vital determinant of both short-term and long-term outcomes following inpatient psychiatric treatment. Studies by Smith et al. reveal that 30% to 50% of individuals admitted to psychiatric hospitals fail to attend post-discharge appointments within 30 days, resulting in adverse outcomes like heightened suicide risk, relapses, homelessness, and criminal justice involvement. Despite mixed evidence, various studies emphasize the significance of timely follow-up visits post-inpatient care in psychiatric units to reduce the risks of re-admission and relapse. Acknowledging the critical impact of care continuity, researchers across numerous studies, institutions, and clinical recommendations have explored targeted initiatives to lower psychiatric re-admission rates by improving transitional care coordination. Providing follow-up care to patients after psychiatric hospitalization can improve patient outcomes, decrease the likelihood of re-hospitalization and the overall cost of outpatient care.

Focus Study Question

- What barriers exist with current healthcare settings that prevent adequate follow-up (within 30 days) for members after mental health hospitalizations?

Process and Documentation

This focus study utilizes Healthcare Effectiveness Data and Information Set (HEDIS®) 2023 and 2024 data for dates of service in 2022 and 2023. The Follow-Up after Hospitalization for Mental Illness (FUH) HEDIS® measure assesses the percentage of inpatient discharges for a diagnosis of mental illness or intentional self-harm among patients age 6 years and older that results in follow-up care with a mental health provider within 7 and 30 days.

Sample Size and Methodology

The literature review was conducted using a systematic and structured approach to identify, evaluate, and synthesize current evidence related to the selected health topic.

The methodology followed established best practices for public health literature reviews to ensure rigor, transparency, and reproducibility.

The review began with the development of a clear research question that defined the population, health condition, and outcomes of interest. Based on this research question, explicit inclusion and exclusion criteria were established. Exclusion criteria included studies lacking primary data, editorials, commentaries, and papers not directly related to the defined topic.

Full-text review was then conducted for all studies that met initial screening criteria or where relevance was uncertain. Data from included studies were extracted using a standardized extraction form that captured study design, population characteristics, intervention or exposure details, outcomes measured, major findings, and noted limitations.

Each included study underwent a quality and risk-of-bias assessment using appropriate appraisal tools corresponding to its study design. Assessment criteria included methodological rigor, clarity of reporting, sample adequacy, potential biases, and appropriateness of analytical methods.

The synthesis focused on identifying common themes, evaluating the strength and consistency of evidence, highlighting areas of agreement or divergence, and identifying gaps in current knowledge. Findings were interpreted in the context of current public health practice and potential implications for local decision-making and future research.

Analysis

Data Limitations

Hennepin Health has a relatively small eligible population size for inclusion in the FUH measure, particularly when considering data at the race and ethnicity level. Literature reviews may not capture all barriers specific to Hennepin County and Hennepin Health's member base.

Results

Figure 1 below outlines Hennepin Health's FUH HEDIS® rates for measurement years 2023 and 2024 and illustrates the need for barrier identification and mitigation. Hennepin Health's small member population, and therefore small numerators and denominators, lead to greater variability in rates.

Figure 1: Follow-Up After Hospitalization (FUH) HEDIS® Rates 2023 and 2024

Product Line	2023	2024
PMAP	60.78%	61.26%
SNBC	63.64%	46.67%
Minnesota Care	28.57%	66.67%

Data Source: Hennepin Health Data Warehouse, Hennepin Health HEDIS® CY 2023 and CY2024

There are several barriers that prevent members from accessing care within the 30 days following an inpatient hospitalization for a mental health diagnosis.

Logistical barriers including transportation difficulties and appointment wait times delay access to care. Members often lack reliable transportation to attend post-discharge appointments post-discharge, and long gaps between discharge and the first available visit increase the likelihood of missed follow-up care [1] [2].

Insurance and system-level challenges, such as provider reimbursement challenges and limited data coordination across Medicaid and Children's Health Insurance Program (CHIP) systems, also contribute to low follow-up rates. Nationally, follow-up among adult Medicaid beneficiaries averages only 55% [3].

Social drivers and socioeconomic factors impact follow-up care. A substantial proportion of discharged patients face housing instability, unemployment, and low education, which correlate with lower health follow-up outcomes [2] [4]. Homelessness or unstable living conditions disrupt continuity of care, and such populations frequently miss outpatient appointments [5] [4].

Clinical and behavioral factors also impact this crucial follow-up. Around 40% of individuals with serious mental illness (SMI) do not attend any outpatient visits post-discharge, a rate driven partly by the effects of disorganized thinking or clinical symptoms [5] [6]. Loss of motivation following acute stabilization, as the immediate crisis subsides, lowers patient engagement in follow-up care [1].

Along with these behavioral factors are both stigma and psychological barriers. Stigma associated with mental health care deters patients from seeking follow-up services [9] [6]. Emotional fatigue or feeling overwhelmed post-hospitalization also acts as a barrier to following through with outpatient referrals [1].

Provider shortages impacts both access and follow-up. Provider shortages, especially in underserved regions, stretch the mental health system thin and create long waiting times for new appointments [10] [6]. Limited appointment availability for high-demand services like psychiatry further worsens follow-up rates. When lack of care continuity is coupled with these shortages, the barriers are amplified and worsened. Lack of timely communication between inpatient and outpatient providers is linked to reduced follow-up attendance, especially among patients who weren't previously engaged in care [1] [3]. Absence of effective discharge planning, including warm handoffs and clearly scheduled appointments, further diminishes follow-up adherence.

Recommendations and Next Steps:

There is need for implementation of the following best practices.

- Educate patients and caregivers on the importance of follow-up care appointments to reduce the risk of inpatient admissions.
- Develop standardized information exchange protocol and formal hand-off procedures between the transferring provider, receiving provider, and other community-based support/case managers.
- Train staff on the "Teach Back Method" to ensure patients and caregivers review and understand discharge instructions and the next steps in their care for follow–up.

- Identify and coordinate existing community support services, e.g. Assertive Community Treatment (ACT), Health Home, other care management, or health plans, that can connect the patient to aftercare (Care Transitions Network).
- Develop patient outreach systems or assign case managers to encourage recently discharged patients to keep follow-up care appointments or reschedule missed appointments.
- Develop community partnerships as an effective strategy for hospitals to successfully reduce readmissions. Collaborating with community agencies, such a local National Alliance on Mental Illness (NAMI) group, faith-based groups, targeted clinics, or other community organizations, can identify strong channels for promoting mental health resources and increases touchpoints with members who may engage with these organizations after hospitalization discharge.
- Develop an outreach process to contact patients who do not keep initial follow-up appointments.
- Consider social drivers of health factors as potential barriers to achieving health equity and ensure that identified needs are addressed through targeted support, referrals, and coordinated care interventions.

By systematically targeting the multi-level barriers—from patients' social contexts to system workflow health systems can significantly improve outpatient follow-up rates and reduce the risk of readmissions, relapses, and adverse health outcomes post-discharge. Knowing these barriers exist, Hennepin Health will work with Accountable Care Model partners, Hennepin County Public Health and Human Services, Hennepin Healthcare Systems, and NorthPoint Health and Wellness Center, to develop and implement strategies to reduce these barriers and ultimately increase the post-hospitalization follow-up rates.

References

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[6] The Continuum of Care and Why Mental Health Support Doesn't End After ...
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[9] Follow-Up to Hospitalization for Mental Illness – Eliminating Barriers
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