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# Impact of the Blaylock Risk Assessment Screening Score on Inpatient Length of Stay on Inpatient Psychiatric Units Within an Acute Care Hospital

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**Abstract**

**Problem Statement:** Insufficient discharge planning at the time of patient admission can result in increased hospitalization length of stay and poor clinical outcomes, including a rapid deterioration of stabilized patients' mental status while unnecessarily waiting for discharge arrangements to be put in place at the time of discharge. **Purpose:** To determine if completing the Blaylock Risk Assessment Screening Score (BRASS) index tool to identify barriers to discharge at the time of patient admission impacts the length of stay for patients admitted to general psychiatric inpatient units. **Methods:** Patient admission and discharge data collected using the BRASS index within 48 hours of admission and before discharge to identify pertinent risk factors (guided by a score of 10 and above) that may require complex discharge planning to be initiated at the time of admission. **Inclusion Criteria:** All adult inpatients 18 years or older admitted to Holly Hill Hospital's inpatient psychiatric units. **Analysis**: An evaluation and comparison of the BRASS index was used to measure inpatient length of stay before and after BRASS implementation. **Implication for Practice:** Adequate discharge planning will improve continuity of care and accessibility to acutely ill patients in need of services, decrease organizational revenue lost, and limit the amount of extended hospital stays related to discharge barriers for psychiatric inpatients in acute care hospital settings.

*Keywords*: discharge planning, discharge screening tool, mental health, inpatient hospitalization, length of hospitalization, Braylock Risk Assessment Screening Score, BRASS

**Impact of the Blaylock Risk Assessment Screening Score on Inpatient Length of Stay in Inpatient Psychiatric Units within an Acute Care Hospital**

Global mental health systems are characterized by weaknesses and deficiencies (Carbonell et al., 2020). The stigma associated with mental illness contributes to developing policies that address concerns and protect the welfare of people with mental illness (Carbonell et al., 2020). One concern is the impact of insufficient discharge planning on increased length of stays for patients admitted to mental health hospitals (Dymond & Branjerdporn, 2021). Insufficient discharge planning at the time of patient admission can result in increased hospitalization length of stay and poor clinical outcomes, including the deterioration of a stable patient's mental status while unnecessarily waiting for discharge arrangements at the time of discharge (Modas & Nunes, 2019).

Barriers to discharge planning include housing insecurity and lack of available community services, including transportation, access issues related to medicine, follow-up appointments and tests, and dietary needs (Modas & Nunes, 2019; Nilsson et al., 2019; Tyler et al., 2019). To mitigate these barriers, tools identifying barriers to discharge at the time of patient admission is an essential step of the hospitalization process to determine if comprehensive discharge planning is warranted (Becker et al., 2021; Goncalves et al., 2022; Provencher et al., 2020).

## Background

Mental health hospital providers are extending patients' length of stay due to the inability of the patient and hospital staff to secure housing and other resources upon discharge (Dymond & Branjerdporn, 2021). Although there has been considerable economic advancement and growth within the last thirty years, housing insecurity continues to plague the United States (Nilsson et al., 2019). In the United States, on any one night, there are over 600,000 housing-insecure individuals, one-

third sleeping on the street and two-thirds in shelters (Meyer et al., 2022). Issues associated with housing insecurity affecting millions of people include suicide attempts and other psychiatric disorders, especially drug addictions (Nilsson et al., 2019). In addition, premature mortality rates are higher in people experiencing housing insecurity than in other populations, and housing insecurity is associated with more emergency room visits, suicide attempts and other psychiatric disorders, especially drug addictions (Nilsson et al., 2019).

While failure to plan adequately and the inability to secure available post-discharge resources and placement are frequent causes of prolonged hospital stays (Colognes et al., 2022; Modas & Nunes, 2019; Coffey et al., 2019; Goncalves et al., 2022), consequences to patients' wellbeing when discharge planning is delayed is depression, confusion, falls, infections, iatrogenic complications, and increased dependency (Modas & Nunes, 2019). These consequences negatively impact the organizations' ability to deliver cost effective care, enhance profits, and reduce the organization's ability to adequately service a community's mental health needs due to the lack of available beds (Currie et al.,2018; Modas & Nunes, 2019; Tyler et al., 2019).

On the inpatient psychiatric units where the DNP project will take place, it is often seen that the longer the patient remains in the hospital past patient stabilization, the more likely the patient will respond to the stress caused by a delayed discharge in a regressive manner. In an email from the hospital's medical director, the director emphasized how prolonged lengths of stay lead to many problems for patients, the community, and the organization (E. Lopez, personal communication, July 1, 2022). Dr. Lopez mentions that patients tend to regress in closed settings, which furthers their dependence on the hospital (E. Lopez, personal communication, July 1, 2022). In addition, families, guardians, and often outpatient providers unrealistically expect hospitals to keep patients beyond what is clinically necessary (E. Lopez, personal communication, July 1, 2022). Providers must identify, lessen, or mitigate possible and actual risk factors associated with environmental stressors to prevent a

response such as mental decompensation, which can further prolong inpatient length of stay (Gonzalo, 2023).

Building upon the insights gathered from this administrative memo, it became evident that factors beyond the severity of symptoms and diagnosis play a pivotal role in extending the length of stay within acute care hospitals, as discussed by Dymond & Branjerdporn in 2021. These factors, notably the reliability and sustainability of aftercare management for patients once they meet discharge criteria, often lead to reduced accessibility of services for acutely ill patients (Dymond & Branjerdporn, 2021).

Provided with this information, this student was led to formulate the following clinical question: Over two months, what is the impact of employing the Blaylock Risk Assessment Screening Score (BRASS) during patient admission to identify discharge barriers on the length of stay for adults in a general psychiatric mental health inpatient unit compared to the current practice of not utilizing the BRASS tool at admission?

A literature search was conducted using PubMed, CINAHL Complete, Joanna Briggs, Embase, Web of Science, Cochrane, and PsychTEST electronic databases. Key terms used during the search strategy were "discharge planning," "mental health," "inpatient hospitalization," "length of hospitalization," "mental disorders," "predictors," "readmissions," "screening tools," "meta-analysis," and "assertive community treatment team." Articles excluded from the search were articles written over five years ago, screening tools that charged a fee, and studies focused on children and adolescents. Fifty-one articles were selected for review, and 18 articles were chosen for the evidence table. Peer-reviewed articles with levels of evidence III and higher that addressed interventions designed to identify and improve discharge barriers in inpatient mental health patients were selected to add 9 level I, 5 level II, and 4 level III to the evidence table. The primary problem interventions looked to address were preventing extended length of stay, reducing readmissions, improving discharge planning, improving

community support utilization, and identifying methods to improve treatment compliance (see Appendix A).

Discharge planning is an essential multidisciplinary process in most health systems worldwide that aims to improve continuity of care and limit the amount of extended hospital stays related to discharge barriers for inpatients in acute care hospital settings (Coffey et al., 2019; Goncalves et al., 2022; Hegedü et al., 2020). Interventions designed to address patients' care needs before discharge are effective measures of support to assist with an appropriate transition from the hospital back into their community (Colognesi et al., 2021; Goncalves et al., 2022' Hegedü et al., 2020). Common interventions used to improve an identified discharge plan are assessments driven by checklist format, extensive collaboration with multilevel influencers, post-discharge follow-up, and community care involvement (Dickson et al., 2022; Goncalves et al., 2022).

Instruments addressing the patient's ability for self-care, distinct pathologies, and age reduce extended days in the hospital, limiting the impact on their well-being and the associated cost (Modas & Nunes, 2019; Zarovska et al., 2018). Such instruments promote patient-centered and evidence-based care designed to improve the population's health by providing adequate services promptly and decreasing potential barriers (Modas & Nunes, 2019; Provencher et al., 2020; Zarovska et al., 2018).

The Blaylock Risk Assessment Screening Score (BRASS) is an easy and straightforward instrument to identify pertinent risk factors that may require complex discharge planning (Colognes et al., 2022; Zarovska et al., 2018). Blaylock and Cason initially used and validated the BRASS index in 1992 on a group of elderly hospitalized patients in the Netherlands (Zarovska et al., 2018). The tool is practical and used in multiple settings and groups of patients (Colognes et al., 2022; Zarovska et al., 2018). Adding the BRASS assessment tool as part of a discharge planning intervention also increases patient satisfaction (Wulandari et al., 2021).

The assessment tool is an ideal intervention for the project site because it is simple and accurate at identifying patients with a greater risk of experiencing challenges during the discharge process (Colognes et al., 2022; Wulandari et al., 2021; Zarovska et al., 2018). The BRASS tool is reliable and can be used by the nursing staff to help plan for the patient's care while hospitalized and their preparation to return home (Modas & Nunes, 2019; Wulandari et al., 2021). The instrument is widely acknowledged for its broad use, which makes it adaptable for a fast-paced acute care inpatient psychiatric unit (Colognes et al., 2022; Zarovska et al., 2018).

The Neuman Systems Model, developed by nursing theorist Betty Neuman, best supports the proposed project because it explains a person's natural response to a stressful environment (Gonzalo, 2023a). The nursing theory is based on the person's relationship to progressive stress, response, and reconstitution factors (Gonzalo, 2023a). Neuman recognized the client as a system in dynamic constant energy exchange with the environment (Gonzalo, 2023a). The model aims to support the system's stability through nursing interventions to prevent and minimize stress (Gonzalo, 2023a).

Based on information gleaned and administrative support, the purpose of this quality improvement project is to determine if using the Blaylock Risk Assessment Screening Score (BRASS) index tool impacts the length of stay on a general psychiatric inpatient unit by identifying barriers to discharge in the admission phase of patients' hospitalization. The description of employing BRASS using the Plan-Do-Study-Act (PDSA) model follows.

## Methods

The PDSA model guided the groundwork for implementing and assessing the Blaylock Risk Assessment Screening Score. The PDSA Model, a four-stage problem-solving model used for improving a process or carrying out change (Institute for Healthcare Improvement, 2023), aligns with the approach for employing BRASS. The steps include planning to test the change (Plan), implementing the plan (Do),

observing, and evaluating the gathered information (Study), and reflecting on the plan and outcome to determine whether modifications are warranted (Act) (Institute for Healthcare Improvement, 2023).

For the project, the planning phase included clearly defining how the BRASS tool will be used and what it aimed to achieve, determining the data elements to be collected and assembling a multidisciplinary team of health care professionals involved in the discharge process. The Do phase consisted of implementing BRASS, integrating the assessment tool into the existing admission workflow, and training the staff on administering and interpreting the assessments. Data was collected and analyzed during the Study phase, and the outcome was evaluated to assess BRASS's impact. The Act phase included communicating and providing feedback to the team members and stakeholders. By applying the PDSA model to the project, the team systematically introduced and adapted the Blaylock Risk Assessment Screen Score to better identify and address patients requiring complex discharge needs.

**Measure and Tool**

The BRASS examines ten important domains that contribute to prolonged length of hospital stay, such as age, functional status, cognition, social support, mobility, sensory deficits, previous admissions, number of active medical problems, and number of drugs (Colognes et al., 2022; Zarovska et al., 2018). The scores on a scale of 0 to 40 indicate the risk of an extended hospital stay, with a score of 10 or higher signifying a greater need for comprehensive discharge planning (Hodgins et al., 2018). The BRASS scores associated with patients' age, length of hospital stays, and discharge disposition have been examined and determined to be valid, revealing reasonable specificity, although with some concerns regarding its sensitivity (Hodgins et al., 2018).

**Data Monitoring**

The project was submitted to the University of South Carolina Institution Review Board for approval. Participants were selected based on their BRASS assessment score (10 or more) completed

during the admission phase of treatment. The participants were all adult inpatients 18 years or older admitted to the psychiatric units, with emphasis on close attention and monitoring for those whose stay exceeds seven days. The student collaborated with psychiatrists, psychiatric mental health nurse practitioners, psychiatric nurses, discharge planning specialists, social workers, and other support staff, to address the problem and assist with developing and implementing the project. The benefits to the participants were that they received prompt patient-centered care that focused on their individual needs throughout their admission to the hospital and increased their readiness to discharge, minimizing problematic situations.

Data was collected through handwritten assessments by the student, a psychiatric mental health nurse practitioner, who evaluated each patient upon admission and just before discharge. The data collected tracked the admission process, identified patients at an elevated risk for increased stay length (BRASS score of 10 or more), and monitored progress. The project leader collected data from the assessments and stored it in a secured folder on a password-protected laptop, ensuring no patient identifiers were used. The project team leader regularly met with the patient's care team, which consisted of nurses, social workers, therapists, and discharge planners, to ensure proper care planning was implemented.

**Data Analysis**

The student analyzed the collected data using descriptive statistics. The evaluation involved comparing the BRASS index outcomes to measure the lengths of patient stays both pre and post BRASS implementation. To assess the impact of BRASS, the student reviewed reports dating back one year, utilizing financial data from the project site's cost report period ending 12/31/2022 and Medicare IPPS claims data for the federal fiscal year ending 09/30/2023 (AHD.com,2024). This approach was necessitated by the lack of availability of other relevant data, representing a limitation of the study. The length of stay was calculated by the number of days from admission to discharge. The student assessed

the project's success by examining whether BRASS effectively identifies discharge barriers and influenced inpatient stays, as demonstrated by a reduction in extending lengths of stay.

**Cost Analysis**

The financial data from the project site's cost report period ending 12/31/2022 and Medicare IPPS claims data for the federal fiscal year ending 09/30/2023 captured the cost of all patients on all the units, and their average length of stay (AHD.com, 2024). The financial report shows how much revenue the hospital has received and lost. The report highlights the hospital's overall performance and compares it to other hospitals in the geographical area (AHD.com, 2024). Previous reports have shown significant revenue losses, with different studies demonstrating the financial impact of increased hospital stays among medically stabilized patients ready for discharge but facing significant discharge barriers (Currie et al.,2018; Modas & Nunes, 2019; Tyler et al., 2019).

The project's total budget was $1,510, encompassing staff salaries and supplies. With the average daily inpatient stay cost at $1,700, addressing the extended stays of three patients by two days presents an opportunity to reduce lost revenue by $10,200 in a month. Implementing the project carries a potential to generate $8,900 in one month and a cumulative $27,290 over three months. (see Appendix B).

## Results

| Category | Details |
|---|---|
| **BRASS Score Distribution and Patient Qualification** | |
| Total Patients Screened | 50 |
| Patients Qualified (BRASS Score ≥ 10) | 29 (58%) |
| **Length of Stay and Discharge Outcomes** | |
| Patients Discharged as Expected | 22 (76% of qualified) |
| Patients Requiring Additional Time | 7 (24% of qualified) |
| **Factors Influencing Length of Stay** | Complex Medication Regimens<br>Housing Instability |

| | |
|---|---|
| | Behavioral and Cognitive Issues |

**Analysis**

This project assessed the impact of the Braylock Risk Assessment Screening Score (BRASS) on the length of stay in a mental health inpatient hospital. Out of 50 patients screened, 29 (58%) had BRASS scores of 10 or above. No patients with BRASS scores ≤ 9 had delayed discharges. Seven patients (14% of the total, 24% with high BRASS scores) experienced extended hospital stays. Three primary factors contributed to delayed discharges, including:

- **Multiple Admissions and Medication Needs:** Patients with higher BRASS scores often had complex medical and psychological needs, including multiple medications and previous hospital admissions, necessitating detailed discharge planning.
    - Example: A patient with a BRASS score of 11, recurrent severe MDD, PTSD, and alcohol dependence was unhoused and had multiple previous admissions, requiring structured discharge planning.
- **Social Support and Housing:** Lack of social support and stable housing were common among patients with higher BRASS scores, impacting their discharge planning.
    - Example: A patient with a BRASS score of 13, schizoaffective disorder, and alcohol dependence was unhoused, requiring coordinated discharge planning to ensure stability post-discharge.
- **Behavioral and Cognitive Factors:** Patients exhibiting significant behavioral issues and cognitive impairments often required tailored discharge plans to ensure a smooth transition out of the hospital.

- Example: A patient with a BRASS score of 15, severe MDD with psychosis, and opioid use disorder needed comprehensive discharge planning due to multiple behavioral issues and cognitive challenges.

## Discussion

Implementing the Blaylock Risk Assessment Screening Score (BRASS) in a mental health inpatient setting provided significant insights into the factors influencing the length of stay (LOS) and discharge outcomes. In this project, a substantial portion of the population required comprehensive discharge planning. Patients with high BRASS scores experienced extended hospital stays. Of the population, 58% scored ten or more on the assessment, and 24% of these high-scoring patients required additional time beyond the anticipated discharge date, accounting for 14% of the total population, which suggests that BRASS effectively identified patients with complex needs that are at risk for extended lengths of stay allowing for proper discharge planning.

The most common reason for extended hospital stays beyond the anticipated discharge date was additional medication adjustments and stabilization time (n=5). A noticeable trend suggested that the day of admission might contribute to these challenges; patients admitted over the weekend were more likely to experience delayed implementation of their treatment plans. The average hospital stay length for the 29 patients with high BRASS scores during the implementation stage was approximately 6.69 days, calculated by dividing the total number of days (194) by the number of patients (29). The average stay time past the anticipated discharge date for a patient was two days, calculated by dividing the total days past (14) by the number of patients (7). A discernible trend was observed where patients diagnosed with schizoaffective disorder (bipolar type) (n=3) and schizophrenia (disorganized) (n=2) were more likely to stay past their anticipated discharge dates. Additionally, severe forms of major depressive disorder (n=2) and comorbid alcohol use disorder (n=3) were common among those requiring extended care, a trend that was not often seen in patients discharged as anticipated.

The primary factors causing extended hospital stays are complex medication regimens, housing instability, and behavioral/cognitive issues. These issues delay discharge by complicating patient stabilization and discharge planning. Such delays are common in similar settings involving vulnerable populations (Dymond & Branjerdporn, 2021). During the BRASS implementation, the average length of stay was 6.69 days, lower than the 10.65 days reported in 2023 (AHD.com, 2024). However, extended stays still occurred partly due to systemic challenges like weekend admissions. Improving weekend staffing and support services could reduce these delays and optimize discharge processes.

Given the average daily hospitalization cost of $1,700 and an average length of stay of 10.65 days in 2023, extended hospital stays due to discharge obstacles place a significant financial strain on healthcare systems, individual hospitals such as the one where the project took place, and the broader healthcare framework (Currie et al.,2018; Modas & Nunes, 2019; Tyler et al., 2019). For instance, the project site reported a gross patient revenue of $134,974,504 but incurred losses of $13,129,133, representing 9.7% of gross revenue (AHD.com, 2024). Integrating the BRASS tool could help mitigate these expenses by facilitating proactive discharge planning and reducing avoidable hospital stays, thereby alleviating the financial burden on healthcare institutions and improving resource allocation.

Key observations from the project highlight BRASS's effectiveness in identifying high-risk patients. Those with scores of 10 or more often faced complex challenges, including multiple medications, previous admissions, and unstable social situations. Detailed discharge planning for these patients, addressing housing, medication adjustments, and social support, was crucial for predictable discharge dates. The project emphasized the importance of social determinants of health, noting that patients with unstable housing or limited support needed extra resources and time. Attending unit treatment team meetings to collaborate with RNs, UR staff, therapists, social workers and discharge planning specialists facilitated coordination with families, community partners and other caregivers.

Consistent follow-up and collaboration with members involved in the patient's care ensured progress and stable discharges.

Resilience in overcoming barriers was crucial for the project's implementation. Initially, the BRASS assessments were to be focused on a specific unit, included in each patient's chart, and conducted upon admission by clinicians in the admission department or nurses on the unit. However, just weeks before implementation, a major administrative staff change occurred, including the CEO, CFO, and critical nursing and admissions managerial staff. This shift required the project leader to regain stakeholder buy-in from the new administration, which was not prioritizing this project. The new stakeholders hesitated to impose additional tasks on staff they were still learning. These challenges led to restructuring the project, limiting assessments to patients directly under the project leader's care. Another limitation was the reduction of the implementation stage duration from three months to two.

## Conclusion

In conclusion, the Blaylock Risk Assessment Screening Score (BRASS) emerges as an invaluable tool in managing the length of stay and discharge outcomes for patients in mental health inpatient settings. Higher BRASS scores reliably indicated more complex patient needs, prompting effective implementation of comprehensive and coordinated discharge planning strategies to address multifaceted health and social challenges. It became evident that factors such as medication management, behavioral considerations, and addressing social determinants of health played pivotal roles in ensuring safe and timely discharges.

Moreover, using BRASS enabled healthcare teams to implement targeted interventions, leading to tangible improvements in patient outcomes. Nevertheless, as healthcare landscapes evolve, further research endeavors are imperative to refine and validate the BRASS tool. Continued studies are necessary to enhance its predictive accuracy and broaden its utility across diverse clinical settings. By

advancing our understanding and application of BRASS, we can strive towards optimizing patient care delivery and promoting better resource utilization within mental health care systems.

An essential element to ensure sustainability will be implementing ongoing training sessions for staff to maintain familiarity with the BRASS tool and its benefits. Establishing regular feedback sessions with the multidisciplinary team to discuss challenges and improvements is imperative. Integrating BRASS assessments into routine workflow should be highly considered to make it a standard part of admission and discharge planning processes. Securing administrative support and resources for the continuous use of the BRASS tool will be vital for long-term sustainability.

For dissemination, a detailed report and presentation will be prepared for internal stakeholders, including hospital administration and clinical staff, to highlight the project's successes and areas for improvement. Results will be shared at a professional conference, such as International Society of Psychiatric-Mental Health Nurses (ISPN) and published in relevant nursing journals; Journal of clinical epidemiology and The Journal of nervous and mental disease to reach a broader audience. By sharing findings and best practices, the aim is to encourage other organizations to adopt similar approaches, thereby enhancing patient care and discharge planning across the healthcare system.

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**Appendix A**

| **Brief reference (author, date, title) Evidence Level & Quality** | **Design (descriptive, systematic review, observational, etc.)** | **Size, Population, & Setting** | **Purpose, Objective, & Outcome** | **Strengths / Weaknesses** | **Results, Conclusions, or Key Findings (that answer your clinical question)** | **Themes (for synthesis)** |
|---|---|---|---|---|---|---|
| Article 1: Coffey, A. et al., 2019.<br><br>Interventions to Promote Early Discharge and Avoid Inappropriate Hospital (Re)Admission: A Systematic Review<br><br>Evidence Level: I<br><br>Quality: High | Systematic review<br><br>Theoretical Framework: PICOS | Size: Review included 90 papers<br>Population: Patients of all ages Discharged from an acute care hospital setting. Spanning classes of intervention before and after hospital discharge.<br><br>Setting: Discharged from an acute care hospital setting. After hospital. Home, community, residential. | To identify all potential interventions that promoted early discharge and avoided inappropriate readmission to acute hospitals | <u>Strengths:</u><br>All ages were included so that the scope of interventions used for early discharge could be reviewed. Conformed to international best practice guidelines as proposed by the PRISMA group. Papers included provided strong evidence. Assessed by two independent reviewers using the CCAT. Multidisciplinary team from the disciplines of nursing, medicine, and pharmacy conducted a review.<br><br><u>Weaknesses:</u><br>Several studies may have been missed because the search was confined to publications in English.<br><br>Long-term follow-up data are needed to determine if interventions will have a sustained impact on patients being discharged earlier from hospital. | Interventions aimed at delivering pre-discharge patient-centered information may be beneficial.<br><br>Early discharge planning also reduces readmission rates.<br><br>Hospital discharge planning by advanced nurse practitioners influenced reductions in readmissions over longer-term periods, especially when combined with home visits.<br><br>Community-based interventions were associated with lower rates of readmissions. Focus on integrating care from hospital and community care providers. | Length of stay<br>Transition<br>Intervention<br>Delay<br>Discharge |

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| Article 2<br>Connolly, S. M. et al. (2021). Mental health interventions by lay counsellors: a systematic review and meta-analysis.<br><br>Evidence Level: I<br><br>Quality: High | Systematic review and meta-analysis.<br><br>Theoretical Framework: not mentioned | Size: Of the 19 studies, 10 were conducted in Africa and nine in Asia.<br>5612 participants<br><br>Population: Professionally trained lay counselors | To investigate the effectiveness of community-based mental health interventions by professionally trained lay counsellors in low- and middle-income countries. | Strengths:<br>No evidence of publication bias or any other form of bias across the studies, and there were no extreme outliers among the study results.<br>Rigorous. Systematic review and meta-analysis<br><br>Weaknesses:<br>Some authors did not adequately report outcome data or provide a satisfactory description of the lay counselors or their training.<br>Some studies involved few participants and appeared to lack adequate statistical power, whereas others did not adequately describe blinding or masking procedures.<br>The cost–effectiveness of using lay counsellors to provide different interventions will need to be evaluated. | The use of professionally trained lay counsellors to provide mental health interventions in low- and middle-income countries was associated with significant improvements in mental health symptoms across a range of settings.<br><br>Of the 20 trials, 14 found that the intervention by professionally trained lay counsellors had a significant effect: in five, it was a large effect, in six, a medium effect; and in three a small effect.<br>Only six trials found no significant effect.<br>Overall, the interventions had a medium effect. | Lay counselor<br><br>Interventions |
| Article 3:<br>Leong, M. Q. et al. (2021). Comparison of Hospital-at-Home models: A systematic | Systematic review<br><br>Theoretical Framework: none mentioned | Size: 100 relevant primary studies<br><br>Population: Healthcare professionals in | To provide an overview of the safety and effectiveness of Hospital-at-Home (HaH) according to | Strengths<br>Provided a comprehensive overview of the safety and efficacy of Hospital-at- | HaH results in similar or improved clinical outcomes compared with inpatient treatment and | Admission avoidance<br>Hospital at home<br>Early discharge<br>Length of stay |

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| review of reviews.<br>Evidence Level: I<br><br>Quality: High | | patients' homes for acute and post-acute conditions that otherwise would require hospital inpatient care.<br><br>Setting: 100 relevant primary studies<br>UK, US, Australia, Italy, and Spain. | program type (early supported discharge (ESD) vs. admission avoidance (AA)) and identify the model with higher evidence for addressing clinical, length of stay (LOS) and cost outcomes. | Home (HaH) according to program type.<br><br>Compares two major HaH program types to offer relevant recommendations for health systems facing capacity constraints and rising costs.<br><br><u>Weaknesses:</u><br>Strength of evidence for comparison between HaH models is low due to heterogeneity in implementation and patient groups across studies.<br>Lack of registered protocol.<br>Small sample size | warrants greater attention in health systems facing capacity constraints and rising costs.<br>Prioritization of AA models over ESD due to potential benefits in costs and clinical outcomes. | |
| Article 4<br>Becker, C. et al., 2021.<br>Interventions to Improve Communication at Hospital Discharge and Rates of Readmission: A Systematic Review and Meta-analysis.<br><br>Evidence Level: I | Systematic review and meta-analysis of randomized clinical trials.<br><br>Theoretical Framework: not mentioned<br>Preferred Reporting Items for Systematic Reviews and Meta-analyses (PRISMA) reporting guideline | Size: 60 randomized clinical trials with a total of 16 070 patients for the qualitative synthesis and 19 trials with 3953 patients for the quantitative synthesis.<br><br>Population: Inpatients<br><br>Setting: medical hospital | To examine the effect of communication interventions in medical patients at hospital discharge on patient-relevant outcomes.<br>Interested in the association of communication interventions with readmission to hospital, adherence to treatment regimens, and patient knowledge 30 days after discharge. | <u>Strengths:</u> RCTs.<br>Large sample size.<br>Used a comprehensive search strategy.<br>Two authors independently extracted the data.<br><br><u>Weaknesses:</u> only included studies that focused on adult medical inpatients and excluded studies with outpatients, pediatric studies, and studies conducted in an outpatient setting.<br><br>Focused on communication | Found communication interventions at discharge to be associated with fewer hospital readmissions and improvement of treatment adherence and patient satisfaction.<br>Meeting with a pharmacist for medication counseling.<br><br>Patients with chronic conditions, such as respiratory illnesses, experienced the | Communication Intervention<br>Educational Intervention<br>Increase adherence<br>Patient education |

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| Quality: Good | | | | interventions in isolation from each other and did not assess the complexity of a multidisciplinary discharge process, limiting the generalizability of the results.<br><br>Evidence of publication bias for some secondary end points.<br><br>Unable to account for social determinants of health, such as race and ethnicity, educational level, and economic status | most benefit from communication interventions regarding readmission rates. | |
| Article 5: Currie, L. B. et al, 2018. Continuity of Care among People Experiencing Homelessness and Mental Illness: Does Community Follow-up Reduce Rehospitalization?<br><br>Evidence Level: I<br><br>Quality: Good | Two parallel longitudinal randomized controlled trials.<br><br>Logistic regression analysis<br><br>Theoretical Framework: not discussed | Size: 433 participants<br><br>Population: participants were at least 19 years of age. Absolute homelessness and current mental illness<br><br>Setting: Vancouver, British Columbia | To examine whether timely outpatient follow-up after hospital discharge reduces the risk of subsequent rehospitalization among people experiencing homelessness and mental illness.<br><br>Hypothesized that community follow-up within 1 week of hospital discharge would be associated with reduced risk of readmission. | Strengths: Data used in this study offered comprehensive medical records of inpatient and community health care encounters during the 5 years prior to recruitment for most participants.<br><br>Criteria used to assess study eligibility in terms of both homelessness and mental illness were rigorously applied for all participants.<br><br>The study is one of the first to assess continuity of care within a sample of participants experiencing both homelessness and mental illness. | Found no association with early outpatient follow up and readmission in homeless cohort. Findings indicate the importance of addressing home security along with discharge planning.<br><br>Results showed more than half of the eligible sample (53 percent; *n* = 128) were re-hospitalized within 1 year following an index hospital discharge. | Continuity of care<br>Collaborative solutions<br>Mental illness<br>Homeless |

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| | | | | Weaknesses: Limited data; available only for those participants (87 percent) who consented for researchers to receive their administrative health records.<br><br>Limited population: hospital admissions and community care encounters outside of the province were not included in these data.<br><br>Due to the retrospective nature of the study; cannot be certain that each person met criteria for both homelessness and acute mental illness at each time point.<br><br>Limited generalization; by the fact that most of our sample was white and male, receiving service by public health system. | | |
| Article 6: Gonçalves-Bradley, D. C. et al, 2022. Discharge planning from hospital<br><br>Evidence Level: I<br><br>Quality: Good | Systematic Review of Randomized trials that compared an individualized discharge plan with routine discharge that was not tailored to individual participants.<br><br>Theoretical Framework: PICO | Size: 33 trials (12,242) participants.<br><br>Population: All ages. Average age range 60 to 84 years<br><br>Grouped studies by older people with a medical condition, people recovering from surgery, and studies that recruited participants with a mix of conditions. | To find out if discharge planning that is tailored to an individual improves the quality of health care delivered by reducing delayed discharge from hospital, reducing transfer back to hospital and improving patients' health status.<br><br>To know how much the intervention cost. | Strengths: Randomized controlled trials. Most have a low risk of bias. There was consistency among trials recruiting patients with a medical condition for the main outcomes of readmission and length of stay, and a moderate level of certainty for these outcomes.<br><br>Weaknesses: Determining the role of discharge | This review indicates that a personalized discharge plan leads to a small reduction in hospital length of stay and slightly reduces readmission rates for people who were admitted to hospital with a medical condition and may increase patient satisfaction.<br><br>There is little evidence on health status, or the cost of discharge | Discharge planning Length of hospital stay. |

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| | | Setting: inpt hospital; North America (16 trials), Europe (13 trials), Asia (4 trials), South America (1 trial), Oceania (1 trial) | | planning in more complex interventions and selecting studies to include is reliant on the level of reporting in individual studies; this might result in studies being incorrectly categorized as included or excluded. | planning to the health service.<br><br>Participants allocated to discharge planning and who were in hospital for a medical condition had a small reduction in the initial hospital length of stay (MD − 0.73, 95% confidence interval (CI) − 1.33 to − 0.12; 11 trials, 2113 participants; moderate-certainty evidence) | |
| Article 7: Gutwinski, S. et al, (2021). The prevalence of mental disorders among homeless people in high-income countries.<br><br>Evidence Level: I<br><br>Quality: Good | Systematic review and meta-regression analysis<br><br>Theoretical Framework: None mentioned | Size of 39 studies including information from over 8,000<br><br>Population homeless individuals in<br><br>Setting: 11 high income countries. | To guide service development, further research, and public policy, reliable estimates on the prevalence of mental disorders among homeless individuals are needed. | <u>Strengths:</u><br>Findings underscore the importance of mental health problems among homeless individuals.<br><br>Researcher carried out multilevel screening process independently from one another<br><br>Multiple diagnosis reviewed<br>Rigorous research methods.<br><br><u>Weaknesses</u><br>Searched a limited number of databases<br><br>Included studies lacked information on comorbidity.<br><br>Limited the number of demographic variables that | Public health and policy interventions to improve the health of homeless people should consider the pattern and extent of psychiatric morbidity.<br><br>Future research should prioritize quantification of unmet healthcare needs, and how they can be identified and effectively treated. Research on subgroups, including younger people and immigrant populations, is a priority for prevalence work.<br><br>Fragmented and siloed services will therefore be typically unable to address these linked psychosocial and health problems | Homeless Mental Health |

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| | | | | conducted heterogeneity analyses on. | | |
| Article 8:<br>Provencher, V. et at, (2020). Supporting at-risk older adults transitioning from hospital to home:<br><br>Evidence Level: I<br><br>Quality: Good | Post-hoc analysis from a randomized trial<br>Theoretical Framework: PICOs | Size 400<br><br>Population: hospitalized older (avg 80y) patients with acute and medical conditions, recruited through 5 sites in Setting: Australia | Examined whether subgroups of "at-risk" older patients benefit more than their counterparts from an evidence-based discharge planning intervention, on the following outcomes: (1) independence in ADL, (2) participation in life roles, (3) unplanned rehospitalizations, and (4) ED presentations. | <u>Strengths:</u><br>Rigorous research.<br>Multiple databases.<br><br><u>Weaknesses:</u><br>small sample numbers represented in subgroups; significant interactions may have been underestimated<br><br>Sample does not include older adults who required assistance for mobility or those with moderate or severe cognitive impairment<br><br>Did not capture the full effect of the HOME intervention, even though it is clinically important to assess whether its effects are maintained over time. | Hospitalized older adults with mild cognitive impairment benefit from the HOME intervention, which involves preparation and post-discharge support in the environment, to reduce unplanned rehospitalizations.<br><br>Improved discharge outcomes in this at-risk subgroup following an occupational therapist-led intervention may enable best care delivery as patients transition from hospital to home. | HOME<br>Intervention<br>Geriatric<br>Rehospitalization |
| Article 9<br>Gallinat, C. et al, 2021. Feasibility of an Intervention Delivered via Mobile Phone and | A 2-arm Randomized Controlled Pilot Study.<br>An intervention group (treatment as usual plus HEINS) | Size: 25 randomized patients | The authors developed the internet-based and mobile | <u>Strengths:</u><br>Randomized<br>Only three participants in the control group and none in the intervention group | Results indicate that the digital program might be suitable to provide support following discharge from intensive care. | Schizophrenia<br>Digital<br>Prevention<br>Aftercare<br>Continuity of care,<br>Relapse |

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| Internet to Improve the Continuity of Care in Schizophrenia: A Randomized Controlled Pilot Study.<br><br>Evidence Level: II<br><br>Quality: Low | and a control group (treatment as usual)<br><br>Theoretical Framework: not mentioned | Population: Primary diagnosis of schizophrenia spectrum disorder. Minimum age of 18<br>16 women (64.0%) and 9 men (36.0%).<br><br>Setting: Completed inpatient treatment at the hospital for General Psychiatry at the University Hospital Heidelberg. | intervention "HEINS" to enhance the continuity of care for individuals with schizophrenia spectrum disorders following inpatient psychiatric treatment.<br><br>Pilot study was conducted in order to investigate patients' willingness to participate, their attitudes towards digital intervention, user satisfaction, and program utilization as well as the feasibility of study procedures. | were re-hospitalized during the study period. It provides insights and may inform other researchers about potential challenges in conducting such a study and helps to minimize publication bias.<br><br><u>Weaknesses:</u><br>Small sample size. Most patients could not be invited to participate because of the criteria regarding technical requirements short observation period of six months | Overall positive attitudes towards the program, high user satisfaction and good adherence to the monitoring module.<br><br>Provides insights into specific barriers to recruitment which may inform future research in the field of digital interventions for severe mental illness. | |
| Article 10: Hegedüs, A. et al, 2020. Effectiveness of Transitional Interventions in Improving Patient Outcomes and Service Use After Discharge from Psychiatric Inpatient Care: A Systematic Review and Meta-Analysis.<br><br>Evidence Level: II<br><br>Quality: Low | A Systematic Review and Meta-Analysis of RCT, quasi-experimental and cohort studies Theoretical Framework | Size:16 studies (10 RCT, three quasi-experimental, three cohort)<br><br>Population: 18-65years Psychiatric diagnosis,<br><br>Setting: discharged from a psychiatric inpatient unit. | Aim to assess the effectiveness of transitional interventions with pre-discharge and post-discharge components in reducing readmissions and improving health-related or social outcomes of patients discharged from psychiatric hospitals. | <u>Strengths:</u><br>Variety of interventions were studied. Rigorous search methods in multiple databases. Highlight the value of pragmatic study design.<br><br><u>Weaknesses</u><br>Additional high-quality research is needed. Limited available studies. Quantitative meta-analysis was not performed. Small sample size | Collaborative care interventions, transition managers, and timely communication between inpt staff and output service providers are crucial bridging components of discharge interventions. Transitional interventions with bridging components; patient-specific group, psychoeducation was no more effective in reducing readmission than treatment as usual; however, based on limited evidence | Interventions Components Readmission |

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| Article 11: Colognesi, S., et al, (2021). Hospital discharge: testing the "Blaylock Risk Assessment Screening Score" in a surgical department. Evidence Level: III Quality High | A prospective observational study<br><br>Theoretical Framework: none list | Size: 428 patients<br><br>Population: hospitalized patients.<br><br>Setting: surgical department of Vimercate hospital. | Standardizing patients' assessment to identify individuals at greater risk in encountering difficulties at discharge. | Strength:<br><br>Large sample size.<br><br>Weakness: inclusion of other patient-specific factors in the assessment process could be valuable for targeting the at-risk population | Found a high specificity for BRASS in identifying patients discharged to their home with assistance or to residential care. | Discharge planning.<br><br>Validation-study<br><br>BRASS indeX |
| Article 12: Forchuk, C. et al, (2021). Transitional discharge model for community mental health integration: A focused ethnographic study of clients' perspectives.<br><br>Evidence Level: III<br><br>Quality: High | A focused ethnographic study of clients' perspectives.<br><br>Theoretical Framework: Transitional Discharge Model | Size: 87<br>Population: clients with mental illness seeking care from nine hospitals across the<br><br>Setting: Province of Ontario, Canada.<br>The average age of clients for both focus groups was 44.2 years. Males and females were equally represented in both groups. Most clients were of Caucasian descent | To evaluate clients' perceptions of benefits and potential adjustments to the implementation of a transitional discharge model (TDM), an intervention that offers clients with psychiatric illness continuous support during the transition from the hospital to the community | Strengths:<br>Contribute insights that may assist healthcare professionals in early discharge planning towards community integration and strategies for improving the client transition from hospital to the community. Study used mixed methods to collect data on the implementation across nine sites over one year.<br><br>Weaknesses<br>Small sample size. | Clients who participated in the TDM reported that the intervention promoted their health outcomes.<br><br>The intervention contributed to clients' reassurance about transitioning from hospitalization to community, reduced feelings of isolation, and enhanced continuity of care and recovery. | Transitional Discharge model Clients |
| Article 13: Luchenski, S. A. et al, (2022). Hospital-based preventative interventions for people experiencing homelessness in high-income countries: A systematic review.<br><br>Evidence Level: III | A systematic review of experimental, quasi-experimental, and observational<br><br>Theoretical Framework: PICOs | Size 28 studies<br><br>Population: People experiencing homelessness over age 18.<br><br>Setting: Any preventative interventions delivered in an acute hospital setting, including inpatient wards, mental health | To describe preventative interventions, defined in their broadest sense, for people experiencing homelessness in a hospital context.<br><br>Secondary aims included mapping outcomes and assessing intervention effectiveness. | Strengths:<br>broad and inclusive nature of the review topic, comprehensive search strategy in electronic databases, and use of two reviewers for assessing full-text articles<br><br>Weaknesses<br>inclusion criteria, synthesis methods, and quality of the underlying studies | Hospital-based preventative interventions for people experiencing homelessness are potentially beneficial, but more rigorous research is needed.<br><br>Policymakers and healthcare providers may wish to consider implementing and evaluating | Homeless Intervention |

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| Quality: High | | hospitals, and EDs | | | preventative interventions | |
| Article 14. Zarovska, A., et al, (2018). Development and validation of a simplified BRASS index to screen hospital patients needing personalized discharge planning.<br><br>Evidence Level: III<br>Quality High | Prospective cohort study<br><br>Theoretical Framework: none mentioned | Size: 6044 patients in the first phase. Validation set: 3325 patients.<br><br>Population: Patients admitted at the general internal medicine wards of tertiary referral hospital in Turin, Italy, and screened within 48 h using the BRASS index | Evaluate the ability of the original BRASS index to predict the risk of complex discharge and hospital mortality.<br><br>Develop and validate a simplified BRASS index by eliminating redundant variables and re-estimating the predictor weights. | <u>Strengths: developed and validated a new simplified version of the index tool. Large sample size.</u><br><br><u>Weakness: cannot be routinely</u> adopted as a predictive risk score, it must first be proven to be clinically effective to provide useful additional information to health care providers to inform outcomes. | The new, simplified BRASS index showed a slightly better performance in predicting the risk of complex discharge and hospital mortality than<br><br>the original tool and takes less time to be applied. | BRASS index<br><br>Assessment<br><br>Discharge planning |
| Article 15: Dickson, K. et al, (2022). Characterization of multilevel influences of mental health care transitions: a comparative case study analysis.<br><br>Evidence Level: III<br><br>Quality: Good | A comparative case study analysis.<br><br>Theoretical Framework: Behavioral Health Service Use Model | Size: 37 published studies that provide supportive or alternative perspectives on how care transition-relevant domains were characterized as of the participant-facilitated discussion<br><br>Population: Mental health care across child, non-VA adult, and adult<br><br>Setting: VA service system and non-VA. | To characterize multilevel influences of mental health care transitions across three United States-based mental health system contexts. | <u>Strengths:</u><br>Multiple case studies reviewed<br>Rigorous research<br><br><u>Weaknesses</u><br>Non-systematic review of the literature<br><br>Additional care transition factors exist but are not represented or disseminated.<br><br>Did not characterize or compare the outcomes associated with the examined care transition factors. | Finding inform key considerations and recommendations for ongoing and future efforts aiming to plan, expand, and better support mental health care transitions. These include timely information sharing, enhanced care coordination and cross setting and provider communication, continued provider/client education, and appropriate tailoring of services to improve mental health care transitions. | Care transition<br>Multilevel<br>Influence |

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| Article 16: Hamline, M. Y. Et al, (2018). Hospital-to-Home Interventions, Use, and Satisfaction: A Meta-analysis<br><br>Evidence Level: III<br><br>Quality: Good | A Meta-analysis<br><br>Theoretical Framework: non mentioned | Size: 87 studies<br><br>Setting Inpatient hospital settings<br><br>Population: Focused on patients under 18 years.<br>A hospital discharge process intervention that was implemented in the inpatient setting and (2) outcomes related to subsequent health care use or patient and family satisfaction with care received. | To determine which pediatric hospital discharge interventions, affect subsequent health care use or parental satisfaction compared with usual care. | <u>Strengths:</u><br>Concise, easy to follow.<br><br>Multiple database search<br><br>Excluded review articles, case studies, or commentaries<br><br><u>Weaknesses</u><br>Variability limited findings and reduced generalizabilit | Highlight the utility of a pediatric discharge bundle in reducing health care use. Study affirms coordinating follow-up, discharge planning, teach back–based parental education, and contingency planning are potential foci for future efforts to improve hospital-to-home transitions. | Continuity of transition care<br>Discharge planning<br>Coordinating Care |
| Article 17.<br><br>Modas DA, Nunes EM. (2019). Instruments for evaluation of the risk of prolongation of hospitalization.<br><br>Evidence Level: III<br>Quality Good | Literature review.<br><br>Theoretical Framework: population - concept - context (PCC) | Size: 7 articles were selected for analysis. | To map the existence of instruments for evaluation of the risk of prolonged hospitalization time with hospital discharge delay of the patient. | <u>Strength:</u> Investing in a preventive methodology of this issue led to care improvement, providing good health care to the population, in a timely manner, minimizing problematic situations.<br><br>Weakness: The research protocol established, with the presented descriptors, led to a set of results that can delimit the research field, suppressing some studies relevant to the analysis. | The risk of prolonged hospitalization time with hospital discharge delay can be evaluated using 4 types of instruments: cognitive, age, mobility, social support. | Risk assessments.<br>Length of stay.<br><br>Discharge |
| Article 18: Tyler, N., Wright, N., & Waring, J. (2019). Interventions to improve discharge from acute adult mental health inpatient care to the community<br>Evidence Level: III<br><br>Quality Good | Systematic review and narrative synthesis.<br><br>Theoretical Framework: none mentioned. | Size: 45 studies included<br><br>Population: Adults<br><br>Setting: admitted to an acute inpatient mental health ward. | To identify the evidence base for interventions to support continuity of care and safety in the transition from acute mental health inpatient to community services at the point of discharge. | <u>Strengths:</u><br>Multiple databases researched.<br>Followed PRISMA guidelines<br>Medical and social databases used.<br>Considerable number of articles researched.<br>Adequate number of studies used. | Some evidence shows that the Transitional Discharge Model reduced readmission and facilitated earlier discharge.<br>The review found various interventions implemented across continents addressing problems related | Transitional Discharge Model<br>Peer support<br>Role-based interventions |

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| | | Health interventions relating to discharge from the acute ward to the community.<br><br>(Higher income) United States of America, UK, Canada, Australia, (Lower income) Iran and China | | <u>Weaknesses</u><br>studies were heterogeneous; difficult to conduct comparative quantitative meta-analysis or synthesis.<br><br>Outcomes reported are broad, and the aim of the studies varied.<br><br>Review did not highlight sub-acute service models such as step-up or step-down services. | to various aspects of discharge. Some interventions followed a distinctly named approach (i.e., Critical Time Intervention, Transitional Discharge Model), others were grouped based on key components (i.e., peer support, pharmacist involvement). The primary problems interventions looked to address were reducing readmission, improving wellbeing, reducing homelessness. | |

## Appendix B: Budget

| **Salaries/Wages** | **Monthly** | **Total** | | |
|---|---|---|---|---|
| **RNs/PMHNPs** | **$250** | **$500** | | |
| **Support staff** | **$100** | **$200** | | |
| **Travel/food** | **$100** | **$300** | | |
| **Total salary/wages Costs** | **$450** | **$1000** | | |

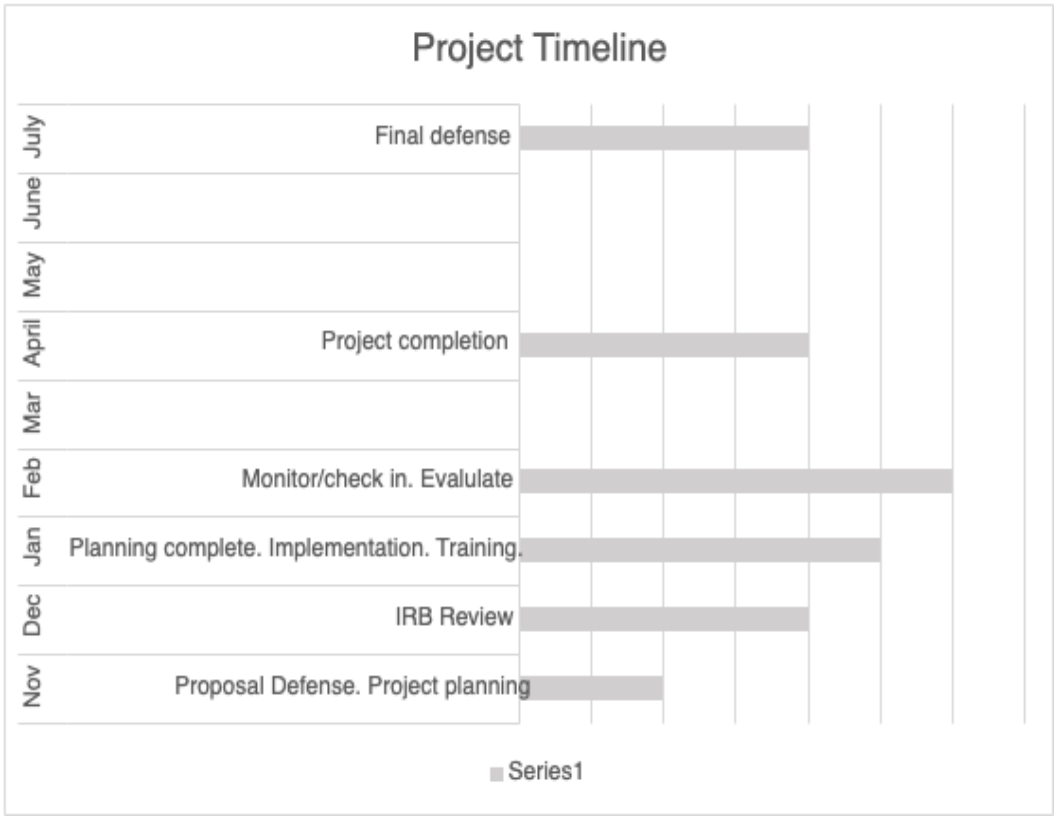
| **Startup Cost** | **Monthly** | **Total** | | |
|---|---|---|---|---|
| **Office Supplies: copies, pens, paper** | **$200** | **$400** | | |
| **Software** | | **$110** | | |
| **Total** | **$200** | **$510** | | |

| **Total Project Expenses** | **Monthly** | **Total** |
|---|---|---|
| | **$650** | **$1510** |

| **Revenue Generation** | **Monthly** | **3 Months** | **Annual** | | |
|---|---|---|---|---|---|
| **Potential savings by decreasing LOS x 2 days** | **$9,600** | **$28,800** | **$115,200** | | |

| | **Monthly** | **3 Months Total** | | |
|---|---|---|---|---|
| **Total Potential Project Revenue** | **$9,600** | **$28,800** | | |
| **Less Expenses** | **$650** | **$1510** | | |
| **Total Program Benefit** | **$8,950** | **$27,290** | | |

## Appendix C: Timeline




**Appendix D: Data Table**

| Admit Date | BRASS Screen Date | BRASS Score | Diagnosis | Anticipated Discharge Date | Actual Discharge Date | Notes | Qualifiers |
|---|---|---|---|---|---|---|---|
| 2/21/24 | 2/22/24 | 9 | MDD, rec mild w psych feat | 2/28/24 | 2/28/24 | Did not qualify | |
| 2/21/24 | 2/22/24 | 8 | BPD, MRE manic w psych | 2/28/24 | 2/28/24 | Did not qualify | |
| 2/21/24 | 2/22/24 | 5 | MDD, single epis, mild | 2/28/24 | 2/28/24 | Did not qualify | |
| 2/21/24 | 2/22/24 | 10 | MDD, severe w/ psych | 2/28/24 | 2/28/24 | Dc as expected | Age Mult medications, behavior, cognition |
| 2/21/24 | 2/22/24 | 11 | MDD, recur,sev PTSD, alcohol dep | 2/28/24 | 2/28/24 | Dc as expected | Mult medications, mult admis, unhoused |
| 2/24/24 | 2/25/24 | 10 | MDD,rec, sev Alcohol dep, uncomp, | 3/2/24 | 3/2/24 | Dc as expected. | mult admis, unhoused, age, behavior |
| 2/24/24 | 2/24/24 | 13 | Schizo-affect, bipo type, Alcohol dep, uncomp, Opioid use disorder | 3/2/24 | 3/2/24 | Dc as expected. | Behavior, limited support, mult meds, mult problems. |
| 2/24/24 | 2/24/24 | 6 | MDD, recurrent | 3/2/24 | 3/2/24 | Did not qualify | |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 3/5/24 | 3/5/24 | 16 | Schizo-affect, bipo type, Alcohol dep, uncomp | 3/11/24 | 3/11/24 | Dc as expected | Age, Mult medications, behaviors, mult problems, < social sup |
| 3/5/24 | 3/5/24 | 9 | MDD, recurrent | 3/11/24 | 3/11/24 | Did not qualify | |
| 3/5/24 | 3/5/24 | 7 | BD, MRE manic w psych | 3/11/24 | 3/11/24 | Did not qualify | |
| 3/5/24 | 3/5/24 | 11 | Schizophrenia, disorg | 3/12/24 | 3/15/24 | Additional time needed for medication adj stabilization | Behavior, mult med, cognition, mult adm, |
| 3/5/24 | 3/5/24 | 4 | MDD, recurrent | 3/12/24 | 3/12/24 | Did not qualify | |
| 3/7/24 | 3/8/24 | 10 | MDD, recurrent, alcohol dep | 3/14/24 | 3/14/24 | Dc as expected | Mult adm, unhoused, behav, limited soc sup. |
| 3/7/24 | 3/8/24 | 15 | Schizoaffect, BP type. | 3/14/24 | 3/15/24 | Medication adjustment | Mult adm, unhoused, behav, limited soc sup, cognition |
| 3/7/24 | 3/8/24 | 5 | Schizoaffec,dep type. | 3/14/24 | 3/14/24 | Did not qualify | |
| 3/12/24 | 3/12/24 | 9 | Opioid-induced psych dis. | 3/19/24 | 3/19/24 | Did not qualify | |

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|---|---|---|---|---|---|---|---|
| 3/12/24 | 3/12/24 | 13 | Schizoaffe c,dep type | 3/19/24 | 3/19/24 | Dc as expected | Age, Mult medications, mult problems, < social sup |
| 3/12/24 | 3/12/24 | 5 | MDD, recurrent | 3/19/24 | 3/19/24 | Did not qualify | |
| 3/16/24 | 3/16/24 | 14 | recurrent, severe, alcohol dep, unc, stimulant use d/o | 3/23/24 | 3/23/24 | Dc as expected | Mult medications, behaviors, mult problems, < social sup, cognition |
| 3/16/24 | 3/16/24 | 11 | MDD, rec, sev, Alcohol dep, uncomp | 3/23/24 | 3/24/24 | Awaiting approv into sober living house | Mult medications, behaviors, mult problems, unhoused |
| 3/16/24 | 3/16/24 | 15 | Schizoaffe ct, BP type | 3/23/24 | 3/28/24 | Patient required placement | Mult medications, behaviors, mult problems, unhoused, funx status |
| 3/16/24 | 3/17/24 | 19 | SzA BP type, alcohol, stimulant | 3/23/24 | 3/23/24 | Dc to shelter | Age, mult medications, behaviors, mult problems, unhoused |
| 3/17/24 | 3/17/24 | 9 | MDD, recurrent | 3/24/24 | 3/24/24 | Did not qualify | |
| 3/17/24 | 3/17/24 | 11 | MDD, rec, mod, PTSD, | 3/24/24 | 3/24/24 | Dc as expected | Mult medications, behavior, |

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|---|---|---|---|---|---|---|---|
| | | | cannabis use d/o | | | | cognition, < social sup |
| 3/17/24 | 3/17/24 | 3 | MDD, sing,mild | 3/24/24 | 3/24/24 | Did not qualify | |
| 3/25/24 | 3/26/24 | 14 | MDD, severe w/ psych | 4/2/2024 | 4/2/2024 | Dc as expected | Mult medications, behavior, cognition, limited social sup |
| 3/25/24 | 3/26/24 | 7 | Alcohol dep, uncomp | 4/2/2024 | 4/2/2024 | Did not qualify | |
| 3/25/24 | 3/26/24 | 13 | MDD, rec, sev w psych, Alcohol dep, uncomp, | 4/2/2024 | 4/2/2024 | Dc as expected. | Mult medications, behaviors, mult problems, unhoused |
| 4/2/24 | 4/3/24 | 11 | Schizoaffect, BP type | 4/9/24 | 4/9/24 | Dc as expected | Mobility, sensory def, behaviors, mult problems |
| 4/2/24 | 4/3/24 | 12 | Alcohol use d/o, uncom, PTSD, cannibis use d/o | 4/9/24 | 4/9/24 | Dc as expected | Mult medications, behaviors, mult problems, < soc support |
| 4/2/24 | 4/3/24 | 12 | GAD | 4/9/2024 | 4/7/2024 | Dc earlier than expected | Mult medications, behaviors, multiple adm, lim soc support |

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|---|---|---|---|---|---|---|---|
| 4/6/2024 | 4/6/2024 | 20 | Schizoaffect, BP type | 4/13/24 | 4/14/24 | Required additional time for medication stabilization | Mult medications, behaviors, mult problems, < soc support |
| 4/6/2024 | 4/6/2024 | 15 | MDD, severe w/ psych, opioid use d/o | 4/13/24 | 4/13/24 | Dc as expected | Mult medications, behaviors, multiple adm, < soc support, mobility |
| 4/6/2024 | 4/6/2024 | 9 | MDD, rec, sev, w/o psych | 4/13/24 | 4/13/24 | Did not qualify | |
| 4/6/2024 | 4/6/2024 | 8 | MDD, rec, mod. Alcohol dep, uncom | 4/13/24 | 4/13/24 | Did not qualify | |
| 4/9/24 | 4/9/24 | 14 | BD, MRE manic w psych | 4/16/24 | 4/16/2024 | Dc as expected | Mult medications, behaviors, multiple adm, < soc support, |
| 4/9/24 | 4/9/24 | 7 | Alcohol dep, uncomp | 4/16/24 | 4/16/24 | Did not qualify | |
| 4/9/24 | 4/9/24 | 15 | MDD, rec, sev, w/ psych, Borderline PD, alcohol use d/o | 4/16/24 | 4/17/24 | Medication adjustment. | Mult medications, behaviors, multiple adm, < soc support, cognition |
| 4/9/24 | 4/9/24 | 7 | MDD, rec, mod | 4/16/24 | 4/16/24 | Did not qualify | |

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|---|---|---|---|---|---|---|---|
| 4/9/24 | 4/9/24 | 11 | BP, MRE dep, PTSD, alcohol use d/o, uncomp | 4/16/24 | 4/16/24 | Dc as expected | Mult medications, behaviors, multiple adm, limited soc support, function status |
| 4/16/23 | 4/17/24 | 9 | MDD, rec, mod | 4/23/24 | 4/23/24 | Did not qualify | |
| 4/16/23 | 4/17/24 | 9 | MDD, rec, mod | 4/23/24 | 4/23/24 | Did not qualify | |
| 4/16/23 | 4/17/24 | 15 | Schizoaffect, BP type | 4/23/24 | 4/23/24 | Dc as expected | Mult adm, mult problems, multi meds, limited support, behaviors, unhoused |
| 4/16/23 | 4/17/24 | 11 | Schizoaffect, BP type, stimulant use disorder, opioid use d/o | 4/23/24 | 4/23/24 | Dc as expected | Mult adm, mult problems, multi meds, limited support, behaviors, |
| 4/19/24 | 4/19/24 | 18 | Schizoaffect, BP type, alcohol use d/o | 4/26/24 | 4/28/24 | Additional medication adjustment. | Mult adm, mult problems, multi meds, limited support, behaviors, functional status, mobilty |

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| 4/19/24 | 4/19/24 | 10 | MDD, severe w/ psych | 4/26/24 | 4/26/24 | Dc as expected | Mult adm, mult meds, behaviors, funx status. |
| 4/19/24 | 4/19/24 | 7 | Schizophrenia, disorg | 4/26/24 | 4/26/24 | Did not qualify | |
| 4/19/24 | 4/19/24 | 11 | Schizo, disorg, cocaine use d/o | 4/26/24 | 4/27/24 | Placement | Mult adm, mult problems, multi meds, limited support, behaviors, functional status, |
| 4/19/24 | 4/19/24 | 9 | BD, MRE manic, Alcohol use d/o | 4/26/24 | 4/26/24 | Did not qualify | |