# POLICY AND PROCEDURE

| | |
|---|---|
| **POLICY TITLE:**<br>DSAMH Discharge from Services | **POLICY #:**<br>DSAMH013 |
| **PREPARED BY:**<br>DSAMH Policy Committee | **DATE ISSUED:**<br>08/14/2019 |
| **RELATED POLICIES:** | **REFERENCE:**<br>DHSS PM 66 - Discharge/Transition Practices/Guidelines |
| **DATES REVIEWED:**<br>09/28/2022<br>09/26/2023 | **DATES REVISED:**<br>10/03/2022<br>08/30/2023 |
| **APPROVED BY:**<br>DocuSigned by:<br>Joanna Champney<br>1B71C05196B24CA...<br>**DATE APPROVED:**<br>12/11/2023 \| 6:04 PM PST | **NOTES:**<br>☐DSAMH Internal Policy<br>☒DSAMH Operated Program<br>☒DSAMH State Providers<br>☐Delaware Psychiatric Center<br>☐Targeted Use Policy (Defined in scope) |

I. **PURPOSE:** The purpose of this policy is to identify the required procedures for discharge from services delivered by DSAMH-operated and DSAMH-contracted providers.

II. **POLICY STATEMENT:** It is the policy of DSAMH to require that all DSAMH-contracted and DSAMH-operated service providers adhere to discharge planning standards established by the Division. This policy applies to clients who have become disconnected or disengaged from services, those who have intentionally made the decision to withdraw from services, individuals who have been discharged because goals were met, or for other reasons where continuation of services is no longer appropriate.

III. **DEFINITIONS:**
**"Warm Hand-Off"** means a transfer of care between two staff from within the same or different agencies, where the transfer occurs with the active involvement of the client and/or family. This transparent transfer of care engages clients and families in communication, allowing them to clarify or correct information or ask questions about their care. It also gives the receiving provider critical information.

IV. **SCOPE:** This policy applies to all DSAMH-operated and DSAMH-contracted programs.

V. **PROCEDURES/RESPONSIBLITIES:**
A. Providers of behavioral health treatment should adhere to the following principles with regard for the successful implementation of discharge and aftercare planning:
1. Discharge planning begins at admission with the goal of stable community reintegration. This includes addressing social determinants of health that may not be directly related to

behavioral health needs;

2. Planning must be individualized, comprehensive, and coordinated with other community-based services;
3. Clients must participate in the discharge planning;
4. Discharge plans should include appropriate ongoing treatment and natural supports;
5. Clients should be educated about appropriate resources based on their needs;
6. Providers shall link clients to next-step services through a warm hand-off based on their needs;
7. Client should be connected to a primary care provider to monitor and address any potential or existing medical issues;
8. Discharge planning should include plans for stable housing to prevent vulnerable clients from becoming homeless or involved in the criminal justice system, as appropriate;
9. Discharge planning should address transportation needs to facilitate clients attending their post-discharge appointments, as appropriate;
10. Discharges to emergency shelters should be used as a last resort, after all other options have been exhausted;
11. Discharges to homeless programs that have 24-hour transitional programs may be made on a case-by-case basis;
12. Discharges to independent housing and other types of supportive housing models are preferred; and
13. Planning should assist clients with re-entry to the community.

B. Service Providers should have a uniform, written, discharge planning process.
C. Programs shall develop discharge plans consistent with the level of care. At a minimum, documentation shall include the following elements:
   1. Client's name, discharge address, and phone number;
   2. Admission and discharge dates;
   3. Summary of the client's progress toward treatment plan objectives;
   4. Summary of client's participation in treatment;
   5. Any unresolved issues including information related to client's ongoing concerns, needs not addressed during treatment, and client's plan to address ongoing needs.
   6. Reason for client's discharge including whether the discharge was voluntary or involuntary; and
   7. Recommendations regarding the need for additional treatment services including referrals provided.
D. If the client is able to be contacted at the time of discharge, the client shall receive written discharge documents that include the following information:
   1. A transfer summary, if transferring to another level of care, which should accompany the client to any other facility or program;
   2. The client's medications if prescribed by the discharging provider;
   3. Appointment times, locations, and name of providers the client is scheduled to meet with post-discharge;
   4. Documentation of transportation arrangements post-discharge;
   5. Contact information for other service providers the client may use to support living in the community;
   6. A list of referred and deferred goals following discharge from treatment;
   7. If required by program standards, the client's crisis plan created with the direct involvement of the client;
   8. Referrals for all aspects of treatment and care in community, including the filling of

medication and information on how to access; and

9. Assistance with ensuring client has proper identification documents needed to successfully live in the community if required by program standards.

**VI. POLICY LIFESPAN:** This policy will be reviewed annually.

**VII. RESOURCES:** N/A