Discharge Planning for Level C Residential

Presented by Clinical and Quality

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The Purpose of This Training is to...

- Communicate the best practices for discharge planning
- Identify and summarize important information about discharge planning
- Provide a better understanding of discharge planning expectations
- Promote follow-up and care coordination necessary for successful transitions to lower levels of care
Discharge Planning Helps To...

- Decrease likelihood of readmission
- Maintain treatment gains
- Step the member down to lower levels of care
- Improve compliance with aftercare services
- Promote recovery and stability in the community
- Provide safety planning
- Empower the member to make choices and have a stake in their mental health treatment and future
Discharge Planning is a Process, Not a Single Event

- Discharge planning starts at the time of admission
- Discharge planning should be tied into the treatment plan which takes into account the member’s specific needs
- The discharge plan should be updated throughout the course of treatment
The Discharge Plan Should Include...

- An anticipated discharge date
- Next level of care and rationale for referral
- A permanency plan
- Updates as treatment progresses
- Evidence of a team approach
At the Time of Discharge...

- Aftercare services should be arranged
  - The first appointment should be within 7 days of discharge
  - Provide the member with the time, date, provider name and phone number

- Recommendations for any additional referrals to community resources should be included, such as:
  - Peer services or mentoring
  - Community and social supports
  - Primary Care Physician
  - Schools
  - Recreational activities
  - Family support groups
Medications

- Member should be given a prescription and/or an adequate supply of medication(s) upon discharge
- Provide clear instructions for how the medication(s) should be taken
  - Include time and date of last dose
  - Include names, dosages, and frequencies for each medication
- Discuss with the member and guardian and/or caregiver, who they can contact if there are side effects, such as the local pharmacy, prescribing or current psychiatrist, primary care physician, etc.
Safety Planning

- Transitioning a member from Level C Residential to community-based services should include a safety plan

- A Safety Plan should include:
  - Member’s strengths, current behaviors, and progress
  - Risk factors for relapse
  - Barriers to follow through with treatment
  - Psycho-education with the family and/or caregiver on ways to support the member and how to identify escalating symptoms
  - Contact information for crisis and support services for the member and the family and/or caregiver
Member and Family Participation

- The member and his or her family should play an active role in discharge planning and have a choice in aftercare services
  - Encourage the member to involve his or her family for support
- The member, family, and provider should all agree with the discharge plan
- Provider should stress the importance of follow through with aftercare appointments
  - Provide information about transportation services, if needed, for access to lower levels of care upon discharge
Magellan and the Discharge Process

- Magellan encourages providers to inform us of the discharge within 3-5 business days of the member leaving the facility.
- Informing Magellan of the discharge allows the member access to other services:
  - If the member is still showing as active in residential, he or she may not be approved for other services.
  - If Magellan is not informed of a residential discharge, a member may not be placed back in his or her MCO on the correct date.
- Providing discharge information also allows Magellan Follow-Up Specialists to contact the member about aftercare appointments and care coordination.
- By completing all of the questions on the Online Discharge form, it allows for Member Focused Outcome data to be gathered and trends in service and discharge needs to be identified.
Providers have two options:

• Fill out the online discharge form found on www.magellanofvirginia.com
  – *The form can be filled out online and submitted electronically*
  – *Magellan asks that providers answer all questions on the online discharge form at the time the member leaves a service*

• Call Customer Service at 1-800-424-4046 and you will be connected with a care manager to complete the discharge over the phone

Magellan no longer accepts faxes

• Discharges submitted via fax will not be processed
In Conclusion, Discharge Planning...

- Starts at the time of admission
- Should be a team approach that emphasizes member and family involvement and input
- May change over the course of services, if needed
- Includes
  - Aftercare appointments to lower levels of care
  - Medication information
  - Safety plan for member and family
  - Recommendations for additional supports and services
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