Navigating Risk in the Sea of Change

Effective Discharge Planning

Assisting Behavioral Health Patients in Community Reintegration

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OBJECTIVES

Identify	Identify the barriers to effective discharge planning and transitions of care.
Discuss	Discuss the factors that contribute to improved care transitions.
Describe	Describe the types of claims associated with transitions of care.
Apply	Apply risk management strategies for safe transitions of care and discharge planning.

CASE SCENARIO

Female patient in her 30's has been treated by her outpatient psychiatrist for several years. The patient last saw her psychiatrist two weeks ago. Unbeknownst to her the psychiatrist, she was admitted to a mental health facility post ED evaluation for attempted suicide.

Her medications were changed, and she was discharged back to her outpatient psychiatrist for follow up care. No communications took place between the facility and the outpatient psychiatrist.

CASE SCENARIO (continued)

The patient shows for her next scheduled visit with her outpatient psychiatrist two weeks later.

During that visit, the patient discloses she was admitted to the hospital for several days for observation after ingesting several prescription medications in an attempted suicide.

The patient reports feeling better and provides her new medications to her outpatient psychiatrist.

Now What?

TRANSITIONS OF CARE OVERVIEW

- Transitions of Care (TOC) Definition
- Relationship Between Discharge Planning and Transitions of Care
- Importance of Transitions of Care Process

POLLING QUESTION #1

Some steps taken to involve the patient's support system in the discharge planning process include:

a) Assessing the level of involvement the support system can provide during the transitions of care

b) Addressing any conflicts or disagreements regarding the discharge plan

c) Explaining the support system's role and responsibilities in supporting the patient after discharge

d) All the Above

FACTORS THAT INFLUENCE IMPROVED CARE TRANSITIONS

- Needs-Based Assessment
- Transitional Care Team
- Communication Protocol
- Medication Reconciliation
- Discharge Instructions
- Care Transition Barriers
- Continuous Education
- Discharge Process
- Care Coordination

TRANSITIONS OF CARE RISKS

$26 billion spent annually on poor care transitions of Medicare patients yearly (ACMA, 2019).

Suicide rate is 200 times higher than that of the general population in the first month after psychiatric hospitalization (Chung, et.al., 2019).

42% - 51% of adult patients and 31% - 45% of youth patients in the US do not attend mental health visits within 30 days after inpatient BH care (Smith, 2023).

Mental health ED visits of youth/young adults - 28.6% received follow-up within 7 days and 46.4% within 30 days; follow up rates low for patients with comorbid SUD (Hugunin, et.al., 2022)

IMPACT OF POOR CARE TRANSITIONS

- Unnecessary Readmissions
- Poor Patient Outcomes
- High Healthcare Expenditures
- Delay in Care
- Provider and Patient Dissatisfaction

REAL CASE SCENARIO

In September 2022, the family of a 29-year-old man with children was awarded $77 million in an addiction treatment case. According to the lawsuit, the decedent, who also had bipolar disorder, was forced out of the addiction treatment center for having a cell phone, a violation of the facility's policy, and was transferred to a sober living facility.

Days later, the patient was reported dead after being hit multiple times by several vehicles while he laid unclothed on a highway. In post-trial interviews, the decedent's family identified various gaps in care processes, including lack of staff training and competency, inappropriate medication management, failure to address co-occurring disabilities (dual diagnosis), and lack of discharge protocols and communication.

POLLING QUESTION #2

Use of discharge criteria including evaluation of the patient's level of stability and functioning help to determine readiness for transitioning to outpatient care or community – based care services.

a) True

b) False

RISK MANAGEMENT CONSIDERATIONS

- Transition of Care Process
- Community Partnership
- Client Intake and Risk Assessment
- Transition Care Team
- Patient Care Plan and Pathway
- Medication Reconciliation

RISK MANAGEMENT CONSIDERATIONS

- Suicide Risk Assessment
- Verbal Handoff Communication
- Management of Provider and Patient Expectations
- Family and Caregiver Involvement
- Staff Training and Education

DOCUMENTATION: RISK ASSESSMENT/PLAN

- Risk Factors
- Specific Threats
- Ability to Follow Through
- Support System
- Treatment Plan
- Considerations:
  - Hospitalization/Higher Level of Care
  - Second Opinion/Consultation
  - **Confirmed** safe discharge plan

RISK CONSIDERATIONS FOR INPATIENT PROVIDERS

- Care Team Coordination
- Documentation for Safe Discharge Planning
- Detailed Communication with the Outpatient Provider/Program
- Contingency Planning when Outpatient the Provider Can Not Meet the Patient's Needs, or the Outpatient Program has a Wait List

RISK CONSIDERATIONS FOR INPATIENT PROVIDERS

- Patient *"Buy-In"*
- Access to Firearms
- Medication Management

RISK CONSIDERATIONS FOR OUTPATIENT PROVIDERS

- Office Policies and Procedures
- Informed Consent
- Coordination of Care Post-Discharge
- Consideration of Termination/Referral to Higher Level of Care

RISK CONSIDERATIONS FOR OUTPATIENT PROVIDERS

- Documentation
- Consultation
- Firearm Access
- Medication Safety
- Consultation with Attorney/Risk Management

QUESTIONS TO CONSIDER WHEN TRANSITIONING OR DISCHARGING A PATIENT

What factors do you consider for discharge readiness?

How do you ensure a smooth transition of care?

How do you involve the support system in the discharge process?

How do you assess for transitioning to outpatient care?

What strategies do you use to address care transition barriers?

QUESTIONS TO CONSIDER WHEN TRANSITIONING OR DISCHARGING A PATIENT

How do you collaborate with other providers to facilitate a successful transition of care?

What resources do you typically recommend during the discharge planning process?

How do you ensure care continuity and ongoing support for patients?

How do you ensure patients have access to necessary medication after discharge?

How do you address patient concerns or fears about community reintegration?

ACTION RECOMMENDATIONS

- Culture, Leadership, Governance
- Patient and Family Engagement
- Workforce Safety and Wellness
- Learning System

Reference: ECRI – Top 10 Patient Safety Concerns 2025 - https://home.ecri.org/blogs/ecri-thought-leadership-resources/top-10-patient-safety-concerns-2025

FINAL WORD

Remember – Utilizing Good Risk Management Techniques

- Improves Patient Satisfaction
- Improves Quality Outcomes
- Decreases the Likelihood of a Medical Malpractice Claim
- Decreases Poor Outcomes
- Supports a Successful Defense!

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Questions/Discussion