FY 2023 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 55% of clients admitted to NVMHI in FY 2023 were diversions from out of region, 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.
	• The Discharge Planning team oversees multiple stages of the discharge process outside of NVMHI, including:
	  ○ Client care for those referred to other state hospitals, when NVMHI is at capacity.
	  ○ Regional Discharge Assistance Program (RDAP), which provides funding to help clients with discharge and ongoing needs to maintain stability in the community.
	  ○ Local Inpatient Purchase of Service (LIPOS), which provides funding to purchase private psychiatric hospital beds for individuals with no healthcare benefits when admission to a state psychiatric hospital is not possible.
	  ○ Not Guilty by Reason of Insanity (NGRI), which involves psychiatric hospital treatment and community monitoring post discharge for clients who have been ruled not guilty by reason of insanity in Virginia courts.
	• There is a full-time forensic discharge planner serving forensic individuals from Arlington at 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 2023, services were provided in a hybrid format. Staff traveled to NVMHI to serve clients in person. For out of region hospitals, staff provided discharge planning services via phone or video conferencing with hospital staff and clients. • In FY 2024, we 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 2020	FY 2021	FY 2022	FY 2023
Total Clients served	138	156	62	130*
Clients served at state hospital	138	156	62	34
Clients discharged– Total / EBL	138 / 9	136 / 7	62/6	106/5
Clients discharged to Arlington CSB	51	41	24	50
Average clients served each month– Total / EBL	21 / 4	20 / 4	12/4	19/3

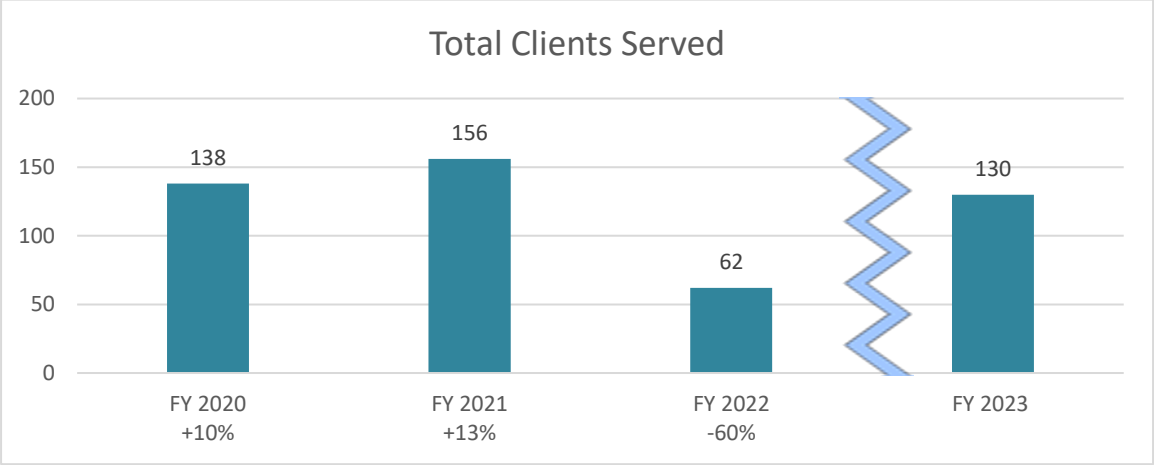
*Beginning in FY 2023, all discharge planning clients were included. In prior years, LIPOS, NGRI, and RDAP clients were excluded.

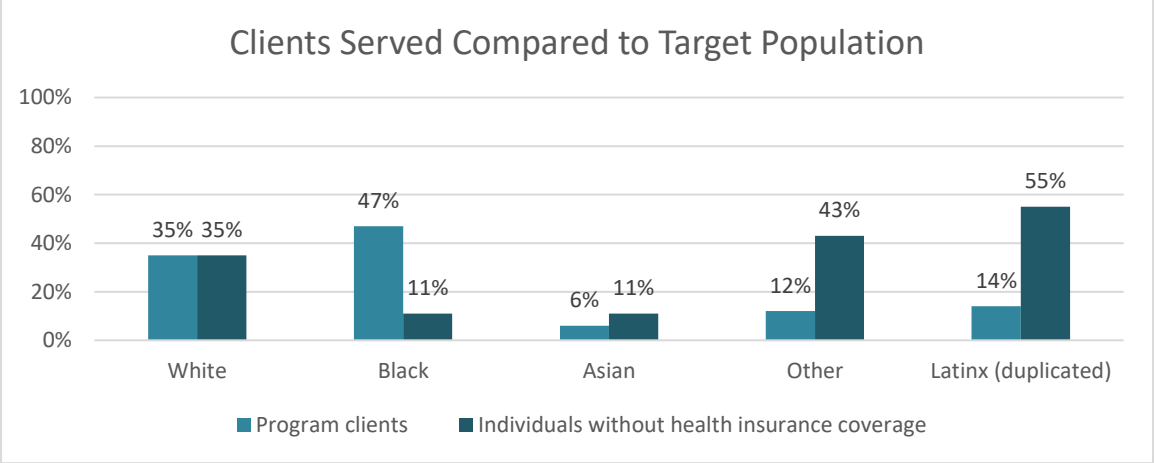
PM2: How well did we do it?	
2.1	Length of stay in state hospital
2.2	NVMHI clients receiving discharge services at least every 14 days
PM3: Is anyone better off?	
3.1	Clients connected with Arlington community-based treatment services
3.2	Stability of housing placement for clients discharged from hospital 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

- In FY 2023, LIPOS, NGRI, and RDAP clients were included for the first time in the client count. FY 2023 numbers are not directly equivalent to prior years.
- Program client demographics are compared to the demographics of Arlington's uninsured residents. Historically, 70-100% of program clients have been uninsured.
- Data is collected from the agency's electronic health record system.

What is the story behind the data?

- At the state hospitals, staffing shortages continued to create extensive bed shortages, greatly limiting the number of admissions to NVMHI in FY 2023.
- In FY 2023, the program continued to be short staffed, but strove to ensure clients were served and appropriately set-up for discharge.
- In recent years, DBHDS launched additional regulatory requirements for discharge planning and DAP monitoring. Placing clients in an appropriate treatment locations has required more forms than was previously needed and additional monitoring post-discharge. These have created an additional workload for staff.
- A trend noted throughout the Behavioral Healthcare Division in FY 2023 is an increasing client acuity, linked to the continuing trauma inflicted by the COVID-19 pandemic. Each case

is taking more time than previously, as staff are working to help clients reach treatment goals.

- 100% of clients did not have private insurance. For these clients, admission to the state hospital may be one of the only treatment options available.
- 65% of the clients served were males. This continues a trend first identified in FY 2022. Male clients may present as more aggressive when experiencing psychosis, requiring a more secure placement to ensure client and clinician safety.
- 66% (86/130) of the clients served by the discharge planning program in FY 2023 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. This may be due to the fact that the majority of the program's clients reside outside Arlington. This also mirrors nationwide trends, which find black individuals involuntarily hospitalized at higher rates than other demographic groups.

Recommendations	Target Dates
• Continue to provide data to the regional office and DBHDS regarding non-County and non-VA residents and make recommendations for the expansion of additional group home and ALF placements to meet these clients' needs	• Q4 FY 2023
• Explore demographic trends to better understand any unmet needs for clients.	• Q3 FY 2023

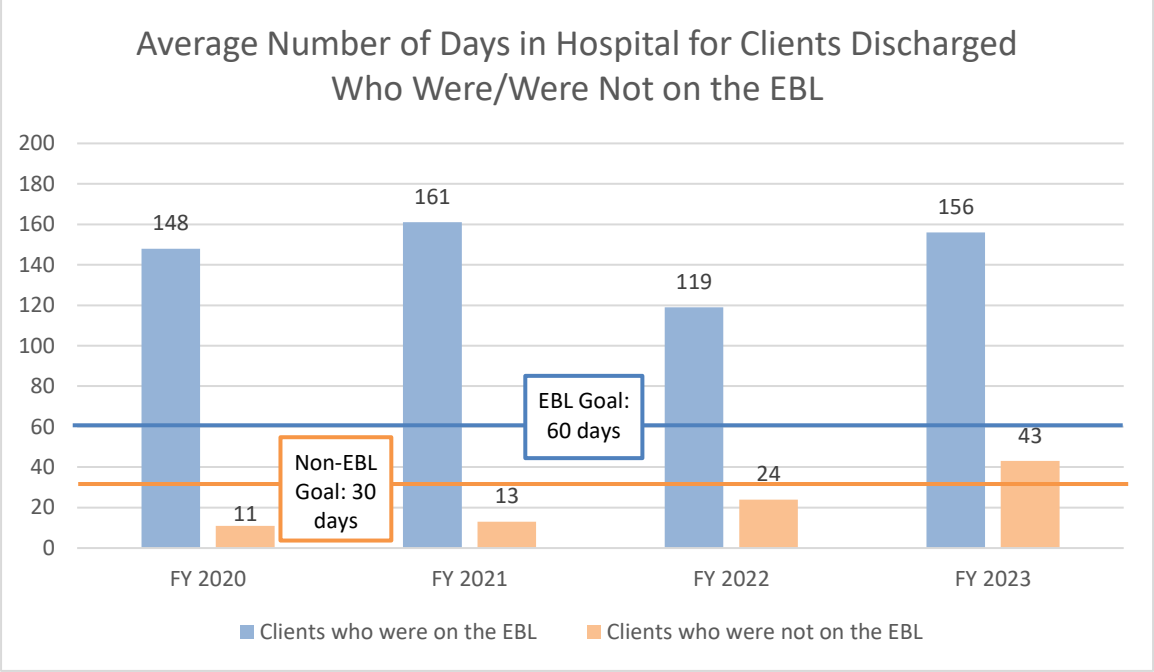
Forecast

- In FY 2024 the program projects serving 120 clients. This slight decrease is due to the more stringent admission system in place at state hospitals.

Discharge Planning

Measure	2.1	Length of stay in state hospital

Data



Data Summary

- In FY 2023, clients who discharged from the state hospital who had been on the EBL had been in the hospital an average of 156 days after being placed on the EBL. Clients discharged who had not been on the EBL had been there an average of 43 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 an increase in length of stay for individuals on the EBL in FY 2023. 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.
- In FY 2023, clients were placed at ten different state hospitals that normally would go to NVMHI which created additional barriers to discharge planning. Discharge planning staff had to collaborate with a far larger number of external providers than in previous years.
- The EBL average was impacted by two out of state individuals who took longer to discharge as guardianship had to be established prior to release. If these individuals are not included in the calculation, time on the EBL drops to 68 days.
- While state hospital clients served decreased in FY 2023, the average length of stay for non-EBL clients nearly doubled. Limitations in both residential placements and outpatient treatment options continued to reduce discharge options.

- Increased acuity of both EBL and non-EBL clients in FY 2023 created additional barriers to discharge with clients needing to wait for openings at specialized group homes, PSH apartments with ACT supports, and/or guardianship to be established prior to discharge.
- Some of the clients served this year were diverted to other state hospitals throughout Virginia due to no availability at NVMHI. As these hospitals are hours away, this impacted staff's ability to meet with clients in person, accurately assess clients, and complete necessary discharge planning responsibilities. Clients in these hospitals were served remotely.
- A new 8 bed Gateway transitional home opened in August of 2021 and continued to be 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
• Utilize the newly opened transitional house when appropriate to help with discharge	• FY 2024 Q1
• Review data more extensively to see if there are underlying reasons for large increase in the average non-EBL length of stay.	• FY 2024 Q1

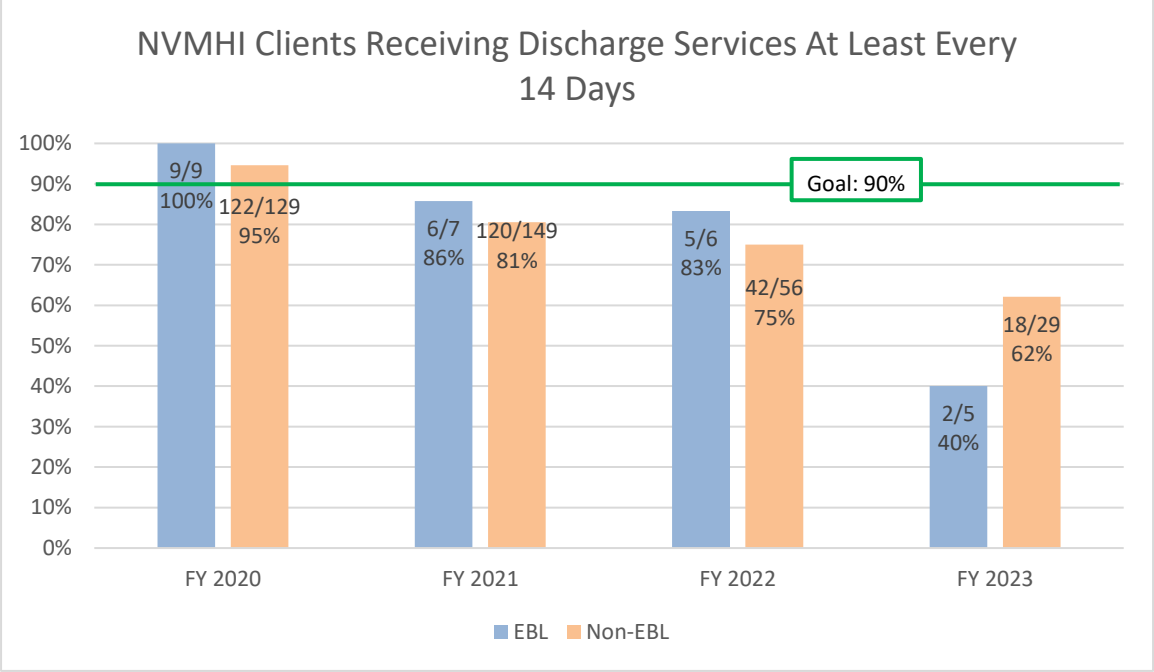
Forecast

- In FY 2024, it is anticipated that the average length of stay for patients discharged from the hospital will be 120 days for clients on the EBL and 30 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 2023, discharge-planning efforts were documented at least every 14 days for non-EBL individuals 62% of the time, and 40% of the time for EBL individuals.
- All EBL and Non-EBL clients received services at least every 30 days, meeting the state's requirement.
- Data obtained from reports from the electronic health record.

What is the story behind the data?

- In FY 2023, documentation of discharge planning services decreased compared to prior years. Staffing shortages impacted the program's ability to maintain agency documentation standards.
- In FY 2023, three clients on the EBL had at least one late contact. All but one of these late contacts were completed on day 15, one day short of the goal. The average date of a late contact for non-EBL clients was 17 days, well within the 30-day state requirement.
- Despite being at 60% staffing, only 6% of services were late in FY 2023, with the vast majority of client services being conducted within one week of the prior service.
- Multiple 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.

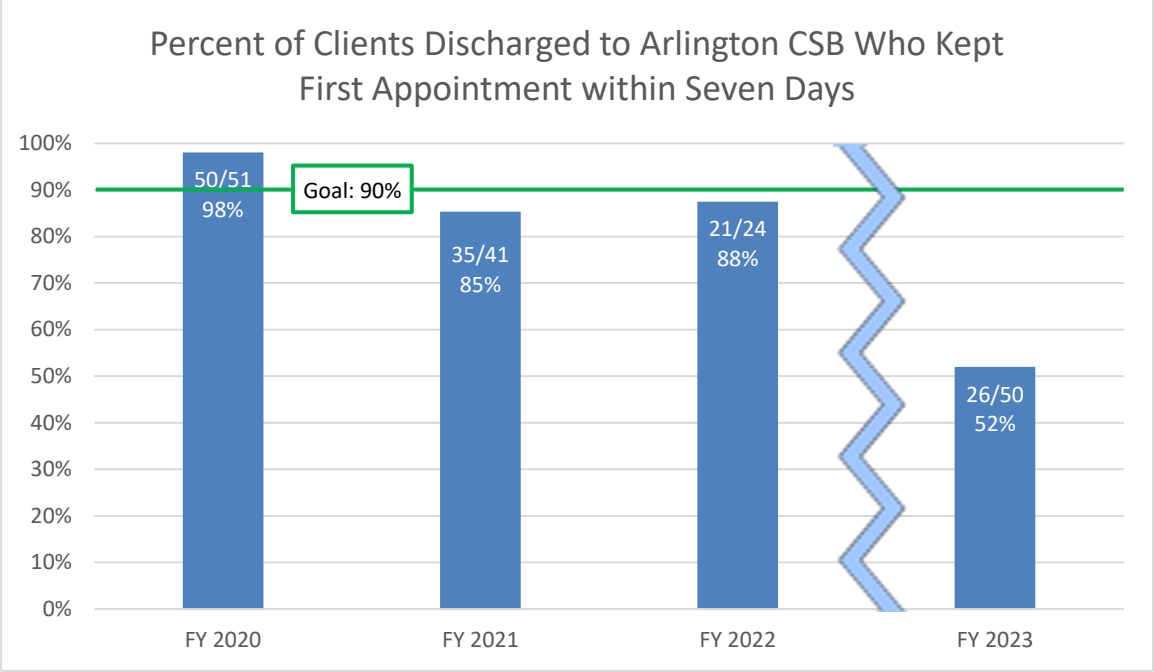
Recommendations	Target Dates

• Continue recruitment efforts to improve staffing, program coverage and overall client care and discharge planning services.	• Ongoing
• Continue weekly discussions on documentation timeliness with staff	• Ongoing
Forecast	
• In FY 2024, 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 2023, 52% (26/50) of clients discharged to Arlington attended a scheduled appointment within seven calendar days post-discharge with outpatient mental health services.
- Prior to FY 2023, LIPOS clients discharged to Arlington, NGRI, and RDAP clients were excluded.
- 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?

- In FY 2023, in addition to the 26 clients who connected to Arlington services with 7 calendar days of discharge, an additional 9 clients (14%) were connected after 7 calendar days.
- In FY 2023, 9 of the clients who did not connect at all to services were LIPOS clients. These clients may have been stabilized in new communities and did not want to receive ongoing outpatient supports from Arlington.
- Efforts were made to connect clients with Same Day Access (SDA) who were not already connected to services. Options were explored to complete SDA intake prior to hospital discharge but this was put on hold due to staffing shortages in both programs.
- 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.
- For clients who were not Virginia residents, efforts were made to link these individuals to services in their home jurisdictions.
- 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. Staff continued to make referrals for appropriate clients to receive this additional assistance in FY 2023.

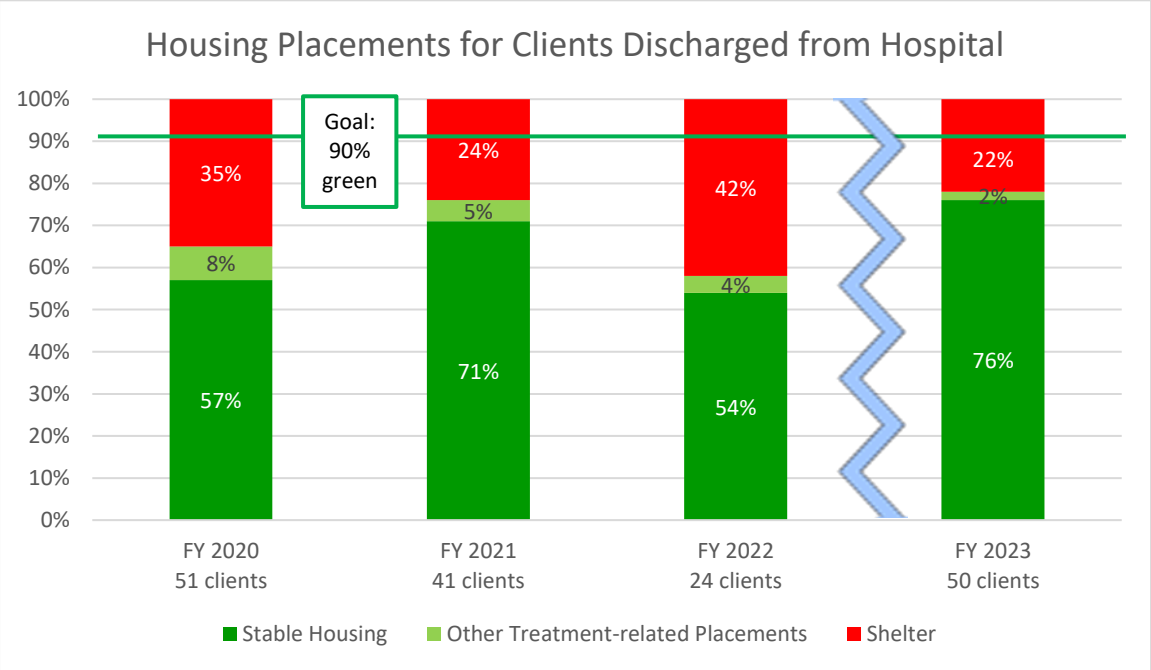
FY 2023 PERFORMANCE PLAN

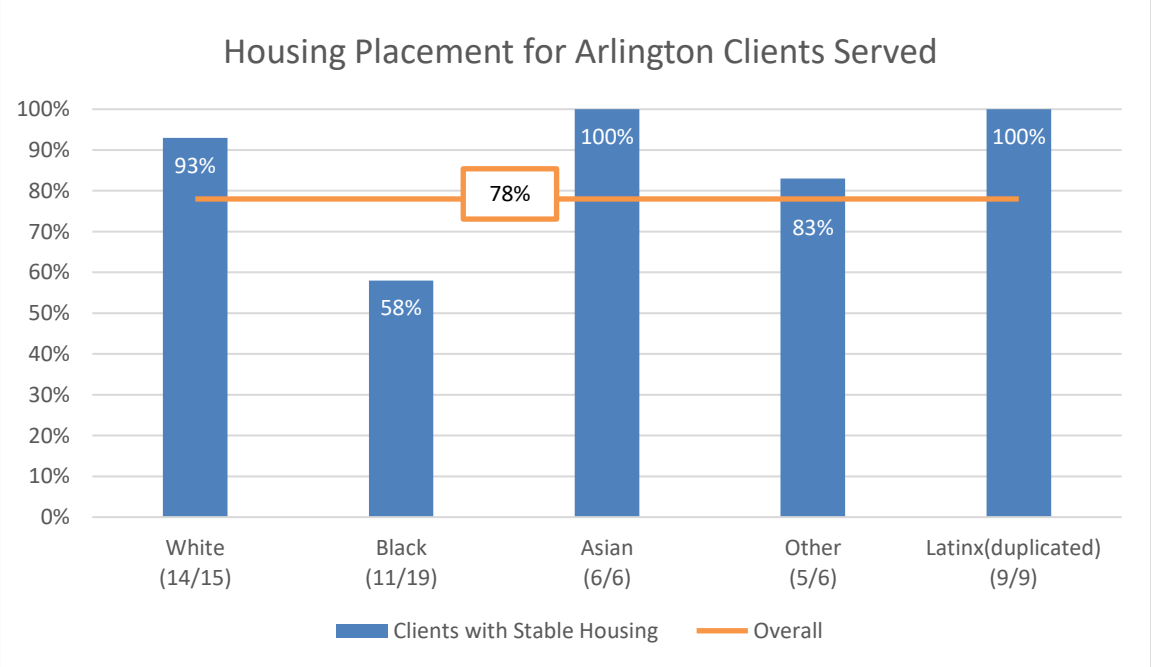
Recommendations	Target Dates
• Continue scheduling necessary aftercare appointments within 7 calendar days of discharge and monitor these to ensure clients get connected to outpatient mental health services.	• Ongoing
• Explore options to improve data tracking for hospital discharge planning in the electronic health record.	• FY 2024 Q1
• 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.	• FY 2024 Q3
• Consider adding notification requirements to LIPOS contracts, to ensure that staff are notified when clients are discharged.	• FY 2024 Q4
• Continue to evaluate clients appropriate for HUV program, make referrals and continue ongoing collaboration to improve client's connection to services post discharge.	• Ongoing
Forecast	
• In FY 2024, it is anticipated that 75% 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 2023:

- 76% of clients (38/50) were discharged to stable housing: their own apartment, a group home, or a residential placement.
- 2% of clients (1/50) was discharged to residential substance use programming.
- 22% of clients (11/50) were discharged to shelter/motel placements.

- In FY 2023, LIPOS clients discharged to Arlington, NGRI, and RDAP clients were included for the first time in the client count. FY 2023 numbers are not directly equivalent to prior years.
- Data was obtained through monthly reports collected from each staff member regarding discharge placements of consumers and the agency's electronic health record system.

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.
- 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.
- An equity analysis indicated possible inequities for black clients. 42% of black Arlington clients served did not have stable housing and were discharged to shelters/ motel placement.
- 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 2022. It is generally not feasible to postpone hospital discharge for this length of time.
- 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, 53% of the clients served were not Virginia residents (66/106). Lack of Arlington residency and Virginia benefits, and complications in gathering prior housing information and treatment history, created additional barriers to discharging these 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 those of other demographic groups and propose recommendations to DBHDS for expansion of services using existing discharge assistance funding. Share race equity data with state and community leaders.	• FY 2024 Q3
• Explore data to determine community inequities, comparing discharge planning numbers with early intervention numbers. Analyze outcomes on a per client basis to determine	• FY 2024 Q3

individuals were previously homeless prior to mental health intervention, and what can be done to assist them.	

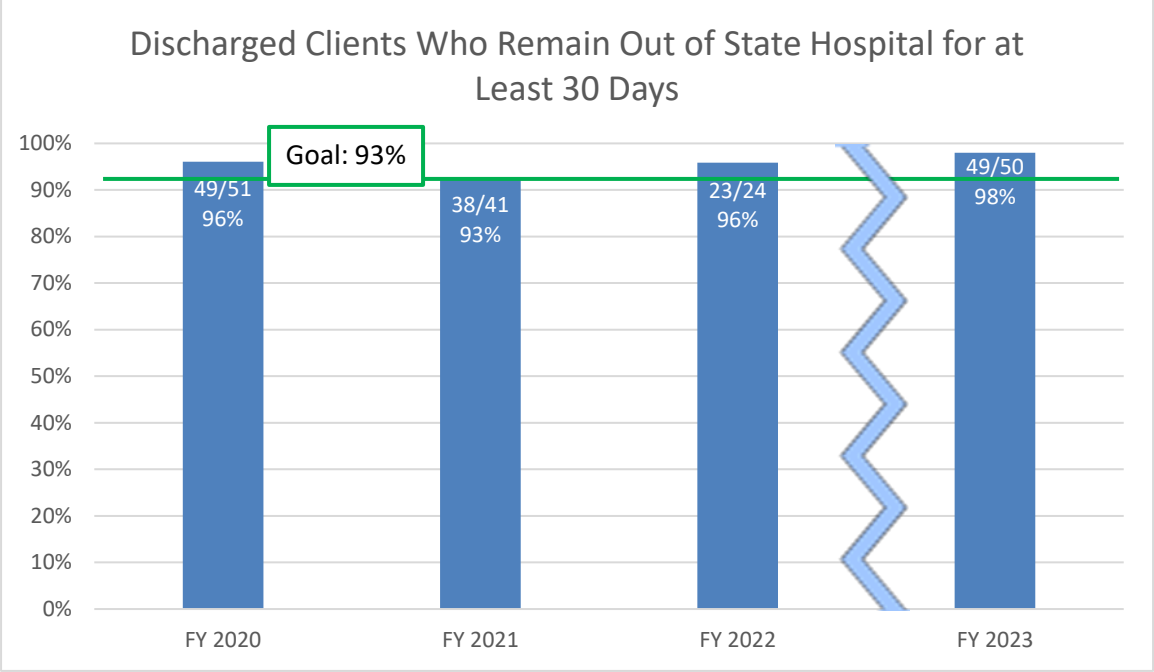
Forecast

- In FY 2024, it is anticipated that 76% 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 2023, 98% (49/50) 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 and the agency's electronic health record.

What is the story behind the data?

- The percentage of individuals who remained out of the state hospital increased slightly in FY 2023, continuing to exceed the state target of 93%.
- 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.
- 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 2023, 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. Staff continued to make referrals for appropriate clients to receive this additional assistance in FY 2023.

Recommendations	Target Dates
• 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
Forecast	
• In FY 2024, it is anticipated that 95% of clients will remain out of the state hospital for at least 30 days.	