Discharge Planning

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Definitions

Discharge planning
- Begins at intake
- Therapeutic process
- Goal setting
- Future oriented recovery process

Discharge Plan
- Consumer’s plan
- Written plan
- Resource for their recovery

Discharge Summary
- Part of clinical record
- Summary of treatment episode
- Shared with receiving providers
Why is discharge planning important?

Aids in treatment planning and establishing rapport
To meet insurance and contract requirements
Ethical practice
  • Document what is being done to move forward in recovery in the least restrictive, most cost effective way possible
  • Having an accurate record - waiting too long or missing documentation means the work done is unsubstantiated and cannot be relied upon for future reference
Decreases chances of readmission to higher level of care and informs future treatment providers
Promotes recovery: Future focus when planning begins upon admission
Discharge planning provides for physical safety

1. Written information helps as discharge can be an emotionally charged time, especially for parents

2. Immediate, hands-on information for line staff (in the case of stepping up to higher level of care), no need to wait for opening of new chart

3. Provides caregiver awareness of issues to watch for during sessions or first hours of adjustment (in the case of admission to higher level of care): i.e. self-harm, run risk, suicide, danger to others

4. Safety plan: potential triggers, successful calming techniques

5. Next provider can immediately meet specific needs of each client at new placement
Basics of the discharge process

Evaluation
• By qualified personnel at beginning of admission process
• Should be written in the consumer’s words, as much as possible

Discussion
• Requires participation of treatment team and active involvement of the member’s family and/or social supports
• What has been their level of participation?
• Education on diagnosis

Planning
• Placement: Return to home and what will that look like without regular therapy sessions, or to another care facility

Determining
• Is caregiver training or other support needed?
• Why are they discharging? i.e. Not showing up? Needs a different level of care or specific modality? Did not feel a rapport? Maybe they were simply not ready to begin processing?
Referrals

- Appropriate support organizations in the community
- Community Resources – Medicaid therapy reimbursements are based on medical necessity, not as support or maintenance service or court order. Once consumer has reached a baseline status, community resources are the appropriate level of service. (i.e. NAMI, USARA, Alliance House, AA, etc.)

Formal Discharge Session

- Arranging follow-up appointments ensures better post-discharge care
- Provides an action plan to continue services, treatment and care without interruption.
Discharge planning during treatment

<table>
<thead>
<tr>
<th>Anticipated discharge date</th>
<th>Next level of care and rationale for referral</th>
<th>Identification of stable social supports</th>
<th>Update as treatment progresses</th>
<th>Evidence of team approach</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Select a target range and modify, if needed</td>
<td>• Step up or down from current LOC</td>
<td>Examples</td>
<td>• Ongoing process</td>
<td>• Client</td>
</tr>
<tr>
<td>• Allows for visualization of life without regularly anticipated therapy sessions</td>
<td>• Needs a different modality than can currently be provided</td>
<td>• Church</td>
<td>• Allows for check-in and enabling consumer’s voice to be heard</td>
<td>• Family/Guardian</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Friends</td>
<td></td>
<td>• PO</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Family</td>
<td></td>
<td>• Case Worker</td>
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<td></td>
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<td>• Co-Workers</td>
<td></td>
<td>• Agency</td>
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<tr>
<td></td>
<td></td>
<td>• Sponsor</td>
<td></td>
<td>• Treatment Team</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Scouts</td>
<td></td>
<td>• Supervising Practitioner</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Athletic teams</td>
<td></td>
<td>• Others</td>
</tr>
</tbody>
</table>
## Discharge plan at the time of discharge

<table>
<thead>
<tr>
<th>First follow-up appointment details</th>
<th>Links to peer support and other community services</th>
<th>Plan for communication with receiving provider</th>
<th>Written Instructions</th>
<th>Evidence of client participation</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Time</td>
<td>• Certified Peer Support Specialist</td>
<td>• Written discharge summary template</td>
<td>• Especially important when a client discharges home from inpatient or residential</td>
<td>• Validates rapport and therapeutic process</td>
</tr>
<tr>
<td>• Date</td>
<td>• School</td>
<td>• Phone call during last session</td>
<td>• Community crisis services (i.e. MCOT or Hopeful Beginnings)</td>
<td>• Promotes realistic and attainable goals</td>
</tr>
<tr>
<td>• Provider phone number</td>
<td>• Spiritual</td>
<td></td>
<td></td>
<td>• Future-oriented focus</td>
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<tr>
<td>• Provider address</td>
<td>• PCP</td>
<td></td>
<td></td>
<td>• Recovery Model</td>
</tr>
<tr>
<td></td>
<td>• Specialists</td>
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</tr>
<tr>
<td></td>
<td>• Scouts</td>
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<td>• Church</td>
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<td>• Others</td>
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</tbody>
</table>
Example discharge plan/info sheet

**DC Placement**

- **Name**: Address Phone #

**Medication**

- **Prescriber**: Rx dosages and frequency Possible side effects

**Safety**

- **Crisis Management**
  - Coping skills
  - Potential triggers
  - Crisis contacts
  - Social supports

**Follow-up Care**

- **Collaboration**
  - Community resources
  - NAMI, AA, Alliance House
  - Educational needs
  - Maintenance: Strengths/Abilities Successful coping techniques

**Who Participated**

- **Sign & Date**
  - Discharging Provider Parent/Guardian Client

![Image of two individuals in a conversation]
Personal Experience

**Review the discharge plan with all involved parties**
I was more likely to follow through if others were aware and able to prompt me to hold myself accountable i.e. physical wellness

**Treatment plan reviews are useful for more than just documentation**
Great time to help the consumer identify strengths as well as their hopes, dreams, passions and goals; Builds confidence and helps with preparation for transition

**Collaboration and Identification**
Warm hand-off; Strengths, weaknesses and triggers specifically identified by the consumer to pass along to the next provider

**Be aware of how transitions effect the consumer and validate**
Recovery is a process that ebbs and flows; Discharge is only a step, it is not the end
DC Summary considerations

At the time of discharge, a summary will be prepared in the EHR that includes the current diagnosis, the extent to which the treatment plan Goal, Objectives and Methods were achieved, services provided, reason for discharge or referral and recommendation for additional services.

Source: Optum Salt Lake County Provider Manual 2016

View of treatment episode

• Robust and at-a-glance
• Allows for continuity of care should the client need to return to services
• Include documentation of any education provided

Treatment goal progress

• Consider what has been most helpful to you, as a provider, when you have an intake, and provide that information for the next caregiver… even if it is a theoretical caregiver.
Requirements

Collaboration with the consumer, consumer's family, referred agencies and resources

Updated diagnosis

OQ/Y-OQ: Intake, every 30 days thereafter, and at discharge
  • Enter questionnaire into OQ Analyst
  • OQ/Y-OQ mandate for mental health treatment providers only

MHER – Intake and update every 90 days thereafter
  • Must be updated in Provider Connect (PCONN)

Source: Optum Salt Lake County Provider Manual 2016
Timeline requirements

Mental health

• Discharged and case closed in EHR no later than 90 days after the last contact for non SPMI clients
• Discharged and case closed in EHR no later than 180 days for all SPMI clients from date of last contact
• Discharge and case closed no later than 180 days from last contact if non SPMI client receives medication management only

Source: Optum Salt Lake County Provider Manual 2016
~In taking care to write up a detailed narrative of the treatment episode, you honor the work you’ve done and you allow yourself to process your experience - which is just as valid as your client’s.
We’re in this together

Optum SLCo Clinical Team
877-370-8953 Prompt #3

Optum SLCo Recovery & Resiliency Team
877-370-8953 Prompt #2

JRC (Juvenile Receiving Ctr)
385-468-4470

UNI Receiving Center
801-587-7988

UNI Crisis Line
801-587-3000
Warm Line (CPSS)
Crisis Team
MCOT (Mobile Crisis Outreach Team)
Hopeful Beginnings Crisis Team for Youth
801-216-3193