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Clinical skills training: Discharge planning

November 2023

Agenda

1. Welcome and introductions
2. Discharge planning process
3. Collaboration and coordination of care
4. Quality audit and documentation requirements
5. A peer perspective on discharge planning

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Discharge planning process

Definitions

Discharge planning

- Begins at intake at all levels of care
- Is part of the therapeutic process
- Involves goal setting
- Is future oriented and part of the recovery process

Discharge Plan

- Developed with input from the individual and others involved in care
- Provides information that may be needed for the days following treatment
- Is easily understood, even for individuals with limited literacy

Discharge Summary

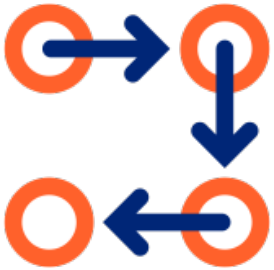
- Part of clinical record
- Summary of treatment episode
- Shared with receiving/aftercare providers

What is discharge planning?

Discharge planning is a process that is ongoing, not a fixed element, and remains a process until the time of discharge.

The process of discharge planning includes the following:

- Early identification and assessment of individuals requiring assistance with planning for discharge;
- Collaborating with the individual, family, and health-care team to facilitate planning for discharge;
- Recommending options for the continuing care.



Why is discharge planning important?

- It aids in treatment planning and establishing rapport.
- It is a transition point along the individual's recovery journey.
- It includes identifying any services or follow-up that may be needed to safely transition from one level of care to the next, to the individual's home or elsewhere.
- It reduces hospital length of stay and decreased the chances of readmission to higher level of care and informs future treatment providers.
- It promotes recovery: Future focus when planning begins upon admission.
- It is an ethical practice.
  - Document what is being done to move forward in recovery in the least restrictive, most cost-effective way possible.
  - Maintain an accurate record - waiting too long or missing documentation means the work done is unsubstantiated and cannot be relied upon for future reference.
- It helps meet insurance and contract requirements.

What is a discharge plan?

A discharge plan is the individual's plan.

It is a written resource for the individual supplied by the provider

An effective discharge plan will include:

- Appointments for follow-up services*

  **Having an aftercare appointment within 7 days of discharge from a hospital is a Medicaid requirement and supports the best outcome.*

- A crisis and/or relapse prevention plan
- A list of discharge medications
- Medication education information
- Plans for obtaining medications
- Diagnosis
- Education about diagnosis
- Resources and referrals to other needed services (i.e., NAMI, USARA, Alliance House, AA, etc.)

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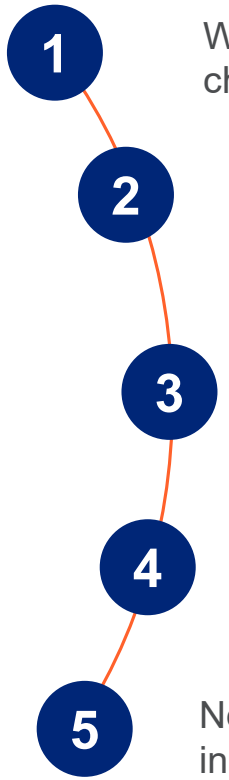
Providing the individual with the discharge plan

The discharge plan should be in the individual's preferred language and written so it is easily understood, even for individuals with limited literacy.

Discharge planning provides for physical safety

People discharged from a behavioral health hospital can also have an elevated risk of suicide immediately following a hospitalization.



Written information helps as discharge can be an emotionally charged time for all involved.

Needed interventions and services are scheduled and delivered timely to support the individual's success and stability post discharge.

Increases 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.

Includes a safety plan, when clinically warranted.

Next provider can immediately meet specific needs of the individual at a new placement.

Safety planning

Developing a safety plan is an important part of each discharge plan.

Each individual should develop a safety plan that includes the names and phone numbers of people that the individual can call for help, including local crisis services and toll-free hotlines.

A safety plan should also include:

- Warning signs of crisis or relapse
- Steps an individual can take when in crisis or following a relapse
- Steps others may need to take (therapist, case manager, peer support specialist)

If appropriate, include online and texting supports in the Safety Plan.

What is a Discharge Summary?

-Written record included in the individual's clinical record
-Shared with need-to-know providers prior to discharge or day of discharge. If same day as discharge is not possible, within 24 hours is necessary for best practice.
-Summary of treatment episode may include:

- identifying information
- treatment/discharge summary
- diagnosis
- course of treatment and plan
- labs
- medications
- status at discharge
- discharge plan and discharge instructions
- referrals made
- any other relevant information
- special needs (an interpreter, social determinants of health, etc.)

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Exchange of information

It is best practice to transmit a discharge summary to the first clinician that the individual will see within 24 hours after discharge. This allows enough time for the clinician to review the information before the individual's follow-up appointment.

Consider what has been most helpful to you, as a provider, when you have an intake, and provide that information for the next provider or caregiver.

Collaboration and coordination of care

What is a warm handoff?

A warm handoff connects the individual to the new provider before discharge.

It is conducted, ideally, in person, through video, or over the phone between two members of the health care team, in front of the individual (and family if present).

Whenever possible when sharing information regarding change in level of care include the individual and their support group.

5 Steps to implementing warm handoffs at your organization:

- Step 1: Obtain leadership buy-in and identify a team or individual.
- Step 2: Design workflows that allow warm handoffs.
- Step 3: Train team members in warm handoffs and in the adjusted workflows.
- Step 4: Make individuals and families aware of warm handoffs.
- Step 5: Evaluate and refine your process as you move forward.

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Effective handoff process:

The Sentara health care organization adopted behavior-based expectations to improve the handoff process and used tools including the five P's. They have reported a 21-percent increase in effective handoffs:(Yates GR, Bernd DL, Sayles SM, et al. Building and sustaining a systemwide culture of safety. Jt Comm J Qual Patient Saf. 2005;31:684–689.)

- Patient [Person] – Take this time to meet the individual, the treatment team currently working with that person, build rapport, and assess needs for best outcome for the individual.
- Plan – Add to the discharge plan and safety plan with the current team. Where will your team pick up care for the individual?
- Purpose – Continue to assess needs, treatment plan, goals, case management, housing, benefits, etc.
- Problems – Identify barriers to treatment, medications, insurance, money, transportation, culture.
- Precautions – What does the individual need to be successful? What is best practice?

Receiving an individual discharging from inpatient to outpatient services

Important steps when receiving an individual being discharged from inpatient services include:

- Requesting clinical information from the referring provider
- Obtaining a release of information
- Communicating with referring provider
- Reviewing the safety plan
- Completing a needs assessment

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When does outpatient discharge planning start?

"Providers are expected to incorporate discharge criteria and planning into the overall treatment plan, beginning at admission." (Optum Provider Manual for Medicaid Services)

The treatment plan should reflect discharge planning.

- Desired outcomes related to the presenting problems and symptoms should be included.
- Goals and objectives should be tied to discharge and transition planning.

What is an effective discharge plan?

An effective discharge plan:

- Is created with the full participation of the individual and others involved in their care.
- Is person-centered.
- Is strengths focused.
- Is individualized.
- Addresses the individual's needs.
- Reflects cultural responsiveness.
- Is easily understood by the individual and/or their caregivers.
- Assesses for barriers the individual may have to complete plan.
- Is sent to new provider.

Cultural considerations

Collaborate with individuals to identify any cultural variables that could impact their recovery and participation in treatment.

Discharge planning tailored to the cultural characteristics is associated with better transition preparedness and has shown to reduce 30-day re-admissions.

A Treatment Improvement Protocol: Improving Cultural Competence (TIP) Series No. 59. HHS Publication No. (SMA) 13-4849.

Cultural considerations

Cultural factors to consider:

-Write the discharge plan in the individual's preferred language if possible.

-Take the time to help the individual understand the plan. Individuals from diverse and racial groups can feel more estranged and disconnected from Treatment services.

-Take a collaborative approach. Traditional plans may not be the best path, consider asking "what type of treatment do you think will help" or "do you have any preferred healing approaches?"

-Get collateral information. Individuals may be unwilling or unable to provide a full personal history. If needed, obtain collateral contacts to better understand their cultural beliefs and beliefs about mental health and addiction.

-Connect with the individual with a provider who can be culturally responsive (i.e., be open and purposeful in learning about working with diverse populations, be respectful of traditions that differ from their own, etc.).

-Support better engagement by incorporating culturally based plans and goals.

Unexpected or AMA discharge

If an individual chooses to leave against medical advice (AMA) it is important to provide the following:

- A crisis and relapse prevention plan
- Referrals to providers
- Community supports/resources (peer support, etc.)

Quality audit and documentation requirements

Quality: Why do discharge planning and a discharge summary?

- It is a standard of practice to begin considering discharge plan needs at the onset of treatment (upon admission) and throughout treatment.
- Discharge planning achieves continuity and coordination of care and treatment (i.e., identifying if the individual has a primary care physician, if the individual is being seen by another behavioral health clinician, and that collaboration occurred with the appropriate clinician(s), etc.)
- Discharge planning progress and updates is a way to attain the individual's cultural characteristics, values, traditions, family, religious and spiritual beliefs that may impact recovery or the discharge disposition.
- Discharge planning progress and updates are documented in the assessment, re-assessment, treatment plan, treatment plan reviews and in the Discharge Summary.
- The Discharge Summary is an effective way for the clinician to provide concise documentation of what occurred during the treatment episode.

The Discharge Summary document must be completed by the provider upon termination of treatment and the document is to be included in the individual's record.

Discharge planning benefits

Including, but not limited to:

- ❑ Provides and/or mobilizes a level of support that corresponds to what the individual will need for community tenure (i.e., the ability for an individual to maintain stability in the community)
- ❑ Aids in care coordination and continuity of care between dispositions
- ❑ Provides the individual with the opportunity to obtain discharge instructions, ask questions, seek individual education, resources, and preparation for discharge
- ❑ Minimizes the chances of relapse or readmission to the level of care from which the individual discharged
- ❑ Gives opportunity for providers to enhance community partnership and collaboration

Discharge Summary documentation requirements

Audit Checklist

Including, but not limited to:

- ✓ DSM-5/ICD-10 current or updated diagnoses
- ✓ Description of the reason(s) for the treatment services
- ✓ Individual progress towards goals (i.e., the extent to which the treatment plan goal(s), objective(s), and method(s) were achieved)
- ✓ Account of individual participation and response to treatment
- ✓ Services provided to the individual
- ✓ Reason for the individual discharge
- ✓ Plan established by the clinician and individual for continuing care
- ✓ Referrals for follow-up treatment and services, recommendations, and appointments for follow-up care
- ✓ Evidence the individual was connected to treatment providers for continuing care at a lower level of care
- ✓ Documentation the OQ/®Y-OQ® was administered at the time of discharge.
- ✓ Completed within timeframe (i.e., 90 days for individuals who do not meet serious mental illness (SMI) and 180 days from date of last contact for individuals who do meet SMI criteria)
    - SUD providers are required to discharge an individual no later than 30 days after the last contact.

Please see the Optum Provider Manual for Medicaid Services for full information and requirements.

Discharge planning from a peer perspective

Personal experience

Collaboration and identification

- Use a warm hand-off to pass information to the next provider. Include strengths, weaknesses and triggers specifically identified by the individual.
- There may be information the provider remembers and has documented that the individual may forget in the event they decompensate.

Be aware of how transitions effect the individual and validate

- Recovery is a process that ebbs and flows; Discharge is only a step, it is not the end.

Review the discharge plan with all involved

- I was more likely to follow through if others were aware of the plan and their part in it.
- It also assisted with me holding myself accountable (i.e., physical wellness).

Treatment plan reviews are useful for more than just documentation

- Reviews are a great time to help the individual identify strengths as well as their hopes, dreams, passions and goals; It builds confidence and helps with preparation for transition

Member experience

Members may experience a variety of barriers throughout the discharge process.

What are some barriers members may experience when discharging to follow-up care?

- Long wait times for appointments
- Appointments not available at preferred times
- Paperwork to be completed prior to scheduling an appointment
- Social determinants of health inadequacies (lack access to transportation for example)

Something to Think about:

How can providers work to solve these barriers to assure members get the follow-up care and services they need?

We’re in this together

Optum SLCo and TCo Clinical Team

- 877-370-8953 Prompt #5

Optum SLCo Recovery & Resiliency Team

- 801-982-3222

Huntsman Mental Health Institute (HMHI) Receiving Center

- 801-583-2500

HMHI Crisis Line
801-587-3000
Warm Line (Staffed by peer support)
Crisis Team
MCOT (Mobile Crisis Outreach Team)

988 SUICIDE & CRISIS LIFELINE

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Q&A

Duration of segment