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

*** A process is ongoing, not a fixed element, and stays a process until discharge

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?

Basics of the discharge process (cont.)

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.

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Discharge planning during treatment

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

Discharge plan at the time of discharge

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

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

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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)

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Source: Optum Salt Lake County Provider Manual 2016

Timeline requirements

Mental health

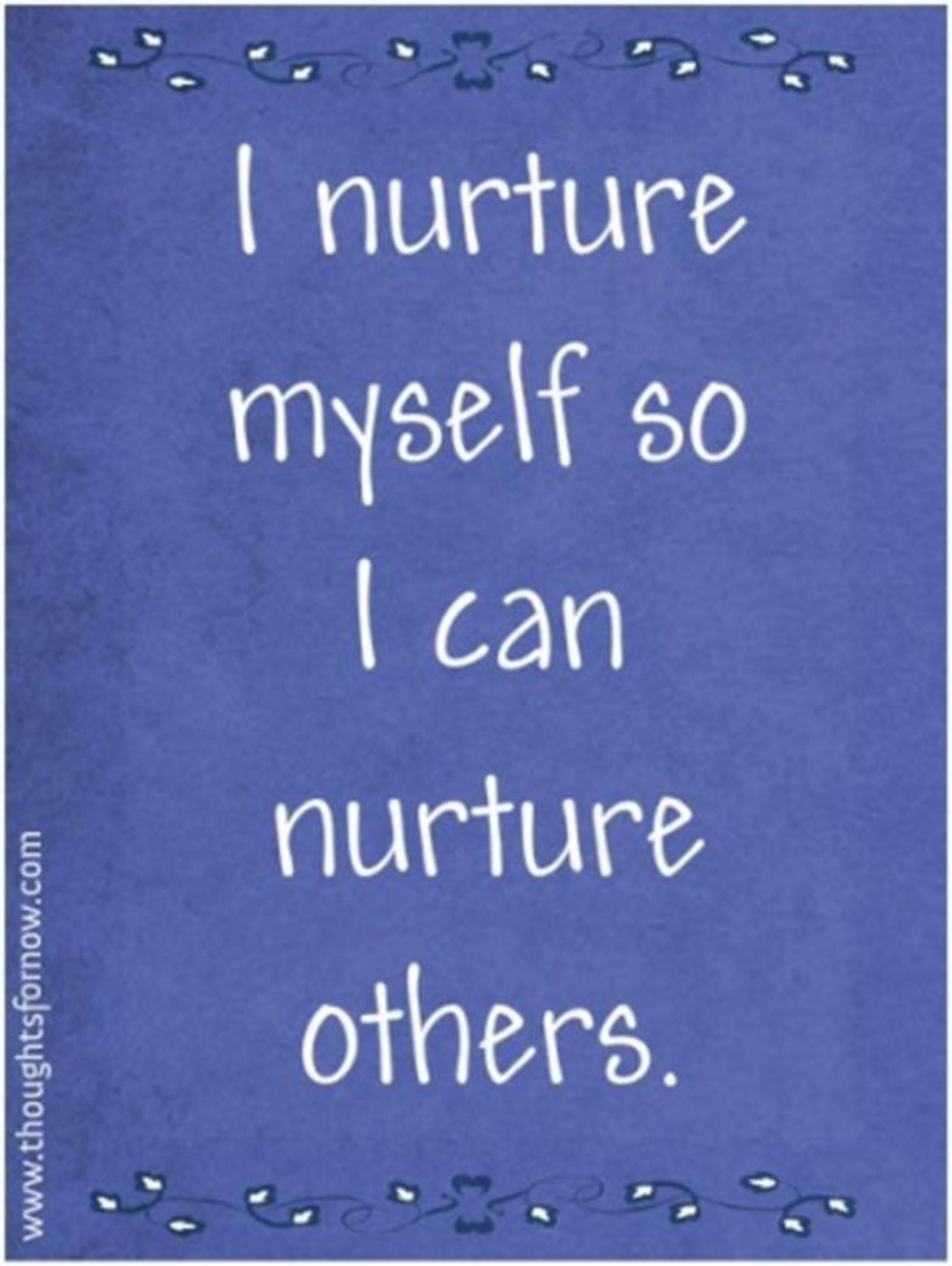
- Discharged and case closed in EHR no later than 90 days after the last contact for non SPMI clients
- Discharged and case closed in EHR no later than 180 days for all SPMI clients from date of last contact
- Discharge and case closed no later than 180 days from last contact if non SPMI client receives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

Substance use treatment

- Discharge within 30 days of last contact
- UWITS client record must be closed within 60 days if no activity, unless client is actively engaged in recovery support services

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.



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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