FY 2022 PERFORMANCE PLAN

Discharge Planning	BHD/CSE	Mark Doering, x4847

Program Purpose

- Connect adults discharged from the state psychiatric hospital to community mental health services and stable housing and prevent their rapid readmission to the state hospital.

Program Information

- Discharge planning is a state-required service for individuals at Northern Virginia Mental Health Institute (NVMHI), a state psychiatric hospital.
- Services include assessment of client needs and placement in appropriate clinical and residential services upon discharge. Services begin upon admission to the hospital.
- Staff engages in quarterly follow-up and monitoring for all regionally funded Arlington clients placed both locally and outside the Northern Virginia area, which may entail significant travel.
- Staff serves Arlington residents and transient individuals.
- Caseloads include clients who have been involuntarily committed to the hospital, enter voluntarily, are not guilty by reason of insanity, or are transfers from other state hospitals.
- Some clients served are on the Extraordinary Barriers List (EBL), a list of patients at every state psychiatric hospital who are determined to be ready for discharge and who have "extraordinary barriers" preventing their discharge such as significant behavioral challenges, need for specialized residential placement, or legal issues.
- Due to staffing shortages at state hospitals more than 50% of clients admitted to NVMHI in FY 2022 were diversions from around the state, greatly reducing local admissions from Arlington.
- NVMHI continued to have reduced admissions during brief periods of active Covid cases, causing some clients to be diverted to other state hospitals.
- There is a full-time forensic discharge planner serving individuals from Arlington at Western State and Central State hospitals. The work of this individual is not included in this plan.
- Partners: Northern Virginia Mental Health Institute, Regional Aftercare Committee, Department of Behavioral Health and Developmental Services.

Service Delivery Model

- In FY 2022, services were provided in a hybrid format. Staff traveled to NVMHI when allowed and appropriate to serve clients in person, participated in video conferencing with hospital staff and clients, and conducted discharge planning over the phone.
- In FY 2023, anticipate utilizing a similar service delivery model.

PM1: How much did we do?

Staff

Total of 3.5 FTEs:

- 0.5 FTE Program Manager, clinical (licensed clinician)
- 0.5 FTE Behavioral Health Therapist III (licensed)
- 1.0 FTE Behavioral Health Therapist (licensed)
- 1.0 FTE Behavioral Health Therapist (supervision)
- 0.5 FTE Behavioral Health Specialist

Customers and Service Data

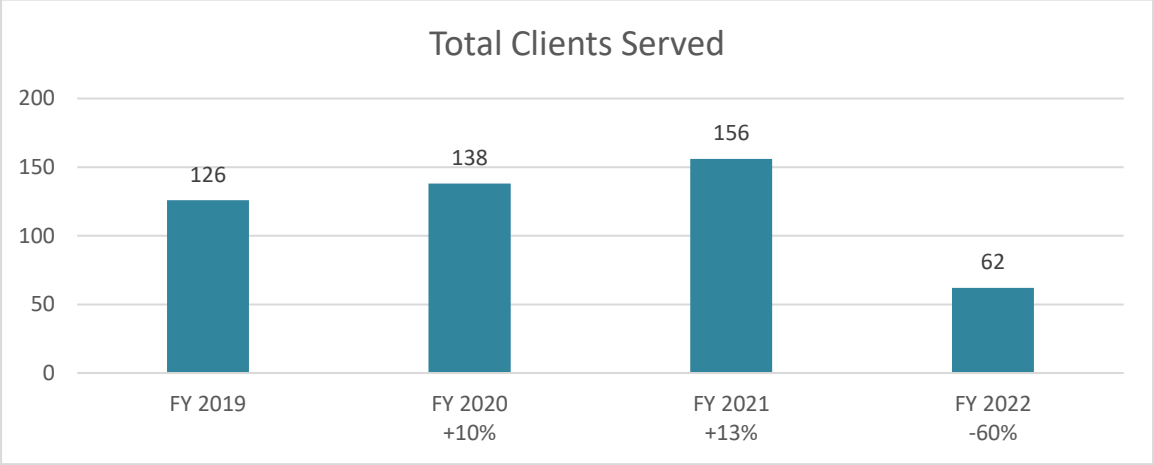
	FY 2019	FY 2020	FY 2021	FY 2022
Total Clients served	126	138	156	62

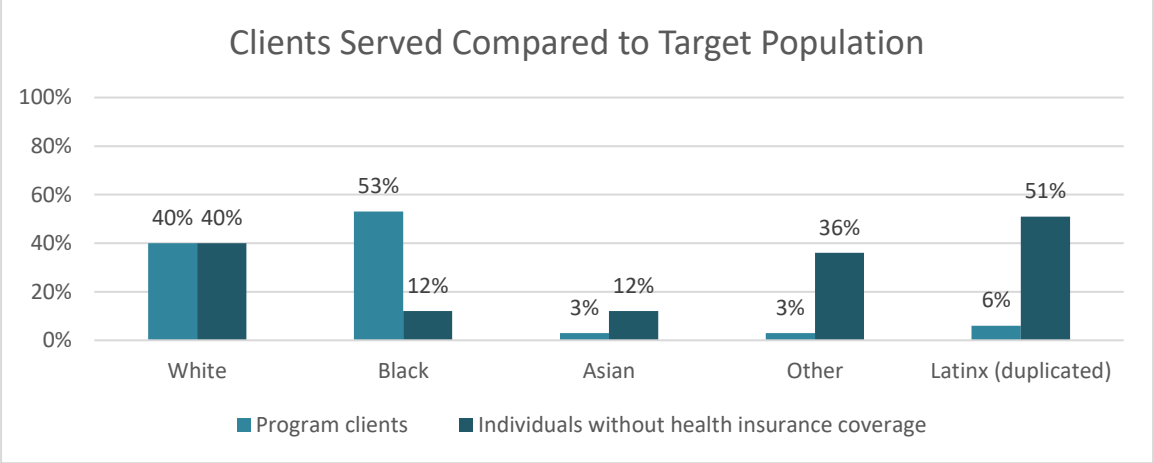
	Clients discharged – Total / EBL	104 / 18	138 / 9	136 / 7	62/6
	Clients discharged to Arlington CSB	63	51	41	24
	Average clients served each month at hospital – Total / EBL	24 / 6	21 / 4	20 / 4	12/4
PM2: How well did we do it?					
2.1	Length of stay in hospital				
2.2	NVMHI clients receiving discharge services at least every 14 days				
PM3: Is anyone better off?					
3.1	Clients connected with Arlington community-based treatment services				
3.2	Stability of housing placement for clients discharged from hospital to placements in Arlington				
3.3	Clients discharged to Arlington who remain out of the state hospital				

Discharge Planning

Measure	1	Total clients served (unduplicated)

Data





Data Summary	• Clients served increased 24% from FY 2019 to 2021, then decreased 60% in FY 2022. • Data is collected from the agency's electronic health record system.

What is the story behind the data?

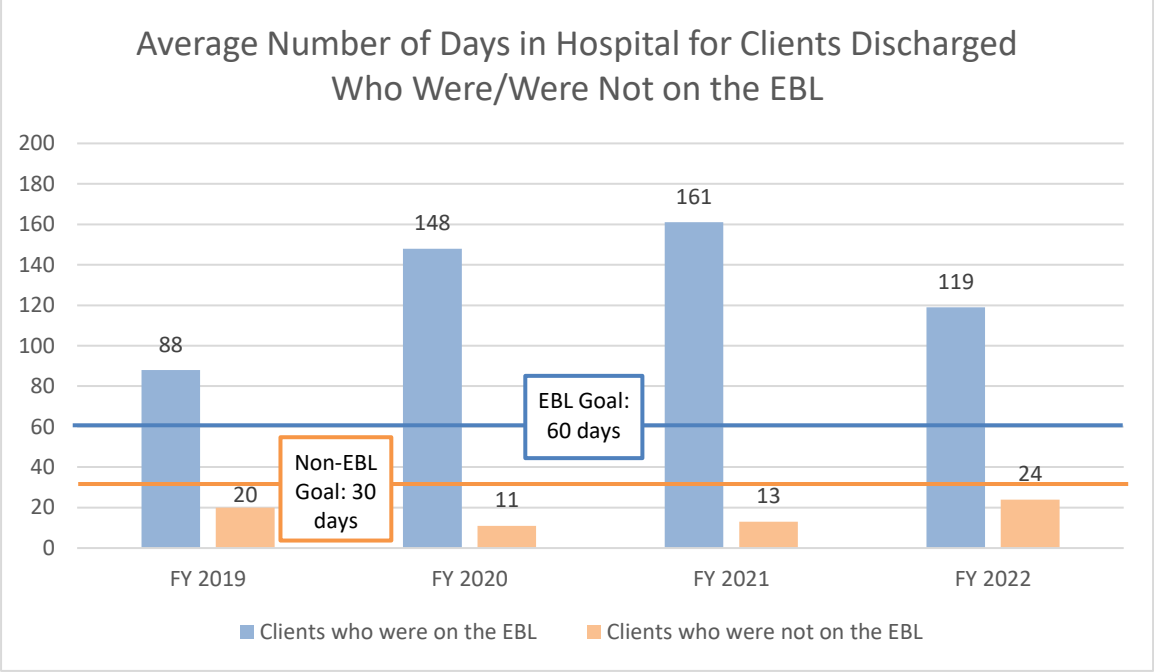
- At the state hospitals, staffing shortages and the Covid pandemic created extensive bed shortages, greatly limiting the number of admissions to NVMHI in FY 2022.
- 71% of clients were uninsured. For these clients, admission to the state hospital may be one of the only treatment options available.
- 73% of the clients served were males. This will be analyzed in future years to determine if this is a program trend.
- 56% (35/62) of the clients served by the discharge planning program in FY 2022 were not Arlington residents.
- The demographics of program's clients do not align closely with the demographics of Arlington's uninsured residents: Black clients are over-represented in the program, and Latinx clients are under-represented. This may be due to the fact that the majority of the program's clients reside outside Arlington.

Recommendations	Target Dates
• Explore ways to include LIPOS, NGRI and Regional Discharge Assistance Program (RDAP) clients in program data to better reflect clients served.	• Q4 FY 2023
• Explore demographic trends to better understand any unmet needs for clients.	• Q3 FY 2023
Forecast	
• In FY 2023 the program projects serving 80 clients.	

Discharge Planning

Measure	2.1	Length of stay in hospital

Data



Data Summary

- In FY 2022, clients who were discharged from the hospital who had been on the EBL had been in the hospital an average of 119 days after being placed on the EBL. Clients discharged who had not been on the EBL had been there an average of 24 days.
- DBHDS has set performance measure in FY 2022 that average length of stay on the EBL is 60 days or less (excluding NGRI clients). Clients will also be added to the EBL 7 days after being identified as ready for discharge.
- This data is collected by averaging the amount of time each consumer discharged during the fiscal year spent in the state hospital from admission date to discharge date.

What is the story behind the data?

- There was a decrease in length of stay for individuals on the EBL in FY 2022. These numbers vary from year to year depending on the types of barriers these individuals face. When clients who have been hospitalized for extended periods of time are able to be discharged, the average length of stay increases.
- The EBL average was impacted by three NGRI individuals who take longer to discharge due to the conditional release process. If these individuals are removed time on the EBL drops to 90 days.
- While total clients served decreased in FY 2022, the average length of stay for non-EBL clients nearly doubled. Challenges due to the pandemic continued to cause limitations in both residential placements and outpatient treatment options, reducing discharge options. Staffing shortages at the CSB and state hospitals also caused delays in coordination of treatment and discharge planning.
- 16% (10/62) of the clients served this year were diverted to other state hospitals throughout Virginia due to no availability at NVMHI. This impacted staff's ability to meet with clients in

person, accurately assess clients, and complete necessary discharge planning responsibilities.
- A new 8 bed Gateway transitional home opened in August of 2021 and has been utilized successfully for several clients.

Recommendations	Target Dates
• Continue to seek regional discharge assistance funds as necessary.	• Ongoing
• Continue collaboration with NVMHI, regional aftercare committee, and DBHDS on alternative placement options for clients on the EBL.	• Ongoing
• Continue to monitor the impact of staffing shortages and the Covid pandemic on state-hospital bed shortages and residential placement options.	• Ongoing
• Review data more extensively to see if there are underlying reasons for large increase in the average non-EBL length of stay.	• Q4 FY 2023

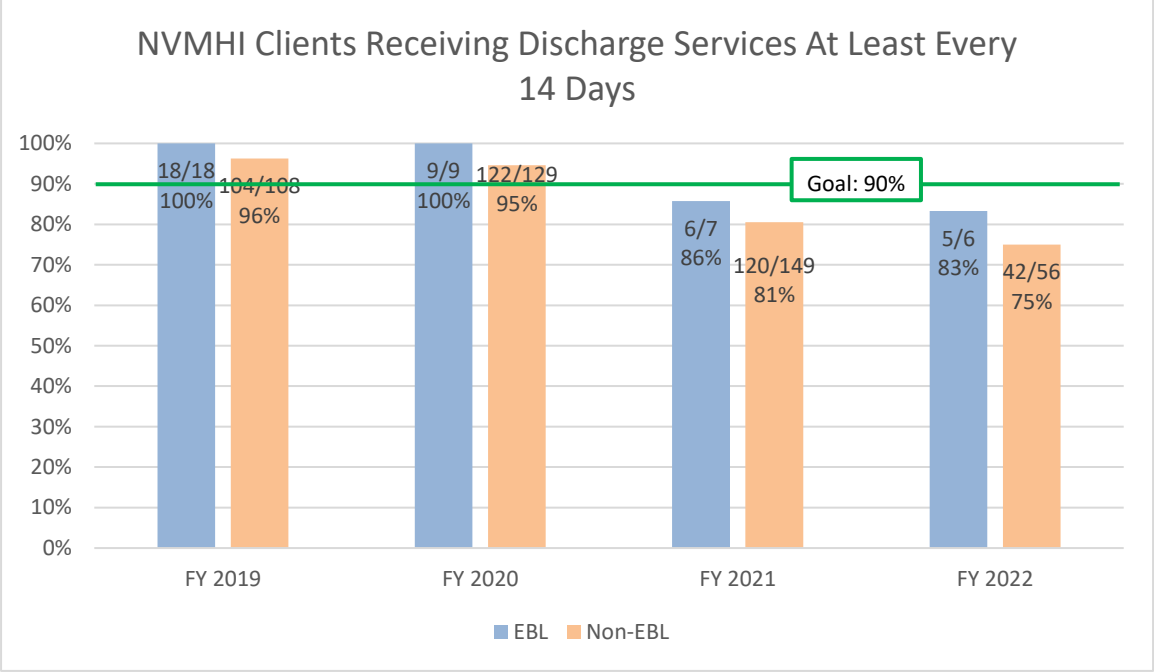
Forecast

- In FY 2023, it is anticipated that the average length of stay for patients discharged from the hospital will be 100 days for clients on the EBL and 20 days for clients not on the EBL.

Discharge Planning

Measure	2.2	NVMHI clients receiving discharge services at least every 14 days

Data



Data Summary

- In FY 2022, discharge-planning efforts were documented at least every 14 days for non-EBL individuals 75% of the time, and 83% of the time for EBL individuals.
- All EBL clients received services at least every 30 days, meeting the state's requirement. Two Non-EBL clients received services more than 30 days but less than 60 days after their previous ones.
- Data obtained from reports from the electronic health record.

What is the story behind the data?

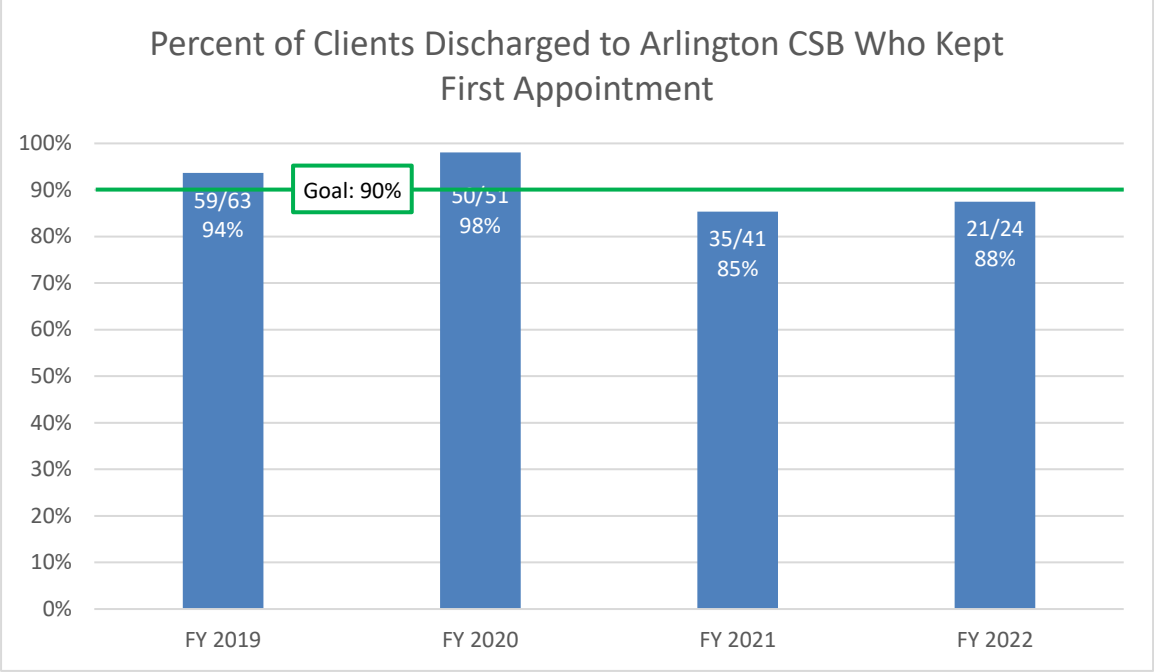
- In FY 2022 documentation of discharge planning services decreased compared to FY 2021.
- The transition to a new electronic health record in FY 2022 created challenges for staff in entering documentation.
- Ongoing challenges due to the pandemic as well as staffing shortages at the state hospitals and in the discharge planning program continued to impact staff's ability to meet with clients and coordinate discharge planning services.
- The program was down one FTE position for much of FY 2022, which made it more difficult to see all clients within the program parameters.
- In FY 2022, the two non-EBL clients who were not seen within 30 days had been assigned to new clinicians, who were still becoming familiar with the documentation process. While contacts were likely made as required, they were not documented.
- 24% (15/62) of clients were diverted to other state hospitals for all or part of their hospitalization, impacting staff's ability to meet with clients and provide discharge planning services.
- The clinical supervisor received weekly progress reports on EBL and non-EBL clients from discharge-planning staff during individual supervision.

• Discharge planning staff only have access to the state hospital electronic health record on site at NVMHI making it more difficult to review documentation and update the CSB's electronic health record.	
Recommendations	**Target Dates**
• Provide staff with follow up education on state and county documentation requirements and refresher training on documentation in Welligent.	• Q2 FY 2023
• Continue receiving weekly progress reports on EBL and non-EBL clients.	• Ongoing
• Continue to dedicate appropriate staffing resources to finding placements for EBL clients.	• Ongoing
• Explore obtaining access to NVMHI's electronic health record remotely.	• Q3 FY 2023
Forecast	
• In FY 2023, it is anticipated that discharge-planning efforts will be made at least every 14 days for 85% of non-EBL individuals, and 90% of individuals on the EBL.	

Discharge Planning

Measure	3.1	Clients connected with Arlington community-based treatment services

Data



Data Summary

- In FY 2022, 88% (21/24) of clients discharged to Arlington attended a scheduled appointment within seven business days post-discharge with outpatient mental health services.
- In FY 2022 DBHDS has set a performance measure that 80% of eligible patients will be seen by a CSB clinical staff member within 7 calendar days of discharge.
- Data is obtained from monthly reports completed by staff.

What is the story behind the data?

- Efforts were made to connect clients with Same Day Access (SDA) who were not already connected to services.
- The three individuals who did not connect to services within 7 days post discharge refused all services offered through the CSB and community providers.
- Clients are tracked for up to 30 days post discharge and ongoing efforts are made to connect them to services if they miss scheduled appointments.
- 45% (28/62) of the clients discharged in FY 2022 were not Virginia residents. Efforts were made to link these individuals to services in their home jurisdictions.
- Options were explored to complete SDA intake prior to hospital discharge but this was put on hold due to staffing shortages in both programs.
- A pilot High Utilizers of Virginia (HUV) program was established by DBHDS in FY 2022 which offers additional care coordination and supports such as a cell phone or transportation assistance to eligible clients post discharge. Three clients were enrolled in these services in FY 2022 to help clients connect to appropriate services.

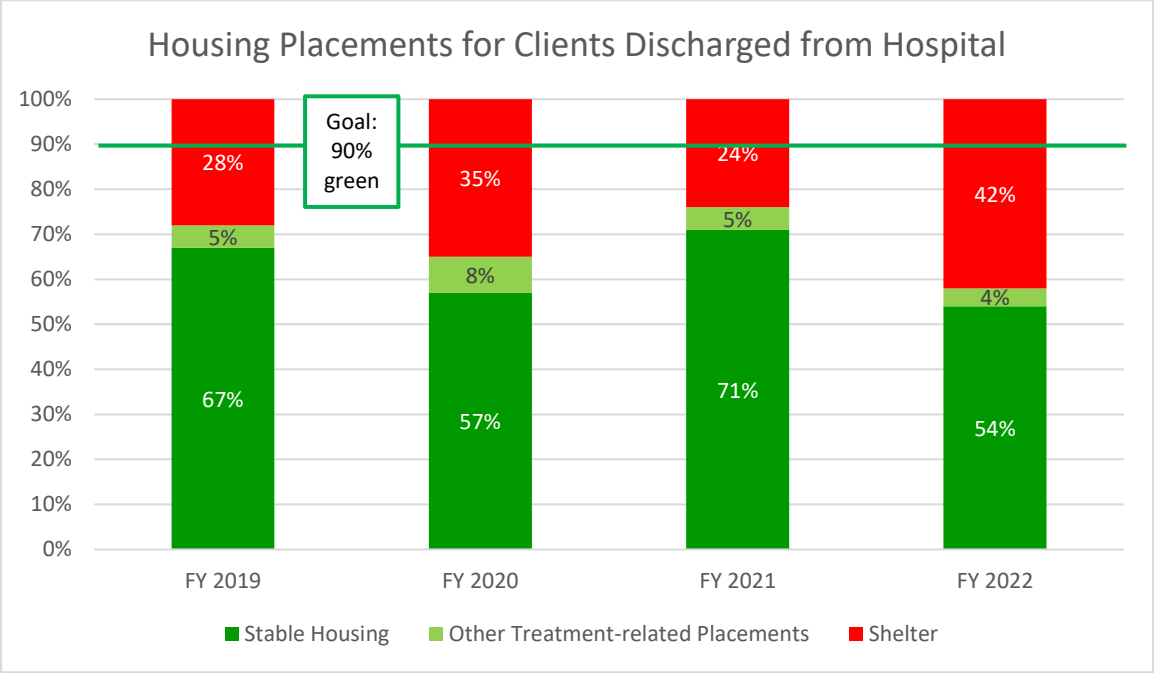
Recommendations	Target Dates

• Continue scheduling necessary aftercare appointments within 7 calendar days of discharge and monitor these to ensure clients get connected to outpatient mental health services.	• Ongoing
• Continue to monitor clients for up to 30 days post-discharge from the state hospital that do not keep their appointment with the CSB and provide outreach to connect to services.	• Ongoing
• Continue to explore completing the SDA intake prior to hospital discharge when staffing improves.	• Q4 FY 2023
• Evaluate clients appropriate for HUV program, make referrals and continue ongoing collaboration to improve clients connection to services post discharge.	• Ongoing
• Explore options for tracking hospital discharge dates in the electronic health record	• Q3 FY 2023
Forecast	
• In FY 2023, it is anticipated that 90% of clients discharged to Arlington will attend an appointment with the CSB within seven business days.	

Discharge Planning

Measure	3.2	Stability of housing placement for individuals discharged from hospital to placements in Arlington

Data



Data Summary

In FY 2022:

- 54% of clients (13/24) were discharged to stable housing: their own apartment, a group home, or a residential placement.
- 4% of clients (1/24) was discharged to residential substance use programming.
- 42% of clients (10/24) were discharged to shelter/motel placements.
- Data was obtained through monthly reports collected from each staff member regarding discharge placements of consumers.

What is the story behind the data?

- Clients with stable housing prior to hospitalization are often able to return to it after discharge, while clients with unstable housing prior to hospitalization often have barriers that encumber the process with obtaining stable housing after discharge.
- One of the six clients on the EBL had stable housing at the time of hospital admission and was able to return at discharge. Of the five who did not, two were placed in group homes, two refused housing assistance and requested discharge to shelter or hotel, and one was discharged to a family home out of the state.
- Bed shortages at state facilities, limited housing options and clients desire to discharge from the hospital before receiving housing assistance continued to increase the demands to discharge individuals to shelter once deemed clinically stable.
- While Permanent Supportive Housing (PSH) can be an option for program clients, the median months from approval to move-in for PSH clients was 5 months in FY 2021. It is generally not feasible to postpone hospital discharge for this length of time.
- A new Gateway 8 bed transition housing program was utilized for 2 clients at discharge.

- Clients who go to the shelter have access to a range of housing services through shelter staff and the Treatment on Wheels team.
- While this measure addresses outcomes for Arlington residents, 56% of the clients served were not Virginia residents (35/62). Lack of Arlington residency and Virginia benefits, and complications in gathering prior housing information and treatment history created additional barriers to discharge clients to stable residential placements.

Recommendations	Target Dates
• Continue to locate stable, appropriate discharge placements as well as advocate for continued hospitalization for clients when appropriate.	• Ongoing
• Continue advocacy efforts with local, regional and statewide partners to develop a wider array of community placement options.	• Ongoing
• Continue collaboration with DHS Housing Bureau leadership to facilitate more rapid housing placements for homeless individuals.	• Ongoing
• Continue to track EBL client housing status at hospital admission and discharge.	• Ongoing
• Examine additional gaps in residential treatment options for EBL clients and propose recommendations to DBHDS for expansion of services using existing discharge assistance funding.	• Q3 FY 2023

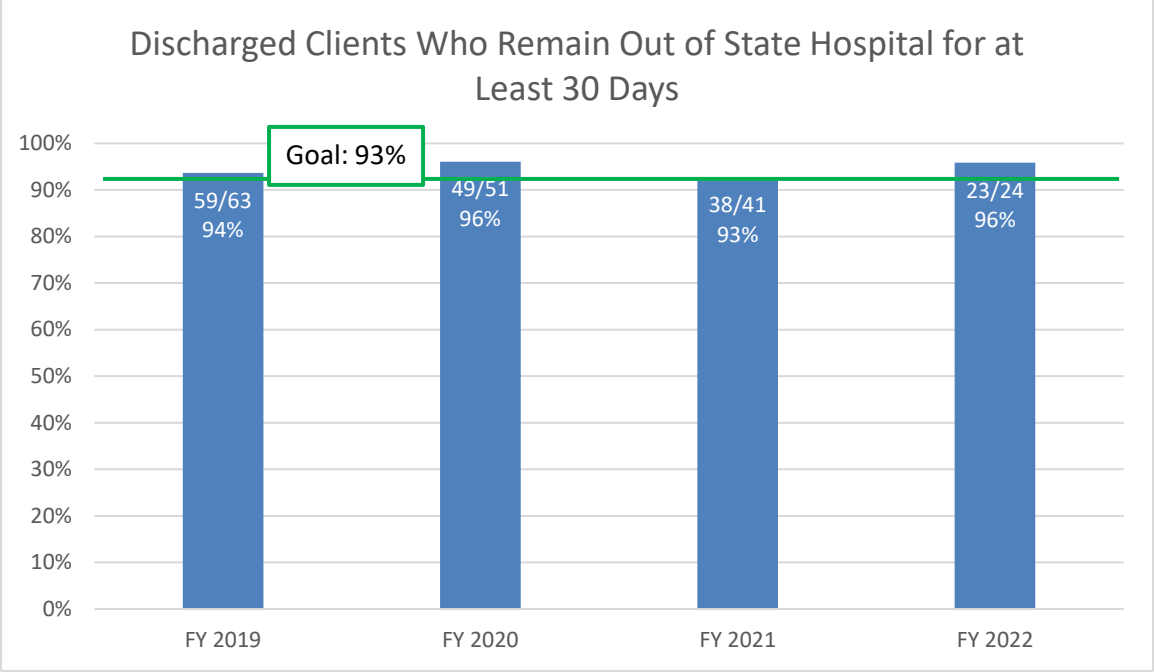
Forecast

- In FY 2023, it is anticipated that 60% of Arlington clients will be discharged to stable housing.

Discharge Planning

Measure	3.3	Clients discharged to Arlington who remain out of the state hospital

Data



Data Summary

- In FY 2022, 96% (23/24) of clients discharged to Arlington remained out of the state hospital for at least 30 days.
- DBHDS has set a performance measure that the client 30-day readmission rate (including non-County residents) be at 7% or lower.
- Data is obtained from readmission statistics supplied by the Northern Virginia Regional Projects Office.

What is the story behind the data?

- The percentage of individuals who remained out of the state hospital increased slightly in FY 2022.
- Discharge planning staff monitor and provide care coordination and support to clients for up to 30 days post discharge to help reduce recidivism and ensure they connect to appropriate services.
- The total 30-day readmission rate (Arlington residents and non-County residents) for FY 2022 was 2% (1/62).
- The one client readmitted within 30 days was in the hospital a week, resistant to treatment, and discharged against program recommendations.
- Recidivism rates are higher among clients who are dismissed at court, discharged early without receiving proper stabilization services, and those who are resistant to treatment. In FY 2022, length of stay for non-EBL clients increased, which provided additional time for clients to achieve stability prior to discharge.
- A pilot High Utilizers of Virginia (HUV) program was established by DBHDS in FY 2022 which offers additional care coordination and supports such as a cell phone or transportation assistance to eligible clients post discharge. Three clients were enrolled in these services in FY 2022 to help reduce 30 day readmissions.

FY 2022 PERFORMANCE PLAN

Recommendations	Target Dates
• Continue to monitor 30-day readmissions in relation to DBHDS performance measures.	• Ongoing
• Continue to provide feedback to NVMHI regarding 30-day readmissions reasons to further examine gaps in the system.	• Ongoing
• Continue to aggressively negotiate readiness for discharge with hospital staff and negotiate removal of clients from EBL if they are not ready for discharge by CSB standards.	• Ongoing
• Continue to identify clients who have had a readmission within 30 days and strategize with the treatment teams to build in extra supportive measures or increased level of care upon discharge.	• Ongoing
• Continue to explore factors related to recidivism and maintain efforts to engage these "hard to serve" clients.	• Ongoing
• Evaluate clients appropriate for HUV program, make referrals and continue ongoing collaboration to help reduce recidivism.	• Ongoing
Forecast	
• In FY 2023, it is anticipated that 95% of clients will remain out of the state hospital for at least 30 days.	