Psychiatric Hospital-to-School Transition of Care Learning Network

A collaboration led in partnership by Cincinnati Children's Center for School Services and Educational Research (CSSER) and MindPeace

Megan Elam, EdD

Michael Cann, EdD (ABD)

Background

What is a Learning Network?

"Learning Networks are **multisite**, **practice-based** clinical networks that use **data for research and improvement**. These networks involve **collaborations** among **engaged** patients and families, multidisciplinary teams of clinicians and staff, scientists and communities. Learning Networks span a broad reach of conditions, settings and geographic locations and **drive the spread of evidence and innovation**."
– James M. Anderson Center for Health Systems Excellence

Background

Our Network Purpose & Goal Statement

Purpose

The Psychiatry Transition of Care Learning Network is designed to **bring together stakeholders from across the community** who are invested in improving **transitions of care and school outcomes** for **school-age youth as well as supporting families** following an **inpatient psychiatric hospitalization** through inter-agency, multidisciplinary collaboration.

Goal Statement

Using a **quality-improvement** based approach, and through standardization and leveraging existing resources and partnerships, participants in this network will **outline present-state concerns, test interventions** to identify solutions for present challenges and barriers, and **report on monthly data and outcomes** to determine progress of efforts.

Background

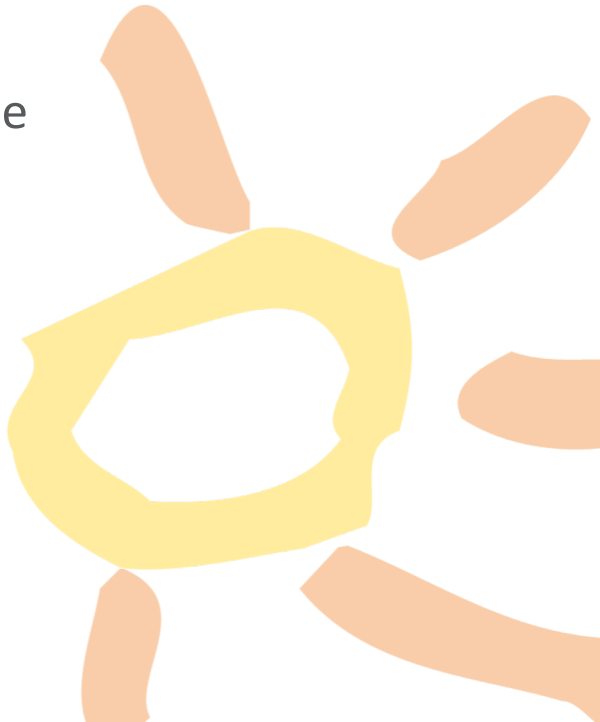
Our Network Vision & Mission

Vision

The Transition of Care Learning Network will lead national improvements in school transition outcomes for youth following psychiatric hospitalization

Mission

Through inter-agency, multidisciplinary collaboration, the Transition of Care Learning Network will lead the development of standardized care coordination from hospital to school for students who are hospitalized for psychiatric care, leading to improved school **and** quality of life outcomes for impacted youth, nationwide



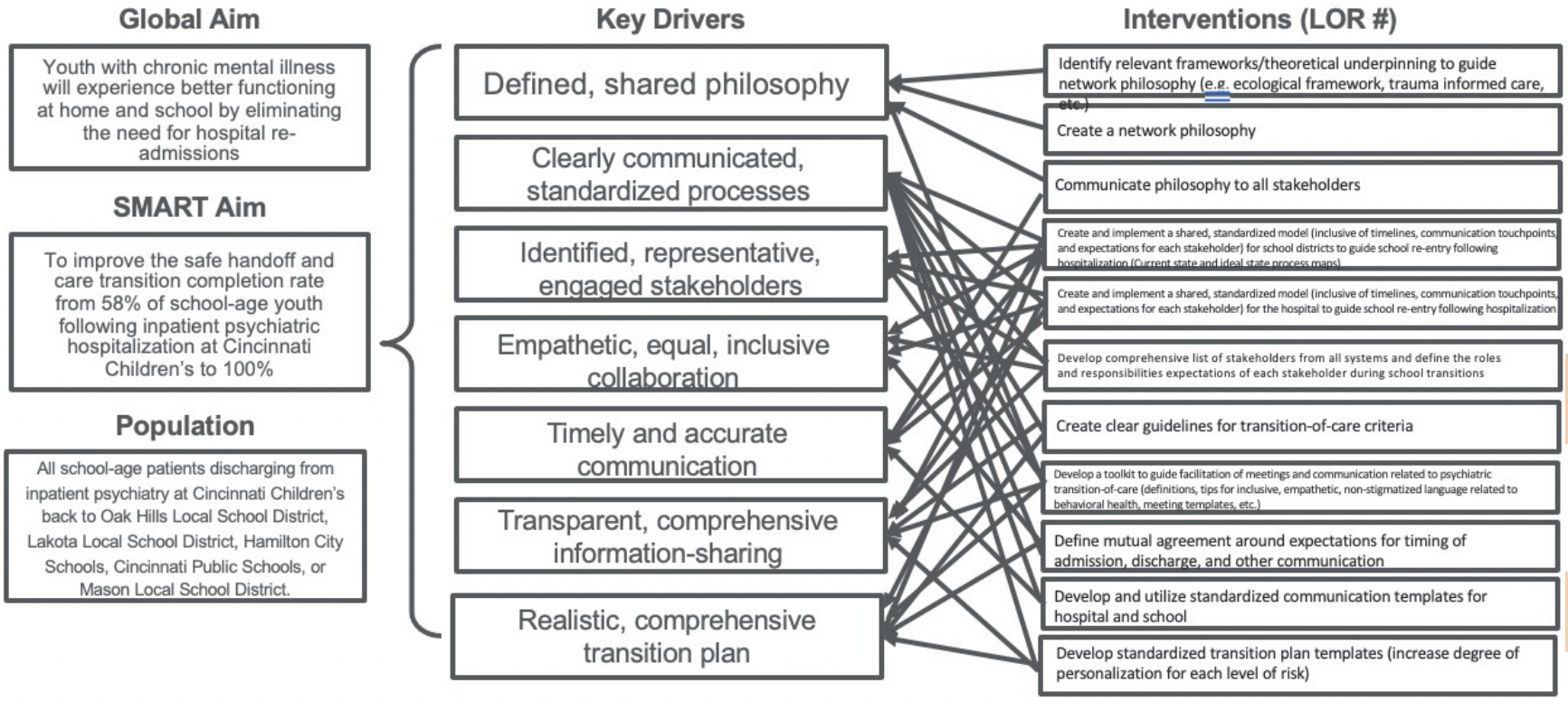
Background
Our Network Vision & Mission

In this Learning Network, we believe that…

- Coordination across multiple, complex systems will result in improved mental health outcomes for students following hospitalization
- Evidence-based and data-driven decision-making contributes to successful transitions between levels of care
- Stakeholder input across the community best informs transition planning that meets the individual needs of children, families, and schools

Background

Key Driver Diagram

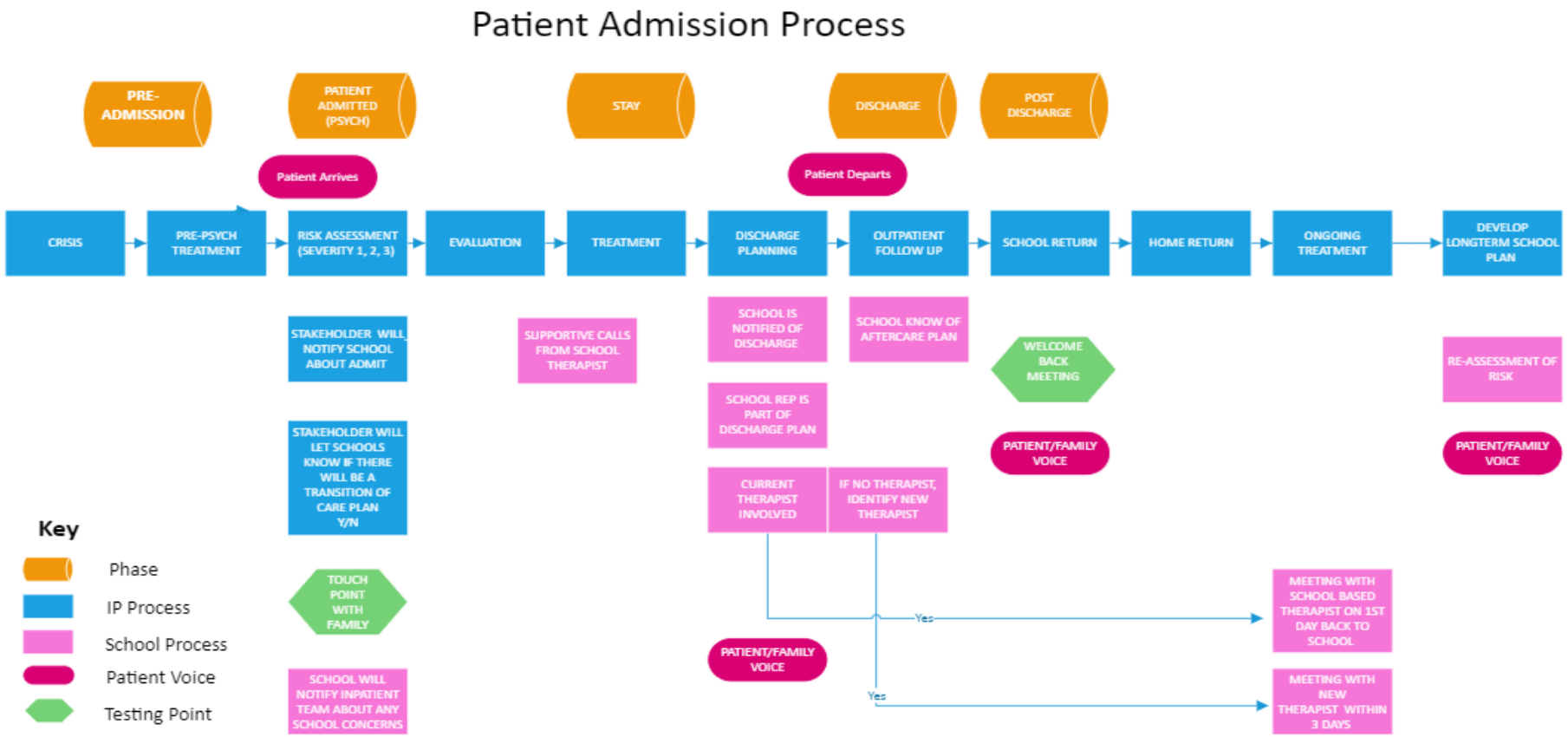


Project/Program or System Details
Changes Introduced / Accomplishments

- Created a philosophy statement
- Began data tracking
- Developed an ideal state process map
- Started PDSA testing
  - Completed school stakeholder survey to understand positive aspects of TOCs and ways to improve communication with schools
  - Began school preparedness survey to get feedback on how prepared school stakeholders felt transitioning a child from inpatient to school setting.
- CSSER improvements implemented: Introduced collaborative school meetings to better assist patients with transition back to school

Project/Program or System Details

Ideal Process Map



Project/Program or System Details
PDSA Worksheet

Intervention Name:	**Collaborative meeting prior to patient discharge**				
What key driver does this test impact?					
Test Cycle #:	1	**Test Cycle Start Date:**	4/19/22	**Test Cycle Completion Date:**	5/19/22

PLAN: *(To be completed before the test cycle)*

Describe the intent and structure of the test cycle:

Establish a collaborative meeting to share medical information, recommendations and family concerns to school stakeholders and to allow school team members to share information/concerns with the hospital team.

What would the successful test look like? Include how you will measure success for this test cycle:

We will measure success on this test based on a quick survey, given at the end of the collaborative meeting, to gauge school's preparedness in helping a patient return to school. At the end of the meeting, our school partners will answer one question. On a scale of 1 – 5, after this collaborative meeting, how prepared do you feel to assist the patient's transition to school.

What do you predict will happen? This should be your realistic prediction.

We predict that the school's preparedness score will be at least 80%.

Action steps to carry out the test cycle (who, what, where, & when):

Who: School specialists, school stakeholders, family (composition of team might vary based on patient needs)
What: Collaborative meeting
Where: Virtual/phone conference
When: During the scheduled family meeting or another time that works for all parties prior to patient discharge.

DO: *(To be completed after the test cycle)*

Describe your observations and data. Was there anything that occurred that was not part of the plan?

For April 2022 the school specialist team sent out 22 surveys to school stakeholders. We only received 4 surveys back which is a response rate of 18%. The average score was 3.5 (70%).

STUDY:

How did the results compare to your prediction? What did you learn?

We were a little surprised by the low number of survey respondents. The sample size was too small to generalize the results or make any changes to our processes. We would like to increase participation and get some qualitative data in addition to the quantitative data.

ACT: *(To be completed after the test cycle)*

Adapt [X]

Adopt [ ]

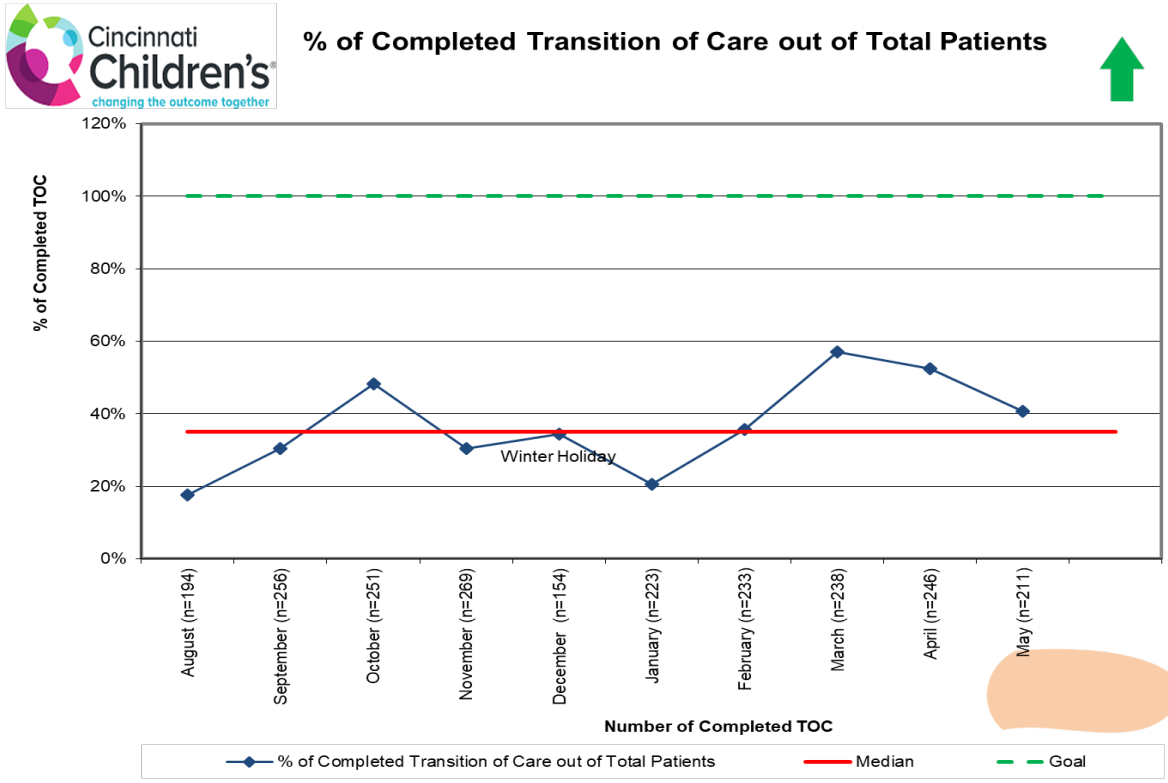
Abandon [ ]

What will you change in the next test if "adapt"? *(Modify intervention to reflect learning and/or increase scale)*

We are currently brainstorming ways to increase survey participation. We hope to make those modifications over the summerr and conduct the survey again in the fall.

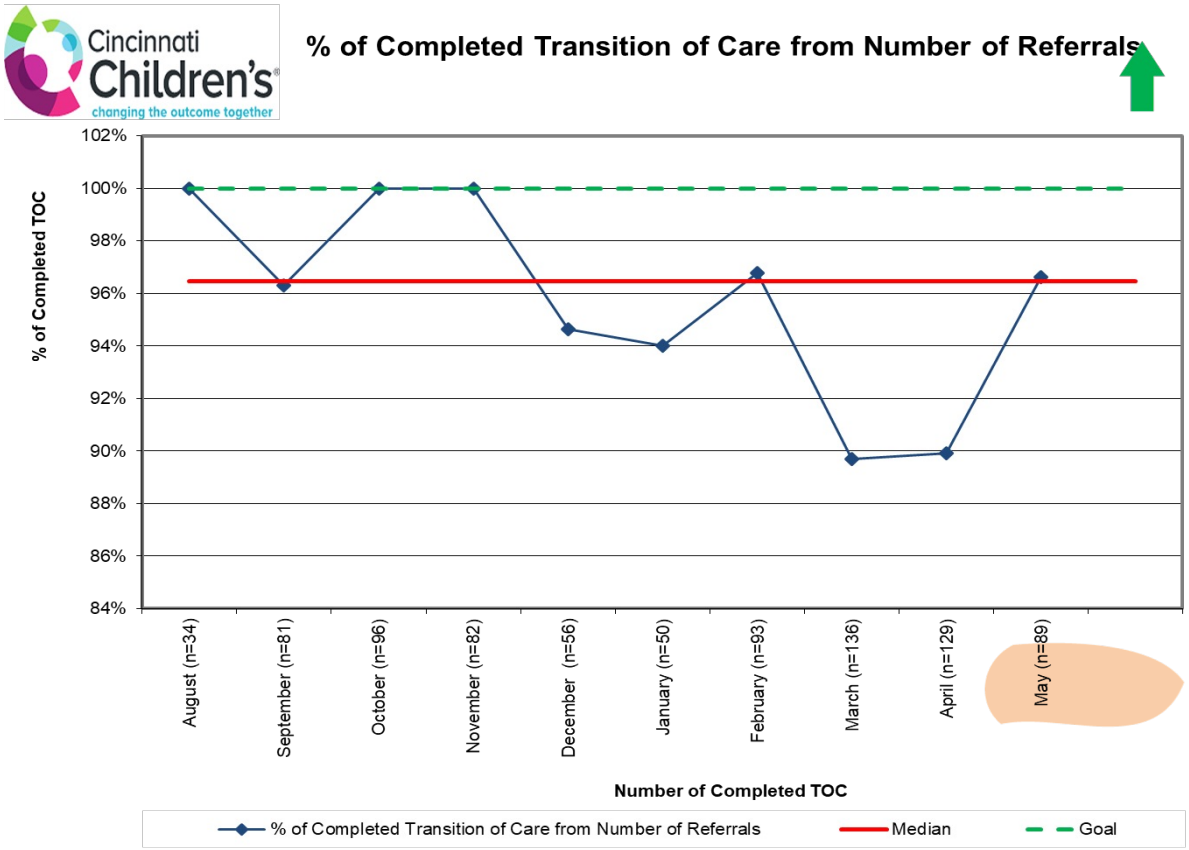
Results

2021 – 2022 Data / Outcomes



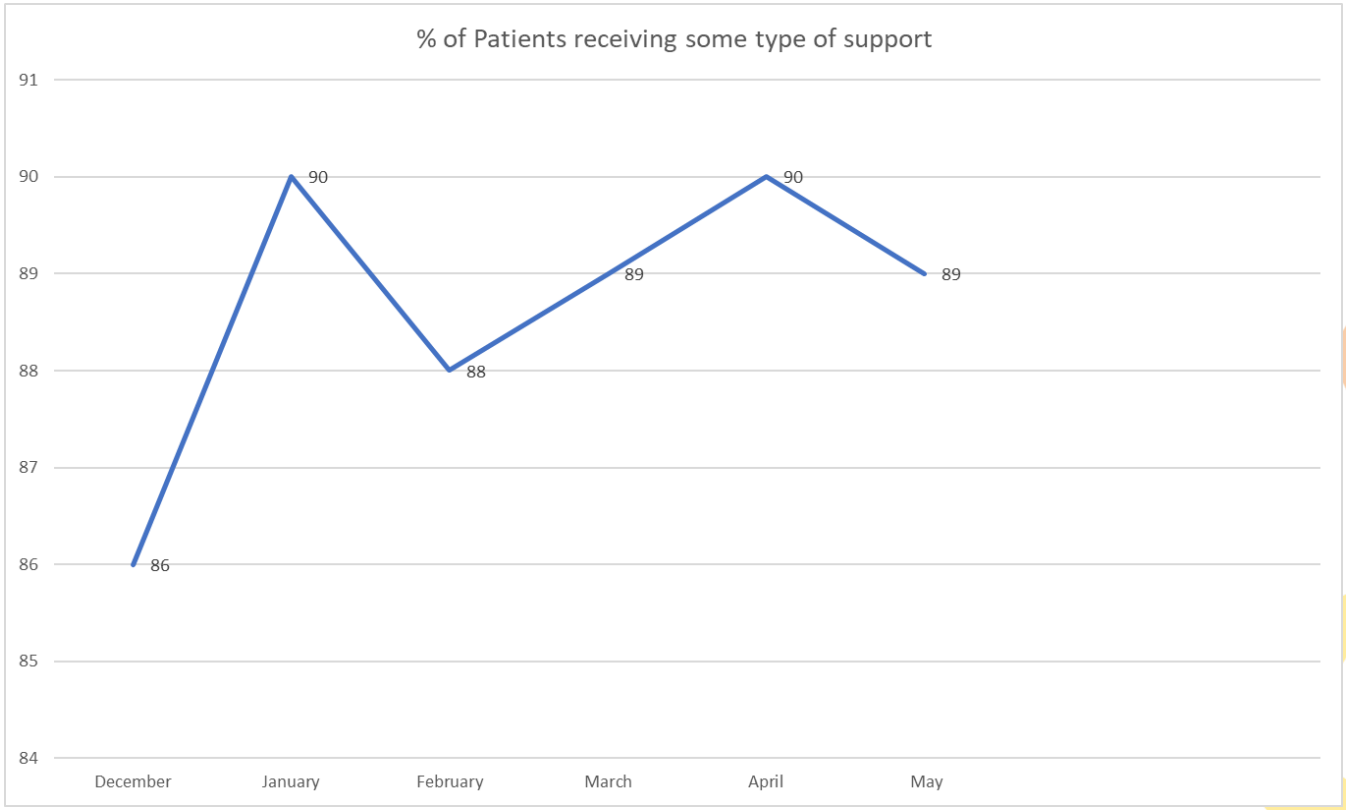
Results

2021 – 2022 Data / Outcomes



Results

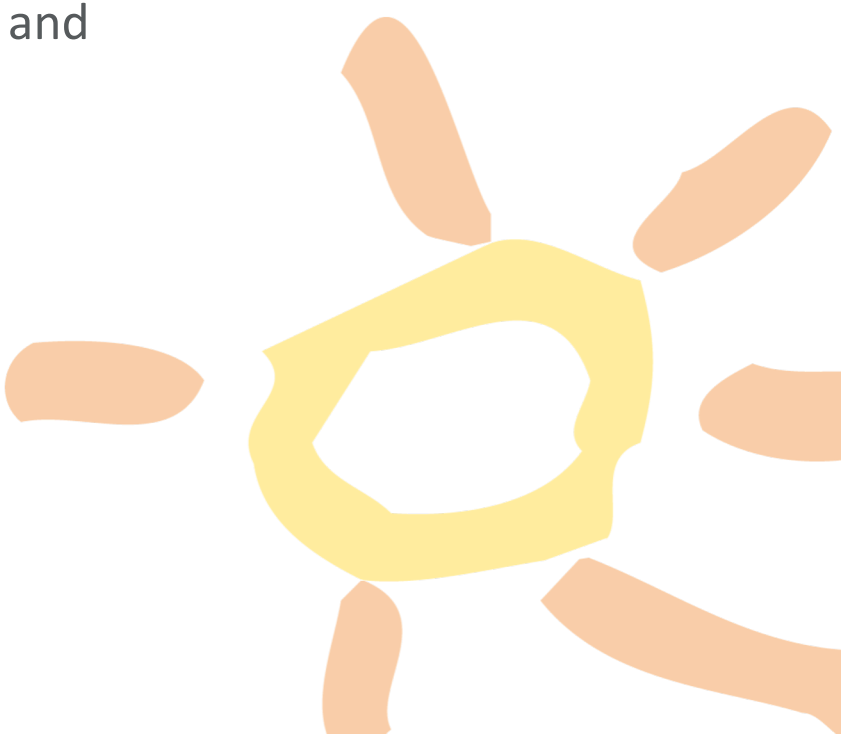
2021 – 2022 Data / Outcomes



Results

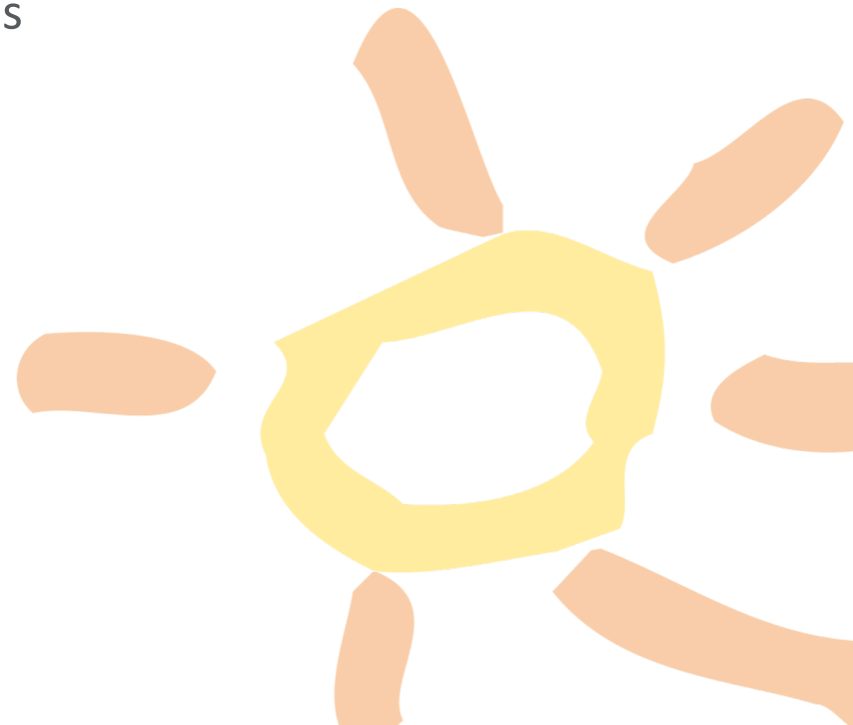
Data: Year in Review

- Completed 804 personalized transitions of care
- Completed 96% of TOC's, on average, for patient referrals received from care team members
- 88% of all patients received some type of school services support (including standard care and individualized transition support)



Recommendations/Plans for 2022-23

- Evaluation of addition of two new measures/data points
  - Hospital readmission rate and weekend admission volume
- Focus on school system reentry processes
  - Role of district partners and community/agency partners



Thank you!

- **Learning Network Partners**
  - Cincinnati Public Schools
  - Hamilton City Schools
  - Lakota Local School District
  - Mason City Schools
  - Oak Hills Local School District
  - Best Point
  - Solutions CCRC
  - Central Clinic
  - CCHMC, MindPeace, CSSER and the SBMH