County of San Diego Health and Human Services Agency, Behavioral Health Services

PERFORMANCE IMPROVEMENT PROJECT

Client Engagement after Discharge from Psychiatric Hospital

EXECUTIVE SUMMARY

Start Date: April 1, 2016 *Completion Date: January, 2018*

BACKGROUND

The County of San Diego Behavioral Health Services (BHS) is required to have two active performance improvement projects (PIPs) every year. In FY 2015-16, the Quality Improvement (QI) Unit started a two-year non-clinical PIP focused on engaging new clients with services after a psychiatric hospital discharge. The preliminary analysis revealed that:

- Only 28% of clients who are new to the system or who have previously been in the system but had been closed, connected to services after discharge from San Diego County Psychiatric Hospital (SDCPH); and
- Clients with no connections after discharge had an average of one more Emergency Psychiatric Unit (EPU) or Psychiatric Emergency Response Team (PERT) service prior to admission compared clients with connections after discharge since January 1, 2015.

Discussions with SDCPH further revealed that when clients with an open assignment were discharged from a psychiatric hospital, they were given an appointment with their current provider within three days. However, clients not active in BHS system were given information on using walk-in services and were provided with a program name, address, and contact. Clients without an active assignment were not given an appointment upon hospital discharge.

A committee was formed to guide the development of the PIP and to provide valuable feedback on the interventions to ensure the PIP's success. The committee, which met every month, included the BHS Clinical Director and representatives from: SDCPH, three County-operated clinics, Next Steps, Health Services Research Center (HSRC), and several BHS staff. Next Steps is a recovery oriented peer and family support program that, in partnership with SDCPH, assists participants with engagement and support.

INTERVENTIONS AND KEY CHANGES TO PROCESS

- ☑ Every discharging client not currently open to BHS was given an appointment at one of the three County-operated clinics within three days of discharge. The clinics worked internally to identify time slots to accommodate these clients.
- ☑ The three clinics contacted the clients 24 hours prior to the appointment.
- ☑ Next Steps worked closely with the SDCPH staff including administering an "Engagement with Services" survey to clients discharging from the SDCPH during the period of May – July, 2017.
- ☑ A one-page flyer was developed to help clients get a better understanding of the clinic they were connected with.

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FINDINGS: ENGAGEMENT WITH SERVICES

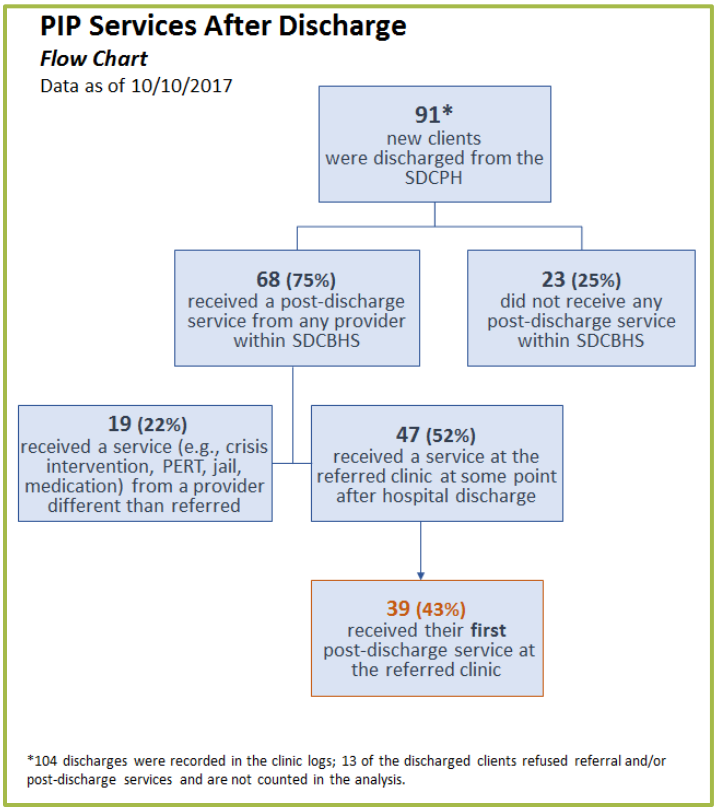
Ninety-one (91) new clients discharged from the SDCPH and eligible for the intervention (i.e., would be a candidate for an appointment at one of the three participating clinics) were identified since the beginning of this intervention on August 1, 2016. At the time of the last follow-up tracking that occurred on October 31, 2017: 34 clients (37%) received their first post-discharge service from the provider they were referred to within 7 days of discharge; 39 clients (43%) received a service within 30 days of discharge; and 40 clients (44%) received services within 90 days of discharge. This represents an increase of 10 to 23 percentage points from baseline system data.

7-, 30-, and 90-Day Engagement Rates

Date of Baseline Measurement	Baseline Measurement (SDCPH) (numerator/denominator)	Results (numerator/denominator)	% Improvement Achieved (change in percentage
FY 2015-16 (systemwide data)	7 days: 334/2,312 = 14%	7 days: 34/91 = 37%	23%
	30 days: 605/2,312 = 26%	30 days: 39/91 = 43%	17%
	90 days: 784/2,312 = 34%	90 days: 40/91 = 44%	10%

The Figure shows the pathways of the 91 discharged clients that were referred to one of the three County-operated clinics.

- 68 clients received a service within the BHS system after discharge.
- 47 of those clients had at least one service at the clinic they were referred to (8 clients had services at another location than the referred clinic before having a service at the referred clinic).
- 39 clients had their first service at the referred clinic after discharge.
- 19 clients did not receive a service from the referred provided, but received a service somewhere else in the system, most commonly for crisis intervention, jail services or other emergency or crisis-related services.



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FINDINGS: READMISSION RATES

Hospital readmission rates for clients in the intervention were 8% (7-day), 11% (30-day), and 12% (90-day). This represents a decrease of between 1 and 10 percentage points from baseline systemwide readmission rates. The main improvements with regard to readmission are seen at the 90-day post discharge period which is significant as an indicator of the success of longer term engagement in lowering readmission rates.

7-, 30-, and 90-Day Readmission Rates

Date of Baseline Measurement	Baseline Measurement (SDCPH) (numerator/denominator)	Results (numerator/denominator)	% Improvement Achieved (change in percentage
FY 2015-16 (systemwide data)	7 days: 198/2,312 = 9%	7 days: 7/91 = 8%	1%
	30 days: 347/2,312 = 15%	30 days: 10/91 = 11%	4%
	90 days: 497/2,312 = 22%	90 days: 11/91 = 12%	10%

ENGAGEMENT WITH SERVICES SURVEY RESULTS

In order to determine client perception of the engagement with services Next Steps began administering an *Engagement with Services* survey to all discharging clients May-July, 2017.

The survey revealed that clients most commonly reported that either a personal message before the appointment or help with transportation to the clinics would increase the likelihood of them attending their follow-up appointment.

Number of submitted surveys: 109
Number of declines/refusals: 17
Number of completed surveys: 92

Items	#	%
1. A personal message from somebody at the clinic before the appointment	**58**	**63%**
a. Phone	**30**	**52%**
b. Text	19	**33%**
c. Email	11	**19%**
d. Other (mail, sister (illegible))	4	**7%**
1. Help with transportation to the clinic	**58**	**63%**
2. Assist with the initial paperwork	41	45%
3. Obtaining medication at first appointment	38	41%
4. Education and support from family/friends	36	39%
5. Education on brain illness.	34	37%
6. Evening and/or weekend appointment	31	34%
7. More information about non-medication treatments	30	33%
8. Education on health impacts of follow-up care	27	29%
9. Day of discharge appointment	25	27%
10. Other	20	22%

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CONCLUSIONS

These results provide evidence that providing a specific referral and appointment time to a new client upon discharge is effective in increasing engagement rates and decreasing readmission rates.

As detailed above, the outcomes for those who do not engage with appropriate outpatient services after discharge are generally severe (crisis intervention, PERT, jail). Given that these are clients whose first exposure to the BHS was through the SDCPH, this finding is even more pronounced, as new clients with a serious mental illness (SMI) are generally difficult to engage into routine services until multiple crisis events have occurred. Given the relatively simple concept (although complex in execution) and rate of success, stakeholders have already begun a push to provide information and materials for other BHS inpatient units and outpatient clinics to consider adopting this model.

SUMMARY OF SUCCESSES AND LESSONS LEARNED

SUCCESSES	LESSONS LEARNED
☑ Improved care coordination and communication between SDCPH and the County-operated clinics.	❖ Reserving appointment times for newly discharged clients was effective in increasing engagement rates. However, it may also lead to an increase in no-shows.
☑ Scheduled appointments within three days of discharge at one of the three County-operated clinics to all new discharging clients not currently open to BHS.	❖ Continuous communication between outpatient clinics and the hospitals is key to successful client engagement with follow-up appointments.
☑ Implemented reminder phone calls 24 hours prior to the appointment, conducted by the clinics.	❖ Clients benefit from reminder phone calls prior to their follow-up appointment.
☑ Increased involvement of Peer Support Specialists and Next Steps.	❖ Clients benefit from interaction with Peer Support Specialists and the involvement of Peer-based organizations such as Next Steps.
☑ Developed a one-page flyer for each of the County-operated clinics to help clients get a better understanding of the clinic they were connected with.	❖ A portion of clients still don't connect – possible solutions need to continue to be explored.