

Hospital-to-Community Partnership

**BEHAVIORAL HEALTH & HOSPITAL COORDINATION
INITIATIVE**

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Transition Goals

- Connecting to adequate services
- Identifying appropriate housing
- Obtaining necessary financial resources
- Establishing community support system
- Pursuing career/education opportunities
- On-going support for continuum of care

Improving Transition Readiness

- Comprehensive treatment planning
- New Treatment Mall
- Evening and weekend active treatment
- Peer support
- Skill development
- Family education
- Community involvement
- Financial resources



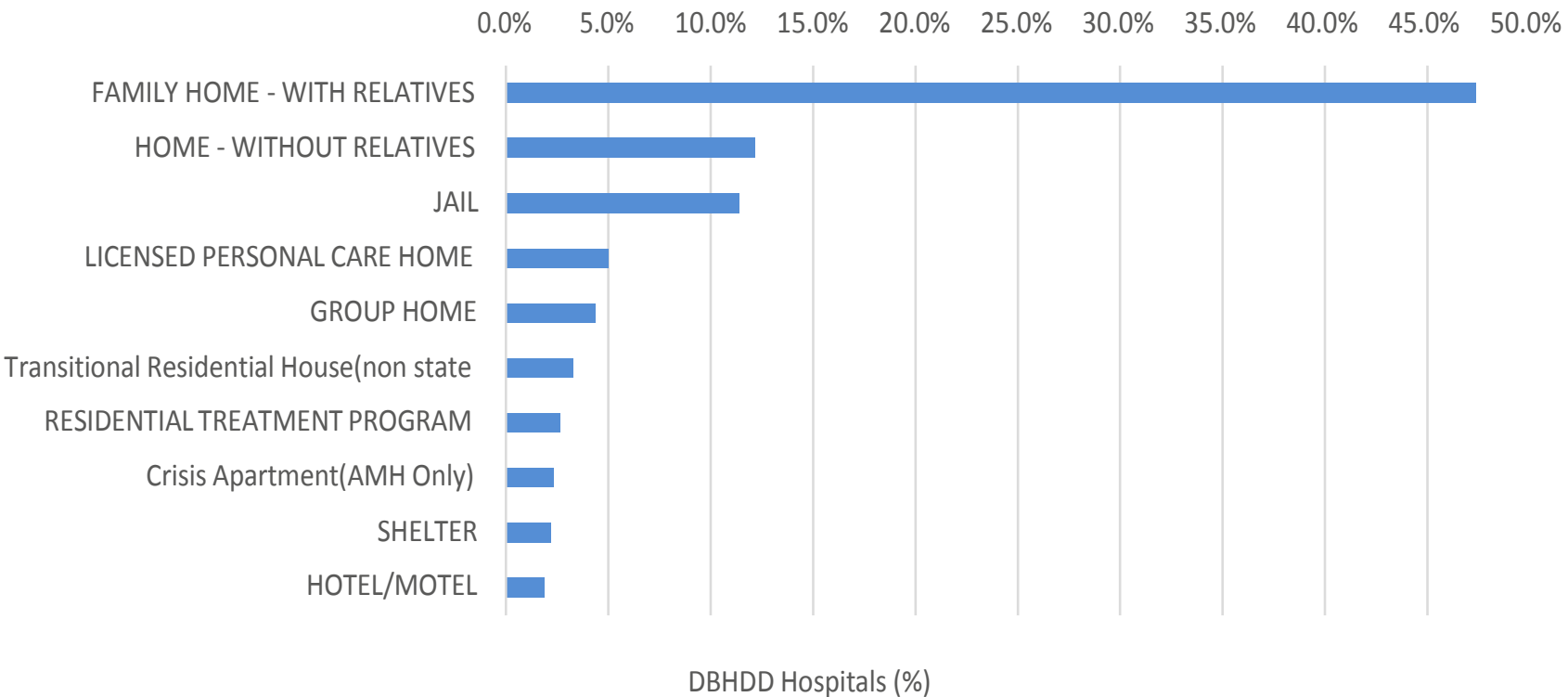
Connecting with Community Services

- Community provider involvement in transition planning process
- Regional transition specialists
- Community provider contract expectations for transition support and key performance indicators
- Transportation support
- Hospital-community meeting

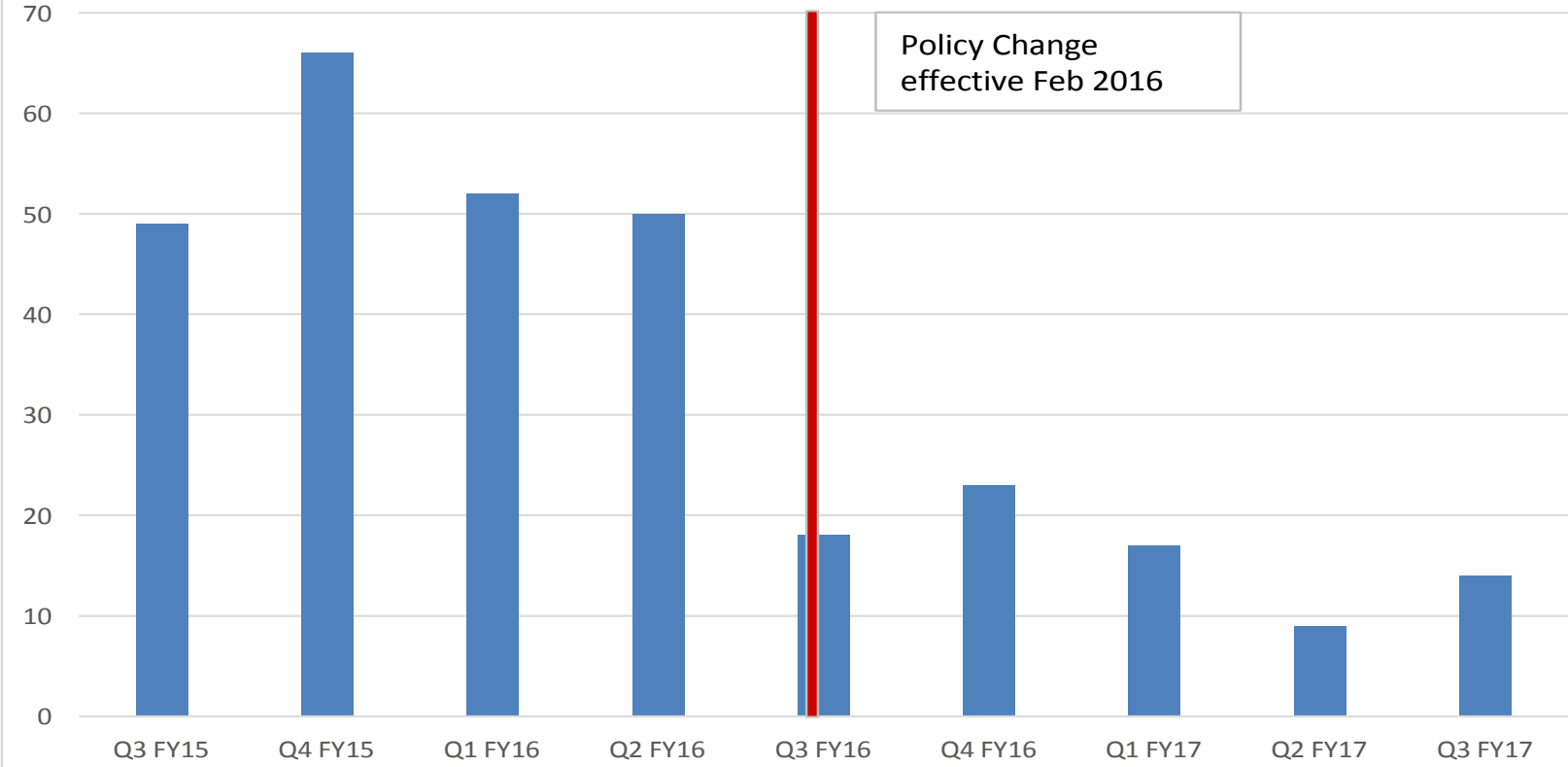
Housing Support

- Collaboration between central office, field office, and hospital
- Housing vouchers
- Transition bridge funding
- Reduction of discharges to shelters

DBHDD Hospitals Residence at Discharge (%)



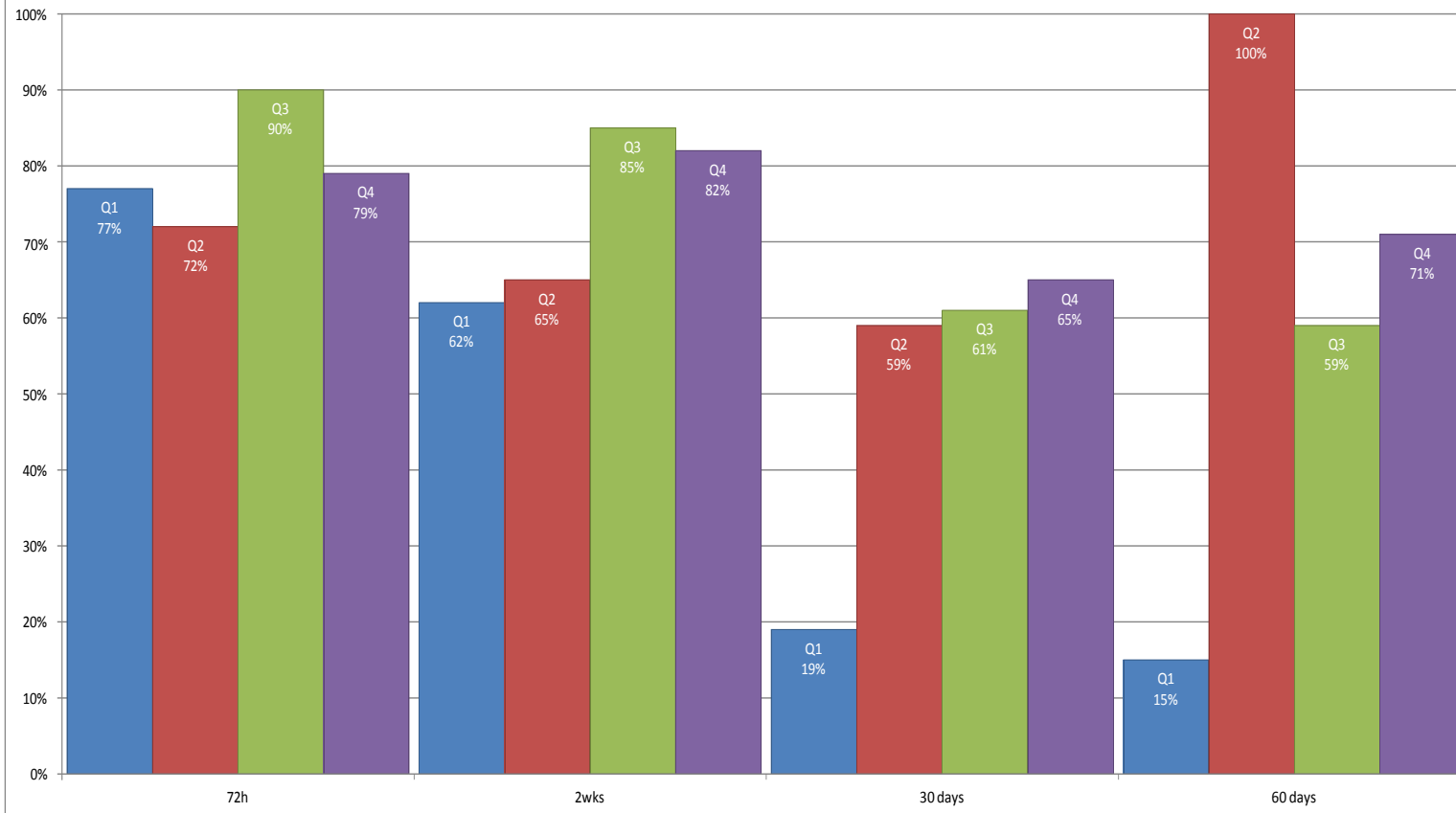
Discharges to a Shelter FY2015 to FY2017



Improved Discharge Process and Post-Discharge Follow-up

- Pre-discharge counseling (new 11-item report)
- “Hand-off” communication
- New “After Discharge Screen” in AVATAR
- After-discharge peer support
- After-discharge follow-up by hospital and field office staff

**State-wide FY 17
By Follow-Up Contact Date**



Transition Barriers

- Criminal history
- Dual-diagnoses (BH/IDD)
- Individuals with no financial resources
- Comorbidity
- Autism and borderline personality disorder
- Long history of aggression and violence