DISCHARGE PLANNING MICROLEARNING AUDIOTRANSCRIPT

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Welcome to our microlearning series, brought to you by the clinical provider training team. This module focuses on Discharge Planning.

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This series will cover Care Coordination, Treatment Planning, Titration of Services and Discharge Planning. Welcome to our module on Discharge Planning

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By the end of this module, you will be able to: Identify two benefits of discharge planning, state two ways to address discharge planning during the course of treatment, and identify three components of discharge.

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On these slides, we'll introduce the member scenario that will be used throughout this module to help apply concepts to real-world clinical practice. You may wish to review the Member Scenario handout located in the handouts for training section of the Course Outline

The member is a 34-year-old female with co-occurring substance use, behavioral health, and medical diagnoses, including Alcohol Use Disorder, Generalized Anxiety Disorder, Major Depressive Disorder, and diabetes.

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The member is involved with multiple systems and service providers. There is legal involvement of probation and the child welfare system, where there has been the removal of the members child who is in the care of the members mother. Additionally, there are behavioral health services of targeted case management and individual therapy, a parenting class, psychiatry for medication management, primary care for diabetes management as well as court-ordered substance use treatment.

For the purpose of this training, assume you are one of the providers involved in this member's care. As we move through the module, we will refer back to this scenario to demonstrate how discharge planning should be addressed throughout treatment, not just at the end of services. Keep this member in mind as we discuss how discharge planning supports continuity of care, promotes stability after services end, and helps the member maintain progress in the community.

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Discharge planning is an important part of a members recovery process.

According to Gowda, Gajero, Srinivasa and Ameen : “Discharge planning can be a patient friendly and highly practical approach to guide them and improve their quality of life and mental health in the community. Proper discharge planning can improve outcome and prognosis of the person with a mental illness.”

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Discharge planning can be a complex process. It is not a one-time event. It includes collaboration between the provider, member, family, integrated care partners and formal and informal supports. For discharge planning to be most effective it should be addressed throughout the treatment process.

The admission and assessment phases should include collaborative information gathering that drives discharge planning. Helpful information to gather at assessment for discharge planning purposes includes: Supports, such as Current providers for whole person, health care supports, such as primary care and health care specialists, AA and NA support groups, substance use providers, and other community supports. Information about strengths, goals, and expectations should be discussed as well.

The assessment period is also a good time to educate the member on the importance of discharge planning to set expectations for eventual discharge. This education should continue at every point. It is important for members to know the goal is for independence and continued wellness after discharge. Important education techniques include practicing teach back techniques and using plain language.

Treatment planning is a set of agreed-upon SMART goals that can be used as a bench mark measure for both the client and provider to know when discharge is appropriate. Treatment plan updates should include a continuous and collaborative discussion about discharge planning.

Care coordination supports the overall health of the member and occurs throughout the treatment episode. Care coordination allows for follow up appointments to be made and encourages exploration of the ways in which other providers and supports can assist the member after discharge. All coordination of care activities should be collaborative and be included in and support the discharge plan.

Titrating services is the continuous appraisal of current needs that will also help identify when discharge is appropriate. When all of the treatment goals and needs have been addressed it is time for discharge.

The final phase of discharge planning is finalizing the plan. The discharge plan is an agreed upon plan to assist the member in effective independent functioning.

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Let's use our case example to walk through how discharge planning begins at intake—and how it evolves over time.

After the initial intake and assessments were completed, the provider and member collaboratively identified clear discharge criteria. The member would be considered ready for discharge once she regained custody of her daughter, had a transportation plan in place until she could drive again, and experienced a reduction in anxiety and depression from a nine out of ten to about a three out of ten on most days. An important part of the plan was also her ability to effectively use coping skills.

At this early stage, natural supports were identified as well, including her mother, participation in AA, and support from her sponsor. These supports helped shape the initial discharge plan and informed expectations for treatment duration.

As treatment progressed, the plan was intentionally revisited and updated. The member returned to church weekly, and joined a moms' group, which helped strengthen her sense of connection. She also developed meaningful relationships with two neighbors who became reliable supports, assisting with transportation and childcare.

In addition, the member began working with a psychiatrist for medication management related to anxiety and attended follow-up appointments to monitor effectiveness. Each of these changes was incorporated into the discharge plan through ongoing re-evaluation and discussion with the member.

Initially, the provider anticipated the member would need approximately twelve months of treatment. However, as her support network expanded and symptoms decreased more quickly than expected, the provider was able to titrate service frequency and adjust the projected timeline for completing treatment plan goals.

This example highlights that discharge planning is not a one-time task, it evolves as the member's supports, symptoms, and functioning change.

It's a dynamic process that should reflect the member's progress, supports, and changing needs throughout treatment - it evolves as the member's supports, symptoms, and functioning change.

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While discharge planning documentation is not required to be submitted, it is a required component of the permanent medical record that will be expected if records are reviewed. Copies of discharge plans should be given to the member, support persons and service providers.

It is recommended that the plan include the components listed here.

Member education should include information on their illness and what signs and symptoms to look for as an indicator to return for treatment.

Self care instructions that are developed collaboratively between the provider and the member should be part of the discharge plan. The plan should include how to identify warning signs or potential problems and how to address these. This will include reminders and cues to use skills developed in treatment. These can be coping skills, problem solving skills, daily self -care activities and more.

The discharge plan should include an integrated care component and aftercare. Appointments with other providers should be outlined in the document.

If the member needs continued medication management after discharge, the provider needs to ensure that they continue to have access to medications, and have a scheduled appointment with the medication providers. The member should know what follow up is needed and why.

The plan should also include any formal and informal support people. Each person's roles and responsibilities should be outlined.

Finally, the discharge plan should describe how to return for care if it is needed, including phone numbers and instructions.

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Discharge planning can be a complex process. It is not a one-time event. It includes collaboration between the provider, member, family, integrated care partners and formal and informal supports. For discharge planning to be most effective it should be addressed throughout the treatment process.

First, the admission and assessment phases should include collaborative information gathering that drives discharge planning. Helpful information to gather at assessment for discharge planning purposes includes supports, strengths, goals and expectations for treatment. The assessment period is also a good time to educate the member on the importance of discharge planning to set expectations for eventual discharge. This education should continue at every point. It is important for members to know the goal is for independence and continued wellness after discharge. Important education techniques include practicing teach back techniques and using plain language

Treatment planning is a set of agreed upon goals that can be used as a bench mark measure for both the client and provider to know when discharge is appropriate. Treatment plan updates should include a collaborative discussion about discharge planning. The treatment plan SMART goals assist in constant re-evaluation of discharge needs.

Care coordination supports the overall health of the member and occurs throughout the treatment episode. Care coordination allows for follow up appointments to be made and encourages exploration of the ways in which other providers and supports can assist the member after

discharge. All coordination of care activities support the discharge plan. It is important to collaborate with others to support the member after discharge. This includes current providers for whole person health care such as primary care and health care specialists, AA and NA support groups, substance use providers, and other community supports. These supports can be included in the discharge plan.

Titrating services, which is the continuous appraisal of current needs and appropriate services and discharge needs will also help identify when discharge is appropriate. When all the treatment goals and needs have been addressed it is time for discharge.

The final phase is finalizing the plan. The discharge plan is an agreed upon plan to assist the member in effective independent functioning.

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This slide provides an example of how discharge planning may look in practice, using our member scenario.

Over the past six months, the member's treatment plan and service package have been continuously updated based on her progress. She has now achieved one year of sobriety, with her substance-use disorder in remission, and presents with a significant reduction in depression and anxiety symptoms.

As the member demonstrated stability and effective use of coping skills, services were gradually titrated. Therapy and Targeted Case Management were reduced from weekly to monthly sessions, and the member continued to show progress at this level of care.

During a recent care team meeting, providers reviewed the member's progress and collaboratively determined she was ready for discharge. The therapist and case manager met with the member to update the treatment plan, review progress, and complete updated screening tools to support the discharge decision.

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Additionally, together they reviewed and finalized the discharge plan, which includes education on signs and symptoms, relapse indicators as well as an overview of skills learned during treatment, identified supports, and scheduled follow-up appointments, including medication management and primary care visits for diabetes management.

The relapse prevention plan was also reviewed, focusing on triggers, warning signs, coping strategies, and available supports.

This example illustrates how discharge planning is collaborative, data-informed, and integrated into treatment over time, ensuring the member is prepared to maintain progress and access support after services conclude.

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Let’s discuss the Discharge Plan components in relation to the member scenario.

First is Member Education: The member is not only provided education on depression, anxiety, and alcohol use disorder, but also co-occurring disorders and the impact these diagnoses can have on one another. The member is aware of the need to look for increased cravings to drink, spending more time in bed than normal, feelings of panic most of the week, and feeling out of control as her biggest signs and symptoms.

Self care: The member has go-to coping skills to be utilized and reminders in her phone for quick access. She will continue to complete a weekly journal entry and use a meditation app on her phone each morning to start the day.

Integrated Medical and Behavioral Health Care: The member will follow up with the psychiatrist regarding continued needs for anxiety medication every 6 months and can outreach to her therapist or case manager if any new needs arise. She is aware of the agencies phone numbers and how to make appointments. The member has crisis numbers and information for any urgent needs.

Natural and Community Supports: The member will continue to attend AA meetings 2 times a week ,and her sponsor remains available for ongoing support. She has joined a mom’s group at her church that meets monthly for support and social events. The member's mother is available to help with childcare, and she also has two neighbors in her apartment building that have offered to help with childcare and transportation as well, until she is able to drive again.

An important part of discharge planning is preparing the member to recognize symptoms, use learned skills, and access continued support across clinical, community, and natural systems.

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References for this microlearning are shown here. If you would like to review any of these references, please click the pause button and write down the items of interest. To move on from this video, please click the “next” button at the bottom of your screen.