Transition & Discharge Planning

St. Clair County
Community Mental Health
Promoting Discovery & Recovery Opportunities for Healthy Minds & Bodies

2024

Outcomes and Description

This module is designed to acquaint you with the Transition and Discharge Process, and the types and functions of documentation needed for implementation.

In this course, you will learn about the four types of documentation, their functions, and usage.

Transition planning is an integral part of the Individual Plan of Service process and threaded throughout the goals and objectives included in the plan.

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Definition

Transition, continuing care, or discharge planning:

- Assists individuals as they move within or between levels of care
- Assists individuals in obtaining services that are needed, but are not available within their current level of care
- May include planned discharge, movement to a different level of service or intensity of contact, or a re-entry program in a criminal justice system.
- Are specific steps that work toward achieving the individual's goals.

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Transition Takes Many Forms

Because transition can take so many forms, few cases will be exactly alike.

For instance, transition from residential SUD to outpatient care will be different than that involving a person who is electing to withdraw from services.

Consider also the differences between a person who is leaving against medical advice versus a person who has achieved their treatment goals.

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When Should It Begin?

Transition planning is initiated with the person served at intake and should be continued throughout treatment.

Attention must be paid to key medical necessity treatment areas such as:

- Diagnosis
- Behavioral response to medication management
- Recipient strengths
- Functional stability
- Community involvement
- Support Systems

It is very important to document all discussions of transition and discharge planning, throughout the course of treatment, not just at the point of discharge/transfer.

Remember, if it is not documented, it never occurred!

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Transition Buzz Words

The best objectives are written so that they are clear and easy to understand. Include the following **BUZZ WORDS** throughout the IPOS objectives in order to capture the transition process within the individual's treatment plan. Transition and discharge planning IS NOT a separate process from the IPOS!

Train	Connect	Demonstrate	
Select	Initiate	Identify	
Examine	Repair	Remove	Change
Organize	Develop	Replace	Define

Note: The following buzz words should be avoided, as their, meanings are open to a number of different interpretations: learn, appreciate, respect, understand, master, know.

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Types of Documentation

There are four types of documentation featured in this course:

1. A **Transition Plan** is completed as part of the Individualized Plan of Service (IPOS).
2. A **Discharge Summary** is to be completed upon the discharge of a person for any reason.
3. A **Program Placement/Transfer** is to be completed whenever an individual transfers between programs, whether laterally or to a different level of care or to another placement
4. A **Post-discharge Survey** is mailed to the individual after discharge (three months after in Lapeer and St. Clair, between three and six months after in Sanilac).

Note: The above types of documentation apply primarily to the PIHP system. In contrast, there is much variation among SUD providers.

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Placement/Transfer Meeting

At the point where an individual is to be transferred between programs, whether laterally, to a different level of care, or to another placement, a **Program Placement Transfer meeting** is to be held. There, the transferring and receiving primary caseholders, the individual receiving services, and individual's representatives (i.e., guardian, family member, designee, if appropriate) will determine the following:

- Purpose of the meeting
- New prioritized treatment needs
- Address individual strengths
- Expectations of the individual receiving services
- Future/follow-up activities
- Individual satisfaction
- Progress to date
- Discharge criteria to less intensive services
- Proactive strategies/Interventions to address new prioritized treatment needs
- New primary caseholder

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Meeting Documentation

Documentation of the meeting must be in the individual's file.

- St. Clair County CMH has one document for adults and another for children, which can be seen on the following pages.

Note: The following examples do not apply to the SUD system. The SUD system uses similar documents, but they vary from provider to provider.

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Transition Planning

The **transition plan** is a section included in the IPOS that provides information about the person's progress in recovery and describes the completion of goals and the efficacy of services provided.

The transition plan is prepared to ensure a seamless transition to another level or component of care, and should address:

- Support persons who assist with movement towards discharge or lesser intensive services
- Anticipated accomplishments/goals and strengths
- How the plan addresses barriers to progress
- The conditions for discharge
- Where they will be moving to i.e., community supports, step down programs/decreased number of days in program, etc.

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Transition Planning

The transition plan is created and revisited during the treatment process. It is first addressed on the Summary page of the Individual Plan of Service. It may also be modified by an amendment (which can occur at any time in treatment).

Periodic reviews for individuals with mental health concerns are completed according to the need or request of the person served (Medicare and other insurances as well as several Evidence Based Practices mandate quarterly periodic reviews).

The criteria for transition or discharge is dependent upon each individual's needs, abilities and support systems.

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Transition Services

Just as the assessment is critical to the success of treatment, transition services are critical for the support of the individual's ongoing recovery or well-being.

Good outcomes may be directly linked to effective transition services.

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Who Assists?

The transition plan is developed with the input and participation of:

- The person served
- The family/legal guardian, when applicable or permitted
- A legally authorized representative, when appropriate
- Personnel
- The referral source, when appropriate
- Other community services, when appropriate

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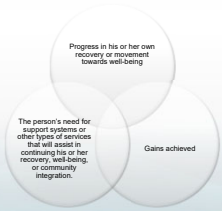
The Transition Plan

The Transition Plan identifies the individual's current:



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The Transition Plan

The following items are included on the transition plan to ensure a smooth or seamless transition to another provider when a person served is transferred to another level or component of care, or is discharged from the program.

- Information on the person's medication(s), when applicable.
- Referral source information, such as contact name, telephone number, locations, hours and days of service, when applicable.
- Communication of information about available options if symptoms recur or additional services are needed, when applicable.

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What Should Be Provided

When transferring an individual to another caseholder, it is important to identify and pass on information about a person's:

- Strengths
- Needs
- Abilities
- Frequency of contact and preferences
- Medication(s) and Follow up Services
- Special circumstances such as Court Orders

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What About Follow-up?

The individual, the referring program, the receiving program and others as requested each receive a copy of the transition plan.

If additional services or supports are indicated, staff are identified and named on the transition plan who will be responsible for follow-up after transition in order to:

- Maintain the continuity and coordination of needed services.
- Determine with the person served whether further services are needed.
- Offer or refer to needed services, when possible.

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Unplanned Transitions

If an unplanned transition or discharge occurs, personnel are identified who will be responsible for follow-up to:

- Determine with the person served and/or guardian whether further services are needed.
- Offer to refer to needed services, when possible.
- Coordinate needed resources throughout the transition process.

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Discharge Summary

A discharge summary, identifying reasons for discharge, is completed when the person leaves services for any reason:

- Planned discharge
- Goals/Objectives have been met
- Individual is being referred elsewhere
- Individual not appropriate for services
- Individual moves out of county
- Against medical advice
- Individual dies
- Individual discontinued treatment with or without notice

Whenever a person transitions or is discharged, it is necessary to be very specific as to where the continued services will take place (if applicable) when indicating to where a person is being transitioned.

Also, it is important to consider the barriers that may arise at discharge. Case holders should identify what possible barriers may arise, and develop plans to address them. The persons strengths should be included as a means of furthering the successful discharge process. In addition, the persons natural support system should be included as well.

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Discharge Form

A discharge form is a tool that facilitates continuity of care and serves to document a baseline which may be helpful for future service provision.

For all persons leaving services, a discharge summary in OASIS is prepared indicating what treatment the individual received and the results of that treatment.

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Discharge Form Requirements

The discharge plan must:

- Include the dates of admission and discharge.
- List the services provided.
- Identify the presenting condition (problem).
- Describe the extent to which established goals and objectives were achieved. Examples include gains achieved by the person served, strides made by the person served in the recovery process, or any positive move toward recovery.
- List the reason(s) for discharge.
- Identify the status of the person served at last contact.
- List recommendations for services or supports. This should include referral source information, contact name, telephone number and hours and days of operation.

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Outreach

Outreach is defined as the service provider's documented attempt to contact the individual (via phone contact, home visit, or mailed correspondence) when the individual has not engaged with treatment. This process applies to all individuals who receive our services.

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Conducting Outreach

Prior to appointments, the following shall be done:

- All programs will implement electronic reminder calls for appointments 24-48 hours in advance.
- Depending upon the clinical judgment of the primary case holder and based upon the individual's unique treatment requirements, the outreach could be provided by peer supports, mental health assistants, primary case holders, or clerical staff.
- Designated staff will utilize motivational interviewing techniques in an attempt to problem-solve barriers and challenges. Designee documents outreach in EHR.

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Conducting Outreach

When an appointment is missed by an individual receiving services on a voluntary basis:

Utilize appropriate staff resources to assist with outreach efforts.	Continue outreach until individual provides a clear directive: "I do not want you to stop by my house" or "I don't want you to call me." However, consider your own safety during this process.	Make sure to document outreach attempts.	Upon consultation with a supervisor, close cases that are inactive for more than 60 calendar days. (except for Central Intake Unit open cases with no follow through are closed after 30 days).

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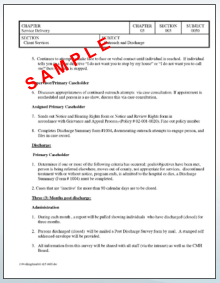
Policies & Surveys


SAMPLE

St. Clair County CMH has an Outreach policy and a post-discharge survey for use by staff.

Note: The above policies do not apply to the SUD system.

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The End

You have reached the end of this course. Please click the "EXIT" tab in right hand corner of this slide to exit course and take exam.

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