Planning for Next Steps

Discharge Criteria and Care Transitions

At New Oakland, our goal to is always to help the people we serve achieve their goals — by connecting individuals to the care they need to live happy, confident, productive lives. This process of understanding an individual's goals is called Person-Centered Planning because it puts the person receiving care at the center of the care planning and delivery process.

An important part of Person-Centered Planning is deciding together what the criteria will be that will help determine when the goals of care have been met. Understanding this part of the process is known as **Discharge Planning** or **Transition Planning** and the milestones that mark progress toward goals are called **Discharge Criteria** or **Transition Criteria**.

Transition/Discharge planning guides every New Oakland consumer in the activities that support the progress made during treatment and assists him or her in moving from one level of care to another. Transition/discharge planning assists the consumer in their recovery and is a crucial component of the treatment process.

As part of an individual's care plan, it is the policy of New Oakland to ensure a Transition/Discharge plan is developed for each consumer. Transition/Discharge planning begins at admission for all New Oakland Family Centers' consumers. During the development of the person-centered plan, transition criteria is addressed and documented. Transition/discharge planning is also updated (in periodic reviews/progress notes) as necessary, during the treatment delivery process, and as treatment is coming to an end (discharge summary).

This is done to prepare each individual for a seamless transition to another level of care, other service providers, community supports, etc. During this process, services and supports are identified to prevent recurrence of symptoms. It is the expectation that each person's length of treatment will be based on need/medical necessity, and assure appropriate utilization of services.

Each person's discharge or transition will be different because each person and his or her care needs are different. But there are some important similarities every New Oakland consumer can expect:

1. **A Transition/Discharge Summary is required for all consumers leaving services.**
2. **A Transition/Discharge summary is developed with the consumer's input, family and/or legal representative (when appropriate), community service providers/referral sources (when appropriate) and the multi-disciplinary treatment team.**
3. **The Primary Therapist is responsible for:**
    a. Scheduling discharge conferences;
    b. Obtaining necessary releases of information to help coordinate care.
    c. Notifying the necessary agencies of the consumer's discharge (i.e. school, work, court, core provider, etc.)

d. Provide all appropriate referrals and resources;
e. Coordinating all discharge plans, as necessary, and schedule aftercare appointments.
f. Doing their due diligence (e.g., calling consumers to set up appointments/attempt to engage in treatment, send letter regarding plan to discharge) prior to closing a case.
g. Informing the consumer of plan to discharge, clarify reasons for discharge, determining service needs, and offering referrals/assistance with services when an unplanned discharge occurs, when possible.
h. Consult with the treatment team (Psychiatrist/Physician/Nurse/Site Supervisor/Director) prior to closing any case where the consumer is currently being prescribed medication from New Oakland, in order to communicate the plan for discharge and coordinate the last medication review appointment, and/or refill of prescription to bridge consumer to another provider for ongoing medication management. Look for any future appointments scheduled in the calendar and request support staff, cancel appointments, and clearly document the plan in the consumer's EMR.
i. Facilitating/assisting the consumer with transition/referral to a higher level of care (if required)

4. **The assigned Primary Therapist is responsible for completing the Transition/Discharge Summary, which includes the following:**
   a. The date of admit and discharge.
   b. The reason for discharge.
   c. The consumer's diagnosis at discharge.
   d. The services provided.
   e. Presenting symptoms, progress toward goals and objectives, and status at last contact.
   f. Discharge medications.
   g. Recommendations for ongoing services and supports, information on options if symptoms recur, and follow-up appointments (name/location, date and times).
   h. Identifying the consumer's Strengths, Needs, Abilities, and Preferences.
   i. The individual's feedback regarding satisfaction/dissatisfaction.

5. **At discharge, the nurse or medication prescriber will review that all consumers have an adequate supply of medication, in order to transition to their aftercare follow-up appointment.**

6. **For individuals in New Oakland's FACE to FACE Partial Hospital Program,** a Discharge Instructions Sheet will be completed with the information necessary to support a smooth transition into the appropriate level of care. The Discharge Instructions Sheet will include the aftercare appointment dates with the name of the clinician being seen and the office name and location. It will also contain the consumer's medication regimen and any further recommendations that will be helpful to the consumer during transition and after discharge. The Discharge Instruction sheet will be reviewed with the consumer.

Discharge planning is an important and exciting part of each person's New Oakland experience because it helps set the person-centered goals we will work toward together. You should always feel free to talk with your primary therapist about your progress toward those goals.