EXHIBIT 13

PURPOSE:

To ensure that elements important to the discharge/aftercare planning phase of patient care are developed and implemented consistently.

POLICY:

It is the policy of Sheppard Pratt Health System to establish realistic discharge and aftercare treatment plans for all patients.

GUIDELINES:

Under the supervision of the Service Chief/Medical Director, the attending physician ensures that each patient receives discharge/aftercare planning services in keeping with the patient's individual needs and resources at different stages throughout treatment. Discharge planning starts at the beginning of the patient's hospitalization. The attending physician shall prescribe the discharge/aftercare plan in coordination with the treatment team. The discharge/aftercare plan is developed as a recommendation to the patient and family and/or guardian. The social worker functions as the discharge coordinator in the absence of a designated discharge coordinator. The social worker integrates efforts of team members and works with the patient, family, and the aftercare providers. Aftercare needs commonly include the following:

a. continued mental health (psychiatric) treatment/medication management
b. place of residence
c. management of daily activity
d. vocational/educational career
e. social support system
f. transportation
g. finances, including eligibility for public entitlement programs
h. designation of treatment manager (i.e., selection of person to have ongoing responsibility for management of treatment)
i. emergency contacts
j. nutrition intervention (if applicable)
k. medication payment resources
l. medical management, when necessary

Any additional aftercare needs will also be stated in the treatment plan. Whenever possible, aftercare providers are included in the treatment planning and the aftercare planning.

PROCEDURE:

I. Intake

The admitting doctor collects sufficient information to permit the development of an initial treatment plan. The attending physician/therapist is responsible for contacting the referring therapist.

II. Assessment

A. The social work psychosocial evaluation will provide information to assess discharge planning issues in the first phase of the treatment process. The attending physician, in consultation with the social worker and/or the discharge coordinator, will be responsible for identifying patients with critical discharge needs.

B. During the Master Treatment Planning process, discharge planning will be discussed and problems identified.

C. Discharge planning issues will be reassessed with the patient and family/guardian, when appropriate, throughout the patient's treatment.

III. Discharge Planning

The attending physician, social worker, and discharge coordinator will plan with the patient and family, when appropriate, for specific discharge/aftercare needs. Generally, patients are referred back to their referring source if further treatment is indicated. If this is not feasible, the patient will be referred to other outpatient services. Unless a patient and/or family/guardian refuse assistance, patients will be discharged with an aftercare appointment within 7 days of discharge. The attending physician or designee will complete the Discharge Summary which will include a description of the discharge plan.

At the time of discharge, the patient's medication will be reconciled. A list of medication that the patient is taking on discharge shall be included with the Discharge Information for Patients document. The patient and the attending physician shall sign the form. The original is given to the patient and/or guardian/significant other, if appropriate. A copy of the Discharge Information for Patients document and medication list shall also be sent/given to the patient's next provider of care.

For patients discharging to a nursing home, a discharge summary, Medical Eligibility Review Form (3871), and Department of Health and Mental Hygiene Preadmission Screening and Annual Resident Review (PASARR) accompany the patient to the nursing home and are also sent to the nursing home within at least 5 days of discharge.

IV. Discharge Follow-up

The attending physician or his/her designee (usually the assigned social worker) provides information to those involved and ensures that they understand the alternative(s) available. Social workers and discharge coordinators facilitate the coordination of all aspects of the aftercare plan.

V. Discharge Summary Guidelines

A discharge summary is required for all discharged patients and all individuals released from Observation Status. The discharge summary will include:

A. Chief complaint and history of present illness
B. Admission mental status
C. Summary of overall psychiatric course while in the hospital
D. Medical course and pertinent medical tests
E. Aftercare plan
F. DSM 5 diagnoses
G. Condition on discharge
H. Type of discharge
I. Prognosis

VI. Categories of Discharge

A discharge order must be documented. The attending physician must document any discharge order other than straight or medical discharge. Clinical judgment regarding the patient's status at the time of departure determines the category of discharge.

A. Straight

Straight discharge is for patients who are clinically ready for discharge with established aftercare arrangements. Straight discharge is granted for patients who leave the hospital in accordance with recommendations of the treatment team.

B. Against Medical Advice

1. Patients who have been voluntarily admitted to the hospital may be discharged "Against Medical Advice" only if all of the following have occurred:

   a. The patient or person who signed the Voluntary Admission Agreement makes a written request to leave the hospital and completes a Three Day Notice of Intent to Leave.

   b. The patient and the treatment team strongly disagree on:
      - the benefit of further inpatient treatment;
      - the need for or type of treatment post discharge;
      - the planned living arrangements post discharge; or
      - the plan for medication post discharge.

   c. The primary therapist must explain to the patient the reasons for the treatment team's objection to the patient's discharge. The explanation and the conversation with the patient must be documented in the patient's medical record.

2. If the patient continues to request discharge, then the patient must be assessed by the attending physician on the following five criteria for certification for involuntary admission:

a. The patient has a mental disorder. "Mental disorder" means a behavioral or emotional illness those results from a psychiatric or neurological disorder. "Mental disorder" includes a mental illness that so substantially impairs the mental or emotional functioning of the patient as to make care or treatment necessary or advisable for the welfare of the patient or for the safety of the person or property of another. "Mental disorder" does not include mental retardation.

b. The patient needs inpatient care or treatment.

c. The patient presents a danger to the life or safety of the patient or others.

d. The patient is unable or unwilling to be admitted voluntarily.

e. There is no available, less restrictive form of intervention that is consistent with the welfare and safety of the patient.

The physician performing this assessment shall document the assessment in the patient's medical record.

3. If the patient does not meet the above criteria for certification for involuntary admission, then the treatment team shall proceed with the following for AMA discharge:

a. If the hospital has an authorization to release protected health information to the patient's family, or the family is present at the time of the patient's discharge, the attending physician or designee (usually the social worker) shall notify the family of the reasons for the treatment team's objection to the patient's discharge. This conversation shall be documented in the patient's medical record.

b. The patient and the patient's family, if present at discharge, shall sign the Against Medical Advice Form (#0101131), which shall be filed in the patient's medical record. If the patient or family member/guardian (if any) refuses to sign, this shall be documented in the patient's medical record. The patient and family, if appropriate, shall also receive the recommended discharge plan. Receipt of the discharge plan shall also be documented in the patient's medical record.

4. If the patient meets the above five criteria for involuntary admission, then the physician shall complete a Certificate for Involuntary Admission based on the assessment, and a physician(s) or psychologist shall assess the patient and complete certificates if the criteria are met. Both certificates must be completed within seventy-two (72) hours of the submission of the patient's completed Three Day Notice of Intent to Leave form.

C. Administrative

Conditions that could lead to an administrative discharge are:

1. a patient refuses to comply with treatment recommendations;

2. a patient exhibits behavior that constitutes a threat to the therapeutic milieu of the unit;

3. a patient who is not on certificates is ordered to be released by a judge or juvenile master and the timing or disposition of the discharge is not recommended; or

4. a patient or guardian (for minors) requests discharge and the timing or disposition of the discharge is not as recommended, but all the criteria for an AMA discharge are not met.

Before an administrative discharge may occur, all facets of the patient's program must be evaluated and documented including the patient's background, the amount of effort by both staff and patient to work through the problems, and particularly the treatment situation of the unit and staff.

Such discharges require approval of the appropriate Medical Director upon recommendation of the Service Chief. Documentation should reflect that it is a team decision to discharge and all other resources have been exhausted. If the hospital has an authorization to release protected health information to the patient's family, the family of the patient shall be notified in advance that an administrative discharge is being considered.

D. Medical

This category applies when a patient leaves SPHS for inpatient medical treatment at a nonpsychiatric medical facility.

VII. Release from Observation Status

Individuals on Observation Status are not eligible for discharge from SPHS. Individuals released prior to hearing or by the Administrative Law Judge are not considered as having been admitted to the Hospital; no discharge category applies. If an observee is released prior to the hearing or by the Administrative Law Judge at the hearing, the doctor shall note in the observee's record that the observee was "released from Observation Status." A discharge summary is necessary. Patients who are placed on Observation Status after a voluntary stay and who are released by the Administrative Law Judge are discharged effective the day Observation Status began.

VIII. Discharge for Admission to Another Psychiatric Facility

When a patient is sent directly from the hospital to another psychiatric facility, the patient is discharged from the hospital using one of the above categories. In the event that a staff member must accompany the patient to the receiving facility, the patient and/or patient's family must be notified that a charge will be made for such staff services. These arrangements must be made well ahead of the actual day of discharge so that the appropriate staff arrangements can be made.

The discharge coordinator or other designated unit staff prepare copies of pertinent clinical documents to be forwarded with the patient. This should include a discharge summary, History and Physical, labs, consults, and psychological testing.

Confirmation that the patient was admitted to the other facility must be documented. A statement by a family member that they plan to take the patient to another facility is not sufficient.

References:

CM-210.3 Inpatient Admissions
CM-210.5 Involuntary Admissions
CM-220.3 Patient Transfers
CM-220.5 Three-Day (72 Hour) Notice and Retraction
CM-320.3 Deceased Inpatients and Organ, Tissue, and Eye Donation Protocol
CM-410.7 Referral Relations
CM-420.4 Health Information Management

Attachments:

Revision Dates:

4/15

Reviewed Dates:

6/87, 2/91, 1/93, 6/94, 1/98, 9/02, 10/03, 4/06, 3/07, 3/09, 4/10, 4/15

Signatures:

Ernestine Cosby: 4/06/15
Robert Roca: 4/06/15