FRESNO COUNTY DEPARTMENT OF BEHAVIORAL HEALTH - OUTCOMES

PROGRAM TITLE: Integrated Discharge Team (IDT) **PROVIDER:** Department of Behavioral Health

PROGRAM DESCRIPTION:

The Integrated Discharge Team (IDT) was developed using Mental Health Services Act (MHSA) Innovations funds. The program purpose is to increase understanding of the variables associated with multiple repeat psychiatric hospitalizations and crisis stabilization services (CSC). Once variables have been identified, IDT uses empirically based approaches to increase access to, and participation in, post hospitalization services. The goal: decreased need for hospitalization, decreased utilization of crisis stabilization services, and shorter stays should psychiatric stabilization be required.

IDT is a linkage and support program that seeks to reduce the risk of re-hospitalization by identifying client resources, formal services, and natural supports via a client driven process of Wellness and Recovery. IDT promotes increased client investment in post hospitalization services by using client defined, culturally relevant, innovative approaches that acknowledge the complexity and co-occurring conditions of people who have multiple re-hospitalizations. IDT works with client identified issues across life domains including: substance use issues, medical issues, legal challenges and socio-environmental struggles such as poverty and homelessness. IDT facilitates multi system collaboration, communication, and treatment planning to ensure successful transition into outpatient services.

Program began seeing clients: 02/10/2012
Implemented outcome collection: 01/01/2013
All positions filled on: 03/18/2013

AGES SERVED:

- ☐ **Children**
- ☒ **TAY**
- ☒ **Adult**
- ☒ **Older Adult**

DATES OF OPERATION: 02/01/2012 - Current
DATES OF DATA REPORTING PERIOD: 02/10/2012 – 05/17/2013 (report for 2012-2013)

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OUTCOME GOAL

Identify demographics of people who have multiple readmissions to crisis stabilization center (CSC) and are not connected to mental health providers.

IDT collected data on 71 clients during the period. Following discharge only 1 client returned for additional services. IDT serviced more males (72%) than females (28%). Ethnicity breakdowns are mostly representative for Fresno County.

Schizophrenia is the most common diagnostic category for clients reviewed. Psychotic Disorder NOS was categorized separately after determining almost all of clients diagnosed with this disorder were also diagnosed with one or more substance use disorders. Twenty-five percent of the diagnoses reviewed were categorized as major depressive disorder. Two clients were diagnosed with other mood disorders. These two clients were identified as having severe alcohol abuse disorders. *

Sixty-five percent of clients reviewed had co-occurring substance use disorders. Co-occurring data was not collected on 30% of the cases. Data collection methods need improvement.

Three clients were on probation, one on conservatorship and two had restraining at the time of admit. Three parolees were enrolled due to high recidivism and two others were assisted through support provided to the parole department.

Of the clients reviewed at enrollment, 11% had a primary care physician and 13% had primary pharmacy. Due to the date of outcome measure implementation, in 50% of the cases the primary doctor and pharmacy data was not collected or missing.

At intake of the clients reviewed, 28% were homeless and 1% received general relief. Thirty-four percent were in stable housing and 38% received SSI.

OUTCOME DATA

Gender		Age		Primary Language	
FM	28%	Min	19	English	97%
M	72%	Max	59	Hmong	1%
				Lao	1%

Ethnicity							
Alaskan Native	1%	Filipino	1%	Mexican/Mexican American	28%	White	28%
American Indian	4%	Laotian	1%	Other Hispanic/ Latin	8%		
Black/ African-Am	25%	Other Asian	3%	Other	6%		

Diagnosis Category		Co-Occurring: Alcohol or Drug		
Schizophrenia (all types)	33%	Yes	No	Not collected
Psychotic Disorder NOS	26%	65%	6%	30%
Major Depressive Disorder (*1 Mood D/O, 1 Depression NOS)	25%			
Bipolar Disorders	14%			
Primary Substance Use Disorder (Alcohol)	1%			

	Yes	No
Primary D	11%	27%
Pharmacy	13%	27%

Income		
Work	SSI	Gen. Relief
1%	38%	1%

Housing		
Homeless	Long-Term	Temporary
28%	34%	17%

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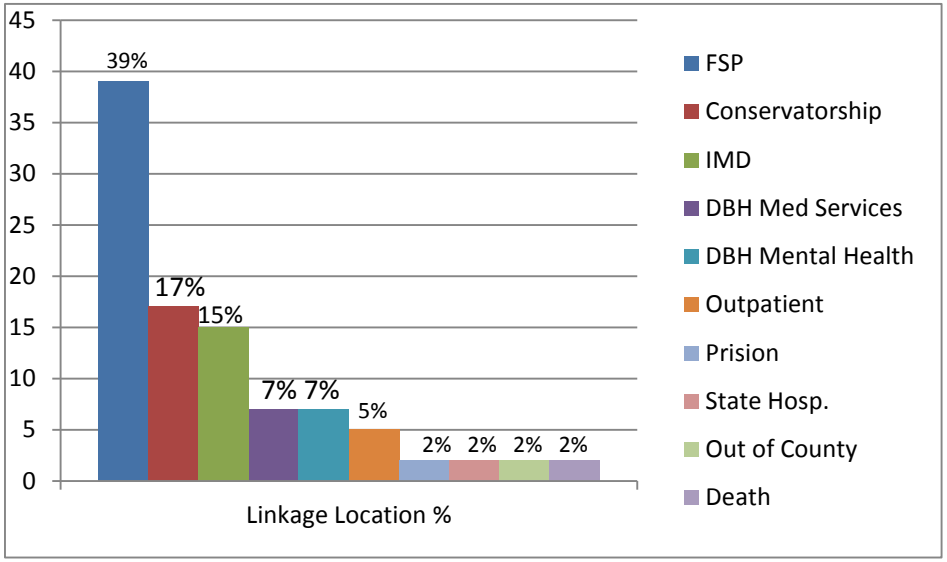
Increase identification of, and connection with, a significant support person.	Access to a significant support person is a key variable in reducing instances of re-hospitalization. Formal/informal supports are identified at enrollment, discharge, and three and six months post discharge to determine if relationships were sustained. The amount of missing data (56%-63%) made calculations unreliable. Data collection began on 01/01/2013. Trends look positive. For every five clients discharged only one was not connected with a support person. These results were sustained three and six months following discharge. With improved data collection continued progress in this area is expected.
Increase access to primary care. Coordination with primary care is essential for the early identification of physical and mental illness, suicide prevention, and is necessary to prevent re-hospitalization. Primary care physicians also provide a monitoring and support functioning and can work to address emerging issues before more intensive care is needed.	Connectedness with primary care is recorded at enrollment, discharge, and at three and six months post discharge. Missing data (40%-50%) made calculations unreliable. Data collection on this outcome began on 01/01/2013. Future reporting is expected to be positive. For every four clients, only one was not connected with a primary care doctor six months post discharge. Based on this trend the expectation is that these numbers will continue to improve.
Connect people who have multiple readmissions to crisis mental health services with resources and treatment providers sufficient to reduce the need for psychiatric hospitalization and use of crisis stabilization services. The majority of clients (39%) were linked to Full Service Partnership (FSP) services. 15% were discharged to an Institute of Mental Disease (IMD) and 17% were discharged to conservatorship and were maintained locally. About 14% were linked with county services and half of those are receiving specialty mental health services as well as medication services. One client is deceased, one is at a state hospital, and one client is in prison. In addition to mental health services about 1/3 also participated in drug treatment services during their time with IDT or during their transition to additional services.	 At the time of engagement by IDT, 38% of the clients had SSI and 1% had General Relief (GR). Six months after discharge 68% has SSI and 6 % had GR.

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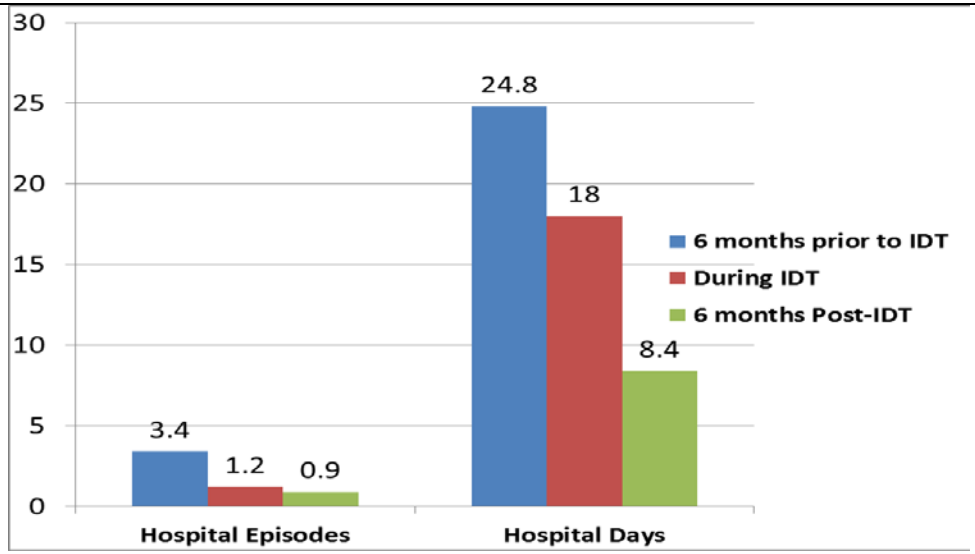
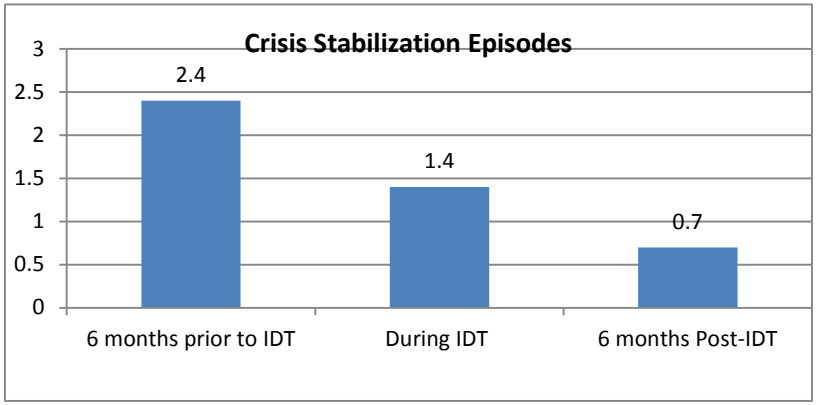
	At the time of engagement by IDT 34% of clients had long term housing. At the time of discharge 65% had long term housing.
Decrease number of psychiatric hospitalizations for people who have a history of frequent readmission to crisis stabilization services. IDT clients had an average of 3.4 psychiatric hospitalizations with an average of 24.8 days of hospitalization during the 6 months prior to being assisted by IDT. While enrolled with IDT (average enrollment = approx. 5 months) clients had an average of 1.2 hospitalization episodes and an average total of 18.0 days of hospitalization. In the six month period following connection to services, clients had an average of 0.9 hospitalization episodes and an average of 8.4 days of hospitalization. **Data collection at the six month marker shows that the effects of this program are sustained over time.** This demonstrates both program effectiveness and efficacy. Clients continue to experience the intended effects of this intervention long after they have transitioned to other services.	
Decrease number of crisis stabilization admits for people who have a history of frequent readmission to crisis mental health services. IDT clients had an average of 2.4 crisis stabilization episodes during the 6 months prior to being assisted by IDT. While enrolled clients had an average of 1.4 crisis stabilization episodes. Three months and six months following transition from IDT the rates of crisis stabilization were 0.3 and 0.7, respectively. **Data collection at the six month marker shows that the effects on use of crisis stabilization services are sustained over time.**	
Reduce the cost per client associated with repeat use of crisis stabilization and psychiatric hospitalization.	**Clients assisted by IDT had an average psychiatric hospitalization cost of $26,751.30 per client for the 6 months prior to being engaged by IDT. In the 6 months following discharge from the program the average cost per client for psychiatric hospitalization was $7,793.66.** **Clients assisted by IDT had and average crisis stabilization cost of $4,355.40 In the 6**

	months following discharge form the program the average cost per client for crisis stabilization services was $2,089.00

DEPARTMENT RECOMMENDATION(S):

Based on outcome measurements reported, the Department recommends to continue MHSA funding for this program for FY 2013-14. The department recommends:

- Continuation of this program with emphasis on establishing more complete data sets to determine if these outcomes remain consistent and continue trending toward cost savings.
- Recommend increasing the number of clients seen over the next year to determine maximum capacity relative to program efficacy and continued cost savings.
- Recommend exploring models used by IDT and beginning discussion about components that can be easily adopted by other programs across the system.

Findings:

Though IDT utilized various empirically based techniques when working to link clients the gains made by this program can easily be replicated in other programs. By changing the *way* client supports are provided we can use existing resources to achieve similar outcomes.

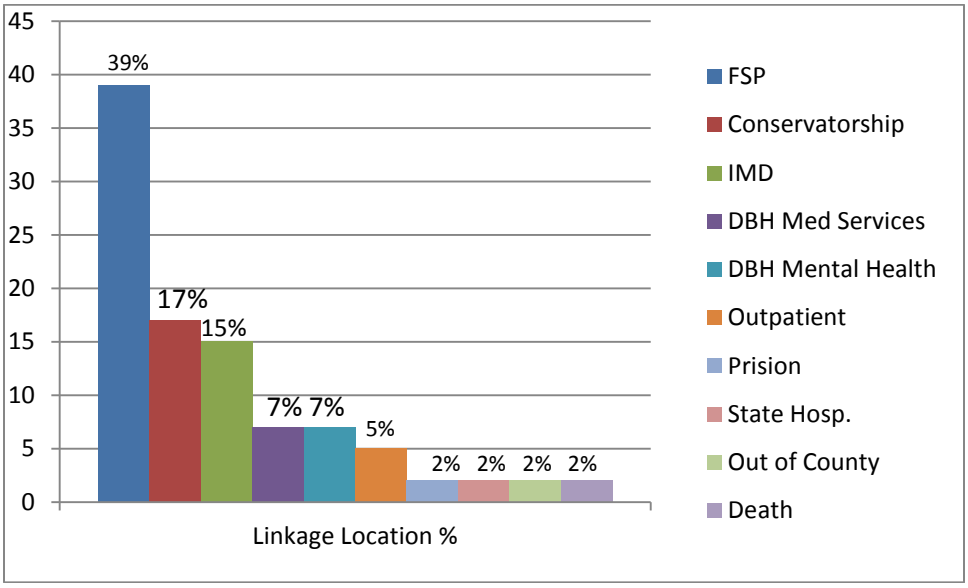
We have found that clients are more likely to be interested in working with practitioners when they have begun to develop a relationship prior to discharge form the facility. We have discovered that increased client engagement is absolutely dependent upon a trusting therapeutic relationship and the fostering of hope. Engagement may take weeks and practitioners may face multiple episodes of rejection knowing that consistency is the foundation of relationship.

The client is the lead and is tasked with identifying and prioritizing his needs. Practitioners use an intensive community based therapeutic case management model. Discharge is discussed at the beginning of enrollment and the team partners with the client to assist him in developing a relationship with his discharge resources.

Communication and coordination are essential. IDT maintains the position that each interaction with other providers must be supportive, reparative, and strengths based. Practitioners involved in the client's care are considered part of the treatment team and are included in decision making, problem solving, and support. Immediate access to email, text, and phone are essential.

We have found that relationships built on trust and respect can be transferred from provider to provider. This leads to increased client investment in self-identified follow up resources. Clients are able to be successfully linked to post hospitalization services after intensive engagement. The effects of the initial therapeutic relationship are maintained over time and across treating programs.

Connect people who have multiple readmissions to crisis mental health services with resources and treatment providers sufficient to reduce the need for psychiatric hospitalization and use of crisis stabilization services.



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