



Best Practices for Behavioral Health Discharge Planning

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"Success is a journey, not a destination. The doing is often more important than the outcome." (Arthur Ashe)



Best Practices: Typed Discharge Plan

A **discharge plan** is not the same as a discharge summary, which is a summary of the clinical aspects of the hospital stay and is intended for the aftercare providers.

The discharge plan is intended for the individual and provides information that may be needed for the days following the hospitalization. The discharge plan should be easily understood, even for individuals with limited health literacy. Development of the discharge plan should be with the input of the patient and others involved in the individuals' care. It is also important to assess the individual's understanding of the discharge plan.

The finalized discharge plan is printed and given to the member before they leave the hospital. The discharge plan should be visually appealing. It may contain a calendar that includes both aftercare arrangements and significant dates in the individual's life for the next 30 days.

Magellan encourages the use of discharge practices informed by **Project RED**. Project Red (Re-Engineered Discharge) is a research group at Boston University, funded by the Agency for Healthcare Research and Quality (AHRQ) and the National Institutes of Health (NIH). Project RED identified several discharge best practices that have been found to be associated with lower hospital readmission rates.

A discharge plan can be developed in any user-friendly format, but a useful Project-RED informed template can be found here:

<https://www.ahrq.gov/sites/default/files/publications/files/goinghomeguide.pdf>

Best Practices: Full-time discharge planner and discharge planning groups



The discharge planner's goal is to **educate** and **advocate** with individuals to prepare them and their families for discharge success. The discharge planner collaborates with the multi-disciplinary team about what the ongoing treatment needs are and how these needs can be addressed at home.

Core functions of a discharge planner may include: 1) providing education to individuals and their support system, 2) teaching about the member's primary diagnosis and comorbidities, prescribed medication, community services, and crisis supports.

Discharge planners engage a teach-back model. They have the member explain the details about the discharge in their own words. Additionally, discharge planners coordinate with individuals in their preferred languages for oral communication, phone calls, and written materials.

Discussion about the importance of aftercare appointments and confirmation that the individual knows where to go and has a plan for getting to appointments is key. This includes a review of transportation options and addressing other issues (childcare, etc.) that may pose as potential barriers to a successful discharge.

Discharge Groups

Hospitals may decide to hold a discharge-readiness group with all members on the unit to talk about members' discharge plans. This creates a rich forum for opportunities in the group. These may include the option of asking questions, talking about barriers that people could experience after discharge, discussing risks that might lead to re-hospitalization. The group also yields an environment to share information about community resources and crisis information.



Best Practices: Medication education and planning to continue medications

Discharge planning includes clear, easy-to-understand, written information about **medications** prescribed to the individual. The discharge plan includes information about medications that were prescribed prior to admission, as well as clear instructions about what medications were discontinued and why.

The discharge planner should check the formulary of the pharmacy benefit plan for **all prescribed medications** (physical health and psychotropic medications) and obtain any needed prior-authorizations before discharge. Whenever possible, it's preferable for planners to arrange for the patient to have medication prescriptions filled by the hospital pharmacy prior to leaving the hospital.

The discharge plan provides a list of all medications prescribed, including the drug name, dosage, schedule for taking these medications, and reason for the medication.

The discharge plan includes information about prescriptions that are sent electronically to the pharmacy and includes the name of the pharmacy, address, and telephone number.

Prior to discharge, a member should be included in conversations about his or her plan to pick up prescriptions. Other considerations for review include when the member plans to go to the pharmacy--notably the plan for transportation, and if he or she can afford the co-payments. If the member notes challenges, this is a venue to discuss what additional supports or resources may be put in place to assist with the unique needs presented during this conversation.



Best Practices: Collaboration with providers

Another important component of best practices for discharge planning is to ensure clinical information from the hospitalization is transmitted to the provider agency or clinician responsible for ongoing behavioral health treatment after discharge. When the clinical information is not properly transmitted, the receiving clinician is unaware of important clinical information and proper ongoing care of the treatment issues. **Collaboration** between the hospital and outpatient providers is an important part of discharge planning.

It is important to transmit a discharge summary to the first clinician that the member will see, within 24 hours after discharge. This allows enough time for the clinician to review the information before the individual's follow-up appointment.

The information can be transmitted by fax or e-mail, but any manner that is rapid and secure is acceptable. Try to find out the preferences of the outpatient providers, to determine the best mode of transmission.

It is important to obtain a clear date and time for the behavioral health follow-up appointment, and to ensure the date and time are acceptable for the patient.

Magellan has a clear expectation that behavioral health outpatient providers give scheduled appointments for individuals coming out of hospitals, rather than expecting them to attend "open access" or "walk-in" intakes. These appointments should be provided to members with a clear date, time, and name of contact at the organization.



Best Practices: Crisis planning

“What should I do if something goes wrong?”

Developing a **crisis plan** is an important part of each discharge plan. Each patient should develop a crisis plan that includes the names and phone numbers of people that the member can call for help, including local crisis services and toll-free hotlines. If appropriate, include online and texting supports in the Crisis Plan.

An effective Crisis Plan includes the individual’s early warning signs and later warning signs of crisis, and steps to take in response to each. These steps should include what the individual will do, and what others will do at each stage, in addition to identifying when the individual will know to ask for help from natural supports, behavioral health supports, and crisis services.

A Crisis Plan can take any form; but, useful tools are available as part of the following well-recognized recovery-based practices:

- Wellness Recovery Action Planning (WRAP®)
- Illness Management & Recovery (IMR)

Discharge planners can refer Magellan members to case management services prior to discharge. Consider other community-based supports as well including Certified Peer Support, Certified Recovery Support, HiFi Wraparound, and others. The following levels of care for further consideration have embedded crisis services- Assertive Community Treatment (ACT), Case Management, Family Based Services, and Dual Diagnosis Treatment Teams.

Teach about developing natural supports in your discharge groups on the unit. Help individuals consider ways to get support from family, friends, faith-based communities, and co-workers. Empower individuals to have clear boundaries about how they want natural supports to help them in preventing or responding to a crisis.



Best Practices: Texting and e-mail initiatives

Magellan has implemented two new interventions to help improve follow up with aftercare appointments. These are e-mail reminders to outpatient providers, and texting reminders to members.

E-mail Reminders:

If permitted by the member, Magellan will e-mail the intake department at the outpatient facility where the follow-up appointment has been made, confirming the date and time of the member's appointment.

Texting Reminders:

If the member signs a consent to receive texts, Magellan will send three text-message reminders of the date, time, and location of behavioral health aftercare appointments. The member also receives an invitation to have Magellan contact him or her, if they think they will have any difficulty with keeping the appointment, so that we can provide extra assistance. The Magellan Care Manager will encourage hospital staff to ask the member to sign the texting consent as part of the regular discharge planning process.

Magellan's *Consent to Receive Text Message Appointment Reminders* form:

<https://www.magellanofpa.com/media/4374/consent-to-receive-text-message-appt-reminders-final-05072019-website.pdf>

Instructions for the Text Consent form:

<https://www.magellanofpa.com/media/4187/text-consent-instructions-01-09-2019.pdf>



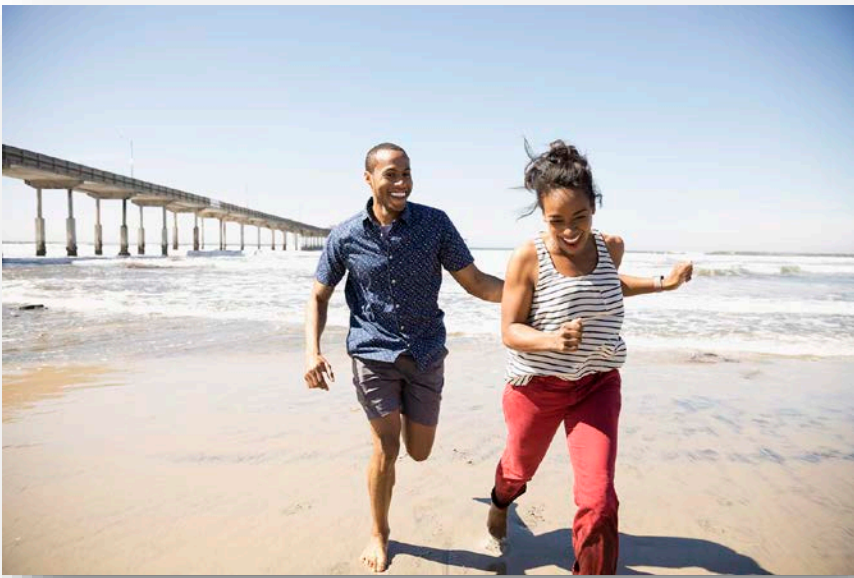
Best Practices: Language preference

The discharge planner discovers the patient's preferred language for oral communication, phone communication and written communication. If language assistance is needed, the discharge planner works to obtain this help so that the patient can participate fully in the treatment and in the planning process in his/her preferred language.

A written discharge plan needs to be provided in the patient's preferred language. The discharge planner will also share information about language preference with the agencies providing aftercare services. Magellan Care Managers will ask about the member's language preference to help ensure that the discharge planning team is taking it into account.

Whenever possible, aftercare services are scheduled with providers who have appropriate linguistic and cultural competence to best meet the individual's needs.

Keep in mind that some components of the aftercare plans may be more complicated than others, such as instructions for prior-authorization of medications, or instructions about preparing for specific lab tests. Even if a person has a good grasp of English as their second language, they may need or prefer these more complicated instructions in their native language.



Best Practices: Awareness of Social Determinants of Health

Strong discharge planning practices consider the individual person's needs in the areas of Social Determinants of Health. These are domains of need or stress in a person's life that can impact their physical or mental health, or their ability to participate in necessary physical and mental health services. There are seven important domains to consider when helping an individual develop a discharge plan.

They are:

- Food Insecurity: Limited or uncertain access to adequate and nutritious food
- Housing Instability: Homelessness, unsafe housing quality, inability to pay mortgage/rent, frequent housing disruptions, eviction
- Utility Needs: Difficulty paying utility bills, shut off notices, discounted phone
- Financial Resource Strain: Public cash benefits, charity emergency funds, financial literacy, medication underuse due to cost, benefit denial
- Transportation: Difficulty accessing/affording transportation (medical or public)
- Exposure to Violence: Intimate partner violence, elder abuse, community violence
- Socio-Demographic Information: Race and ethnicity, educational attainment, family income level, immigration status, languages spoken

While a discharge plan cannot resolve all the needs listed above, having open conversations and asking questions about Social Determinants of Health will certainly help hospital staff develop the best possible plan for the individual.

It is possible that needs or stressors in these areas can lead to re-admission or contribute to lack of follow up with outpatient care.



Best Practices: Follow-up after hospitalization

Follow up with behavioral health care after a hospitalization is essential to supporting stability and leads to improved community tenure. Re-admission to a hospital setting is especially prevalent in behavioral health, and this is the reason why the first 30 days after discharge are so important for individuals.

People discharged from a behavioral health hospital can also have an elevated risk of suicide immediately following a hospitalization.

Having an aftercare appointment within 7 days of discharge from a hospital is the “gold standard.” This standard is something that state regulatory agencies, funding sources, and accreditation entities like NCQA review closely.

The discharge plan should include follow-up behavioral health appointments, medical appointments, as well as other follow-up activities like obtaining medications, getting lab work completed, and attending support groups.

Aftercare appointments are not only important for the hospital to meet their accreditation standards, but also because follow-up is lifesaving for some and life enhancing for all.



Best Practices: Get to know HEDIS®

Get to Know HEDIS® and Why it Matters to Magellan

Increasingly, the clinical team at Magellan is being asked about the importance of HEDIS® and why it's so significant to our business. In short, HEDIS is important to our organization, because it is a vital component in maintaining our clinical excellence and financial growth.

Magellan measures to the HEDIS Standards

Licensed by the National Committee for Quality Assurance (NCQA), HEDIS is an acronym for *Healthcare Effectiveness Data and Information Set* and is used across the country to measure population health outcomes for the prevention and treatment of physical and behavioral health disorders.

While the outcome of these measures is used for accreditation of health plans by NCQA, state agencies and other organizations use selected measures from the HEDIS set and contract with us to measure them. These measures are used to evaluate the quality of healthcare services that are provided and are used to drive improvement.

Magellan is typically asked to report on the HEDIS behavioral health measures, such as ambulatory follow up within seven days, prescription refills for anti-depressant medication, and routine appointments for children on Attention Deficit Hyperactivity Disorder medications.

Magellan HEDIS Tips for Behavioral Health Measures		
HEDIS Measures and Definitions	What you can do	Coding Tips
HEDIS Measure: “Follow-Up After Hospitalization for Mental Illness (FUH)”	Explain the importance of follow-up to members.	99201 Outpatient visit 99202 Outpatient visit 99203 Outpatient visit 99204 Outpatient visit 99205 Outpatient visit 99211 Outpatient visit/Psychiatric clinic medication visit
HEDIS Definition: “This HEDIS indicator measures the percentage of discharges for members six years of age and older who were hospitalized for treatment of selected mental health disorders and who had a follow-up visit with a mental health practitioner. “	Reach out to members that do not keep initial follow-up appointments and reschedule them right away. Provide priority appointments at your agency for recent hospital discharges.	99212 Outpatient Visit for Eval & Mgmt of Established Patient, Problem Ltd or Minor, face to face w/ patient and/or family 99241 Outpatient 99242 Outpatient 99243 Home visit, 99341 Home visit, 99342 Home visit 99343 Outpatient H0004 Outpatient H0031 BHRSCA Extended Evaluation H0034 Med Mgmt Visit
Two rates are reported: The percentage of discharges for which the member received follow-up within 7 days of discharge. The percentage of discharges for which the member received follow-up within 30 days of discharge.	Ask members about what might get in the way of keeping a follow-up appointment and strategize how to address each of those barriers.	H0035 Partial Acute Mental Health H0036 Psych Rehab – Site based/mobile H0039 CTT/MAST/PACT/ACT H2010 Med Mgmt Visit H2011 Mobile Crisis H2012 Chester Upland School Program H2014 BHRS Assessment, Assist New TSS worker H2017 Psychosocial Rehabilitation Svc H2019 Mobile Therapy
2018 Update: Follow-up visits that occur on the same day as the hospital discharge do not count towards the HEDIS score.	Keep in mind that unless it’s something medically necessary, it’s not advisable to schedule the person’s aftercare appointment the same day they are being discharged from the hospital. The transition from the hospital to home may be enough for one day.	S9484 Crisis In-home support S9485 Crisis Residential T1015 FQHC

Resources

1. Project RED (Re-Engineered Discharge)
<https://www.bu.edu/fammed/projectred/>
Toolkit Provided Online (free)
www.ahrq.gov/sites/default/files/publications/files/redtoolkit.pdf
Agency for Healthcare Research and Quality
2. Social Needs Screening Toolkit
<https://healthleadsusa.org/wp-content/uploads/2016/07/Health-Leads-Screening-Toolkit-July-2016.pdf>
Field-tested, up-to-date tools and resources to help health systems launch social needs screening initiatives.
3. NCQA website for more information about HEDIS.
<https://www.ncqa.org/hedis/>
4. Wellness Recovery Action Planning (WRAP)
<https://mentalhealthrecovery.com/>
5. Illness Management & Recovery (IMR) Toolkit
<https://store.samhsa.gov/system/files/practitionerguidesandhandouts.pdf>