Best Practices for Discharge Planning

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Sparking innovation to build healthier and brighter futures.

Our Mission

Magellan guides individuals to make better decisions, and live healthier and more fulfilling lives, by improving the overall quality and affordability of healthcare.

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Leading humanity to healthy, vibrant lives

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What are the Best Practices for Discharge Planning?

Discharge planning should start at the beginning of treatment

Give families voice and choice and think outside the box

Understand language preferences

Consider Social Determinants of Health

Make sure Medical Necessity Criteria is met for the level of care you are referring the family to

Collaborate with other providers and hold an ISPT meeting

Revisit the crisis plan

Create a calendar

Provide a typed discharge plan with additional documents (written orders, assessments, and treatment plans)

Let's look at the "whole child" to assess discharge supports

- Is a higher or lower level of care needed based on progress?
- Is the family in need of more supports based on systems already in place? Are any additional referrals being made to support siblings if there are concerns?
- Are basic needs being met and/or are there other SDOH?
- Is there coordination of care between all providers involved (i.e., an ISPT meeting)?
- Have physical or medical concerns been ruled out or appropriately referred out for follow up?
- Any diagnostic concerns in either the mental health and school environment?
- Is their medication management plan appropriate?
- What is the functioning level of the individual? Do they understand what discharge means?

A Closer look at the Best Practices

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A Discharge Summary is not a Discharge Plan

Discharge **summaries** examine clinical aspects of the IBHS treatment and should be individualized, not generic

Discharge summaries are intended for providers and help to highlight the strengths, needs, and skills of the individual

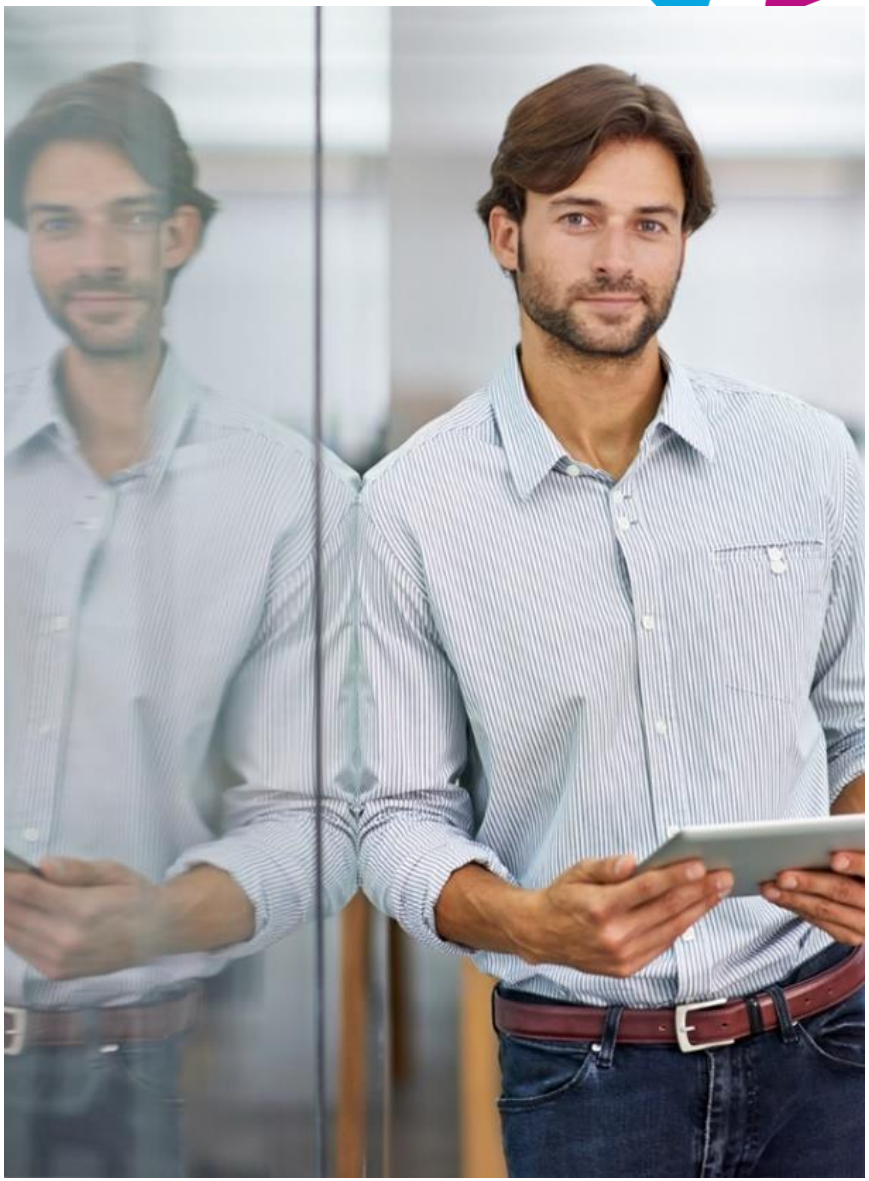
Discharge **plans** are for the individual.

Discharge plans provide information needed for the days/weeks/months following the ending of IBHS treatment

Discharge plans should be a tool for the family and easy to understand and access

Discharge plans are printed out and given to the family at/before the final session

Discharge plans should be reviewed with the family and their input should be utilized when creating the plan for what they feel they may need to succeed for discharge



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Components of a Discharge Plan

- Cover page (individual's name, discharge date, home address, phone number, emergency contact person).
- Agency contact including phone number.
- Transferring agency contact and phone number
- Aftercare appointments.
- Appointments for follow-up (medical, lab work, specialist).

- School supports with contact information
- Medication information including drug name, dose schedule and reason for the medication.
- Community Connections.
- Crisis Plan.
- Language assistance needs.
- Support Connections
  - Disabilities Rights Network
  - PEAL
  - SSI
  - Magellan's Customer Service Line
- Additional Providers within the location of where the family lives

Discharge Planning

- Discharge planning should begin immediately and continue throughout the IBHS authorization
- Thorough discharge planning prepares individuals and their families for discharge success
- Discharge planning should address the needs of the individual and referrals should be explored if additional family members need supports
- The IBHS team collaborates with the individual and family about their specific aftercare needs.
- Use creativity to identify informal/natural supports.
- Talk about barriers that people could experience after discharge.

Language Preference

Discover the individual and family's preferred language.

Inquire about oral communication, phone communication and written communication.

Obtain language assistance for the individual/family to ensure full participation in treatment and planning.

Provide the discharge plan in the individual/family's preferred language and review with an interpreter

Schedule aftercare services with providers who have appropriate linguistic and cultural competence.

Social Determinants of Health

There are seven primary social need domains to consider when developing a discharge plan.

Have open dialogue with the patient and ask questions about **Social Determinants of Health.**

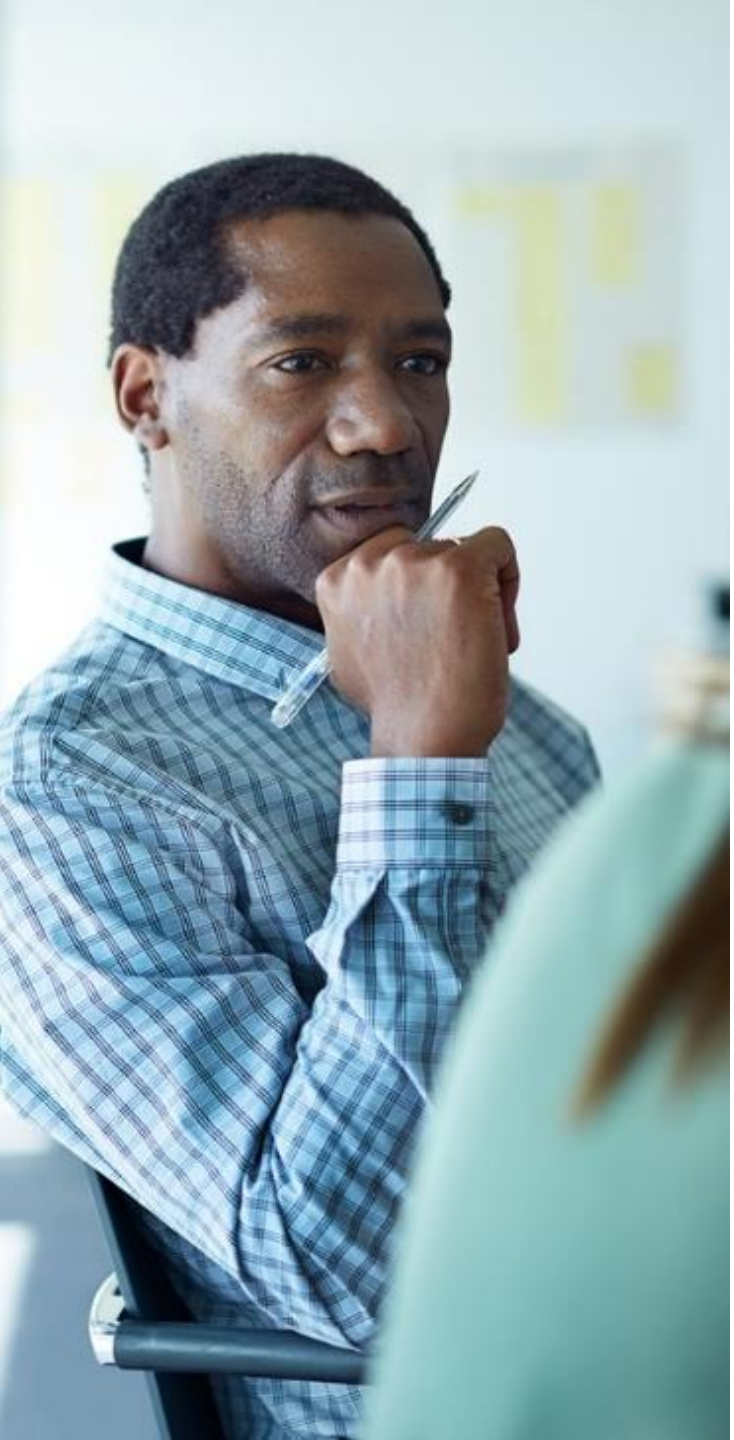
1. Food Insecurity: Limited or uncertain access to adequate and nutritious food.
2. Housing Instability: Homelessness, frequent housing disruptions, eviction.
3. Utility Needs: shut off notices.
4. Financial Resource Strain: financial literacy, medication under-use due to cost.
5. Transportation: Difficulty accessing or affording transportation.
6. Exposure to Violence: Intimate partner violence, community violence.
7. Socio-Demographic Information.

Aftercare Planning

- Consider the needs of all family members, not just the individual
- Make sure MNC is met for the level of care you are referring the individual/family to https://www.magellanofpa.com/for-providers/provider-resources/medical-necessity-criteria/
- Make timely referrals
- Consider community-based or other supports including Case Management, Certified Peer Support, HiFi Wraparound, Outpatient, Social Skills Groups, and others.
- Think outside the box

Things **not** to do when Discharge Planning

- Creating an aftercare plan without family collaboration or involvement
- Only refer to your own agency
- Place the family on a waiting list without additional supports
- Ignore a family's culture or language preference



Collaboration

Attempt to hold an ISPT meeting with all individuals involved in the child's care

If possible, have a session with the transferring and receiving provider to help build rapport and appropriately transition

Ask the individual/family "is this therapist a good fit for you?"

Collaborate with the aftercare services, including providing them with a discharge summary and additional treatment documents

Aftercare providers need to know about important clinical information and ongoing treatment issues.

Revisiting the Crisis Plan

A **Crisis Plan** is an important part of the discharge plan.

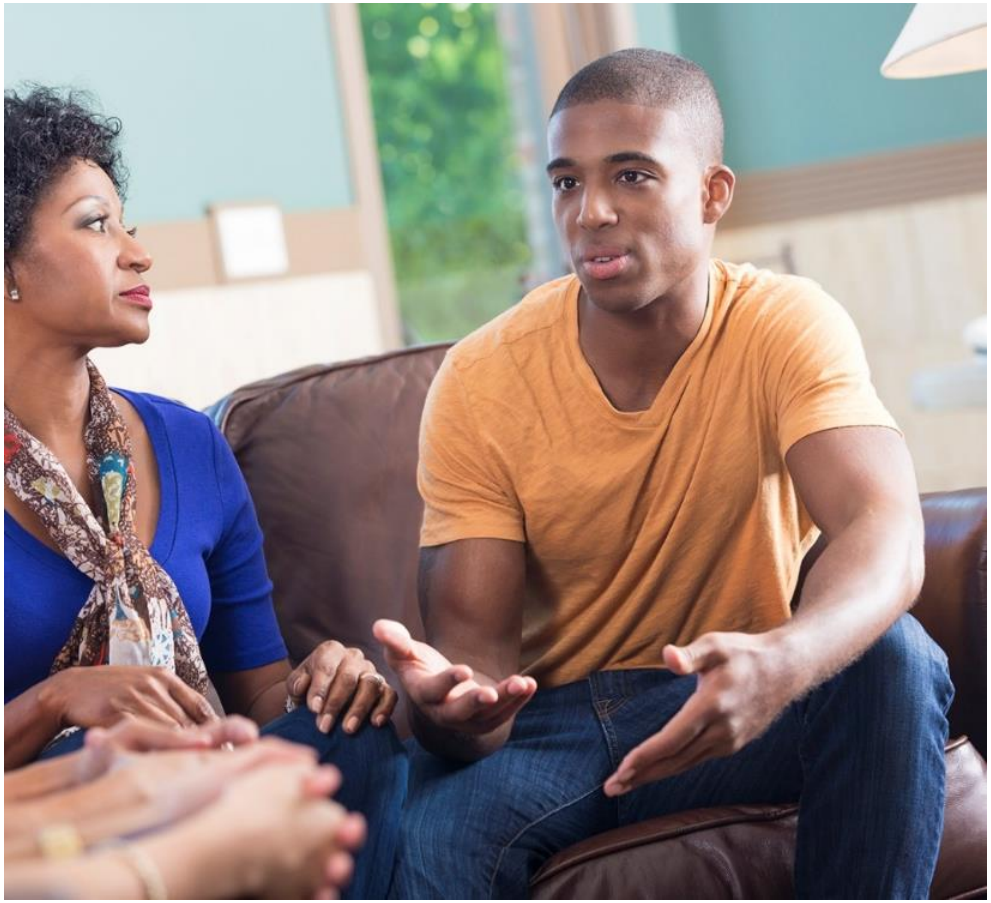
Revisit the previous plan – are the components still relevant for the individual/family?

Revise as needed to reflect new coping skills and supports.

Have the individual and/or family complete the crisis plan with the clinical team

List the names and phone numbers of people that the individual/family can call for help.

Include information about local crisis services and toll-free hotlines in the written Discharge Plan.



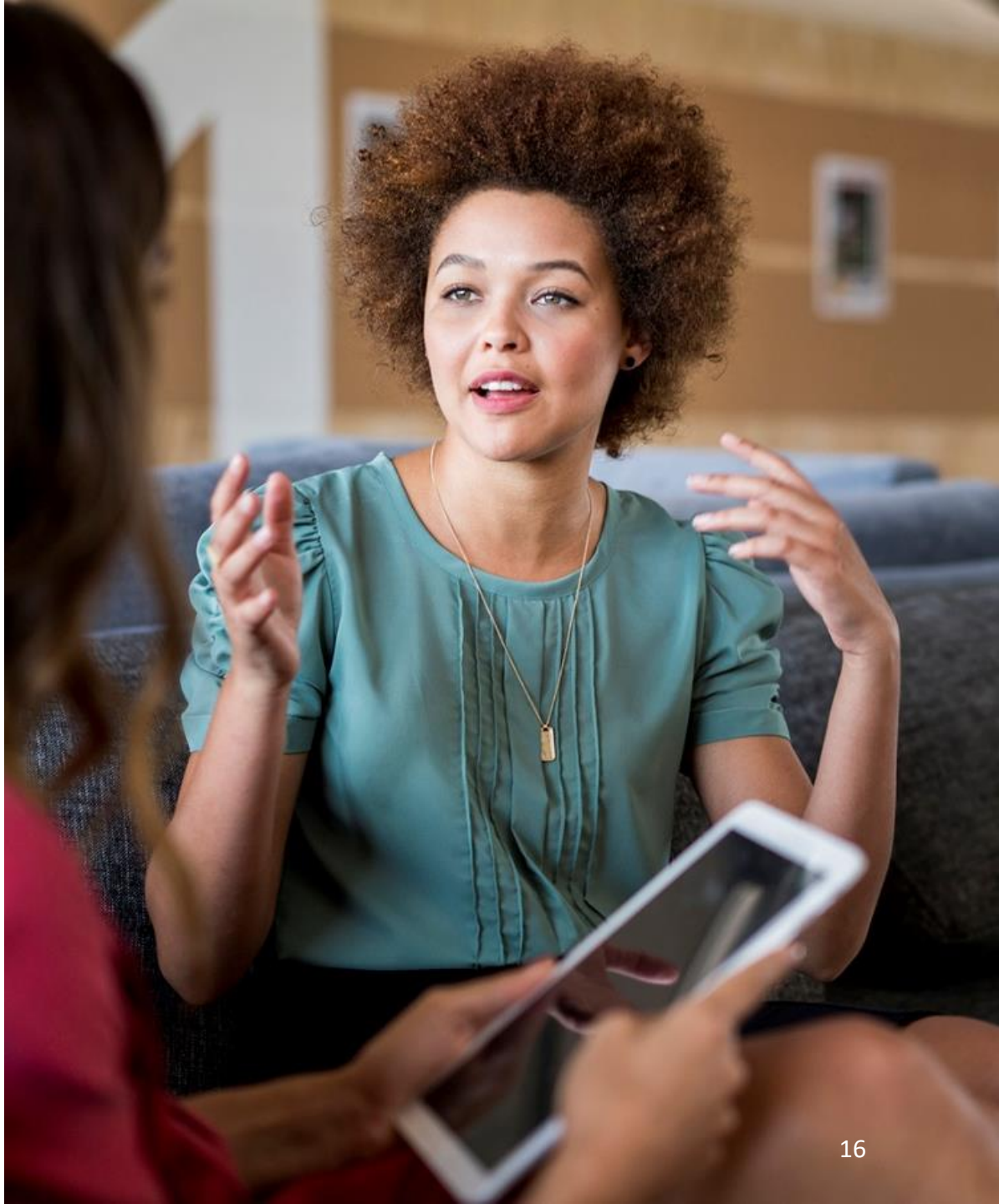
Create a Calendar

Develop a calendar for the first month after discharge.

Print out the calendar and include with the Discharge Plan.

Include dates/times of all appointments as well as special dates for the individual/family.

This activity is very helpful to assist individuals/families to visualize and prepare for the time immediately following discharge IBHS



Questions and Comments

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