RESIDENTIAL/OUTPATIENT DISCHARGE & TRANSITION PLANNING

POLICY:

Discharge and transition planning is incorporated into the treatment process from the time of admission. Accomplishment of treatment goals, individual client strengths and weakness, family and community resources are all considered in formulating discharge and transition plans for follow up care. It is the policy of The Lighthouse to ensure that planning for discharge or other transitions in treatment for each client is completed with the assistance of all involved parties including the client, guardians or other support systems, providers of care, and other relevant stakeholders, and to notify all relevant parties of discharge recommendations. The goal of all discharge or transition planning is to ensure a successful transition to the most appropriate environment. A written discharge or transition plan will be provided for the client and other stakeholders at the time of the appropriate team meeting.

PROCEDURE:

1. If adequate notice is given prior to discharge, a discharge meeting will be conducted for all residents, and for any outpatient who requests this meeting.

   A. A discharge team meeting date shall be established, and all stakeholders notified. Written discharge or transition recommendations, developed by the treatment team, are provided as appropriate to the client, family/support system, primary care physicians, referral source, case manager, other treatment providers, personal care assistants, payer source, therapists, home managers, and any other stakeholders.

   B. The treatment team shall prepare discharge/transition reports which include the following information:
      a. Diagnosis and activity limitations
      b. Strengths, abilities, needs, and preferences of the client
      c. Desired outcomes and goals, and achieved goals
      d. Service(s) provided
      e. The reason for discharge
      f. Education, referrals and recommendations to assist the client to maintain and/or improve functioning, as well as self-advocacy skills. This also includes contingency plans as needed.
      g. Identified next environment location for transition or discharge, including but not limited to:
         i. Facilitating factors – such as with transitional agencies i.e Region VII
         ii. Barriers – such as the home does not have a wheelchair ramp etc.
      h. The treatment team will conduct verification that the discharge plan recommendations have been reviewed with the client and responsible party including the level of understanding of the support system. In addition, the team will review the capability of the family or other support system to provide the expected level of support.
      i. The name and official title of the person to whom the client was discharged to, if applicable, will be documented on the discharge release form.

C. At the discharge meeting, team members will identify recommendations which include possible issues relevant to individual success at the discharge or transitional environment. Expectations from the person served and their support system will be discussed and included in the final recommendations. Depending on the needs of the individual, contributing factors may include but not be limited to the following:
   a. Aging issues
   b. Case management
   c. Substance use
   j. Community integration services and life routines
   d. Education and training for family and support system as well as the person served.
   e. Functional issues
   f. Medications
   g. Ongoing treatment recommendations, medications, medical/physiological concerns, pain management, ADLs.
   h. Recommendations to increase safety including but not limited to environmental factors, equipment, risks, precautions, secondary prevention care, and emergency preparedness.
   i. Behavior, cognition, psychosocial issues and/or communication needs
   j. Support system including family support, friends, case management, and supervision needs.
   k. Community resources that will be involved as well as plan to coordinate care with other resources.
   l. Relationship issues
   m. Financial resources
   n. Access to healthcare
   o. Transportation
   p. Resource and time management
   q. Vocational issues
   r. Recreation and leisure
   s. Transition planning.

2. The treatment team will review the follow-up recommendations for each person served. All discharge or transition reports will include a summary of follow up services with appointment dates/times and addresses for residents who leave the geographical service area of The Lighthouse.

3. The external case manager will be designated as the individual responsible for coordination of the follow-up plan for the person served. If an individual doesn't have an external case manager, The Lighthouse will refer the individual and their support system to possible case managers. Lighthouse will remain available for consultation and assistance as needed after the individual has been discharged or transitioned to a different program.

4. If the discharge or transition timeframe does not allow enough time for a meeting with all stakeholders, the above information will be reviewed in the discharge or transition reports which will be distributed to the person served, support system, case manager, physicians, other care providers and other stakeholders. Discharge reports will be

documented by all treating therapists, assigned nursing staff, home managers, vocational director and case management personnel.

5. Upon discharge, a discharge follow-up survey is administered to the client and/or responsible party.
    a. Residents are contacted at 1 month and 6 months post-discharge.
    b. Outpatients are given a satisfaction survey following the completion of services.

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