Best Practices for Behavioral Health Discharge Planning

from Substance Use Disorder Facilities

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Best Practices:
Typed/Written Discharge Plan

The **discharge plan** is intended for the individual and provides information that may be needed for the days following the hospitalization or stay in a residential rehabilitation facility ("rehab"). 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 member and others involved in the individual's care.

A copy of the finalized discharge plan should be given to the individual before they leave the hospital or rehab. An effective discharge plan will include appointments for follow-up services, a crisis and/or relapse prevention plan, discharge medications, along with medication education information and plans for obtaining those medications, and referrals to other needed services. The plan may also contain a calendar that includes both aftercare arrangements and significant dates in the individual's life for the next 30 days.

It is also important to assess the individual's understanding of the discharge plan and make adjustments when there is a lack of understanding. The best way to ensure the individual's understanding of the discharge plan is to fully involve the individual in developing the discharge plan from the start. If there are aspects of the discharge plan that the person does not understand, additional psychoeducation must be provided.

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

Best Practices:
Full Involvement of the Member in Discharge Planning

Core values of the recovery philosophy include self-direction and person-centeredness. Just as service planning *during* treatment must include the full participation of the member, so does planning for discharge and aftercare. A discharge plan should never be something that is "prescribed" or simply given to the person in services. The member should be involved in all aspects of the planning process.

It's important to keep in mind the other major recovery principles during discharge planning, such as: individualization, respect, empowerment, connectedness, strengths focus, cultural competence, holistic perspective, and trauma informed approach.

The member's participation is essential. Discharge planners can develop wonderful plans for follow-up, but only the person in services can say whether there may be barriers to those plans.

- You may teach about the importance of getting lab work done, but if the person has an intense fear of needles, the likelihood of follow-through is reduced unless this barrier is addressed.
- You may educate about how the medications work and the importance of the meds for recovery, but if the person has no way of getting to a pharmacy, the likelihood of follow-through will be reduced unless the transportation barrier is addressed.
- You may set up a follow-up appointment for the person being discharged, but if this conflicts with the person's usual work schedule, the likelihood of follow-though will be reduced unless the individual has input into the date and time of the appointment.

The professionals may have the expertise in services and treatment, but the individual is the expert on the issues/barriers/supports in their life.

Best Practices:
Discharge Planning Informed by Project RED

Magellan encourages the use of discharge practices informed by **Project RED**. Project RED (Re-Engineered Discharge) is an evidence-based set of discharge planning practices developed by 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. Magellan encourages the use of Project RED informed discharge planning for discharges from hospitals and also from substance use rehabilitation (rehab) facilities.

The components of Project RED informed discharge planning that Magellan most emphasizes:

1. Ascertain the need for and obtain language assistance
2. Education about the discharge plan with full member input
3. Assessment of the person's understanding of all aspects of the discharge plan
4. Crisis planning, including relapse prevention planning
5. Education about the diagnoses/conditions and strategies that help recovery
6. Education about medications and plans to obtain them after discharge
7. Make appointments (not just referrals) for behavioral health follow-up, with the member's input into the date and time
8. Make appointments for any needed medical follow-up care

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
(This template is focused on physical health, but can be easily adapted to behavioral health.)

Best Practices:
Language and Cultural Preferences or Needs

The discharge planner must identify the member's preferred language for oral communication, phone communication and written communication. If language assistance is needed, the discharge planner should obtain this help so that the individual can participate fully in the services and in the planning process in their preferred language.

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

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 good proficiency in English as their second language, they may need or prefer these more complicated instructions in their native language.

Whenever possible, aftercare services should be scheduled with providers who have appropriate linguistic and cultural competence to best meet the individual's needs. Discharge planners should collaborate with the individual to identify any cultural issues that could impact the person's recovery and participation in treatment. Consider what you know about the cultural competence of the providers to which you are referring the individual.

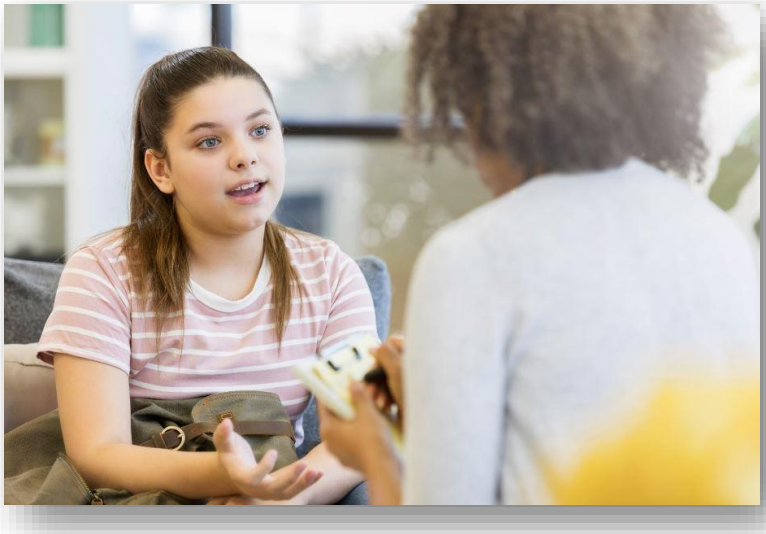
Best Practices:
Medication Education and Plan to Continue Medications

Discharge planning should include clear, easy-to-understand, written information about **medications** prescribed to the individual, including Medication-Assisted Treatment (MAT). The discharge plan should also include information about medications that were prescribed prior to admission, as well as a clear explanation about what medications were discontinued and why. The discharge plan should provide a list of all medications prescribed, including the drug name, dosage, schedule for taking these medications, and reason for the medication. The discharge plan should also include information about prescriptions that are sent electronically to the pharmacy and includes the name of the pharmacy, address, and telephone number.

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 discharge planners in a hospital setting to arrange for the member to have medication prescriptions filled by the hospital pharmacy prior to leaving the hospital.

Prior to discharge, the individual should be included in conversations about their 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 any co-payments. If the member notes challenges, this is an opportunity to discuss what additional supports or resources may be put in place to assist with the unique needs presented during this conversation.

If the person is taking MAT, it is essential to ensure that the follow-up providers being considered actually provide that particular form of MAT.



Best Practices:
Crisis and Relapse Prevention Planning

Developing a **Crisis and Relapse Prevention Plan** is an important part of every discharge plan. Each plan should include 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. If the individual has both mental health and substance use challenges, the plan should include how to prevent and respond to a mental health crisis as well as how to prevent or respond to substance use relapse. A Crisis and Relapse Prevention Plan may be separate plans or combined.

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

They 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)
- Enhanced Illness Management & Recovery (E-IMR)
- Integrated Treatment for Co-Occurring Disorders

It is important to include other involved service providers in the crisis or relapse prevention plan, as well as any involved family members or other natural supports. Assist the individual to have clear boundaries about how they want natural supports to help them in preventing or responding to a crisis or relapse.

Best Practices:
Education About Behavioral Health Condition

Project RED was initially developed for medical hospital discharges, and then expanded to include psychiatric hospital discharges. A major component of Project RED informed discharge planning involves educating the individual about their *diagnosis*. In a behavioral health setting, the diagnosis itself may not be as important as learning about the condition or conditions for which the person is receiving services, how to recognize signs, symptoms, and risk factors related to those conditions, and recovery or treatment strategies that have the best chance of effectiveness with those conditions.

In a behavioral health setting, the conditions being addressed might be mental health conditions like Major Depression, Bipolar Disorder, or Post-Traumatic Stress Disorder, or they might be substance use disorders like Alcohol Use Disorder or Opioid Use Disorder. In many cases, there may be Co-Occurring conditions, meaning the person is living with *both* mental health symptoms and a substance use challenge. It's very important to educate the individual about how the substance use interacts with the mental health challenges.

It's best to assess how much the person already knows and understands, and then assist them in getting closer to becoming an "expert" on his or her own conditions in an individualized way. "Schizoaffective Disorder" or "Amphetamine Use Disorder" might look a certain way in a textbook, but what's important is how they present with each individual, and what works best for each individual. Also discuss how this education can continue after discharge.

Best Practices:
Addressing Social Determinants of Health

Effective discharge planning considers the individual's needs in the areas of Social Determinants of Health (SDoH). These are domains of need or stress in a person's life that can impact their physical health, their mental health, their recovery, or their ability to participate in necessary services. Important domains to consider when helping an individual develop a discharge plan include:

- **Food Insecurity:** Limited or uncertain access to adequate nutritious food
- **Housing Instability:** Homelessness, risk of homelessness, unsafe housing, eviction
- **Utility Needs:** Difficulty paying utility bills, shut off notices, need for a discounted phone
- **Financial Strain**: No benefits or insufficient benefits, unemployment, financial literacy
- **Transportation:** Difficulty accessing/affording transportation (medical or public)
- **Exposure to Violence:** Partner violence, elder abuse, community violence

While a discharge plan cannot resolve all the needs listed above, having open conversations and asking questions about SDoH factors will certainly help hospital or rehab staff develop the best possible plan for the individual.

It is possible that needs or stressors in any of these areas can lead to re-admission or contribute to lack of follow up with outpatient care. Please discuss identified SDoH issues with your Magellan Care Manager and collaborate on strategies to access necessary supports.

If a person is struggling to have something as basic as food or housing, keeping appointments might be less of a priority. It's advisable to always discuss transportation needs with individuals engaged in discharge planning. This is a major factor that can impact a person's ability to keep appointments for follow-up care.

Best Practices:
Collaboration with Providers, Continuum of Care Planning

Another important component of best practices for discharge planning is to ensure that clinical information from the stay in 24-hour care is sent to the provider agency or clinician responsible for ongoing behavioral health treatment after discharge. When the clinical information is not shared, the receiving providers are unaware of important clinical information and needs for proper ongoing care. **Collaboration** between the 24-hour provider and outpatient or "step down" providers is an important part of discharge planning.

It is important to explain the value of sharing information with follow-up providers, and encourage the person to sign an authorization to release information to allow this communication. If the individual refuses this at first, don't give up. As the person moves along in their recovery, even during a relatively short stay in 24-hour care, they may begin to recognize the value of sharing at least minimum, necessary information to their next stop along the continuum of care.

It is important to send the discharge summary to the next provider that the member will see, within 24 hours after discharge. This allows enough time for the receiving provider to review the information before the individual's follow-up appointment. This applies when referring to outpatient/intensive outpatient as well as when referring to step-down residential services.

Magellan has an expectation that outpatient providers give scheduled appointments for individuals coming out of 24-hour levels of care, 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 the contact person at the organization.

Best Practices:
Behavioral Health Follow-up Care

Follow up with behavioral health care after a hospitalization or a stay in residential rehab is essential to supporting stability and leads to improved community tenure. Re-admission to a 24-hour setting is especially prevalent in behavioral health, and this is the reason why the first 30 days after discharge are so important for individuals. It is also important to keep in mind that 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 24-hour level of care is the "gold standard." This standard is something that state regulatory agencies, funding sources, and accreditation entities review closely. 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 individual.

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

Discharge planners should also consider referring Magellan members to case management services prior to discharge. Consider other community-based supports as well including Certified Peer Support, Certified Recovery Support, Certified Family Recovery Specialist, 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 Duel Diagnosis Treatment Teams. Please speak to your Magellan Care Manager for information about such referral resources.

Best Practices:
Medical Follow-up Care

Follow up with medical/physical health care after a hospitalization or a stay in residential rehab is also important. Physical health and behavioral health are not separate but are integrated parts of the whole person. Stressors and symptoms related to physical health conditions can impact mental health, functioning, and recovery. Similarly, stressors and symptoms related to behavioral health can impact physical health.

If the person has chronic medical conditions, follow-up for routine medical care may need to be arranged during the discharge planning process. If the individual is currently diagnosed with, or being assessed for, a new medical condition, follow-up appointments and testing might need to be scheduled.

If lab studies have been ordered, ensure that the person understands what the tests are for, and how to prepare for the tests. Identify where they will go for the lab work, and how they will get there.

Just as it is important to educate the person about their behavioral health condition, it's very important to educate them about their medical conditions. The person needs to be educated about self-monitoring and self-management of medical conditions, and when to seek additional support from medical professionals. Talk to your Magellan Care Manager about plans for medical care and strategies for better integrating physical and behavioral health care.

Best Practices:
Involvement of Family Members, Partners and Significant Others

Effective discharge planning can be enhanced by involving family members or significant others in the planning, with the individual's permission. During the person's stay in 24-hour care, it is important to ask the person about the natural supports in their life, and encourage the involvement of those individuals in discharge planning.

Natural supports are people in the person's life that are not professional treatment/ service providers. Natural supports to consider might include: a sibling, a spouse, a partner, a parent, an adult child. But non-family "significant others" might include a friend, a clergy person, a 12-step sponsor, etc.

These natural supports can help with: checking in with the person about their follow-up care or taking their medication, assisting with transportation to service providers or to the pharmacy, taking a role in the crisis plan/relapse prevention plan, and assisting with accessing other resources for the identified SDoH needs.

If the individual in treatment is refusing to allow contact with natural supports, don't give up! As the person moves along in their recovery, even during a relatively short stay in 24-hour care, they may begin to accept and embrace the involvement of their loved ones in their discharge planning. Using motivational strategies can help the person to see the benefits of this.

Best Practices:
Discharge Planning with People Who Decide to Leave "AMA"

Just as for inpatient medical settings, people sometimes choose to leave behavioral health facilities before their services are completed, or Against Medical Advice (AMA) or Against Facility Advice (AFA). Magellan expects that providers routinely build AMA prevention strategies into their daily practices, and also take steps to intervene when someone begins to talk about leaving AMA.

Some ongoing AMA prevention strategies might include: education of staff of all levels and roles to recognize the early warning signs of an AMA discharge, ensuring that patients/clients/members have a great deal of input into not only their own services but into program design and policies, practicing active listening skills in every encounter with an individual, ensuring adequate detoxification time, and assisting people with planning how to address pressing concerns in their home life so that they don't feel urgency to leave to attend to these things in person.

Some providers also employ "AMA blocking" strategies, which are interventions to help a person to stop, think, and possibly delay leaving. Teaching staff to recognize and intervene with impulsive decision-making is essential. Some providers designate certain staff with excellent engagement skills to intervene when an AMA discharge might be imminent.

If a person ultimately decided to leave AMA, some discharge planning MUST still take place. This must include crisis and relapse prevention planning, linkage to alternative follow-up care, communication with involved family or significant others, arrangements for medications, connections to community supports, connection to peer support, referral to the local Opioid Center of Excellence, if appropriate. In addition, Magellan expects providers to notify the Care Manager about the AMA discharge within 24 hours of discharge.

An Optional Best Practice: Designated Discharge Planner

Project RED includes strong recommendations about hiring or designating a full-time Discharge Planner to implement discharge planning best practices. This person does not have to deliver all of the discharge planning components, but should ensure that they all occur. The Discharge Planner could coordinate the activities of all the involved "Discharge Educators" involved in a person's discharge planning, assigning pieces of the planning and education to a nurse, a clinician, a peer specialist, etc. The Discharge Planner will then ensure that the person being discharged is ultimately provided with a clear, comprehensive, hard copy of their discharge plan. Magellan recognizes that providers may not currently have the resources for a full-time designated Discharge Planner, but we strongly suggest that this option be considered, and that the costs and benefits be assessed.

Resources

1. **Project RED (Re-Engineered Discharge)**
   https://www.bu.edu/fammed/projectred/

   www.ahrq.gov/sites/default/files/publications/files/redtoolkit.pdf

2. **Social Determinants of Health Resources**
   https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-of-health

   https://www.cdc.gov/socialdeterminants/index.htm

3. **Wellness Recovery Action Planning (WRAP)**
   https://mentalhealthrecovery.com/

4. **Illness Management & Recovery (IMR) Toolkit**
   https://store.samhsa.gov/product/Illness-Management-and-Recovery-Evidence-Based-Practices-EBP-KIT/SMA09-4462

5. **Enhanced Illness management & Recovery (E-IMR)**
   https://practicetransformation.umn.edu/wp-content/uploads/2020/02/Pages-from-Preview-for-Web.pdf

6. **Integrated Treatment for Co-Occurring Disorders**
   https://store.samhsa.gov/product/Integrated-Treatment-for-Co-Occurring-Disorders-Evidence-Based-Practices-EBP-KIT/SMA08-4366