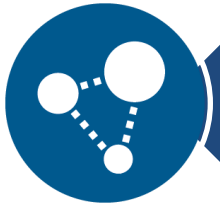
Discharge Planning

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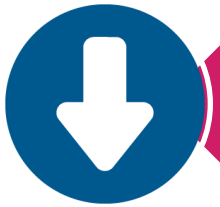
Provider Engagement Series



Care Coordination



Treatment Planning



Titration of Services



Discharge Planning

Learning Objectives

1. Identify two benefits of discharge planning
2. State two ways to address discharge planning during treatment
3. Identify three components of a discharge plan

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Member Scenario



- Member is a 34-year-old female.



- Alcohol Use Disorder, Severe
- Generalized Anxiety Disorder
- Major Depressive Disorder, Moderate, Recurrent
- Diabetes

Member Scenario:
Care Coordination/Service Engagement



Legal/Department of Children and Families (DCF)

- Probation involvement
- DCF involvement - removal of child from care.
- Member's mother is child's current caregiver following DCF involvement



Services at Multiple Agencies

- Behavioral Health Provider - Targeted Case Management and Individual Therapy
- Parenting Program Provider - Parenting Class
- Psychiatry Provider - Medication Management
- Medical Provider - PCP for diabetes management
- Substance Use Treatment Provider - Court ordered substance use groups

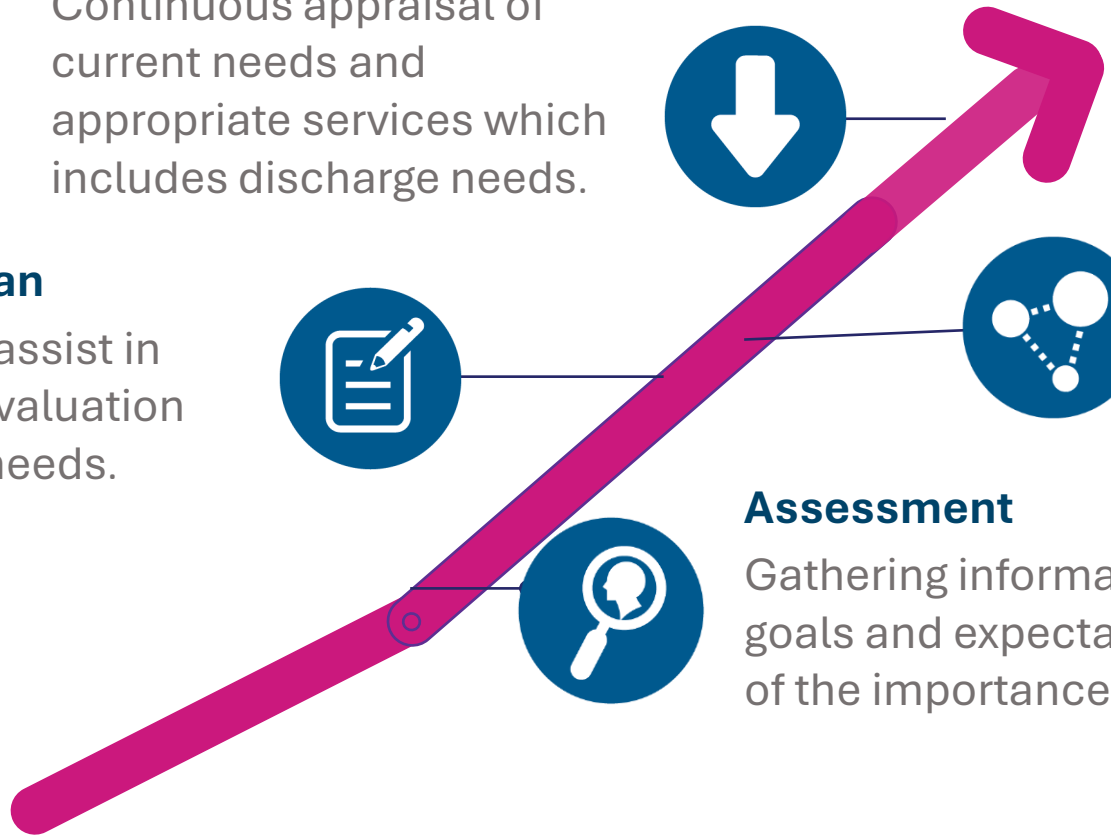
What is Discharge Planning?

"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."

– Gowda, Gajero, Srinivasa, & Ameen

(Gowda, et.al.,2019)

Discharge Planning Process



Discharge Planning

An agreed upon plan to assist member in effective independent functioning.

Titrating Services

Continuous appraisal of current needs and appropriate services which includes discharge needs.

Care Coordination

Collaborates with others to support the member after discharge and can be included in discharge plan.

Treatment Plan

SMART goals assist in constant re-evaluation of discharge needs.

Assessment

Gathering information about supports, strengths, goals and expectations for treatment, discussion of the importance of discharge.

(Agency for Healthcare Research and Quality [AHRQ], n.d.; Health Services Advisory Group [HSAG], n.d.)

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Member Scenario: Discharge Planning Process

Initial Discharge Criteria (Established at Intake):

- Regain custody of daughter
- Transportation plan in place until able to drive
- Anxiety and depression reduced from 9/10 to 3/10 most days
- Demonstrates effective use of coping skills
- Natural supports identified: Mother, AA, and sponsor

Re-Evaluation During Treatment:

- Returned to church and joined a weekly mom's group
- Developed new natural supports:
  - Two supportive neighbors
  - Assistance with transportation and childcare
- Began psychiatric medication management with ongoing follow-ups

Impact on Discharge Plan:

- Discharge plan updated to include new formal and informal supports
- Increased support led to faster symptom reduction
- Provider adjusted service frequency (titration)
- Anticipated treatment duration shortened from initial 12-month estimate

(Agency for Healthcare Research and Quality [AHRQ], n.d.; Health Services Advisory Group [HSAG], n.d.)

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Discharge Plan Components



Member education

Illness education

Signs & symptom recognition



Self-Care

Reminders and queues to use skills developed in treatment



Integrated Care

Follow up appointments



Medication Management

Ensure access to medication & medication management provider



Supports

Include supports, roles & responsibilities

Consider formal support groups



How to return for care

Phone numbers and instructions

(AHRQ, n.d., HSAG, n.d.)

Discharge Planning Process

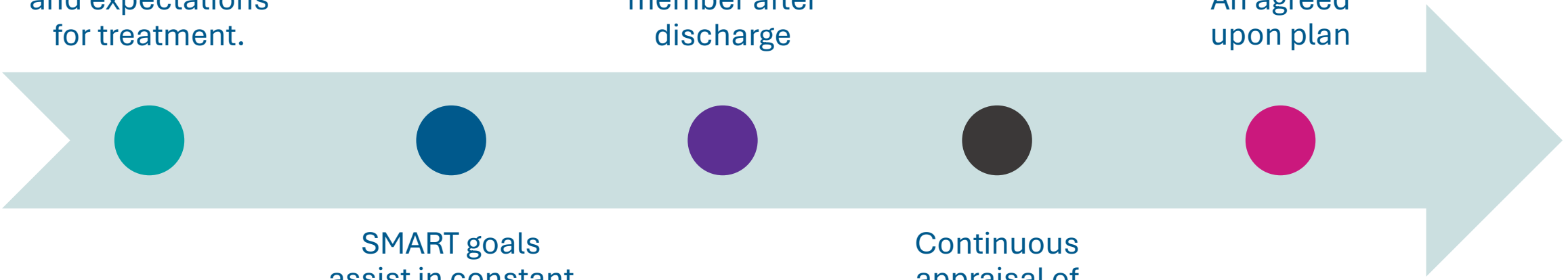
Gathering information about supports, strengths, goals and expectations for treatment.

SMART goals assist in constant re-evaluation of discharge needs

Collaborates with others to support the member after discharge

Continuous appraisal of current needs and appropriate services and discharge needs.

An agreed upon plan



(Agency for Healthcare Research and Quality [AHRQ], n.d.; Health Services Advisory Group [HSAG], n.d.)

Member Scenario: Example of Discharge Plan

Member Progress & Stability

- Ongoing treatment plan updates over six months
- One year of sobriety; substance use disorder in remission
- Significant reduction in depression and anxiety symptoms

Service Titration

- Demonstrated stability and effective coping skill use
- Individual therapy reduced from weekly → monthly
- Targeted Case Management reduced from weekly → monthly
- Continued progress maintained at reduced level of care

Collaborative Discharge Decision

- Care team reviewed progress and updated screening results
- Therapist and case manager met with the member
- Discharge readiness determined collaboratively

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Member Scenario: Example of Discharge Plan, cont. d

Finalized Discharge Plan

- Education on signs, symptoms, and relapse indicators
- Review of skills learned during treatment
- Identification of natural and community supports
- Scheduled follow-up care:
  - Medication management
  - Primary care visits (diabetes management)

Relapse Prevention

- Reviewed triggers and warning signs
- Identified coping strategies
- Confirmed available supports

Key: Discharge planning is collaborative, data-informed, and integrated throughout treatment—supporting sustained progress beyond services.

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Member Scenario: Discharge Plan Components

Member Education

- Education on Depression, anxiety, and alcohol use and co-occurring conditions
- Member recognizes personal warning signs:
  - Increased cravings
  - Withdraw or staying in bed
  - Frequent feelings of panic
  - Feeling overwhelmed or out of control

Self Care

- Go to coping skills identified
- Phone reminders used for quick access
- Ongoing routines:
  - Weekly reflective journaling
  - Daily meditation

Integrated Care

- Psychiatric follow-up every 6 months assess ongoing medication needs
- Ability to re-engage therapist or case manager as needed
- Knows how to:
  - Contact the agency & schedule appts.
- Crisis resources reviewed

Supports

- AA meetings twice weekly
- Sponsor support
- Monthly moms' group through church
- Family and informal supports:
  - Mother (childcare)
  - Neighbors (transportation & childcare)

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References

- Agency for Healthcare Research and Quality (n.d.) *Care transitions from hospital to home: IDEAL discharge planning implementation handbook.* https://www.ahrq.gov/sites/default/files/wysiwyg/professionals/systems/hospital/engagingfamilies/strategy4/Strat4_Implement_Hndbook_508_v2.pdf

- Health Services Advisory Group (n.d.) *Care coordination best practices toolkit.* Quality Improvement Organizations Centers for Medicare and Medicaid Services. https://www.hsag.com/globalassets/care-coordination/carecoordtoolkit032019final508.pdf

- Gowda, M., Gajera, G., Srinivasa, P., & Ameen, S. (2019). Discharge planning and Mental Healthcare Act 2017. *Indian journal of psychiatry*, *61*(Suppl 4), S706–S709. https://doi.org/10.4103/psychiatry.IndianJPsychiatry_72_19

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