Partners in Recovery	**POLICY AND STANDARDS**

Direct Care Clinics (DCC) Policy:

Policy Number:	**PRG – 3001**
Policy Name:	**Inpatient Admission and Discharge Planning**
Date of Inception:	
Previous Approval Date:	
Current Approval Date:	

Corporate and Partners in Recovery Approval(s):

Partners in Recovery, Representative Title		Date
Partners in Recovery, Representative Title		Date
Partners in Recovery, Representative Title		Date
Partners in Recovery, Representative Title		Date

Cross Reference(s)

Primary Care Physician Coordination and Continuity of Care policy; Morning Meeting Workflow and Procedures

Policy Statement

Partners in Recovery begins inpatient discharge planning immediately for those behavioral health recipients identified as needing inpatient services or upon admission.

Purpose

To establish key elements and case management responsibilities in:

- The review of medical necessity criteria for psychiatric inpatient admissions;
- The development of an inpatient discharge plan;
- The requirements for completing hospital discharge plans;
- The revision of a person's individual service plan (ISP);
- The review of discharge requirements from an inpatient facility; and
- The review/modification of the person's treatment plan, within 7 days of discharge from, or upon readmission, to an inpatient facility.

Scope

Partners in Recovery Direct Care Clinics.

Key Terms

Additional Policy Terms & Definitions are available should the reader need to inquire as to the definition of a term used in this policy.

To access the *Policy Terms & Definitions Glossary* in MagIC, click on the below link:

Policy Terms & Definitions Glossary

Standards

I. Admission Criteria to Psychiatric Acute Hospital or Sub-Acute Facility (A person must meet ALL criteria in Sections A., C., and D., and at least ONE of the criteria in Section B).

A. Diagnosis

- A specific diagnosis is not a condition for admission to an inpatient setting; however a specified diagnosis within the range of 290 through 316.99 is required to be documented at the time of discharge from inpatient services.

B. Behavior and Functioning

1. Imminent risk of danger to self or others as a result of a behavioral health condition as evidenced by:
   a) Current suicidal ideation, behavior or intent;

b) Current homicidal ideation, behavior or intent;

c) Significant ideation to assault, behavior or intent; or

d) Immediate physiologic jeopardy.

2. Disturbance of mood, thought or behavior which renders the person acutely incapable of developmentally appropriate self-care or self-regulation;

3. Disturbance of mood, thought or behavior that requires an assessment or medication trial that cannot be safely or adequately implemented in a less restrictive setting; or

4. Level of functioning that does not meet the above criteria, but less restrictive levels of care suitable to the behavioral health needs of the person are unavailable, or the person cannot return to his or her residence due to risk of harm to self or others due to a treatable behavioral health disorder, or there is a likelihood of imminent behavioral decompensation.

C. Intensity of Service

- This type of service provides planned, comprehensive assessment or treatment involving close daily psychiatric supervision and 24 hour medical supervision. Treatment should be in the least restrictive type of service consistent with the person's need and therefore should not be instituted unless there is documentation of a failure to respond to or professional judgment of an inability to be safely managed in a less restrictive type of service.

D. Expected Response

- The client's behaviors and symptoms, which were identified as reasons for admission, can be effectively treated by medically indicated treatment available in this setting. The treatment can reasonably be expected to improve or stabilize the patient's condition so that this type of service will no longer be needed.

II. Development of the Inpatient Discharge Plan:

A. The clinical team will begin planning for a person's discharge as soon as the team determines inpatient psychiatric treatment is required.

B. The discharge plan involves:

1. Reviewing events that occurred prior to the person's inpatient admission to determine if there were early warning signs indicating the person was becoming ill. Common early warning signs can include:

a) An increase in mental health symptoms;

b) Refusal to participate in some or all of the interventions outlined in their treatment plan;

c) Refusal to take some or all prescribed medications;

d) Missing or not showing up for scheduled appointments with any member of the treatment team;

e) Decrease in hygiene or personal care;

f) An increase in isolation or isolative behaviors;

g) Refusal to participate in activities previously of interest; or

h) Increased substance use.

2. Engaging the person and other involved parties in discussions about the importance of identifying and recognizing early warning signs as a method to avoid increased symptoms requiring higher levels of care and treatment.

3. Discussing and planning interventions, services and/or supports that will be required to assist the person in maintaining the level of stability obtained through inpatient psychiatric treatment.

C. Requirements for discharge planning can be found in the Inpatient Discharge Planning Checklist.

III. Case Management Responsibilities for Discharge Planning:

A. Within 24 hours following an inpatient psychiatric admission or a clinic assignment after new SMI determination, the following must occur:

1. The clinical team Behavioral Health Medical Practitioner (BHMP) will contact the inpatient treatment Prescriber to discuss:

a) The reason for the person's admission;

b) The person's current symptoms;

c) Past and current treatment received by the person; and

d) Goals for inpatient treatment.

2. The outpatient BHMP will be responsible for initiating and completing a weekly consultation with the inpatient BHMP. The consultation will include clinical updates and review of the hospital discharge plan. The information from these consultations will be communicated to the clinical team at the next Morning Meeting.

3. The person will be tracked in the Morning Meeting, per the Morning Meeting Workflow and Procedures document, on a daily basis throughout the entire inpatient hospitalization and at least 5 working days following discharge.

4. The Clinical Coordinator (CC) or Clinical Director (CD) will contact the inpatient Social Worker to begin discussion of a plan for treatment upon discharge (discharge plan) and to schedule a date within 72 hours for an initial staffing to be held at the inpatient facility. Thereafter, staffings should occur weekly and within 24 hours of discharge.
5. The Case Manager (CM) or representative from the clinical team shall visit the person at the hospital and maintain contact with the inpatient Social Worker every 72 hours at minimum throughout the duration of the person's inpatient hospitalization to monitor the patient's current status, discharge plan, and readiness for discharge. Contact may be established via email providing precautions have been implemented to maintain the security of protected health information (i.e. encryption, SIGABA account, password protected).
6. The CC or CD and the CM from the clinical team will conduct a hospital visit at least once a week in conjunction with the scheduled staffings while the person remains hospitalized.

B. Within 72 hours of admission, the CC or CD and the CM from the clinical team will visit the person at the inpatient facility and conduct a staffing with the inpatient clinical team. During this meeting, the following with occur:

1. Provide a copy of the person's Individual Service Plan to the inpatient clinical team.
2. Discuss the plans for discharge with the person based on his/her presenting symptoms at the time of admission and his/her anticipated needs at the time of discharge; and
3. Document the contact with the person on a progress note provided by the inpatient facility and have it filed in the person's inpatient medical record. This contact will also need to be documented at the DCC in ClaimTrak.
4. Reconciliation of the initial hospital discharge plan developed by the outpatient and inpatient clinical teams.
    a) The outpatient clinical team will utilize the Review of Progress for Hospitalized Persons form (ROP) to document the hospital discharge plan. The ROP is a living document that must be updated weekly or as needed to reflect any changes to the hospital discharge plan.
    b) The inpatient clinical team will utilize the Inpatient Treatment and Discharge form (ITDP) to document the hospital discharge plan. The ITDP is a living document that must be updated weekly or as needed to reflect any changes to the hospital discharge plan.
    c) The CD at the DCC and the Care Management Department at the RBHA will both be responsible for ensuring the ROP and ITDP are consistent and updated weekly or as needed.

d) Any disagreements between the outpatient and inpatient clinical teams that cannot be resolved should be presented to the appropriate Medical Director for final resolution.

C. Within 24 hours of completing the staffing and hospital visit the ROP will be completed by the clinical team. The CD will review the completed ROP and track the person's progress throughout the hospitalization.

1. The CD will be the person of contact for the RBHA Care Management Department. The CD will also ensure the ROP is faxed to the Care Management Department at **1-888-290-1285**.
2. The RBHA Care Management Department will, upon receipt, compare the ROP to the initial ITDP obtained from the hospital to ensure consistency in treatment planning between the outpatient and inpatient clinical teams. Thereafter, these documents will be reviewed and updated weekly or as needed.
3. Any inconsistencies with the ROP and ITDP should be presented to the RBHA Adult Medical Director and the CD for resolution.

D. If the person remains hospitalized for 7 days or longer, the CD will ensure a copy of the Inpatient Treatment and Discharge Plan (ITDP) is be obtained by the 10th day and placed in the person's medical record. The CD will ensure the ITDP prepared by the inpatient clinical team is consistent with the ROP prepared by the outpatient clinical team.

E. Prior to the person's discharge from the hospital, the CC or CD will ensure the Hospital Discharge Plan has been reviewed with the person as evidenced by the person signing the ROP.

F. The case manager will obtain the documentation outlined below under Section V. E before the scheduled appointment with the BHMP.

G. The clinical team shall never consider referral of the person from an inpatient setting to a Supervisory Care/Board and Care Home (SCH/BCH) as a suitable plan for discharge.

1. The person, clinical team and inpatient team must evaluate the person's anticipated treatment needs upon discharge from the inpatient facility and make referrals to appropriate treatment providers immediately. If a recommended covered service is unavailable, the Clinical Director or designee will enter the need in the unmet needs data base.
2. If the person was residing in a SCH/BCH prior to inpatient admission, the clinical team and inpatient team must make efforts to assist the person in locating and obtaining alternative housing options in effort prevent the person's return to SCH/BCH.
3. No person shall ever be discharged from an Inpatient Level I Acute facility to a Halfway House, without approval from the Site Clinical Director.

4. No person shall ever be discharged from an Inpatient Level I Acute facility to a Shelter without prior approval from the Site Clinical Director.

IV. Completing the Hospital Discharge Plan Process

A. If the person remains in an inpatient setting for three days or longer, the clinical team and inpatient psychiatric team will assist the person to develop a Hospital Discharge Plan that will be incorporated in the person's Individual Service Plan (ISP) based on the ROP and ITDP.

B. The hospital discharge planning process will include an appropriate disposition, significant supports, and goals to help the individual remain out of the hospital.

C. The Case Manager or clinical team representative will revise the treatment plan and will incorporate recommendations from other members of both the inpatient and outpatient clinical teams, family members, and provider agencies currently involved in providing care to the person.

D. It is the responsibility of the Case Manager/Clinical Liaison with the participation of the entire clinical team (including the person and his/her identified supports) to ensure the completion of any revisions to the person's ISP within 7 days of discharge from an inpatient facility.

E. The person and clinical team must sign the revised ISP and give a copy to the person.

F. If the person is court-ordered to receive treatment at the time of discharge, in addition to the Hospital Discharge Plan the Case Manager will work with the person, the Prescriber, and the clinical team to develop the person's Special Treatment Plan (STP) within 72 hours of discharge.

V. Requirements for Discharge from an Inpatient Facility

A. A staffing scheduled by the inpatient Social Worker and Clinical Coordinator shall be held prior to discharge during which time the person and all members of the clinical team will review the Hospital Discharge Plan.

B. Prescriptions (and any related prior authorizations) need to be obtained for a minimum of a 7 day supply for all Discharge Medication. The At Risk Crisis Plan (ARCP) shall be updated to incorporate information included in the Hospital Discharge Plan, as appropriate.

C. The Case Manager will ensure the person has adequate transportation from the inpatient facility to their home. If a person is being discharged from a Level I Sub-Acute facility during business hours the Case Manager should provide transportation.

D. The Case Manager and clinical team will assist the person in obtaining medications in accordance with the discharge plan upon discharge from the inpatient facility.

E. Within 72 hours of discharge, the person will be evaluated at the assigned clinic by the BHMP. The following documents will be obtained from the inpatient facility and provided to the BHMP prior to the scheduled appointment:

1. The hospital's final discharge plan or ITDP.
2. The ROP.
3. Copy of the Psychiatric Admission Initial Evaluation.
4. Copy of the Medical Physical Examination.
5. Copy of most recent laboratory results from the inpatient facility.
6. List of final discharge medications provided by the inpatient facility.
7. Copy of any Prior Authorizations obtained.
8. Copy of any medical consultations provided during the hospitalization from the inpatient facility.

F. A member of the clinical team shall maintain daily contact with the person via telephonic and/or face-to-face contact during the first five (5) working days following discharge.

G. The clinical team will ensure the person's AHCCCS provider or other primary care provider is notified of the person's inpatient admission in accordance with the *Primary Care Physician Coordination and Continuity of Care policy*.

H. For persons considered to be at-risk for re-admission, the Case Manager will meet with the clinical team weekly to discuss the person's progress toward the goals identified in the discharge plan.

VI. Reviewing the Discharge Plan and Modification of the Treatment Plan

A. For persons who are either discharged or readmitted within the last 30 days, the following will occur within the next 7 days:

1. The CC and the CM will meet with the person for a clinical consultation to review both the discharge plan and ISP. The review will include:

   a) Determination of whether the discharge plan was successful in assisting the person in returning to the community upon discharge from the inpatient facility; and

   b) Determination of whether the ISP requires additional revisions because the person's goals have changed or the interventions and methods of achieving the person's goals are no longer current.

B. If a person was court-ordered to receive treatment at the time of their inpatient admission, a review of the treatment plan will also include a review of the person's STP. The person's early warning signs or risk factors for non-adherence and the actions to be taken or treatment that will be provided to address each early warning sign or risk factor shall be included.

C. The person's ISP will be updated to incorporate the information listed in Standard VI. B. as appropriate.

Associated Partners in Recovery Direct Care Clinic Forms & Attachments

Inpatient Discharge Planning Checklist

Review of Progress for Hospitalized Persons form

Inpatient Admission and Discharge Planning flowchart

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