SB26 Implementation

Capacity Management and Continuity of Care

Texas State Hospitals
Health and Specialty Care System

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Texas Health and Human Services Commission

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Meet Our Team

- **Capacity Management & Continuity of Care**
  - Dr. Jeffery Matthews-Chief Medical Officer
  - Matthew Moravec-Gallagher-Continuity of Services Director
  - **Transition/Discharge Services**
  - Lambra Lewellen-Transition Program Coordinator
  - Sandra Tillery-Transition Specialist (TSH/RSH/NTSH)
  - Andrea Hall-Transition Specialist (ASH/EPPC/BSSH)
  - Maegan Abney-Transition Specialist (SASH/KSH/RGSH)
  - Josephine Donnell, Ronna Dunson, Regina Neal-Clearinghouse Coordinators

Here and Now vs. Then and There

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- Identify, assess and facilitate a successful transition of psychiatrically and/or medically fragile patients who are challenging to place in traditional settings, but are clinically appropriate for transitioning with proper supports.

From Start to Current

- Formulating Position Descriptions
- Posting and Hiring
- Establishing Initial Goals and Objectives
- Identifying Specific Caseloads
- Educating Facilities and Partner Agencies
- Engagement, Problem-Solving and Collaboration
- Data and Discharges

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Primary Shared Goal

Least Restrictive Environment

TAC: Title 25; Part 1; Chapter 404; Subchapter E; Rule §404.154: Persons receiving mental health services from department facilities, community centers and psychiatric hospitals have the following rights:

(4) The right to appropriate treatment in the least restrictive appropriate setting available consistent with the protection of the individual and the protection of the community.

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Senate Bill 26

- The commission shall require each facility to designate at least one employee to provide transition support services for patients who are determined medically appropriate for discharge from the facility.

- The commission shall ensure that each department facility concentrates the provision of transition support services for patients who:

❖ have been admitted to and discharged from a facility multiple times during a 30-day period;

OR

❖ has been in the facility for longer than 365 consecutive days.

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Senate Bill 26 Community Side

- Transition support services provided by the Local Mental Health Authority (LMHA) must be designed to compliment joint discharge planning efforts and may include:

❖Enhanced services and supports for complex or high-needs patients, including services and supports necessary to create viable discharge or outpatient management plans.

❖Post-discharge monitoring for up to one year after the discharge date to reduce the likelihood of readmission.

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What is a Discharge Specialist?

- The Discharge Specialist (DS) is a position primarily focused on complex inpatient cases with an emphasis on post discharge placement and support.

This is not your traditional Texas State Hospital social worker position

- The DS oversees and assists with transfers, passes, furloughs, and community placement discharges by involving the individual, their family/LAR/significant others (with consent), as well as the committing court, and Local Mental Health Authority (LMHA) or Local Intellectual Developmental Disability Authority (LIDDA) to establish an individualized care plan that includes a referral for continued treatment and services as needed and medication and personal possessions through the use of person-centered practices.

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Discharge Specialist Position Examples

- Coordinating and conducting tours of identified discharge options for individuals and families;
- Engagement and communication with state and judicial systems as well as facility or treatment providers;
- Providing information to the local authority to assist in obtaining required documents for discharge planning including certified birth certificates, Independent School District (ISD) records and social security cards and
- Coordinating with the receiving facility or discharge destination for individuals transferring to include transportation and the transfer of individual information, personal possessions, medication, etc.

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Discharge Specialists at the State Hospitals

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- Each facility across the state hospital system, including Waco Center for the Youth, has onboarded a discharge specialist for a total of 11 employees.
- The Discharge Specialists meet biweekly with the Transition Program Coordinator to problem-solve difficult cases to transition out of the facility.
- All social work departments participate in a monthly meeting facilitated by the Transition Program Coordinator to discuss & problem-solve cases not on the DS caseloads. Resource sharing across the state also occurs at this meeting. Always an opportunity for individuals to present as well!

Transition Review Panels (TRP)

- The Transition Review Panel (TRP) serves as a collaborative approach to reviewing, researching, and discussing patients with specific barriers to discharge.

- The TRP provides an opportunity to discuss case specific challenges with state hospital representatives, Local Mental Health Authority or Local Intellectual Developmental Disability Authority representatives, and other key stakeholders in overall efforts to transition long-term patients back to the community by recognizing self-imposed and uncontrollable barriers in an unbiased and non-critical manner.

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Recommended TRP Attendees

- The facility Treatment Team
- The facility Clinical Leadership
- Consideration of other facility staff with beneficial case awareness (PNA/Peer Support/Ed-Rehab/etc.)
- Family, LAR or social supports for the individual
- HHSC Representatives (Capacity Management and Continuity of Care Team)
- Members of the individual's Local Mental Health Authority or Local Intellectual Developmental Disability Authority
- Our HHSC BHS partners
- The individual may also be involved

OUTCOME MEASURES

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Data Tracking Points:

- Patient Discharge Needs Form (PDNF) completed by State Hospital Social Workers
- Transitions from the Discharge Specialist caseloads with 30-day follow-up with LMHA/LIDDA.
- Discharges following cases presented to Transitional Review Panels (TRP)
- Tracking successful transitions for long-term patients of the SH system.
- Following transitions to Step-Down programs for one year following discharge from SH system.
- Monitoring HCBS-AMH homes & their availability across the state, while tracking areas lacking placement options.

Outcome Measures Continued

Barriers to Discharge

- Guardianship
- Immigration Status
- Funding Source
- Lack of secure placements across the state:
  - Step-Down homes
  - HCBS-AMH homes
  - Nursing homes
  - Board & Care homes
  - Unavailable placement options due to level of care needs (24-hour secure setting)

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Preliminary Data Reports

- There have been (40) total discharges across all facilities that were facilitated by the Discharge Specialist carrying a caseload of (10) or fewer for the 2024 year.
    - Noteworthy numbers:

1. North Texas State Hospital- Wichita Falls (NTSH-WF) had (10) discharges facilitated by their Discharge Specialist and 4 of the patients had a length of stay of four thousand days or more, and one patient discharged had a length of stay of 5,473 days.
2. Waco Center for Youth (WCY)- has had (11) discharges facilitated by their Discharge Specialist
3. Rusk State Hospital (RSH)-had (4) discharges and (3) were following Transition Review Panels
4. El Paso Psychiatric Center (EPPC) had (3) discharges and (2) were following Transition Review Panels

**Data from May 2024*

Successful Transitions

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- A patient was discharged & their length of stay was 5473 days. They were on a Civil Commitment. Barriers to transition were their length of stay, family, and history of aggression. The patient's sister reported they would call the governor of Texas if NTSH tried to discharge them. SW sent 20 to 25 placement packets before securing a nursing home.
- The treatment team provided psychoeducation to the sister to increase her understanding that the nursing home was the best and least restrictive place that could meet all their sister's needs.
- Upon the 30-day follow-up with the LMHA, it's reported the person served attended their outpatient appointment with their case worker. They have been sleeping well & taking their medication with prompts. There have been no noted problems with this transition.

- The Discharge Specialist at RGSC worked with a 42-year-old patient with a length of stay of 202 days during their 14th admission to facility. The individual lacked any family support or involvement and had a long history of homelessness, arrests, and treatment non-adherence in the community.
- The social worker worked closely with the courts to get this individual's charges dismissed & assisted them with applying to an HCBS-AMH home in the Austin area, where they once resided. The treatment team worked closely with the individual on psychoeducation to reduce their recidivism and to foster a successful transition to the community. They were set up with the local LMHA and have been successful in their placement.

- A patient with a length of stay of 716 days at EPPC was denied admission to Skilled Nursing homes in El Paso & Big Springs due to concerns related to sexual and physically aggressive behaviors.
- Once they were approved for the Medicaid Star Plus waiver program, they were discharged to a home on the Molina Healthcare list.
- The LMHA assisted with arranging ACT team services. The individual had a guardian who supported this transition as they did not have family support or involvement.

How Can We Help YOU?

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- We are a team dedicated to supporting and assisting with all things discharge and transition related.
- We can and will advocate for the specific needs of each facility.
- We will communicate to stakeholders within HHSC the importance of expanding mental health resources and placement options across the state.
- We plan to continue sharing information and resources across SH Social Work Departments and other clinical teams.
- You may reach our team by emailing:

smahhsctshtransitionsupport@txhhs.onmicrosoft.com

Questions?

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Let's keep the collaboration going!

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