POST CRISIS DISCHARGE PLANNING & PATIENT ENGAGEMENT

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THE CRISIS

- Crisis begins
- Person seeks help or help is sought for them
- Treatment begins (Crisis center, Inpatient Hospital, Emergency room, Rehab/Residential facility)
- Short and Long-Term treatment plan is formulated

- What should this look like?
- What do you need to consider?
- How do you get the patient engaged?
THE CRISIS: SOCIAL DETERMINANTS TO CONSIDER

- How did the patient end up in crisis?
- Do they have finances?
- Do they have a support system in place?
- Do they have a safe place to live?
- Do they have legal history or current legal issues?
- How did the patient end up in crisis?
- Do they have access to food and toiletries?
- Are they familiar with community resources?
- Do they know what to do if they are in crisis again?
- Do they have transportation?
WHAT DOES TREATMENT LOOK LIKE?

- Inpatient treatment isn’t long term
- Hospitalization is primarily acute crisis stabilization
  - Does the crisis end at discharge?
- Crisis stabilization
  - 23 hours
  - 3-7 days
- Safe Environment
- Group therapy
- Activity Therapy
- Medication
- Family support/involvement
- Discharge planning
THE CRISIS PLAN

- What does a crisis plan look like?
- NAMI recommends considering a document that has some basic information for the patient if they are to experience a crisis [1]
  - Patient's demographic and insurance information
  - Crisis phone numbers
  - Crisis walk in centers
  - Names of primary support people and their phone numbers
  - List of current medication
  - Triggers
  - What skills have helped in the past
THE TREATMENT PLAN

- Who decides on the plan for the patient?
  - The Doctor
  - The Therapist/social services clinician
  - The outpatient clinical team
  - The patient
  - The patient's family/support system
  - The inpatient clinical team
  - Probation officers or other legal entities
THE TREATMENT PLAN

- Team approach
  - The patient is the captain of the team
- The team provides
  - Medication stabilization
  - Therapy (individual, group, activity, family)
  - Discharge planning
- What does the patient need to be ready for discharge?
- What will the discharge plan look like?
DISCHARGE PLANNING

Discharge to:

To be picked up by:

Appointment with:

PCP appointment:

1 + 2 = 3

A + B = C
DISCHARGE PLANNING

- Is the formula this simple?
- Re-consider all of those social determinants
- What will make the patient most successful?
- “Discharge planning is a dynamic, comprehensive, and collaborative process that should be started at the time of admission” [3]
- “Discharge planning is a methodology, a discipline, a function, a movement, and a solution” [3]
“Nonpsychiatric obstacles such as housing, employment and need for income that serve as difficult barriers to effective planning must be dealt with” [3]
“Inpatient treatment should include the coordination of community services that are matched to the patient’s level of functioning” [3]

Level of functioning:
- SMI
- GMH
- DDD

Do we assume level of functioning is related to RBHA/Benefit status?
- Does GMH = Higher functioning
- Does SMI = Lower functioning
- Does DDD = Lower functioning or lack of independence
DISCHARGE PLANNING

- What is required in a discharge plan?
  - HEDIS measures
    - PCP appointment
    - BH appointment within 7 days
  - Transmittal documents
- If the minimum is met, is that enough?
- Can a patient be successful with the minimum expectations met?
Some patients can be successful with the minimum necessary discharge plan

- Return home
- Fill Rx at local pharmacy
- Appointment with PCP
- Appointment with Psychiatric provider
- Appointment with Therapist
- Family support in place
- Return to work
What about all the others?

- **SMI**
  - Assigned clinic
  - Assigned case manager
  - RN
  - Provider
  - Therapy
  - Integrated with PCP or communicating with PCP
  - Support groups
  - Transportation
  - Vocational rehab benefits
  - Housing benefits

- **GMH/Commercial**
  - Community clinics available
  - Minimal case management
  - Therapy
  - Provider

- What happens if they don’t make it to an appointment?
- Does anyone check?
SUPPORT WITH DISCHARGE PLANNING

1. Intake
2. Provider
3. Therapy
4. PCP

Community Clinic appointment:

- IOP/PHP/Momentum
- Meds to Beds SLBHC
- Probation/Parole/Legal Services

- Transportation services
- Sober living

Connections Transitions Program

- Navigator Programs CBI, Valle Del Sol, Terros
- Residential Programs & TLP's
COMMUNITY COLLABORATION

- Carol Friesen MPH, FHFMA the VP of Health Systems Services in Bryan, Nebraska states, “patients want to see their providers as a partner in their health” [2]
- “Successful community healthcare partnerships usually have 3 key stakeholders- the hospital and it’s partners within the community” [2]
- How do you develop those relationships with community partners?

- Just like with the treatment plan, the collaboration in the community is a team process

Who are the team members?
LET’S TALK FOOTBALL

Quarterback = Patient

Who protects/supports the quarterback?
It’s not enough to hand the patient a list of referral sources, housing facilities etc.

When you partner with other agencies, get to know their staff, understand their processes, you are better able to guide/support the patient to make decisions about their healthcare and help them to engage in services.

Educating a patient and helping them understand what to expect in treatment engages them in their services more effectively and doesn’t take that much extra time for you.

- If they have met a person at the next level of care, talked to someone there, or are brought there with a supportive member of a treatment team, they will engage actively in their treatment plan.
- If they are scared or confused they may not...
COLLABORATIVE PARTNERSHIPS

- Housing facilities
- IOP/PHP
- Vocational Programs
- Integrated PCP/BH programs
- MAT clinics
- Transitional Programs
- Navigation Programs

Behavioral Health Hospital
Scenario: Male adult patient with GMH AHCCCS benefits discharging from the inpatient hospital. He has dual diagnosis of Unspecified Bipolar Disorder and Substance Use Disorder (opioid dependence). He has appointments with an outpatient clinic for initial intake in 4 days. He is homeless, has no transportation and no supports in the community.

- You give the patient a list of sober living houses and tell him to see if he can find a bed. “Hi I am looking for a place a live”

- You call the sober living houses and talk to the managers who you talk to regularly, “Hey Bob how’s it going? I have a great resident for you, do you have any beds?”

- Who gets the bed?
- Is collaborating that important?
LET’S DISCHARGE SOME PATIENTS

Sally Smith 35y female

- In a crisis after her a break-up from her boyfriend, was suicidal with a plan to overdose
- History of meth abuse
- Lost kids to DCS
- Only support is a sister in Tucson
- GMH on AHCCCS
- Been to UPC twice before but never attended follow up appointments
- Lost job recently due to meth use

Frank Foster 52y male

- In crisis after a job loss laid off due to covid, history of working as a car mechanic
- Became depressed and anxious post layoff and attempted suicide by hanging, ceiling fan broke
- Divorced & his children are grown and out of state
- Just got AHCCCS
- Has unemployment income but fearful it will run out
- Has never been in treatment before
REFERENCES


