Jim Taliaferro Community Mental Health Center

Lawton, Oklahoma

The Jim Taliaferro Community Health Center is a comprehensive mental health and substance abuse facility serving southwest Oklahoma, with a main office in Lawton and three satellite clinics in Duncan, Anadarko, and Altus. The Center offers inpatient, outpatient, emergency intervention, counseling, screening, referral, aftercare, psychosocial rehabilitation, intensive case management, and home-based children's services.

IMPROVE TRANSITIONS FROM INPATIENT TO OUTPATIENT

Aims

- Increase the percentage of clients who continue from inpatient to outpatient treatment.
- Increase the show rate for clients attending doctors' appointments two weeks after completing inpatient treatment services (for current or new issues and prescription of medications).
- Reduce the number of readmits within 30 days of discharge from inpatient services.

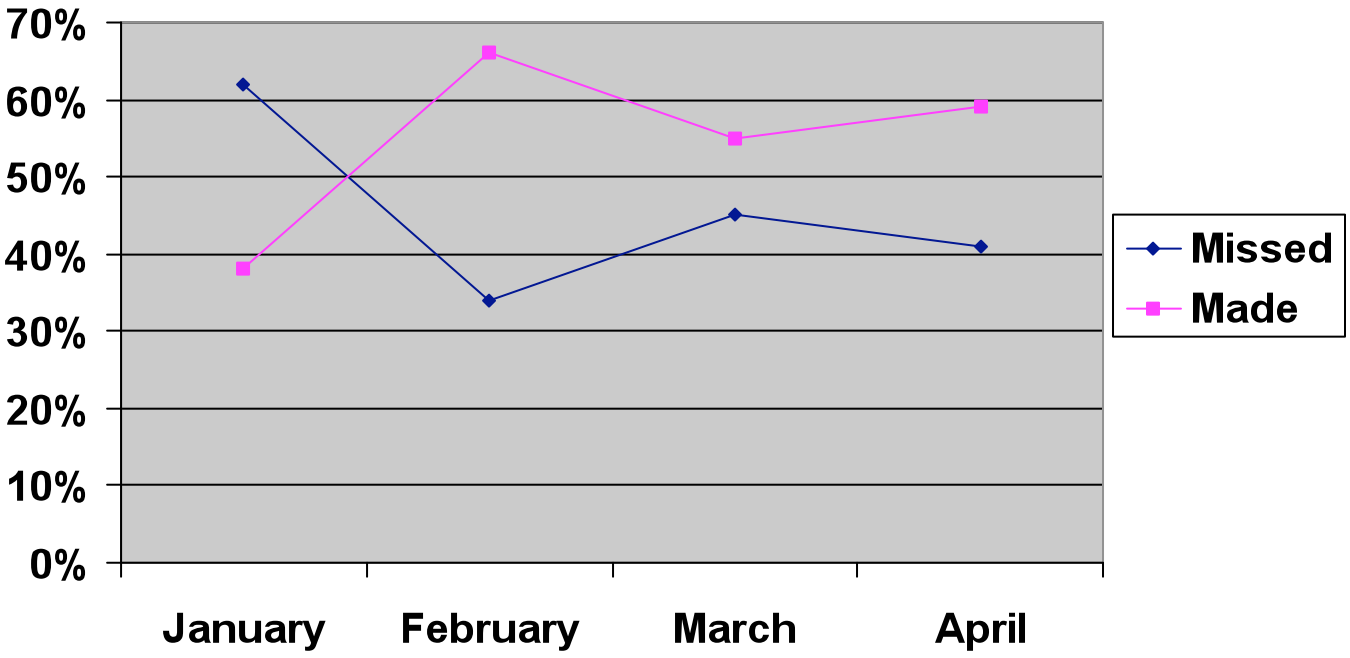
Changes

- An outpatient Case Manager meets with inpatients prior to discharge to support clients as they make the transition to outpatient treatment. The Case Manager's responsibilities include the following:
    - Attend morning report in inpatient.
    - Do discharge planning from inpatient to outpatient.
    - At discharge, the Case Manager transports clients home and follows up with phone calls.
    - Follow up with the client for two weeks after discharge to make sure that services are continued, needs are being met, treatment plans are being followed and that there is no interruption in services.
    - Assist clients to find housing.

  Case management services are billable. These certified Case Managers are entry level and have BA degrees.
- Use telemedicine for staffings and consultations between clients and satellite clinics.

Results

The results showed that the transition team, consisting of the two outpatient Case Managers, did make an impact. The no-show rate to the first doctor's appointment decreased from 64.3% to 40%. See graph below. The transition team does a great job of doing treatment plans upon discharge and contacting consumers to make sure that their needs are being met. The number of referrals to individual sessions and attendance also increased.



Lessons Learned

This project was difficult to start because the transition team itself had not been put into place upon beginning the project. When staff was finally assigned and the team was fully in place on 3-3-08, they still had their own OP case management case loads assigned to them. This had to be taken care of immediately because they were going to IP and having to help OP consumers all at the same time. This made it very difficult for them to concentrate on the job at hand. When that was finally done, things fell into place and we were seeing more treatment plans.

Another lesson learned was in data collection. There is a great deal of data to collect because of so many consumers transitioning from IP to OP on a daily basis. It had to be narrowed down greatly to focus on what was important.

Another lesson learned from NIATx was making sure we were collecting the correct data on what we were actually looking. It was finally decided that the data would concentrate on all consumers transitioning from IP to OP. We were trying to break it down into too many variables. Ultimately IP affects OP and that's what we concentrated on. We kept it as simple as we could.

Next Steps

The next steps are to ask consumers and the transition team what worked and what did not work. It is important to know this because it may open some areas to change that we did not know or think existed. Their feedback is very important.

We will also be working towards sustaining the project so we will be continuing to collect data. We will also be concentrating on the 30 day readmits and possibly make some changes in this area.