Report on Discharges to Shelters

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Overview

This progress report summarizes the independent review of discharges to shelters from Georgia Regional Hospital-Atlanta (GRHA) between July 1 and December 31, 2016 (19 shelter discharges) and from Georgia Regional Hospital-Savannah (GRHS) between July 1 and September 2016 (5 shelter discharges). (There were two additional discharges to shelters from GRHS between October and December 2016 that this writer was not able to review.) There were no shelter discharges from either East Central Regional Hospital (ECRH) or West Central Regional Hospital (WCRH) between July 1 and December 31, 2016. In addition, discharges from GRHA hotels/motels between July 1 and December 31, 2016 were briefly reviewed to check readmission rates. Data were reviewed and compared with data from shelter discharges between January 1 and June 30, 2016. Finally, implementation of recommendations from a prior report was reviewed; additional recommendations are offered below.

Methodology

This review included interviews with individuals in care, clinicians at GRHA and GRHS, extensive record review (records of all individuals discharged from GRHA to shelters between July 1 and December 31, 2016 and all individuals discharged to shelters from GRHS between July 1, 2016 and September 30, 2016), policy review, tours of GRHA and GRHS, and the DBHDD shelter discharge reports for Quarters 1 and 2 for Fiscal Year (FY) 2017. In addition, this writer met with advocates and had discussions with central office staff from the Department of Behavioral Health and Developmental Disabilities (DBHDD).

Findings

1. Compared to FY 2016, discharges to shelters in the first two Quarters of FY 2017 remain significantly lower than in FY 2016. Furthermore, the numbers of discharges in the 2nd Quarter of FY 2017 are significantly lower than in the 1st Quarter of FY 2017 (17 compared to 9). This likely reflects the continued adherence to the DBHDD change in policy that occurred in February 2016. This policy change requires a review of all shelter discharges by the Chief Medical Officer of DBHDD. There are increased efforts by staff to find alternative placements and to engage the individual in discharge planning. For example, at GRHS, the clinical leadership team collectively meets with each individual

requesting shelter placement and, at times, is successful in convincing an individual to remain a little longer in order to take advantage of more permanent housing options.

Of note, however, is that the number of placements to hotels/motels and transitional residential housing (non-state) increased from the 1st Quarter to 2nd Quarter of FY 2017. For example, at GRHA, those discharged to transitional residential housing (extended stay hotel/motel) increased from 17 in the 1st Quarter to 42 in the 2nd Quarter. At GRHS, the number went from 1 in the 1st Quarter to 19 in the 2nd Quarter. In reviewing all available DBHDD shelter discharge reports, the number discharged to transitional residential housing (extended stay hotels) quadrupled in the most recent Quarter compared with the prior three Quarters. This bears watching, given the readmission rates for those discharged to hotels.

Despite increased efforts to locate alternative housing options and refer to PATH, discharge planning for some individuals begins in earnest only several days prior to discharge. Record review indicates that there are more discussions about discharge in the weeks leading up to discharge yet effecting a plan sometimes does not begin until the individual signs the Request for Shelter Placement form. With some exceptions, the most common scenario at GRHA continues to be that an individual requests discharge, the Request for Shelter Placement form is completed, and the individual is discharged within a day or two of the request. For the majority of individuals, the records clearly reflect efforts by social workers to offer a variety of other resources (e.g., PATH, placement in a Personal Care Home, transitional housing, residential substance abuse treatment, BOSU assistance, ACT, ICM, housing voucher). However, in most instances, individuals refused all offers of assistance. Though there has been progress with respect to increased referrals to PATH, making this connection between the individual and PATH staff continues to be a challenge prior to discharge, especially at GRHA.

The average length of stay (LOS) for individuals discharged from GRHA between July 1, 2016 and September 30, 2016 was 34 days. One individual was excluded from this calculation as his LOS was over two years and would have skewed the mean. The average LOS for individuals discharged between October 1, 2016 and December 31, 2016 was 16 days. For comparison purposes, the average LOS for individuals discharged between January 1, 2016 and March 31, 2016 was 14 days and the average LOS for individuals discharged between April 1, 2016 and June 30, 2016 was 18 days. The average LOS for individuals discharged from GRHS between July 1, 2016 and September 30, 2016 was 18 days.

2. Assertive Community Treatment (ACT) and Intensive Case Management (ICM) continue to be underutilized resources. Over half of the individuals met criteria for ACT and/or ICM and while the number referred for either ACT or ICM increased since the last review, the linkage with community providers did not routinely occur prior to discharge, particularly at GRHA. At GRHS, this linkage generally occurred prior to discharge. While significantly more individuals were offered these services than in the 3rd and 4th

Quarters of FY 2016, the most common scenario is that the individual refuses to accept the referral. In addition, discussion about referral for such services continues to occur close to discharge as opposed to earlier in admission. As a result, time for actively engaging the individual in discharge planning is limited. On a more positive note, significantly more individuals have been referred to PATH in the 1st and 2nd Quarters of FY 2017. However, in only a small number of instances, the PATH staff met with the individual prior to discharge. Without making this connection prior to discharge, it is unlikely this service will be provided after discharge. Again, this linkage occurs with more regularity at GRHS than at GRHA. Given that individuals residing in shelters are typically not permitted to remain in the shelter during the day, coupled with the limited attendance at outpatient appointments, PATH services are quite likely underutilized as well.

3. Readmission following shelter placement continues to occur with some regularity. For example, out of the 19 shelter discharges from GRHA reviewed since July 1, 2016, 6 individuals (32%) were readmitted to GRHA following discharge as of February 9, 2017. In addition, of the 12 discharged from GRHA to hotels/motels since July 1, 2016, 4 individuals (25%) have been readmitted as of February 9, 2017. This writer does not have readmission data from GRHS.

4. Metro Task Force for the Homeless shelter at Peachtree and Pine continues to be the shelter most frequently used for referrals, primarily because identification is not required for admission. 50% of those discharged to shelters from GRHA went to Peachtree and Pine and 21% went to Atlanta Union Mission. By comparison, in the 3rd and 4th Quarters of FY 2016, 63% went to Peachtree and Pine and 27% went to Atlanta Union Mission. Additionally, the most frequently referred outpatient provider by far is Grady Momentum Clinic. Of note is that this writer reviewed an aftercare report completed by the hospital social worker 72 hours after discharge that checks whether the individual showed up for his/her scheduled outpatient appointment. In the majority of cases, when the report was completed, the individual did not show up for this scheduled appointment.

5. There continues to be limited consideration of civil commitment and guardianship as temporary tools to assist individuals with recovery and treatment compliance. Similarly, utilizing newer antipsychotic medications (e.g., Clozaril) for individuals with particularly refractory symptoms could be considered as well. For example, for one individual whose psychotic symptoms interfere with discharge planning and for whom her current medication regime does not appear to be effectively treating these symptoms, it may be worthwhile considering alternative treatment.

6. The Recovery Plan form continues to be unwieldy, repetitive, and not conducive to the development of interventions that are individualized, targeted towards transition, and skills-based. The revised form that was piloted at GRHS has not been rolled out statewide yet. It is expected that this template will assist with developing more

focused, individualized objectives and interventions geared towards transition and successful community placement.

7. Engaging individuals in discharge planning early in admission is critical. There are limited unit-based treatment interventions focused on discharge planning and building knowledge of community resources. There is also inconsistent participation by community providers in recovery planning. At GRHS, staff consistently report greater participation by community providers in recovery planning and strong collaborative relationships with community providers. GRHS staff also host regular partnership meetings with community providers. If not able to be present at team meetings, staff utilize teleconference capability. In addition, staff also consistently reported the positive impact that peer specialists and peer mentors have on engaging individuals in discharge planning.

8. While there are considerable housing resources for individuals, there continue to be challenges with accessing residential substance use treatment for dually-diagnosed individuals, especially for those transitioning from GRHS and who have limited or no funds. Furthermore, admission criteria have changed for at least one residential program (Social detox), such that if an individual has already detoxed's in the hospital, that makes them ineligible for admission. In addition, there are long waits for crisis stabilization and crisis respite apartments.

Recommendations

In order to increase the likelihood of successful placement in permanent housing as well as to reduce the readmission rate for individuals discharged to shelters and hotels/motels, the following recommendations are offered for consideration by DBHDD:

1. In order for discharge (or transition) planning to be successful, it must be jointly shared by all team members and community providers and be a primary focus upon admission. In addition, there should be greater focus on the development of unit-based programming centered on improving awareness of community resources, as the majority of individuals do not attend the TLC due to the relatively brief lengths of stay.

2. With the pending roll out of the revised treatment plan form, this is an ideal opportunity to provide training to all RPT staff and encourage ownership of discharge planning by all team members and community providers. Conducting such training jointly with inpatient staff and community providers will promote shared ownership of successful outplacement planning. DBHDD should consider adopting

at GRHA the effective approach used at GRHS in which community providers and clinical leadership meet regularly to build collaborative relationships and improve communication. That said, there are certainly challenges in Atlanta related to volume and capacity of providers that are somewhat unique relative to other parts of Georgia. It follows that employing strategies that have been effective elsewhere will require adaptation and creativity, especially in light of resources.

3. In order to increase the likelihood of successful outplacement following discharge, a) referral to ACT, ICM, and PATH should be initiated as soon as practicable after admission to allow for these community-based staff to come to the hospital prior to an individual's discharge; b) referral to Benefits Outreach Services Unit (BOSU) should be made a standard practice early in the admission since assisting with the application for benefits will enable individual to access more resources once in the community; c) individuals should be helped to obtain an ID earlier in admission; this should be a standard practice.

4. DBHDD should expand use of peer transition specialists in unit-based programming and/or in community transition activities (e.g., visits to Personal Care Homes or transitional housing, etc.). Many individuals are reluctant to accept community resources and may be more receptive to consideration of these resources if informed by peers.

5. DBHDD should evaluate appropriate use of civil commitment, especially for individuals with multiple readmissions for whom more intensive outpatient treatment has not been successful. DBHDD should consider instituting routine supervisory review of how decisions are made regarding civil commitment.

6. DBHDD should evaluate the efficacy of its transition planning processes, performed by both inpatient staff as well as community providers. For example, there has been a 15% increase in the Transition Action Plans (TAP) completed between July 1, 2016 and December 31, 2016 compared with the prior review period (77% compared to 62%). It was also reported that of the TAP reviews submitted, no specialty providers had an individual discharged to a shelter. Since there have been individuals discharged to shelters with a specialty provider, further in-depth analysis of TAPs by provider (specific ACT team, ICM, etc.) for individuals discharged to shelters, hotels/motels, and transitional housing (extended stay hotel/motel) is necessary to determine how the specialty providers not completing TAPs differ in their treatment approach and how to improve their performance.

7. DBHDD should consider strategies for increasing residential substance use treatment capacity and ensuring that admission criteria match the needs of those transitioning out of hospitals. DBHDD should also consider increasing its capacity of crisis respite apartments, especially in the greater Savannah area.