Emergency Procedures Stakeholders Group – 6/14/21

Discharge Planning discussion

- For both Designated facilities and Emergency Departments
- Define "Discharge Summary"
- There should be added language outlining access to needed medications until outpatient care begins
- Discharge note
  - Typically two separate discharge summaries
    - Formal discharge summary with narrative and smaller brief summary
  - Difficult to get course of treatment document prior to discharge
  - More involved medication education – informed consent
    - Should there be more focus on support utilization/ training/ transition into society as opposed to medication
    - Include pharmacists on medication education – more comprehensive medication understanding/ more time to relay information
- Meds you can get in a hospital are often not covered as an outpatient
- Each individuals formulary information should be available for discharge planning
- Require an effort be made to place person as close to their home as possible
- Requirement for effort made to find medical history on patient
- Build a statewide system for BH that all agencies can access 24/7 for health records
  - EHRs are expensive – community MH centers have trouble affording
- Medicaid also influences the location and level of care that clients in crisis can access, which contributes to long placement times as well as other barriers.
- Behavioral Health Records are often (if not always) treated with a higher level of confidentiality (even in those more robust EHR systems like Epic) than "regular" medical/health records, so a shared system may not solve the access to records issue unless that component is also addressed
- One concepts noted is that discharge begins on admission. However, in my experience we are often asked to accept a certification a day or two prior to discharge and it strikes me that facilities are aware of their movement toward a Certification a week or more prior to discharge and planning with outpatient teams could begin much earlier. Our system has a very hard time being prepared to take on a Certification as and outpatient with 1-2 days notice at most.
- Required staffing pattern for inpatient facilities – serious staff/ provider shortage
  - Incorporate peer components
- Discharge planning should include the warm handoff – concern around follow up with patient when immediate referral or care is not available
- EHR affordability and data sharing is a priority
- What role can BHA play when a hospital or provider hits a wall – unable to find placement/ placement too far out
  - Statewide psych bed database?
    - In progress

- There should be opportunity to stay in facility beyond 72 hrs voluntarily rather than be released before they're fully stabilized
    - length of stay is also impacted by insurance/medical necessity criteria, esp. Medicaid
- Stepdown inpatient facility need
- Need to address the IMD exclusion and expand the 1115 waiver to add residential as an option for mental health along with SUD