Discharge Planning

PUTTING AN END TO THE GOLDEN THREAD

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Training Outline

- ❑ Reference CRHC Policy C6 – all about case closure!
- ❑ Review difference between disengaged and not meaningfully engaged
- ❑ Key factors for a successful discharge reviewing, planning and communication
- ❑ Common Care Coordinator activities - documentation
- ❑ Writing a comprehensive Discharge Summary

CRHC Policy C6:
Case Closure and Re-engagement

CRHC Policy C6 addresses all aspects of case closure at any time during case progression for any reason.

A. Case Closure and Re-engagement during Outreach
B. Identifying Members Ready for Disenrollment
C. Excluded Setting: Hospitalizations and Incarcerations
D. Disengagement and Transition to Diligent Search Efforts
E. Diligent Search Efforts
F. Member Re-engagement
G. Documentation Requirements at Case Closure

**Plus SEVERAL helpful attachments!

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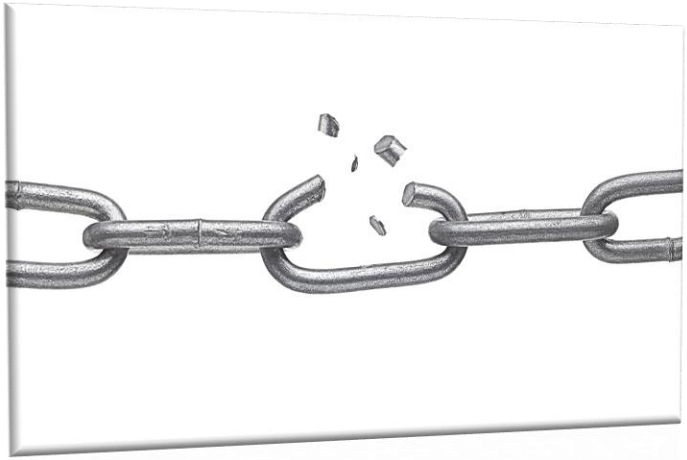
Definitions:
Not Meaningful Engaged vs Disengaged

Members who are not meaningfully engaged are those we are in contact with, but not making progress with.

Disengaged Members are those we lost contact with over time.



Members who are disengaged go into Diligent Search Efforts

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Definition: Disengaged

A Member is considered Disengaged when one of the following has occurred:

- ❑ The Care Coordinator has not been able to make direct contact with the Member in 30 days and this lack of contact is out of character for the Member.

- ❑ The Care Coordinator has not been able to make direct contact with the Member in 60 days.

After 60 days without direct contact, the Member is considered Disengaged and must be placed in Diligent Search Efforts status.

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The 30-to-60-day clock starts at the time of the first unsuccessful contact with the Member!

Definition: Discharge

Discharge is a planned exit from Health Home program. A Member may be ready for discharge when one of the following occurs.

Plan of Care Objectives Met:

- The Care Coordinator and Member have discussed the current Plan of Care and determined that the articulated goals, objectives and interventions have been achieved to the extent they can be under Health Home services and there are no additional goals to pursue related to the Member's overall wellness.

Not Meaningfully Engaged:

- The Member opts not to engage with the program and possibly has limited communication with the Care Coordinator.

No Longer Eligible:

- The Member is no longer eligible for Health Home services.

Key Factors for a Successful Discharge

Two key reasons why a discharge may not be successful….

Lack of Planning

Lack of Communication

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Discharge is a Process

If successful discharges need to be Planned and Communicated, the likely cannot be successfully done in one meeting.

Think of discharge as a process rather than an event

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Why Make it a Process

- ✓ It's good Member care
- ✓ Helps Members to see that they are "ready to leave"
  1. POC objectives met
  2. Self-care capacity / Skill development
  3. Successes
- ✓ Helps Members to know that they can return if they feel they need services again
- ✓ Allows for time to communicate among providers and supports
- ✓ Allows time for Care Coordinator and Member to terminate the therapeutic relationship

Why Make it a Process

Viewing discharges as a process can help prepare the Member and ensure a successful transition off Health Home services.

1. Review to determine if ready for Discharge
2. Plan the Discharge
3. Communicate the Discharge Plan
4. Document the Discharge

These steps may occur over several months.

Discharge is a Process: Review

While there are some criteria for Discharge, it is really a case-by-case decision.

Some factors to consider:

1. Are there current Objectives and Interventions in the Plan of Care ones that the Member is ready to work on?

2. While the Member may not be making significant progress on Plan of Care Objectives and Interventions or all seem resolved, is he or she still benefitting from Health Home services?

3. Will the Member be at significant risk in terms of medical, mental health or substance abuse needs if the Member is discharged?

If discharge does not seem like the best option, review the Plan of Care with the Member to update Objectives and Interventions the Member is ready to work on.

Discharge is a Process: Review

Be sure to update you Plan of Care so that it reflects the Member's status at time of discharge.

If Objectives and Interventions are complete, mark them as complete on your Plan!

If a Member is ready for Discharge, the **planning** begins!

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Tool: Graduation Readiness Questionnaire

Tool that can be used as Care Coordinators see fit to help determine if a Member is ready to graduate from services.

Discharge: Graduation Readiness Questionnaire

Graduation / discharge should be considered when the Care Coordinator and the Member have discussed the current Plan of Care and determined that the articulated goals have been achieved to the extent they can be under Health Home services and there are no additional goals to pursue related to the Member's overall wellness. This questionnaire may be used to help determine if additional goals should be worked on with the Member.

The intention of this questionnaire is not to create set criteria for discharge/graduation. Decisions to discharge someone should be made on a case-by-case basis and discussed with the Member and Care Coordinator's Supervisor. This checklist may serve as a guide when discussing graduation readiness.

Utilization	Yes	No	N/A
Has the Member managed to avoid unnecessary ED visits in the past six months?	☐	☐	☐
Has the Member managed to avoid unnecessary inpatient hospitalizations in the past six months?	☐	☐	☐
Comments:			

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Discharge is a Process: Planning

What will help the Member maintain and sustain self-care on their own in the community?

Things to consider:

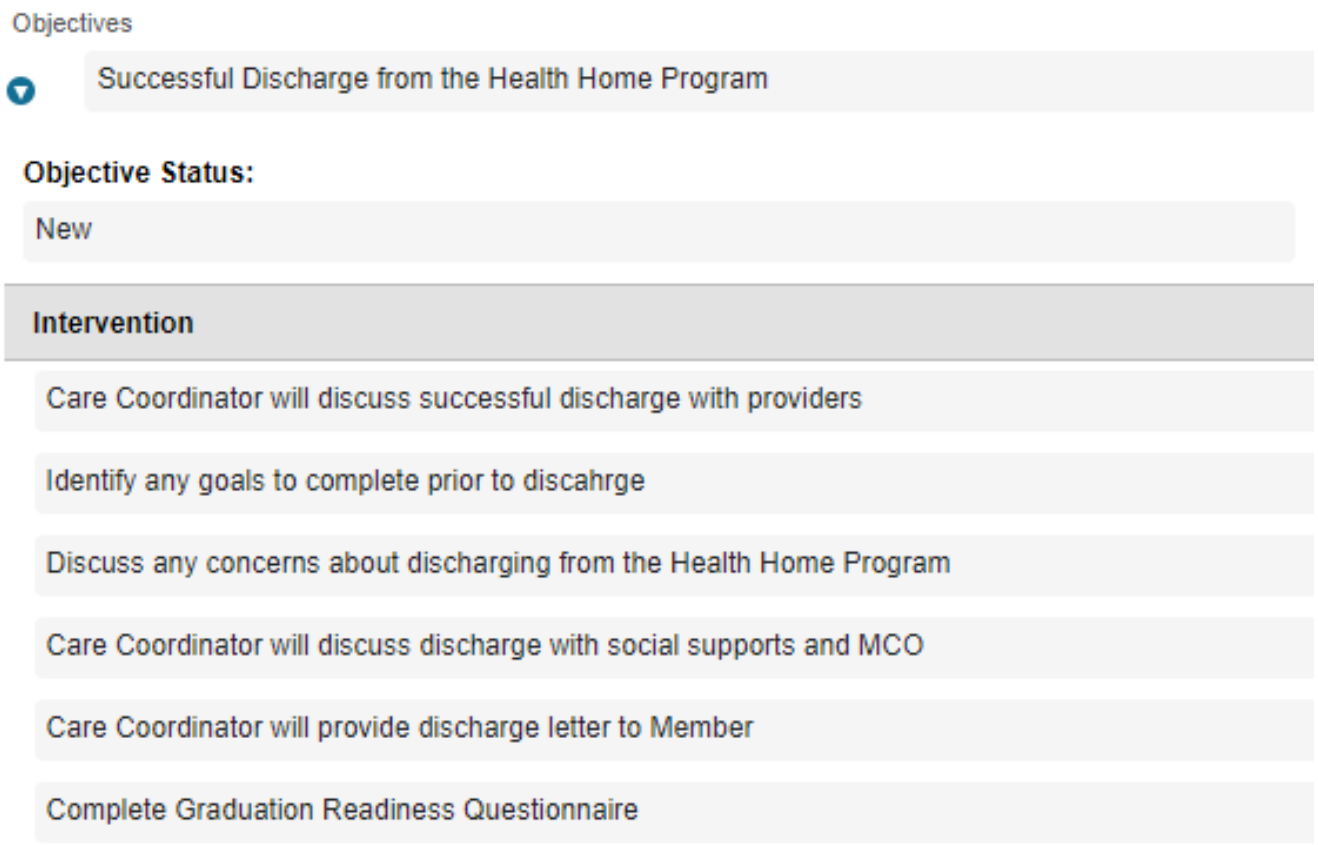
1. Does the Member know who all their providers are and when to engage with them?
2. Can the Member schedule/arrange for their own transportation?
3. Does the Member know what medications they need to take and how to refill them?
4. Are there any outstanding Social Determinants that need to be addressed (food, housing, etc.)?

Best Practice: Update the Plan of Care to include steps needed to be prepared for discharge.

Discharge is a Process: Planning

Plan of Care Amendment

Objective: Successful Discharge



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Discharge is a Process: Communication

Once the plan for discharge is created, it is time to start **communicating** that plan.

What should be communicated?

1. Plan of Care
2. Anticipated timeframe for discharge
3. Supports / Providers who will continue providing care post-discharge

Discharge is a Process: Communication

Who should be informed of the plan for discharge?

1. Consented Providers / Supports
2. Member's MCO, if applicable
3. Referral Source, if still involved in the Member's care
4. The Member

Don't forget to solicit the provider / support / Member for their input on the plan for discharge.

- *Do they have concerns?*
- *Anticipate barriers?*
- *Have suggestions for additional resources for the Member?*

Tool: Provider and Support List

This optional resource is one way to communicate the plan for post-discharge supports with the Member.

Provider and Support List

Member Name: _____ Anticipated Discharge Date: _____

Provider/Support	Name	Telephone	Address, if applicable	Next Appointment, if applicable
Primary Care				
Behavioral Health				
Substance Use				
Preferred Pharmacy				
Supports and Resources				
Specialty Provider				
Specialty Provider				
Specialty Provider				

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Discharge is a Process: Documentation

Documentation is just as important as the work we do!

Documentation to provide to the Member

- Required Disenrollment Letter
- DOH 5235: Notification of Disenrollment
  - *Only required for discharge reasons listed on form!*

Documentation in CareManager

- Opt-out Hixny Consent in CareManager
- Final HML
- Discharge Summary and Proper Closure Reason

Tool: Case Closure Workflow

Checklist that can be used to make sure all steps are covered, particularly around forms and documentation.

Case Closure and Workflow

The following workflow follows CRHC Policy and Procedure C6. Care Coordination Case Closure and Re-Engagement. This document seeks to outline the required paperwork and documentation at time of case closure.

Discharge Readiness
☐ Discuss discharge with the Member to ensure readiness and prepare the Member. This preparation may take more than on meeting or contact – discharge is a process, not an event.
☐ Review the Plan of Care with the Member and update Objectives or Interventions as appropriate. Close out any that were achieved. Be sure to at least leave on the Care Coordination activities so you can continue to document billable notes as needed.
☐ If there are unmet needs, be sure the Member has the appropriate resources or supports in place to address them post-discharge.
☐ Contact any relevant and engaged providers on the Care Team to let them know about the upcoming discharge including the anticipated timeframe. Be sure to solicit for their thoughts on the Members readiness for discharge.
☐ Communicate the discharge to the MCO if applicable. Don't forget that Members with Fidelis may be able to benefit from their telephonic case management services.

Documentation Requirements
☐ If the Member's case is closed due to ineligibility, inappropriateness or loss of contact, provide the DOH 5235 *Notification of Disenrollment in the NY Health Home Program* to Member at least ten (10) days in advance of closing case and upload a copy into CareManager.
☐ Regardless of closure reason the CRHC Disenrollment Letter must be sent to the Member letting him or her know that the case is being closed. Please be sure to update all information to tailor the letter to your Member and their reason for closure and put the letter on your agency's letterhead.
☐ End the Consent in CareManager by opened the Electronic HIE consent, clicking Edit and changing the value in the Client Opt-in/Out drop down to "Client Opt-out" and save.

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DOH 5235 Clarification

DOH 5235:

Only provided if one of these apply

OR

the Member is not in agreement with the closure.

Sent 10 days prior to closure!

This is to advise you that effective _____ (Date) this agency _____ (Name of Health Home) will

Disenroll you from the Health Home Program

You do not meet the criteria necessary for continued enrollment and you are being disenrolled from the Health Home Program, as of the effective date listed above, for the following reason(s):

- ☐ You no longer require Health Home Care Management Services because you do not meet the appropriateness criteria below (check all that apply)
  - ☐ You have currently met all of your wellness and recovery goals
  - ☐ You are no longer at risk for an adverse event (e.g., death, disability, inpatient or nursing home admission, mandated preventive services, or out of home placement)
  - ☐ You currently have adequate social/family/housing support
  - ☐ You currently have no serious changes in family relationships
  - ☐ You currently have adequate connectivity with the healthcare system
  - ☐ You currently adhere to treatments
  - ☐ You currently do not have difficulty managing medications
  - ☐ You no longer have impairments in activities of daily living, learning or cognition issues
  - ☐ Other _____
- ☐ You are concurrently eligible or enrolled, along with either your child or caregiver in another Health Home
- ☐ You currently reside in an excluded setting (e.g., Residential Treatment Facility, Nursing Home, Incarceration etc.)
- ☐ You have been lost to follow up and we are unable to provide Health Home Care Management Services to you
- ☐ You no longer meet the Health Home chronic condition eligibility criteria. You must have either:
  - Two or more chronic conditions OR
  - One single qualifying chronic condition:
    - HIV/AIDS (Adults and Children) or
    - Serious Mental Illness (SMI) (Adults only) or
    - Serious Emotional Disturbances (SED) (Children only) or
    - Complex Trauma (Children only)
- ☐ You no longer have the appropriate type of Medicaid Coverage for Health Home Services.

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Required Disenrollment Letter

This letter must be sent at time of closure.

The letter must be on your CMA letterhead.

You can edit the reason for closure, but all else needs to stay the same.

Dear [MEMBER NAME],

This letter is to let you know that you are officially being disenrolled from the Health Home program at [CMA NAME]. Your case is being closed because [INSERT REASON].

This means that effective [CLOSURE DATE] all consents you signed for the program are no longer valid, active consents.

If you need help with care coordination in the future or would like any of the documents we completed together, please contact us at [PHONE NUMBER]. You can also contact any of the numbers below in you need help in the future.

Capital Region Health Connections, your Health Home at [CMA NAME]	[CMA NUMBER]
Your Managed Care Organization (MCO): _____	[MCO NUMBER]
New York State Medicaid Helpline	800-541-2831
New York State Medicaid Choice	800-505-5678
New York State Office of Temporary Disability Assistance (OTDA)	518-473-1090

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Tool: Graduation Certificate

Celebrate the successes!!

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Discharge is a Process: Documentation

The discharge summary is essentially a summary of the discharge process.

At a minimum, the following should be included.

Circumstances the led to discharge	Review
The Member's status at time of discharge and plans for maintaining	Plan
Who is involved in the care of the Member and who we notified of discharge	Communicate
Notes paperwork completed or any lacking required documentation and why it is lacking	Document

Discharge is a Process: Documentation

Discharge Summary Example – Not so good.

Discharge Date	Discharge Time
05/30/2019	02:13 PM EDT
Discharged By	**Reason for Discharge**
[redacted]	12 - Refused to Sign or Rescinded Consent

Comment

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Discharge is a Process: Documentation

Discharge Summary Example – Not so good.

Member opted to withdraw from Health Home services.

Discharge is a Process: Documentation

Discharge Summary Example – Not so good.

Despite multiple attempts to engage client, care coordinator was unsuccessful.

Discharge is a Process: Documentation

Discharge Summary Example – Good.

Member was referred to the HH in November 2019 by HARP Case Manager at Fidelis for risk of losing housing, assistance with transportation, lack of social support, food insecurities, poor connectivity with health care providers, and high-risk health issues. Member is diagnosed with Carpal Tunnel, social phobia, depression, and asthma. During Member's enrollment with HH program Member was rarely engaged with this writer. In the month of July Member was placed into Diligent Search Efforts (DSE) due to having no contact with previous CC for more than 30 days. Writer made attempts to contact Member through notifying Member's MCO, phone calls, face to face visits as well as pop-up visits. Writer sent Member multiple notifications through mail that if Member would like to remain receiving the services from the HH program to reach out to writer. Writer never received notice from Member stating that they would like to remain in the program. Member remained in DSE for the month of July and August and these attempts were made throughout those months. Member was provided the Notification of Disenrollment on 8-17-21. Due to Member's lack of engagement member will be disenrolled with the HH program as of 8-31-21. Member's MCO and mental health provider [Provider] were notified of the closure.

Discharge is a Process: Documentation

Discharge Summary Example – Good.

Member is being discharged due to residing in an excluded setting. Member entered excluded setting status on 5/1/19 when member entered Conifer Park. Member was transferred from Conifer Park to another excluding setting: Samaritan Village which is a 6 to 9 month stay. On 6/4/19, writer informed MMTP Counselor [Provider Name], FACTS provider [Provider Name], and LEAD [Provider Name], via e-mail that due to member being in excluded setting with Health Home since 5/1/19 (after his admission to Conifer Park) and due to Samaritan Village being a 6-9 month program, member will need to be discharged from Health Home services. Writer stated that writer will be reaching out to Samaritan regarding this and will also be mailing member the discharge paperwork directly to Samaritan. Writer also informed these providers that member can be referred back to health home services upon discharge if member is still in need of services. Writer stated that member's official discharge date with health home will be 6/14/19. On 6/4/19, writer also left detailed message for referral source St Catherine's [Provider Name] regarding members discharge on 6/14/19. Writer had also informed Samaritan Village of this discharge on 6/4/19. Writer mailed member a discharge letter and NOD for disenrollment informing member of upcoming discharge on 6/14/19 due to residing in an excluded setting. This documentation was mailed to Richman Hill location at 13020 89th Road Richman Hill NY 11418.

Discharge is a Process: Documentation

Discharge Summary Example – Good.

Member is being successfully discharge from Health Home. HHCC [CC Name] discussed a successful discharge with member face to face. Since member has worked with HHCC [CC Name] she has linked member to Whitney Young Health for primary care and dental, linked him to a urologist that accepts member insurance, changed member managed care plan that works in his favor, assist him with getting a safe link cellphone and taking steps to get him hearing aids. Member agreed with these things and agreed he was ready for a successful discharge. HHCC [CC Name] and member completed the graduation readiness discharge questionnaire. Member identified he has stable housing, able to maintain his benefits, he is linked to all his provider (PCP, dental, behavioral health and urologist), calls and makes his medical appointments, utilizes public transportation to get around in the community and has not had any recent hospitalizations. Member identified his family, friend of 17 years, people at NA/AA groups and his clinician [Provider Name] as his supports. HHCC [CC Name] contacted member PCP [Provider Name] and [Provider Name] to inform them of member successful discharge. HHCC [CC Name] mailed member a discharge letter informing him he will be discharged on 5/24/2019. Member has no questions or concerns with being successfully discharged.

Discharge is a Process: Documentation

Discharge Summary Example – Good.

[Member] was enrolled into the Health Home Samaritan Care Management program on November 1, 2020. [Member] was referred to care coordination for lack of social and family support, lack of attending appointments as well as taking medications as prescribed. Since working with Samaritan Care Management, [Member] was connected with providers needed such as Cardiology, Gastroenterology and Hematology. [Member] was provided with reminders of medical appointments as well as transportation and assistance at her appointments. Since care coordinator was transferred [Member]'s case in April, she has been hospitalized six times due to decline in health related to COPD, Renal Failure, Anemia and Aortic Valve Stenosis. Care Coordinator received a HIXNY alert of [Member]'s discharge from Samaritan on 09.05.21 where it was learned [Member] passed away on this date. [Member]'s family signed a DNR and DNI during Member's latest hospitalization. Care Coordinator proceeded to leave a voicemail for [Member]'s son to give her condolences at this time. Care Coordinator also informed Twin River's Medical where [Member] was seen by [Provider] as her PCP and [Provider] from Nascentia of her passing.

Discharge is a Process: Documentation

Discharge Summary Example – Good.

[Member] was enrolled in the Health Home program on 10/07/2020. At the time of enrollment, [Member] identified that he needs assistance with being more consistent when it comes scheduling and attending his medical appointments to maintain optimal health. During his time in the program, [Member] attended various medical appointments. He also started to submit applications to move out of his sister's residence. [Member] went to visit with family in Florida on 4/2020 and had told his Care Coordinator that he would return soon. [Member] has now been in Florida for several months and states that he is planning to stay with family in Florida for an extended period and does not have a set return timeframe. Due to this, [Member] will be discharge from the Health Home program. [Member] was told that he can re-enroll on his return. [Member] is being disenrolled since he is not currently living in a serviceable area for Capital Region Health Connections. Member's PCP and MCO were notified of his relocation. No mailing address was provided, and therefore discharge paperwork was unable to be mailed to the Member.

Discharge is a Process: Recap

Steps	Purpose	Tools / Resources
Review	Is the Member ready, or close to ready for discharge?	Graduation Readiness Questionnaire
Plan	What needs to be accomplished for the Member to be discharged?	Add a Discharge Objective to the Plan of Care
Communicate	Make sure the Member, consented providers and supports know the plan and have an opportunity to weigh in on the plan	Provider / Support Template
Document	• Provide the Member with the Required Discharge Letter and DOH 5235 (if applicable) • Document in CareManager (Opt-out Hixny Consent, Final HML, Discharge Summary and appropriate closure code)	• Case Closure Workflow • Required Discharge Letter • Graduation Certificate

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This process can occur over several months – it's never too early to start to plan for discharge!