Capital Region RPC: Transitions in Care Ad Hoc Work Group

Background: The Transitions in Care Workgroup was developed in July of 2019 to address the regions homeless adult population who are admitted for inpatient psychiatric treatment (community hospital) and have a longer hospitalization because hospitals are unable to discharge to safe housing, as this would increase their risk for readmission within 30 days.

A Survey was completed to reboot the Workgroup in October 2020; please see below for the issues identified in the Region.

Survey Results:

- Community population is changing, individuals with greater needs than current services we can provide, getting creative, asking agencies to collaborate together to provide range of services, creating "team" around high need individuals, need for low barrier housing, criminal justice reform and housing re-design contributing factors
- Need for more crisis beds; RSS- Applied to convert South Lake to all crisis beds, would add 5 to Region; Unity House- Applied for funding for crisis residence, 6 beds, E-SHY awards- Unity House- waiting on signed OMH contract to put 15 bed online, supportive, permanent housing, another project in works to add 28 more beds to open June 2021; RSS- 10 E-SHY beds opened in June, filled quickly
- Waiver extension for COC funded housing through coordinated entry; previously if there for 90+ days lose homeless status, extended to 120+ days
- Long term stays, especially those requiring nursing home level of care/resistance of nursing homes to take seriously mentally ill people
- Many providers now providing hybrid of services, tele practice and in-person with safety precautions for higher need individuals
- Support of bi-directional capacity with primary care, moving maintenance clients to primary care providers to open up space for folks challenging the primary care system with higher needs
- Transportation barriers- closing of transportation services, lack of reliability of uber, lyft, medicab

Three Identified Focus Areas for 2021:

- **Standardized Form:** Hospital to hospital transition management, standard template for referral process, streamline form to send to network that is standard, less paperwork, inpatient access from ED setting, transfers- utilize resources that are available, wide range of requirements from hospital to hospital, tracker through Health Commerce System, supposed to be up to date real time, inaccurate, could OMH/Central Party able to manage that on tracking basis
- **Regional Huddles:** Pull together key stakeholders from multiple health systems, real time mechanism for escalating, current email group to let people know psychiatric diversions, making diversion decisions, what do regional resources look like, global responsibility to meet client's needs regionally, utilization of beds, gather for 10-15 minute huddle to discuss decisions regionally, should be made aware and kept apprised of status, instead of email become operational huddle to initiate immediate contact when necessary
- **Payer Landscape:** Research NYC initiative where MCO/insurance provider, ability to pay or provide funding for beds, available to their members/on reserve, look at funding sources for crisis beds, higher regional capacity (housing, beds), ways to better engage payers in Regional conversations

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