



MONTANA STATE HOSPITAL POLICY AND PROCEDURE

DISCHARGE PLANNING

Effective Date: April 21, 2016

Policy: AD-04

Page 1 of 4

- I. PURPOSE:** To specify discharge planning procedures to ensure that discharge planning begins at the time of admission and is updated throughout the duration of hospitalization.
- II. POLICY:** Each person admitted to Montana State Hospital (MSH) will have an individualized aftercare plan specifying services and referrals needed upon discharge. MSH staff will work closely with the patient, the patient's family/significant others and appropriate community agencies to ensure continuity of care is addressed and Montana state statute requirements are met.
- III. DEFINITIONS:**
 - A. ***Community Reentry Plan*** – A document that provides basic information to begin discharge planning procedures early in the patient's stay.
 - B. ***Aftercare Plan*** – A document that addresses major aspects of a patient's living situation and treatment needs following hospitalization.
 - C. ***Discharge Summary*** – A recapitulation of the patient's hospital course including a summary of the aftercare plan.
- IV. RESPONSIBILITIES:**
 - A. ***Social Worker***– the staff member who is assigned primary responsibility for coordinating aftercare planning procedures.
 - B. ***Discharge Technician*** – a position within the Social Work department that assists in the discharge process by ensuring that tasks related to discharge are completed and critical information is tracked and reported.
- V. PROCEDURE:**
 - A. **COMMUNITY REENTRY PLAN**
 1. Each patient admitted to MSH will have a Community Reentry Plan developed by that patient's designated Social Worker as soon as practical. The Community Reentry Plan will focus on the individual needs of the patient and will be formulated with the participation of the patient or guardian. Also, participation

will include available family members, significant others and related community agencies.

2. The Community Reentry Plan will be completed on a form developed by MSH (Attachment A) and will identify a community mental health contact person and a MSH Social Worker in order to facilitate communication within 10 days of patient's admission. If the Social Worker obtains authorization from the client, this plan will be faxed to the community. A description of each contact related to discharge planning will be entered in the patient's medical record.
3. It is recognized that discharge planning will be an ongoing process during a person's hospitalization and that changes are likely to occur in the discharge plan. The discharge plan will be regularly and systematically reviewed by the patient, the Social Worker and treatment team with changes made to reflect the needs and desires of the patient. These changes must be noted in the progress notes.

When a patient is transferred to another unit or the Social Worker is changed, the new Social Worker should be brought up-to-date at the earliest opportunity by the previous Social Worker.

5. Every effort should be made to involve the community mental health contact person or other aftercare providers in the discharge plan review process. Aftercare providers should be informed whenever significant modifications to a patient's discharge plan are made. This can be done through written, e-mail, fax, or telephone communications.
6. A packet of clinical information will be sent, using the MSH Referral for Aftercare Form (attachment B). The packet shall include:
 - a. Social History or Interim History
 - b. Most recent Psychiatric Evaluation
 - c. Relevant Laboratory results/TB exam
 - d. 60 days of Progress Notes
 - e. Nursing Assessment
 - f. Recent Physical Examination Summary, including Medical Consultations
 - g. Forensic Review Board Report if (if relevant)

It is the Social Worker's responsibility to ensure that up-to-date information is sent to aftercare agencies.

7. The Social Work Discharge Process will be followed by the Discharge Technician to facilitate a safe discharge that ensures continuity of care is addressed and Montana State Statute requirements are met.

B. AFTERCARE PLAN

1. Near the end of hospitalization, work pertaining to discharge planning will culminate with the completion of the Aftercare Plan. The Aftercare Plan (Attachment B) serves four functions:
 - a. To provide identifying information on the patient that the aftercare provider(s) may find helpful in the provision of services.
 - b. To provide specific information regarding the patient's discharge plan; i.e., where the person will live, source of income, medical needs and scheduled appointments.
 - c. To provide information that the community mental health program may find helpful in developing a community treatment plan; i.e., major problems, needs, concerns, strengths, and personal goals.
 - d. To provide recommendations by MSH staff for aftercare services.

2. The Aftercare Plan is developed through a cooperative effort involving the patient, the MSH Social Worker, the family and significant others of the patient, the community mental health contact person, and other aftercare service providers. The Aftercare is completed in TIER. Upon completion of the Aftercare, the Social Worker will review the Aftercare Plan with the patient prior to discharge. The Social Worker will fax Aftercare Plan to the community mental health center, community Licensed Independent Practitioner and other agencies within 48-24 hours before discharge. A copy of the Aftercare Plan is placed in the patient's medical record filed under the discharge tab. The Social Worker will save the final copy of Aftercare Plan in TIER by initialing the document. If the patient has a Guardian, the Aftercare Plan will be reviewed with the Guardian and the Guardian must be provided a copy of the Aftercare Plan. The Aftercare Plan may also be mailed. All applicable HIPPA regulations must be followed when communicating information to aftercare providers or other persons.

C. DISCHARGE INSTRUCTION SHEET

The Discharge Instruction Sheet will be initiated in TIER by licensed nursing staff and completed at the time of discharge. The Social Worker completes and electronically signs the lower portion of this form to indicate scheduled appointments. This document will be reviewed with the patient by the licensed nursing staff prior to discharge. The licensed nurse will sign the document with the patient. A copy will be provided to the patient and a copy will be placed in the patient's MSH medical record.

D. DISCHARGE SUMMARY

A discharge summary will be completed by the Licensed Independent Practitioner within 15 days of the patient's discharge and sent to appropriate aftercare providers (see MSH policy HI-04, Discharge Summary).

- VI. REFERENCES:** 53-21-180 M.C.A.
- VII. COLLABORATED WITH:** Medical Director, Hospital Administrator, Social Work Quality Improvement Team.
- VIII. RESCISSIONS:** AD-04, *Discharge Planning*, dated March 12, 2012; AD-04, *Discharge Planning*, dated November 9, 2009; AD-04, *Discharge Planning Policy* dated August 28, 2006; AD-04, *Discharge Planning Policy* dated September 8, 2003; AD-02, *Discharge Policy*, dated May 15, 2001.
- IX. DISTRIBUTION:** All hospital policy manuals.
- X. ANNUAL REVIEW AND AUTHORIZATION:** This policy is subject to annual review and authorization for use by either the Administrator or the Medical Director with written documentation of the review per ARM § 37-106-330.
- XI. FOLLOW-UP RESPONSIBILITY:** Director of Clinical Services.
- XII. ATTACHMENTS:** For internal use only.
- A. Initial Treatment Plan & Community Reentry Plan
 - B. Montana State Hospital Referral for Aftercare

Signatures:

John W. Glueckert
Hospital Administrator

Thomas Gray, MD
Medical Director