



**Treatment Improvement Initiative:  
Improved Planning for Youths being Discharged from Inpatient Care  
CT BHP 2007**

**Introduction**

During 2007, CT BHP partnered with family members and providers to address the problem of children and adolescents experiencing unnecessarily long stays on inpatient behavioral health units. The term “discharge delay” is used to describe the situation where a youth no longer requires the clinical intensity of an inpatient unit, but cannot be discharged due to systemic barriers that are preventing access to a clinically appropriate discharge disposition. As part of this year long discharge delay project, CT BHP obtained input from a variety of sources, including family and provider focus groups, a literature review and standards set by The Joint Commission on Accreditation of Healthcare Organizations (The Joint Commission). Through this research, it was determined that one aspect of addressing the problem of discharge delay is to identify and utilize best practices in discharge planning.

A Connecticut parent shared the following experience:

“Discharge planning for children who go inpatient is very important. I will tell you why from my own experience. My 12 year old child has gone inpatient on several occasions. On one occasion we did not talk about her discharge at all. I went in for a family session and then the next day I received a phone call that she was being discharged. There was nothing in place for her. I was given a prescription and sent on my way. That very same day, later in the afternoon, my daughter tried to kill herself in my home. I was mad at the hospital for discharging my daughter with nothing in place and we didn’t know where to turn. I had to call 911. My daughter ended up back in the emergency department and she went back to an inpatient unit. This was an awful experience for both me and my daughter.

On another occasion my daughter went inpatient again. This time right from the start we talked about discharge planning. A meeting was set up with me and providers in the community to wrap around our family. She was discharged when all was in place and now is home. She has been home for four weeks and for my daughter that is awesome.”

Long lengths of stay in hospitals are frequently influenced by lack of availability of step-down programs. However, some delay is accounted for by lack of:

- Child-specific planning
- Establishment of an alternative/ interim discharge plan while awaiting admission to difficult to access programs
- Consistent follow-through with effectuating the discharge plan
- Knowledge of community home-based services that could be used as alternatives to higher levels of care.

## **Literature Review**

A review of the literature yielded a wealth of articles and other material that focused on discharge planning for the entire inpatient population, both medical and behavioral health, but none specific to children or adolescents. Despite this, there is a sizable body of knowledge to draw from regarding this topic that appears to apply equally to children, adolescents, and adults.

Within the last ten years, increased attention has been given to improving discharge planning, including major projects from the U.S. Health and Human Services Substance Abuse and Mental Health Services Administration (SAMHSA), and The Joint Commission. The increased focus on discharge planning occurred in response to improved understanding of the serious risk issues associated with poor discharge planning practices. **Inadequate discharge planning leads to poor patient outcomes.**

A clear relationship has been found between clinical outcome and access to relevant discharge information. In one study, Wilson, et al., (2001) reported that less than half the Primary Care Physicians (PCPs) were provided with information about discharge medication and plans for recently discharged patients. Moore, Wisnivesky, Williams, and McGinn (2002) reported that, as a result of the failure to communicate with the provider receiving the patient, that 49% of patients experienced at least 1 medical error. They concluded that “the prevalence of errors related to the discontinuity of care from the inpatient to the outpatient setting, is high”. Similarly, The Joint Commission (2003) found that errors along the continuum of care accounted for 13% of all sentinel events reported to The Joint Commission. Most of those errors were related to poor education of the patient regarding their discharge plans and lack of understanding of new medication regimens begun while in the hospital.

In response to their own findings as well as those in the literature, The Joint Commission established Patient Safety Standards to address the problems described. As part of the Patient Safety Goals, The Joint Commission requires facilities to meet goals related to improving the effectiveness of communication among caregivers (Goal 2) and accurately and completely reconciling medications across the continuum of care (Goal 8).

One aspect of Goal 2 focuses on “hand-over communication”. Hand-over communication refers to “the process of passing patient-specific information from one caregiver to another, from one team of caregivers to the next, or from caregivers to the patient and family for the purpose of ensuring patient care continuity and safety.” The Joint Commission suggests that hospitals implement a standard approach to “hand off”

communications, including an opportunity for the patient and family members to ask and respond to questions. Additionally, in Goal 8, they suggest that hospitals implement “medication reconciliation”, a process in which a complete list of the individual’s medications is clearly communicated to the next care provider. Both of these processes are “best practices”.

Other practices to improve the process of discharge planning identified as a result of the literature review included:

- The use of an interdisciplinary team approach to care planning in which the member, family or significant other, case manager, providers, and peer supports are involved. In this approach, a team leader is identified who is responsible for overseeing implementation of the discharge plan and ongoing assessment of the plan during the stay and after discharge. (SAMHSA)
- Automate the Discharge Summary to facilitate its timely dissemination and improve communication between hospital caregivers and follow-up provider(s). (Agency for Healthcare Research and Quality, AHRQ)
- Follow-up outreach within 24-48 hours of the discharge by nurses, hospitalists or pharmacists, to reinforce discharge education, determine if post-discharge plan is working, and respond to questions. (AHRQ)

## **Focus Groups**

During July 2007, the Connecticut Behavioral Health Partnership (CT BHP) held a series of facilitated focus groups designed to elicit information regarding best practice protocols for youth receiving inpatient behavioral health treatment. A total of 420 invitations were sent, and a total of 95 individuals attended the focus groups. A number of important constituencies were represented, including family members, foster parents, advocates, DCF leadership, inpatient units, school based healthcare providers, community mental health centers, outpatient providers, and emergency mobile/ crisis care providers. Participation was active and robust at each of the focus groups. The primary feedback themes addressed the importance of consistent discharge planning and comprehensive communication among all the family members and providers involved in the youth’s care.

## **Best Practice Recommendations for Discharge Planning from Inpatient Care**

Two primary recommendations were developed based on the synthesis of all available input. The following are best practice recommendations for youth receiving inpatient behavioral health treatment.

1. Discharge planning should occur for every child and adolescent who is admitted to an inpatient behavioral health unit, and should begin at the time of admission. The discharge planning process will be supported by the development and consistent use of a standard discharge planning format, including specific forms that will include but are not limited to:

- A summary of treatment received on the inpatient unit
- Documentation of communication that has occurred with all involved family members and providers;
- Discharge medications, and

- Discharge disposition, including a specific ambulatory follow up appointment that has already been scheduled.

2. Children and adolescents often have a number of different family members and providers that are involved in their care and well-being. It is essential that all of these family members and providers, including those involved in the youth's natural support system, engage in timely and comprehensive communication about the youth's treatment throughout both the inpatient stay and the implementation of the discharge plan. Coordination of care among family members and providers is essential to maximize treatment success. It is recommended that standardized communication pathways be established for this purpose, including but not limited to mechanisms to:

- Alert all involved family members and providers that an inpatient admission has occurred
- Obtain timely input from these family members and providers at the beginning of the admission regarding the discharge plan
- Ensure periodic updates throughout the youth's inpatient stay
- Facilitate a smooth transition from inpatient care to outpatient or residential providers, and
- Notify all involved family members and providers that the youth has been discharged from inpatient care, and provide discharge summary material for use in treatment coordination.

The best practices for communication pathways should include standards for the timeliness of the communication actions listed above and the content and quality of those communications.

### **Assistance in Implementing Best Practices in Discharge Planning**

CT BHP recognizes that it can be challenging for any organization to implement new workflows and procedures. During 2008, CT BHP will provide technical assistance to support the customization and operationalization of best practices for discharge planning in specific inpatient behavioral health units. CT BHP will make available two separate packages of materials that facilities can adopt or revise to suit their individual needs.

- The first is a prototype of a "Care Kit" that can be distributed to members or their families to assist and support them as they participate in the discharge planning process and beyond. Included in the Care Kit is:
  - A member pamphlet entitled "Important Information About Your Care After You Leave the Hospital" that includes a section with tips for good discharge planning as well as space for the member to document the specifics of the discharge plan and emergency contact numbers should they encounter problems. This pamphlet is available for use by all CMAP network providers. To obtain copies of this pamphlet for distribution, call CT BHP at 877-552-8247 and speak with a Customer Service Representative,
  - Information about the Peer Support services offered by CT BHP and how to access them,
  - A Joint Commission publication entitled "Speak Up: Planning your Follow-Up Care" that provides members with a helpful check list of questions to ask their physician about their condition and medications they

- are taking. This checklist can be accessed through the Joint Commissions website, [www.jointcommission.org](http://www.jointcommission.org) and
- CT BHP Member Handbook.
  - The second is a toolkit for providers that includes a set of sample forms that can be used by facilities to track communications, discharge plan at the time of admission, treatment planning input, treatment updates, final discharge plan, and crisis plan. To obtain copies of these sample forms call CT BHP at 877-552-8247 and speak with a Customer Service Representative. The forms area available by e-mail so that you can adjust them to suit your needs.

## References

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