SANTA BARBARA COUNTY DEPARTMENT OF Behavioral Wellness
A System of Care and Recovery

Programmatic Policy and Procedure

Section	Psychiatric Health Facility (PHF)	**Effective:**	9/1998
Sub-section	Nursing-Patient Care-Social Services	**Version:**	2.0
Policy	Discharge and Aftercare Planning	**Last Revised:**	DRAFT

Director's Approval _____ **Date** _____
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Approvals: PHF Medical Practice Committee: PHF Governing Board:

1. PURPOSE/SCOPE

1.1. To ensure Santa Barbara County Psychiatric Health Facility (hereafter the "PHF") staff initiate and complete discharge and aftercare planning activities in accordance with federal and state regulatory requirements, ethical standards and best practices.

2. DEFINITIONS

The following terms are limited to the purposes of this policy:

2.1. **Discharge Planning Evaluation** – a process focused on early identification and assessment of the patient's needs in order to achieve a successful discharge, provide continuity of care and promote optimal psychosocial functioning. ~~The interdisciplinary treatment team collectively leads the Discharge Planning process.~~

2.2. **Aftercare Services** – those services to, and on behalf of, a patient following discharge from the PHF for the purpose of enabling the patient to achieve an optimal level of functioning**.**

3. POLICY

3.1. The PHF will ensure that Discharge Planning Evaluations are initiated at admission for all patients. The initial discharge plan (as part of the treatment plan) will address interventions designed to meet specific discharge goals.

~~3.2. Prior to discharge, a written aftercare summary plan will be completed and a copy provided to the patient and, when applicable, the patient's conservator, guardian, or other legally authorized representative. The patient shall be advised by PHF staff that they may~~

~~designate another person to receive a copy of the aftercare plan. A copy of the aftercare plan shall be given to any person designated by the patient.~~

4. ~~INITIATION OF~~ DISCHARGE PLANNING EVALUATION ~~AT ADMISSION~~

4.1. The PHF shall provide a Discharge Planning Evaluation to:

1. Patients identified as likely to suffer adverse health consequences upon discharge if there is no adequate discharge planning, and
2. Any other patient upon the patient's request, the request of the person acting on the patient's behalf, or the request of the physician.

4.2. The PHF interdisciplinary team consisting of at least a registered nurse, social worker, or other appropriately qualified personnel must develop or supervise the development of the Discharge Planning Evaluation.

1. The Discharge Planning Evaluation must include an evaluation of:
   a. The likelihood of a patient needing post-hospital services and of the availability of the services; and
   b. The likelihood of a patient's capacity for self-care or of the possibility of the patient being cared for in the environment from which he or she entered the PHF.
2. The PHF shall complete the Discharge Planning Evaluation on a timely basis so that appropriate arrangements for post-hospital care are made before discharge, and to avoid unnecessary delays in discharge.
3. The PHF shall include the Discharge Planning Evaluation in the patient's medical record for use in establishing an appropriate discharge plan and must discuss the results of the evaluation with the patient or individual acting on their behalf.

5. IMPLEMENTATION OF DISCHARGE PLAN

5.1. Upon the request of a patient's physician, the PHF shall arrange for the initial implementation of the patient's discharge plan.

1. Social Services staff and attending psychiatrist will collectively lead the discharge planning process.
2. Efforts will be made to consult and encourage patients to actively participate in the discharge planning process.
   a. ~~If the patient~~ For patients ~~is~~ on conservatorship, PHF will seek the participation of the patient's conservator/legal guardian in the planning of the patient's discharge. ~~the conservator will be consulted. The conservatee's cooperation should be solicited~~ to help encourage ~~successful~~ discharge planning.
3. The discharge plan will be informed by the social, medical and psychological information collected in addition to the patient's goals, needs, strengths and supports.
4. The focus of the discharge plan will promote the patient's successful recovery following the hospital stay.

5.2. As a part of the discharge planning process, each patient may identify one (1) family caregiver who may assist in Aftercare Services. This information will be documented in the patient's medical record.

1. Due to incapacitation upon admittance, some patients may be unable to identify a family caregiver at the time of admission.

   a. The PHF shall provide the patient upon regaining capacity or the patient's conservator/legal guardian with an opportunity to designate a caregiver during the patient's stay.

   b. Attempts to designate a caregiver shall promptly be documented in the patient's medical record.

2. In the event the patient or the conservator/legal guardian declines to designate a caregiver, the PHF shall promptly document this declination the patient's medical record.

5.3. The PHF shall reassess the patient's discharge plan if there are factors that may affect continuing care needs or the appropriateness of the discharge plan.

6. AFTERCARE PLANNING AND DISCHARGE PROCEDURES

6.1. Prior to discharge, a written aftercare plan will be completed and a copy provided to the patient and, when applicable, the patient's conservator, guardian, or other legally authorized representative. ~~Any necessary post-discharge services will be determined prior to the patient's discharge.~~

1. Appropriate arrangements for aftercare will be made prior to discharge.

2. If the PHF determines that the patient and family members or interested persons need to be counseled to prepare them for aftercare, the PHF shall provide for that counseling.

3. Upon receipt of order to discharge, nursing staff will confirm the timeline of discharge with the patient.

6.2. The patient's conservator, guardian, or other legal authorized representative will be notified of the patient's discharge or transfer to another facility as soon as possible and, in any event, upon issuance of a discharge order by the patient's psychiatrist.

1. If the PHF is unable to contact the designated family caregiver or conservator/legal guardian, the lack of contact shall not interfere with, delay, or otherwise affect the care provided to the patient or an appropriate discharge of the patient. Attempts to notify the designated family caregiver will be documented in the patient's medical record.

2. ~~The conservator/legal guardian will partiicapte in the planning of the patients discharge planning and will preapprove the plan prior to patient discharge.~~

~~6.3. Based on the patient's aftercare needs, a Crisis Triage referral will be initiated by Social Services. A referral is required if the patient will need support to successfully transition from inpatient to outpatient services or if the patient is not already service connected.~~

6.4. ~~The patient will be provided a hard copy of the aftercare plan with the following information~~ PHF staff will ensure that the patient will be provided with a discharge packet, which will include but will not be limited to the Social Services Transfer Summary and Aftercare Plan, along with community referrals and resource materials. The written aftercare plan shall include, to the extent known, all of the following components:

1. The nature of the illness and follow-up required;
2. Medication regimen including dosage, times, special instructions and possible side effects;
    a. If the patient was given an informed consent form with their medications, the form shall satisfy the requirement for information on side effects of the medications.
    b. Discharge Medication Knowledge form will be completed, confirming that medication education and printed medication information materials were provided at the time of discharge.
3. Expected course of recovery;
4. Recommendations regarding treatment that are relevant to the patient's care;
5. Referrals to providers of medical and mental health services;
6. Date, time and location of scheduled appointment(s);
7. Living arrangements or arrangements for out-of-home placement if necessary;
8. Arrangements for medication supervision if indicated;
9. Instructions on obtaining community social, vocational and educational services, if appropriate;
10. Firearms Prohibition reports. For further information, see the Report of Firearms Prohibition policy; and
11. Other relevant information.

6.5. The PHF shall provide the patient and their designated family caregiver or conservator/legal guardian information and, when appropriate, instruction regarding the aftercare needs of the patient. This information shall:

1. Include, but is not limited to: education and counseling about the patient's medications, including dosing and proper use of medication delivery devices, when applicable;
2. Include their freedom to choose among participating Medicare providers and suppliers of post-discharge services without interference from PHF staff; and
3. Be provided in a culturally competent manner and in a language that is comprehensible to the patient and caregiver, consistent with the requirements of state and federal law, and shall include an opportunity for the caregiver to ask questions about the aftercare needs of the patient.

6.6. The PHF Internist will provide direction to PHF nursing staff to schedule follow up medical appointments post discharge as needed. ~~will ensure that any presenting medical needs that require follow-up after discharge are brought to the attention of nursing staff. The~~

~~PHF Internist will collaborate with nursing staff will complete any necessary referrals or medical to schedule appointments as part of the aftercare plan~~. Notice of any scheduled follow up medical appointments will be provided to the patient in their Social Services Transfer Summary and Aftercare Plan.

6.7. Social Services staff will contact outpatient providers to schedule a ~~ensure that the patient has~~ follow-up mental health appointment(s) ~~scheduled~~ to occur within seven (7) days of discharge or as soon as appointments are available.

6.8. The PHF Recreational Therapist will complete the rehabilitation portion of the Aftercare/Transfer Summary filed under the "Discharge" tab in the medical record. The rehabilitation portion includes identified:

1. Strengths,
2. Skills,
3. Rehabilitation potential,
4. Aftercare goals and
5. Recommendations for continued treatment.

6.9. The medication nurse and nursing staff will:

1. Verify that all discharge medication orders and/or prescriptions are complete;
   a. If a prescription is written by the psychiatrist or internist, the original is given to the patient and a copy placed in the medical record under the "Discharge" tab.
2. Review the Discharge Medication Knowledge form confirming and documenting patient understanding.; and
3. Provide medication side effect forms at discharge. Please refer to the PHF's policy *Discharge Medications* for more information.

6.10. The patient's assigned nurse will complete the nursing portion of the Aftercare/Transfer Summary which summarizes effective interventions, treatment plan goals reached and aftercare recommendations for continued treatment.

1. If the assigned nurse is a licensed psychiatric technician (LPT) or licensed vocational nurse (LVN), the PHF Team Leader must co-sign the Aftercare/Transfer Summary.

6.11. The PHF Team Leader and Social Services staff will collaborate on the patient's transportation needs.

6.12. Assigned PHF staff will gather the patient's property as identified on the Patient Property Sheet.

6.13. A member of the interdisciplinary team, designated by the clinical director, shall be responsible for ensuring that the referral of the patient to the appropriate aftercare service has been completed and documented in the patient's health record.

6.14. A patient released from the PHF on a voluntary basis may refuse any or all services under the written aftercare plan.

6.15. For additional discharge planning requirements for homeless patients, please refer to the PHF's policy *Discharge Planning for Homeless Patients*.

7. RELEASE OF INFORMATION

7.1. To support continuity of care, social services and Health Information Management (HIM) staff will obtain a Release of Information (ROI) in order to provide aftercare service providers all pertinent records regarding the patient's course of hospitalization and aftercare instructions. However, an ROI is not required if the patient is being discharged to a Behavioral Wellness provider.

7.2. If the patient designates a person to receive their aftercare plan, an ROI will be completed and filed in the "Legal" section of the patient's chart. A copy of the ROI will be provided to the designated person.

8. OUT-OF-COUNTY PLACEMENT

8.1. Social Services staff will:

1. Contact the out-of-county placement liaison to provide relevant patient information, discuss placement needs and explore available options.
2. Present the patient's legal status and any related issues that may impact the placement process (e.g., 1370 status, conservatorship, medical complexity) during the daily treatment team meeting; and
3. Submit a pro-pay application if the application for a Lanterman-Petris-Short (LPS) conservatorship is initiated while the patient is at the PHF.

8.2. The PHF Patient Representative will confirm the patient's benefits status.

1. The presence or absence of Social Security Income (SSI), Medi-Cal, Medicare or other forms of income or benefits will impact the successful placement of the patient.
2. Social services staff will communicate this information to the out-of-county placement liaison.

9. OUT-OF-STATE PLACEMENT

9.1. In some instances, a patient may express the desire to return or relocate to another state when ready for discharge. Social services staff will:

1. Work with the patient to contact and engage family members and/or significant others to ensure their participation in the discharge and aftercare planning process;
2. Identify local resources to ensure the patient's needs for food, clothing and shelter are provided for if this placement is not with family members and/or significant others, but a temporary placement is identified as optimal for the patient,

3. Contact the respective county mental health department and/or indicated provider to assist with the identification of shelters, food banks and local mental health clinics.

10. DISCHARGE AND AFTERCARE SUMMARIES

10.1. If the receiving facility or agency does not have access to or utilizes the Behavioral Wellness electronic health record (i.e., Clinician's Gateway):
1. Discharge and aftercare summaries will be submitted to the receiving facility or agency via scanned email or fax.
2. Proof of submission will be included with all discharge and aftercare documentation.

10.2. Upon request, HIM will submit the discharge and aftercare summaries of a conservatee to the Santa Barbara County Public Guardian's office.

11. REASSESSMENT OF DISCHARGE PLANNING PROCESS

11.1. The PHF must reassess its Discharge Planning process on an on-going basis. The reassessment must include a review of discharge plans to ensure that they are responsive to discharge needs.

REFERENCE

Code of Federal Regulations – Public Health
Title 42, Sections 482.43

California Welfare and Institutions Code – Community Mental Health Services
Part 2, Chapter 1, Section 5622

California Code of Regulations – Social Security
Title 22, Section 77071

California Health and Safety Code
Division 2, Chapter 2, Sections 1262 and 1262.5

RELATED POLICIES

Discharge Planning for Homeless Patients

Discharge Medications

Report of Firearms Prohibition

REVISION RECORD

DATE	VERSION	REVISION DESCRIPTION
DRAFT	2.0	• Deleted Attachments to Firearms Prohibition. • Added language about assessment of discharge planning process.

		• Added discharge planning evaluation language. • Added aftercare planning language..
10/21/18	1.1	• Included reference to policy on Discharge Planning for Homeless Patients. • Patients may identify one (1) post-discharge designated family caregiver. • The patient's designated family caregiver or conservator will be notified of the patient's discharge or transfer to another facility as soon as possible and, in any event, upon issuance of a discharge order by the patient's psychiatrist. • Removed information regarding referral to Crisis Triage. All patients receive referrals for outpatient care post-discharge. • Added additional provisions required by Welfare and Institutions Code, Health and Safety Code, and Title 22.

Culturally and Linguistically Competent Policies

The Department of Behavioral Wellness is committed to the tenets of cultural competency and understands that culturally and linguistically appropriate services are respectful of and responsive to the health beliefs, practices and needs of diverse individuals. All policies and procedures are intended to reflect the integration of diversity and cultural literacy throughout the Department. To the fullest extent possible, information, services and treatments will be provided (in verbal and/or written form) in the individual's preferred language or mode of communication (i.e. assistive devices for blind/deaf).