Origination:	*11/2008*
Effective:	*09/2020*
Last Approved:	*09/2020*
Last Revised:	*09/2020*
Next Review:	*09/2022*
Owner:	*Larry Jasper: Interim Director of Social Services*
Area:	*Social Services*
Tags:	*P&P*

Discharge Planning

SCOPE

This policy applies to both Cedar Hills Hospital (CHH)/ Cedar Hills Outpatient Services (CHOPS).

POLICY

Discharge Planning begins on admission and should include, if permitted by the patient, a "lay caregiver" who offers support and assistance, when necessary, in following the aftercare plan once the patient is discharged from the hospital (cf. OAR 333-505-0055; OR HB3378). The patient's demonstrated readiness for discharge should be linked to the achievement of treatment goals, although some long-term goals will be continued at other levels of care following hospital discharge. Long-term goals represent the highest level of functioning which the patient could possibly achieve during this current episode of illness. The longer-term goals may not be accomplished completely by the time of discharge from hospitalization or current level of care. These goals should reflect the expectation for the patient's highest level of functioning.

Discharge goals represent the achievements expected, for the identified problem, by the time of discharge when the patient is ready to step down to a less intensive level of care. Shorter-term goals represent the stepping stones toward achieving the discharge goals; these are more specific, objective, and measurable in comparison to discharge and long-term goals.

PROCEDURE(S)

As a component of the assessment process, aftercare treatment recommendations are formulated. These recommendations include the various levels of care indicated to ensure that patients are treated at the appropriate level of care.

I. The Discharge Plan should:

   A. Prepare the patient and family and/or a patient-designated lay caregiver for the transition to the next level of care.

   B. Address the patient's and family's (or, other lay-caregiver's) need for instructions about continued treatment.

   C. Delineate how progress made in the current level of care will continue after discharge.

   D. Identify problems to be addressed in the next level of care.

   E. Identify the responsibility for ensuring that the prescribed follow-up is accomplished.

II. One of the best predictors of sustained response to treatment is compliance with treatment after discharge. The discharge plan should take into account (1) The continuation or completion of those treatments which were generated in the current level of care and (2) the initiation of those treatments which are needed but were deferred to another phase of treatment.

III. At admission and upon discharge, the patient is asked if they would like to identify a family member, friend, or other support person as a lay caregiver who will provide assistance to the patient following their discharge from the hospital.

   A. All patients are provided at admission, or anytime during their hospitalization, a Cedar Hills Hospital/ Cedar Hills Outpatient Services Handbook, This handbook includes information that describes what a lay caregiver is and that encourages the patient to identify someone that can serve as their lay caregiver.

   B. If a lay caregiver is identified, the caregiver's name and contact information is noted on the Clinical Assessment as well as documented on a "Release of Information" form signed by the patient. The lay caregiver is, then, included in conversations along with the patient about discharge needs and continuing care appointments.

   C. The patient's primary therapist or discharge planner contacts the lay caregiver and invites their participation in the patient's discharge needs assessment, discharge and aftercare appointment setting, the discharge process prior to and on the day of discharge, and successful transition to outside providers that have been recommended and/or arranged.

IV. In developing discharge / aftercare plans, these areas of focus are considered during the discharge needs assessment conducted within ninety-six (96) hours after admission by the patient's primary therapist or discharge planner:

   A. Patient's capacity for self-care

   B. Family relationships, lay caregiver participation, and other support

   C. Physical and psychiatric needs

   D. Financial needs

   E. Appropriateness of current housing or housing needs

   F. Employment needs

   G. Educational / vocational needs

   H. Social and recreational needs

   I. Accessibility to community resources; need for referrals

   J. Personal support systems

   K. Spiritual needs

   L. Transportation problems related to discharge and aftercare treatment

   M. Ability to access prescribed medications

   N. Potential for recidivism.

V. The discharge / aftercare plan should define these areas of focus:

   A. Final diagnosis

   B. The level of care which the patient will be discharged to (i.e., partial hospitalization, intensive

outpatient, RTC, outpatient, etc.)

C. A listing of all medications that patient is to continue taking after discharge

D. All professionals who will follow-up with the patient, including medical follow-up to monitor medications

E. Referrals to self-help groups, support groups, peer support, and/or community-based resources

F. Follow-up appointments that are based upon the patient's clinical need and that occur within seven (7) days of discharge.

VI. Aftercare plans are communicated to the patient and family / lay-caregiver, as appropriate and if permitted by the patient, and documented on the Continuing Care Discharge Plan.

A. The therapist or discharge planner will complete the Continuing Care discharge plan except for sections dealing with physical problems and medications that will be completed by the Nurse.

B. The therapist or discharge planner will explain to the patient and family / lay caregiver the details of the final discharge / aftercare plan, including what to expect from their outpatient providers. Instructions address what assistance the patient may need post discharge, the securing and administering medications, crisis safety plans, name and location of follow-up appointment and community resources, or any other anticipated assistance relating to the patient's condition.

C. The patient and family / lay caregiver will signify understanding the of the aftercare plan by signing the Continuing Care Discharge Plan.

D. The therapist or discharge planner will fax the Continuing Care Discharge Plan to receiving and referring mental and medical health providers within 24 hours of the patients' discharge.

E. Utilization Management staff the faxes Continuing Care Discharge Plan to requesting managed care companies.

VII. When appropriate, therapists or discharge planners will assist patients in applying for benefits for which they are qualified.

REFERENCES / CITATIONS

OR HB2023, *Discharge Planning From IP Mental Health Facilities*
OR HB3378, *Lay Caregivers*
OR HB2948, Disclosure of Protected Health Information

Attachments

No Attachments

Approval Signatures

Approver	Date
Larry Jasper: Interim Director of Social Services	09/2020