

# Discharge Planning

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# Definitions

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## 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?

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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

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

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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.)

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## 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

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Anticipated discharge date	Next level of care and rationale for referral	Identification of stable social supports	Update as treatment progresses	Evidence of team approach
<ul style="list-style-type: none"><li>• Select a target range and modify, if needed</li><li>• Allows for visualization of life without regularly anticipated therapy sessions</li></ul>	<ul style="list-style-type: none"><li>• Step up or down from current LOC</li><li>• Needs a different modality than can currently be provided</li></ul>	<p>Examples</p> <ul style="list-style-type: none"><li>• Church</li><li>• Friends</li><li>• Family</li><li>• Co-Workers</li><li>• Sponsor</li><li>• Scouts</li><li>• Athletic teams</li></ul>	<ul style="list-style-type: none"><li>• Ongoing process</li><li>• Allows for check-in and enabling consumer's voice to be heard</li></ul>	<ul style="list-style-type: none"><li>• Client</li><li>• Family/Guardian</li><li>• PO</li><li>• Case Worker</li><li>• Agency</li><li>• Treatment Team</li><li>• Supervising Practitioner</li><li>• Others</li></ul>

# Discharge plan at the time of discharge

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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
<ul style="list-style-type: none"><li>• Time</li><li>• Date</li><li>• Provider phone number</li><li>• Provider address</li></ul>	<ul style="list-style-type: none"><li>• Certified Peer Support Specialist</li><li>• School</li><li>• Spiritual</li><li>• PCP</li><li>• Specialists</li><li>• Scouts</li><li>• Church</li><li>• Others</li></ul>	<ul style="list-style-type: none"><li>• Written discharge summary template</li><li>• Phone call during last session</li></ul>	<ul style="list-style-type: none"><li>• Especially important when a client discharges home from inpatient or residential</li><li>• Community crisis services (i.e. MCOT or Hopeful Beginnings)</li></ul>	<ul style="list-style-type: none"><li>• Validates rapport and therapeutic process</li><li>• Promotes realistic and attainable goals</li><li>• Future-oriented focus</li><li>• Recovery Model</li></ul>



# Example discharge plan/info sheet



# Personal Experience

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## 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

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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

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**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)

# Timeline requirements

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## Mental health

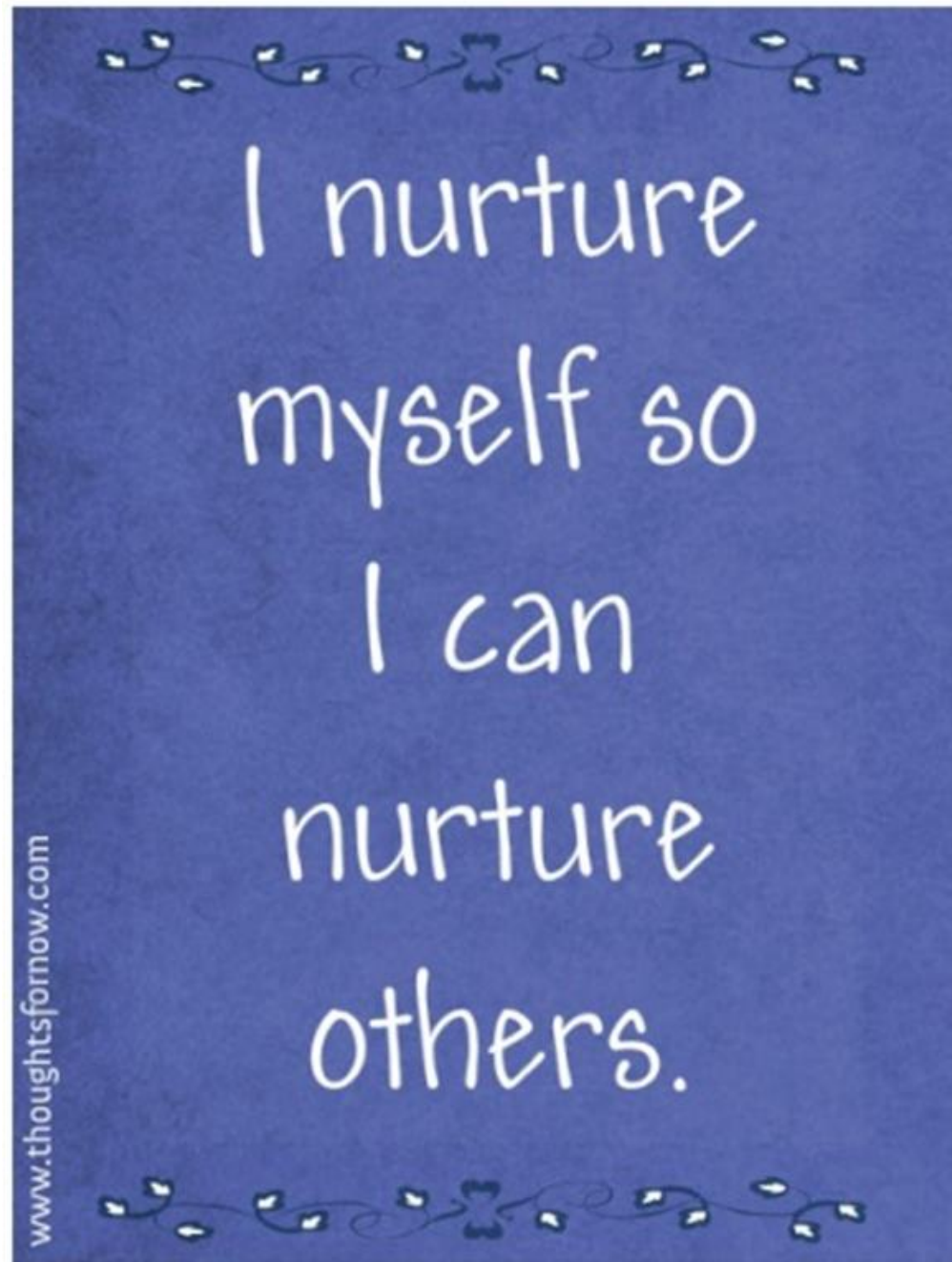
- Discharged and case closed in EHR no later than 90 days after the last contact for non SPMI clients
- Discharged and case closed in EHR no later than 180 days for all SPMI clients from date of last contact
- Discharge and case closed no later than 180 days from last contact if non SPMI client receives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



**~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

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## 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