# DMC-ODS Discharge Services

**Santa Cruz County Behavioral Health**

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Quality Improvement

June 1, 2018

Updated 2/24/21 Sara Avila

# Training Goals & Objectives

## Goals

- Review required DMC-ODS activities related to Discharge Service for all Levels Of Care
- Clarify documentation requirements for discharge types
- Identify documentation methods located within Avatar

## Objectives

- ✓ You will be able to identify the 3 types of discharge services
- ✓ You will learn the key DMC-ODS Discharge Service activities requirements
- ✓ You will be able to navigate Avatar forms to document various discharge service types, including which service code

Resource: DMC-ODS state contract (IA/Interagency Agreement) Exhibit A, Attachment I

# Discharge Services – All Levels Of Care

- Per DHCS, DMC-ODS Discharge Services are "the processes to prepare the client for referral into another level of care, post treatment return or reentry into the community, and/or the linkage of the client to essential community treatment, housing and human services."
- Discharge from treatment may be voluntary or involuntary. (All discharges prior to completion of treatment = a NOABD Termination letter)
- Service may include case management activities to coordinate services to ensure successful linkage of care transfer. (linkage and contact information to: next LOC treatment program, support and/or 12-step groups, medical/PCP, housing, educational and/or vocational resources)
- Three (3) types of Discharge Services:
  - Anticipated discharge planning
  - Client stops engagement in treatment (Loss of contact, AMA/ASA)
  - Client Transfers to another level of care **within the same DMC Provider location**

# Anticipated Discharges

**Anticipated discharge =** When the program and client are preparing to end current treatment. Client has made successful progress in treatment and towards treatment goals and no longer needs current LOC treatment per ASAM criteria **AND** either:

- (1) ending treatment (re-entry into community supports) or
- (2) continuing treatment with another provider/location. (Not meeting the definition of a "transfer").

**Required:** (1) develop & sign Discharge Plan &

(2) coordination of care/CM activities to ensure connection to post-treatment services.

(3) Write discharge summary PN for last F2F session refer to slide #22 & 31 for more information.

Discharge Plan = prepared within 30 calendar days prior to the scheduled date of the last F2F treatment session. (*Example: Scheduled discharge on 6/30. Last F2F before discharge is 6/29. DC Plan to be completed with client before 6/29 so can have ready for final review and obtain signatures/dates.)*

- Use "Discharge Planning" Service Code to write notes on Discharge Plan and for final F2F session
- Use Case Management code for linkage and coordination of care activities

Discharge Plan = a minimum of (and not limited to):

- A description of each of the client's relapse triggers
- A plan to assist client to avoid relapse when confronted with each trigger
- A support plan

Resource: DMC-ODS state contract (IA/Interagency Agreement) Exhibit A, Attachment I

# Client unexpected discharges

**Unexpected discharge =** When the client has disengaged from treatment, such as:

**(1)** "Loss of Contact" (Client no longer showing up for treatment services, even after staff has outreached client.)- voluntary discharge (Term NOABD)

**(2)** Client leaves program unexpectedly – AMA (Against Medical Advice) or ASA (Against Staff Advice)-voluntary discharge (Term NOABD).

**(3)** Client is asked to leave treatment (violation of program safety rules) – involuntary discharge (Term NOABD)

## Required: (1) coordination of care/CM activities as possible, (2) Treatment/Discharge Summary Form & (3) Discharge Summary PN

Treatment/Discharge Summary Form and Discharge Summary PN = prepared by Counselor or LPHA within 30 calendar days of the last F2F treatment contact with client. Staff to make client outreach efforts to reengage client back into treatment.

**For Discharge Summary PN**: Use A001 Non-billable code ("loss of contact", AMA/ASA, involuntary discharge), refer to slide # 22& 31 for content information

- **Use Case Management code for linkage and coordination of care activities**

Treatment/Discharge Summary Form = required to include all of the following:

- The duration of the client's treatment, including the dates of admission to the discharge.
- The reason for discharge.
- A narrative summary of the treatment episode.
- The staff's assessment of the client's recovery prognosis without treatment.

Resource: DMC-ODS state contract (IA/Interagency Agreement) Exhibit A, Attachment I

# Client transfer to another Level of Care

"**Transfer**" = When a client moves from a higher or lower level of care based on ASAM criteria within the same DMC certified program *(**same DMC certified location***)*.

**Transfers = Discharge Summary requirements**

Meaning, a client:

- Can "transfer" between Encompass Alto North IOP ⟷ OP (same site/provider)
- Can "transfer" between Encompass Alto South IOP ⟷ OP (same site/provider)
- Can "transfer" between Janus Detox ⟷ Janus Main Res ⟷ Janus IOP (same site/provider)
- Can "transfer" between Sobriety Works IOP ⟷ OP (same site/provider)
- CAN NOT "transfer" between Encompass residential & Encompass Alto IOP/OP (different sites)
- CAN NOT "transfer" between Encompass residential & Sobriety Works IOP (different providers)
- CAN NOT "transfer" between Janus Detox & Janus Peri residential or Peri to IOP(different site)
- CAN NOT "transfer" between Encompass residential & Janus Detox (different providers)

* QI confirmed with DHCS that transfers can only occur between programs that are available at same facility location.

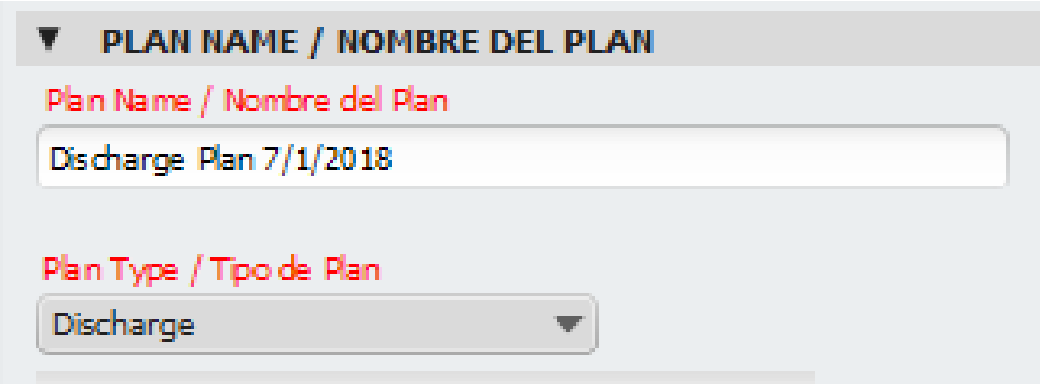
# pause for questions

# Avatar - #1 Discharge Plan (planned DC)

1. Discharge Plan Document is located in the SUD Tx Plan form!!!
   a. DMC-ODS requires client signature and date on DC Plan so we need to use this format.
2. To create: Open form and Click on “ADD” on right side.
3. DO NOT “Default” (accept) prior Treatment Plan information.
   a. Answer “NO” to the question. – “Do you want to default?”
      i. This allows you to have a blank form.
4. There are inserted documentation prompts and templates in each field so you capture each required item.
5. Next few slides will cover these prompts/templates

# Avatar - Discharge Plan

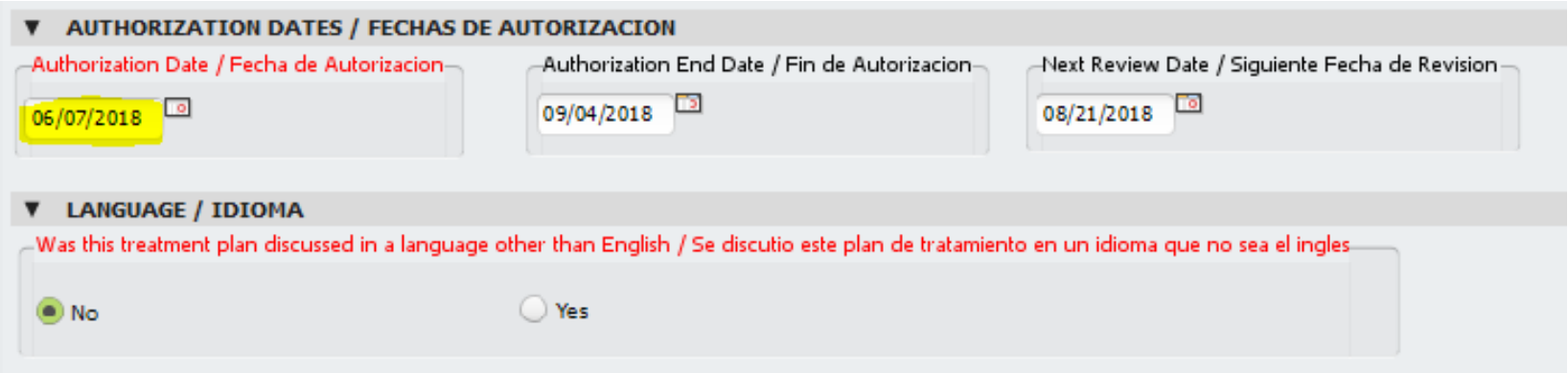
6. Add Plan Name “Discharge Plan” and the date of the anticipated discharge.
7. Pick the “Discharge” Plan Type.




Choosing the Discharge Plan Type activates the Discharge related fields and suppresses the treatment plan fields.

# Avatar - Discharge Plan

8. Enter Authorization Date as “Today”(within 30 days of DC date)
   a. *Disregarding the auto populated Auth End date and Next Review.*

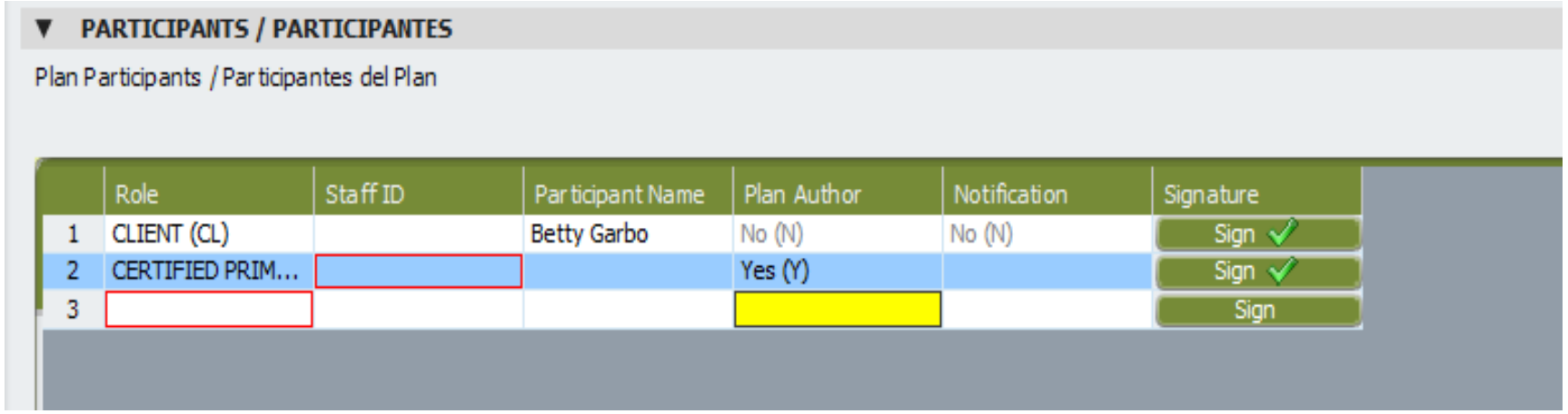



9. Select appropriate answer to the Language question.

   *a. Be sure to include additional translation if client prefers non-English Discharge Plan. (Format: English content\Spanish content)*

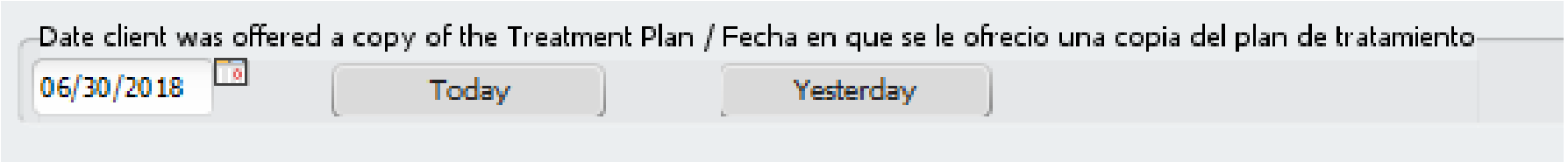
# Avatar - Discharge Plan

10. Skip over “Problems” section and Enter Plan Participants.
11. Enter Client and Primary Counselor names and roles.
12. Collect electronic signatures/dates at last F2F meeting, for more information refer to slide 21.



# Avatar - Discharge Plan

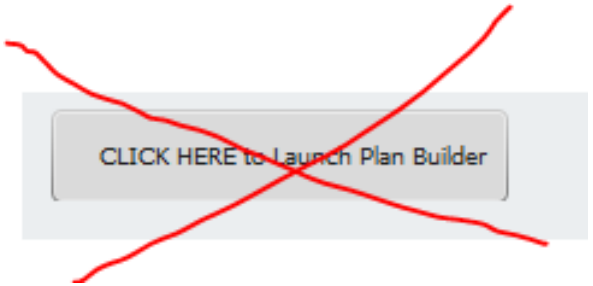
13. Capture the date the client was offered/given a copy.




14. Compete Strengths, Needs, Preferences Section.

    *Phase of Treatment = Discharge*

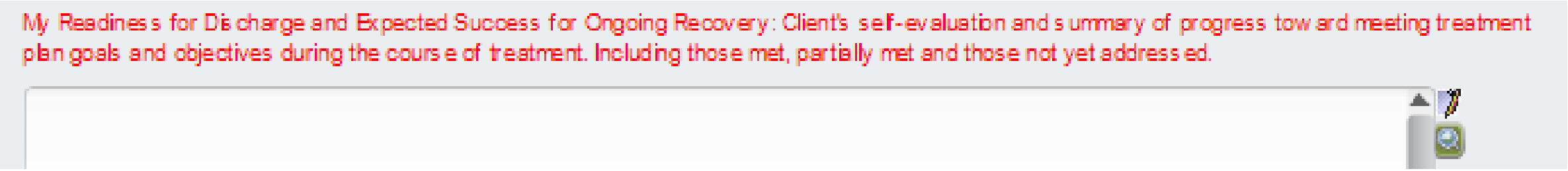
15. Do not click on Plan Builder



# Avatar – New Discharge Plan Section

## New Discharge Planning Section

## 1st Field: Readiness for Discharge and Expected Success

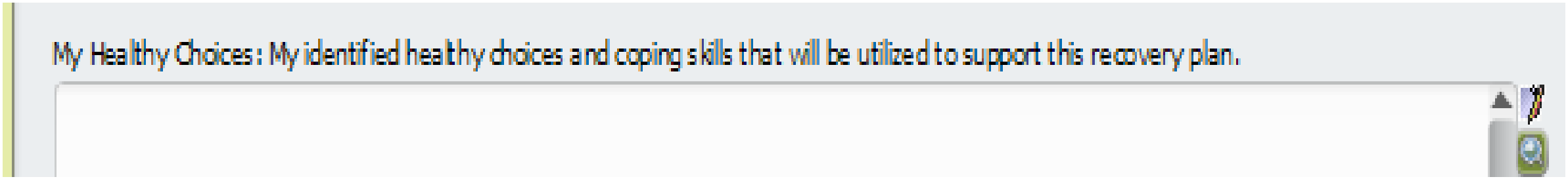



## Type in narrative that addresses each item:

- Client self evaluation of progress towards meeting treatment goals and action steps/objectives.
  - *Identify which goals/action steps have been met*
  - *Identify which goals/action steps have been partially met*
  - *Identify which goals/action steps have not been addressed yet*

# Avatar - Discharge Plan Section (con't)

## 2nd Field: Optional




This field is available to capture the client's healthy choices and developed coping skills that support ongoing recovery success and utilization of the discharge plan.

# Avatar - Discharge Plan Section (con't)

## 3rd Field: Trigger Relapse Plan

My Trigger Relapse Plan: Describe each relapse trigger. For each trigger outline a plan to avoid relapse when confronted with the trigger.

This field has a template available for use to capture each trigger and the related plan/strategy the client will use to avoid relapse.

To access:

1. Right Click in narrative box

2. A box will show up and Select the last option "System Templates" with the arrow.

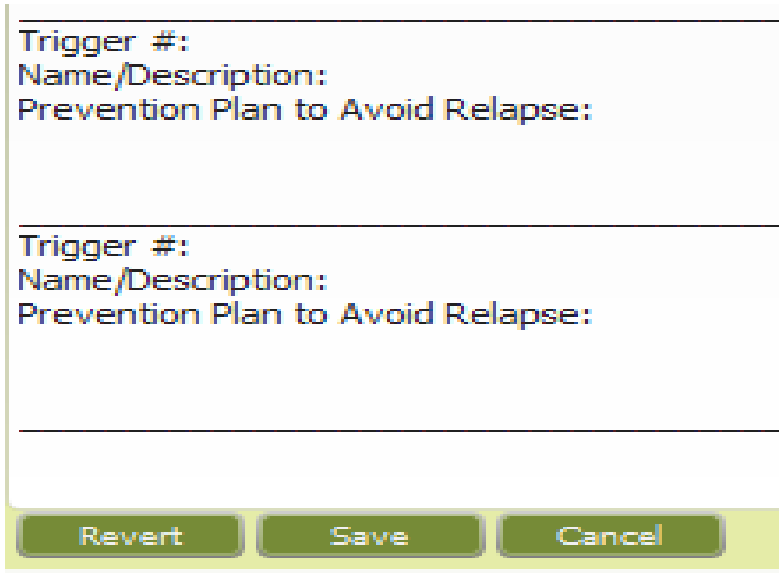
3. Select "Triggers" and template will auto populate in narrative field. You can click on  to access easy typing box.

# Avatar - Discharge Plan Section (con't)

"Triggers" template content:

The template consists of a 3-line template repeated 8 times

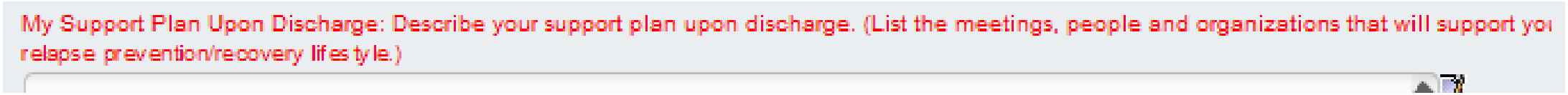
- *Less than 8 triggers = Delete unused format*
- *More than 8 triggers = ADD more format (copy & paste)*




*Describe each Trigger and Plan with enough content to support the client's ability to use the information for support.*

# Avatar - Discharge Plan Section (con't)

## 4th Field: My Support Plan Upon Discharge




This field also has a template available for use to capture the client's support plan.

To access:

1. Click in narrative box & then Right Click

2. A box will show up and Select the last option "System Templates" with the arrow.

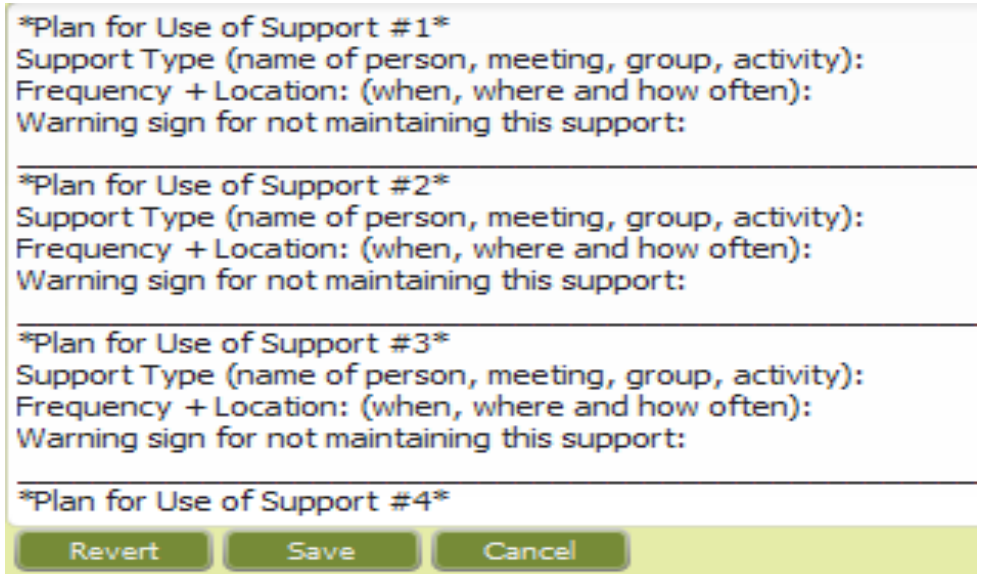
3. Select "List Supports" and template will auto populate in narrative field. You can click on  to access easy typing box.

# Avatar - Discharge Plan Section (con't)

"List Supports" template content:

The template consists of a 3-line template repeated 5 times

- *Less than 5 Supports = Delete unused format*
- *More than 5 Supports = ADD more format (copy & paste)*




*Describe each section with enough content to support the client's ability to use the information for support.*

# Avatar - Discharge Plan Section (con't)

## 5th Field: My Additional Discharge Information


This field also has a template available for use to capture the client's support plan.

To access:

1. Click in narrative box & then Right Click

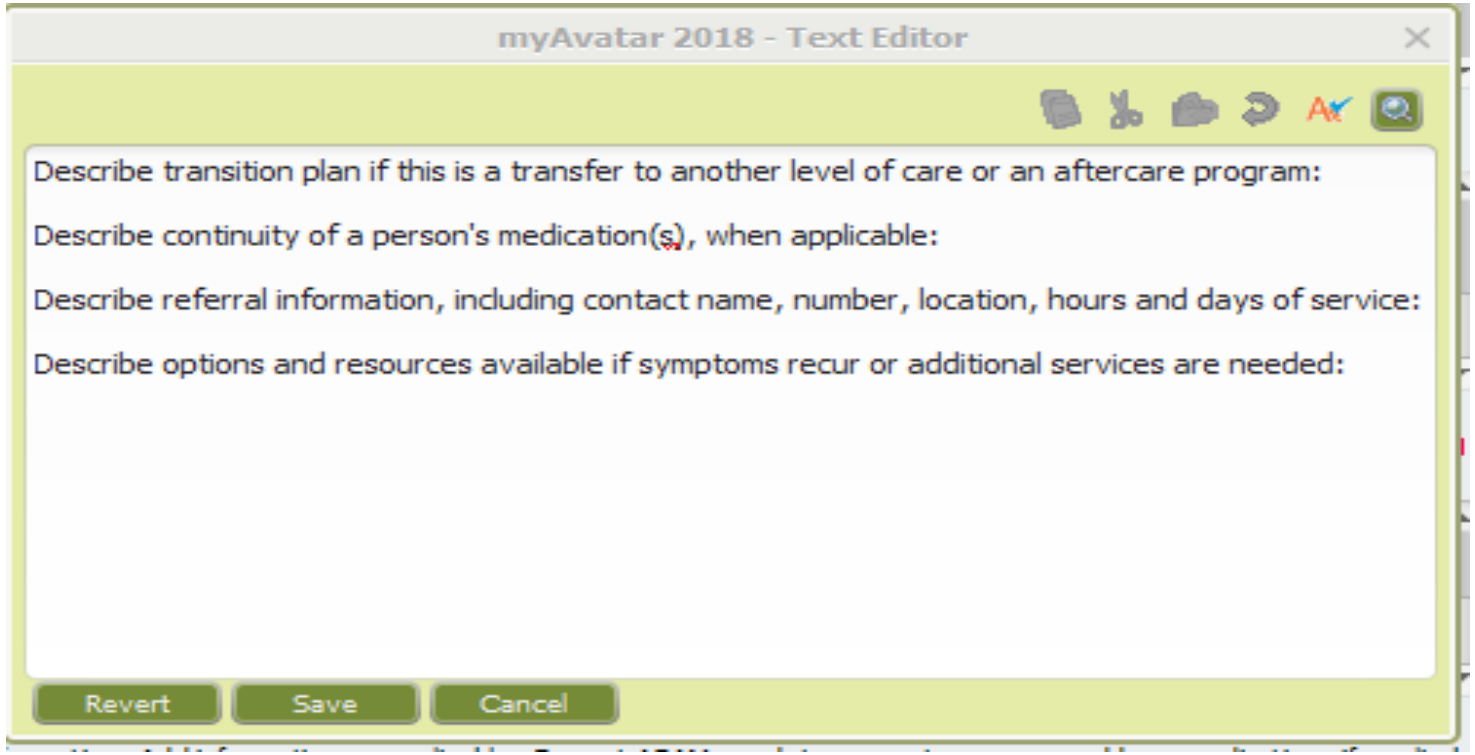
2. A box will show up and Select the last option "System Templates" with the arrow.

3. Select "Addl Info CARF" and template will auto populate in narrative field. You can click on  to access easy typing box.

# Avatar - Discharge Plan Section (con't)

"Additional Info CARF" template content:

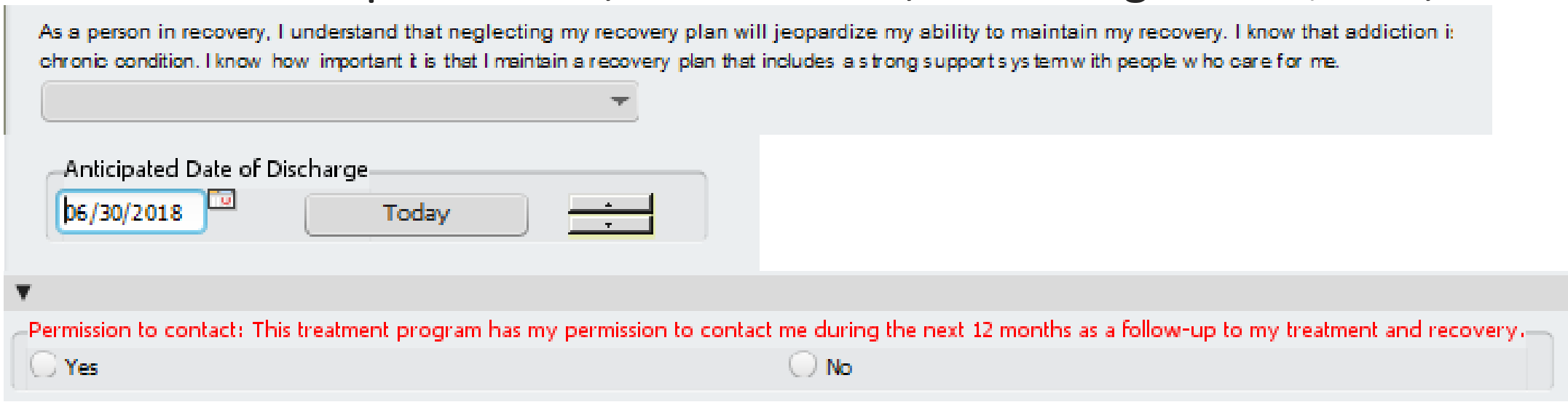
The template prompts description of related aftercare services



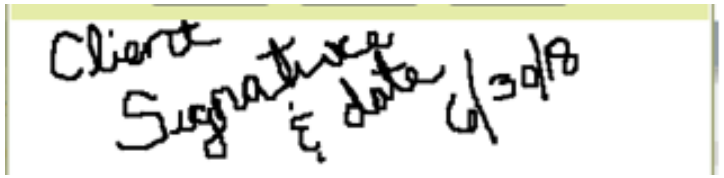

*Describe each section with enough content to support the client's ability to use the information for support.*

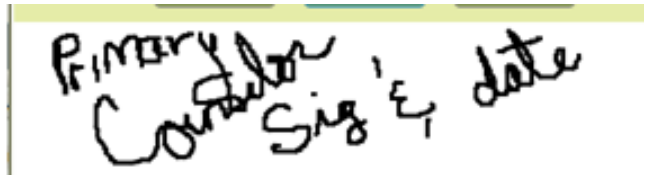
# Avatar - Discharge Plan Section (con't)

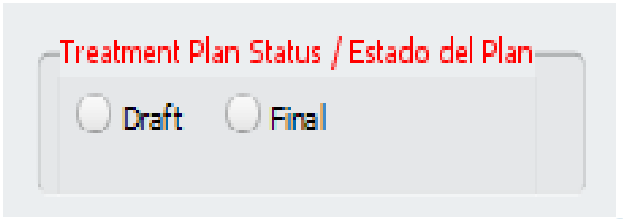
## Last Items: Complete these, Save as Draft, Collect signatures/date, Finalize




Make sure to include the counselor's signature, credentials and date in addition to the client's signature and date. If unable to sign due to COVID-19 safety protocols put "verbal" in place of signature and include the reason why it was unable to be signed in the TX plan template where it asks if the client did not sign explain why. Include that the client gave verbal consent due to COVID-19 safety protocols. In progress note for this session, document that client gave verbal permission to authorize Discharge Plan, as is allowable per COVID-19 pandemic.



# Discharge Progress Note

Staff are to write a discharge note in chart that recaps provided discharge services.

❖ OP/IOP & NTP: Use discharge planning service code when there is a last F2F session with the client and A001 non-billable service code when there is not a lasts F2F session with the client.

❖OP Discharge Planning Service Code= Over 21 A1439/ U21 A2439

❖IOP Discharge Planning Service Code= Over 21 A1239/ U21 A2239

❖NTP Discharge Planning Service Code= A1339

❖ Residential Weekly note: A001, ADD discharge note content to last weekly summary OR write a separate note for discharge summary (A001).

Note content: updated ASAM reassessment results, length of treatment duration, client's readiness for discharge & prognosis, completion of the appropriate discharge form, name referrals to aftercare services and ongoing medication management if applicable.

Case management service code used when there is coordination of care/linkage activities *prior to discharge* from program.

# pause for questions

# Discharge Summary Form
# Unexpected discharges & Transfers

**Unexpected discharge =** When the client has disengaged from treatment, such as:

**(1)** "Loss of Contact" (Client no longer showing up for treatment services, even after staff has outreached client.)-voluntary discharge (Term NOABD)

**(2)** Client leaves program unexpectedly – AMA (Against Medical Advice) or ASA (Against Staff Advice)-voluntary discharge (Term NOABD)

**(3)** Client is asked to leave treatment (violation of program safety rules) – involuntary discharge (Term NOABD)

"**Transfer**" = When a client moves from a higher or lower level of care based on ASAM criteria within the same DMC certified program *(same DMC certified location*)*.

**Requirement:** (1) coordination of care/CM activities as possible, (2) Treatment/Discharge Summary Form & (3) Discharge Summary PN

Treatment/Discharge Summary Form and Discharge Summary PN = prepared by Counselor or LPHA within 30 calendar days of the last F2F treatment contact with client. Staff to make client outreach efforts to reengage client back into treatment.

- **Discharge Summary PN:** Use A001 Non-billable code ("loss of contact", AMA/ASA, involuntary discharge)
- **Use Case Management code for linkage and coordination of care activities**

Treatment/Discharge Summary Form = Required to include all of the following:

- The duration of the client's treatment, including the dates of admission to the discharge.
- The reason for discharge.
- A narrative summary of the treatment episode.
- The staff's assessment of the client's recovery prognosis without treatment.



Resource: DMC-ODS state contract (IA/Interagency Agreement) Exhibit A, Attachment I

# Avatar – Treatment/Discharge Summary form

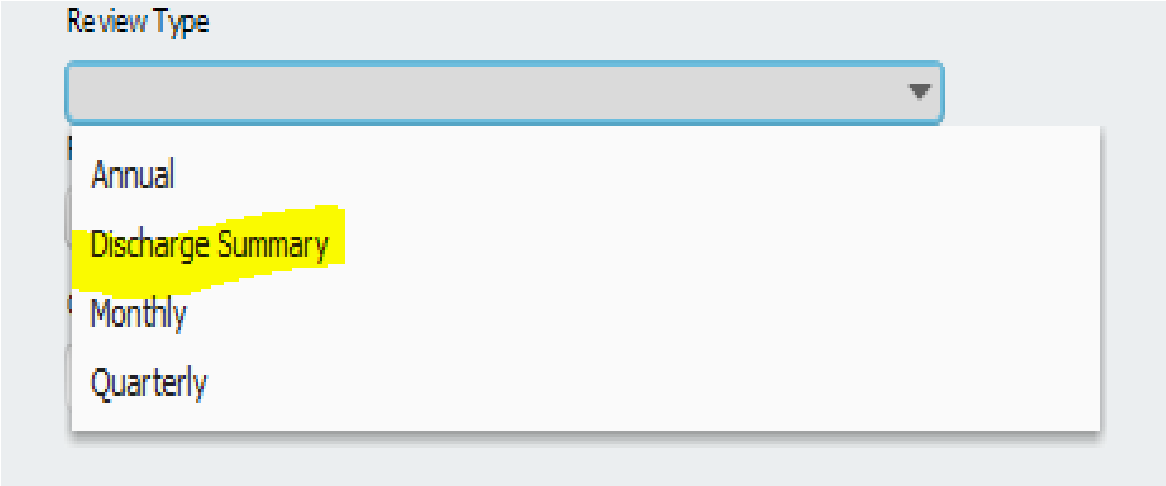
1. DMC-ODS Discharge Summaries are documented in the "Treatment/Discharge Summary form.
   a. No signature and date requirement

To create Discharge Summary:

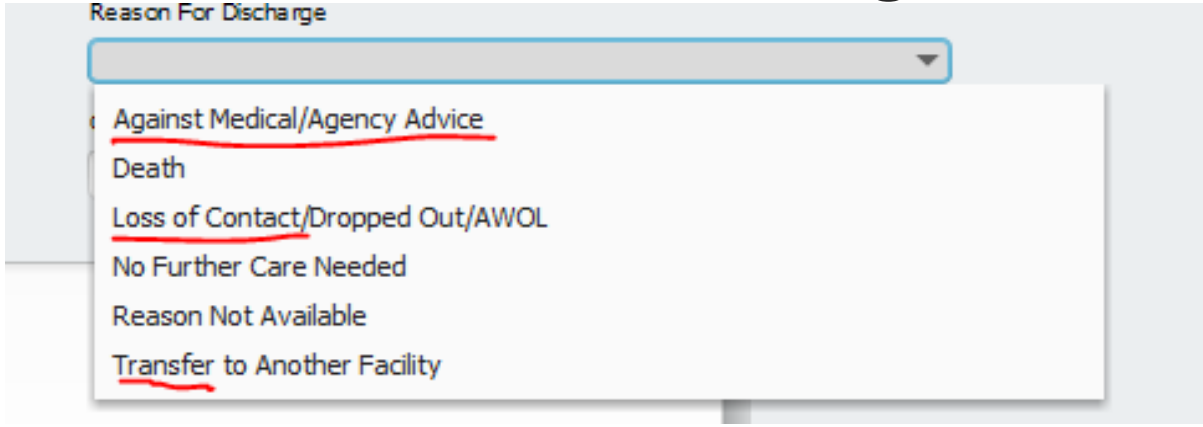
1. Open form and Click on "ADD" on upper right side.
2. Enter Summary Date (date you are completing the form)
3. Enter Time of completing summary
4. Select Final if completed by a SUD Counselor or LPHA

# Avatar – Treatment/Discharge Summary (con't)

## 5. Select Review Type as Discharge Summary

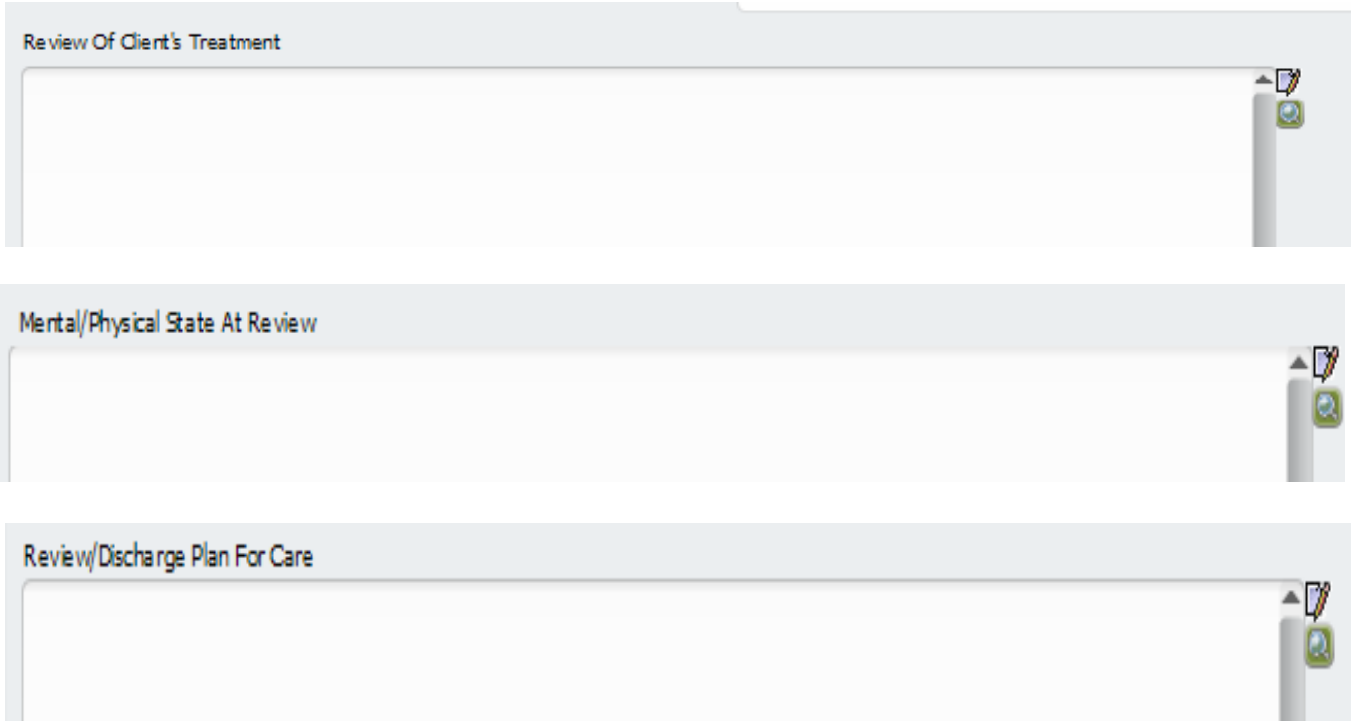



## 6. Select Reason for Discharge: Loss of Contact OR Transfer Or AMA



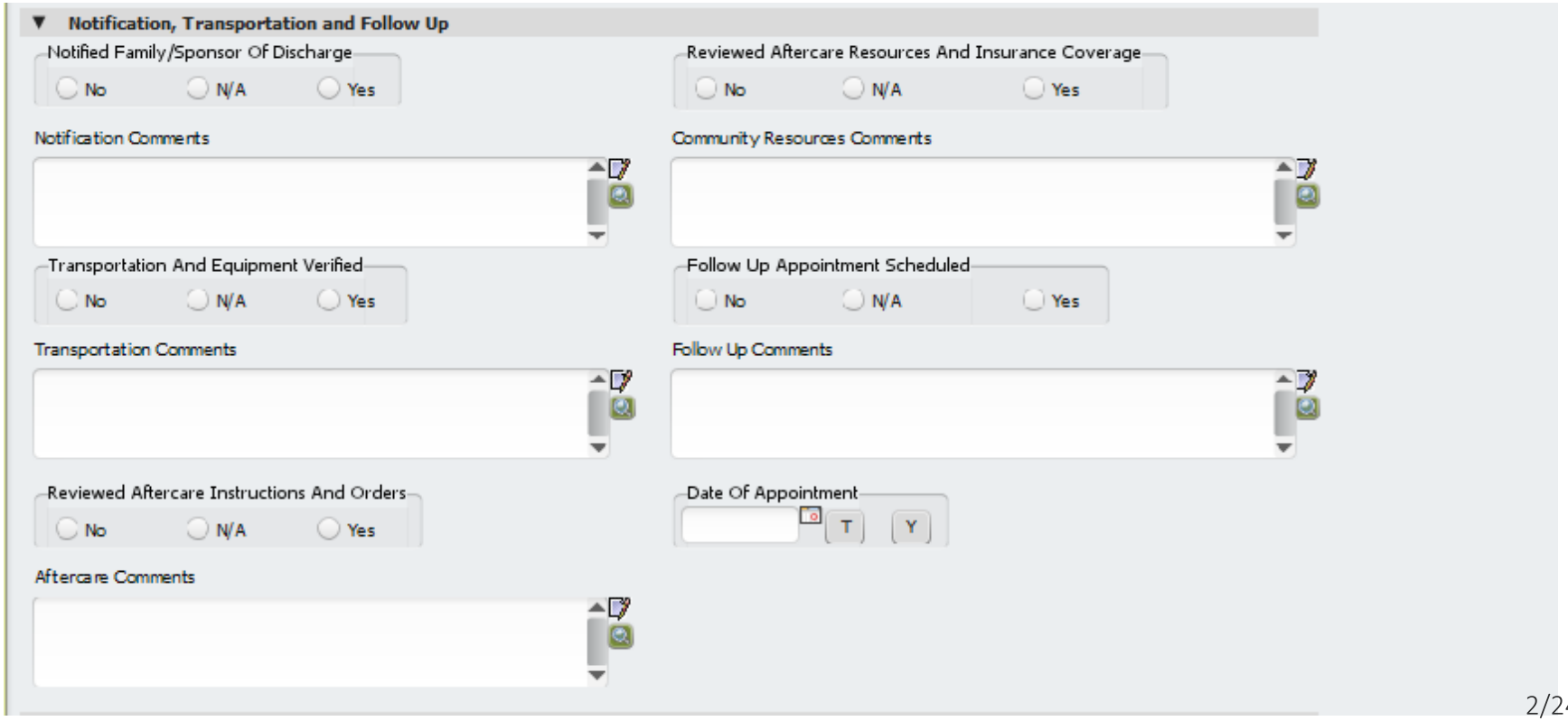
# Avatar – Treatment/Discharge Summary (con't)

7. Complete narrative fields as appropriate, using N/A when needed: Review of Client's Treatment, Mental/Physical State at Review, Review/Discharge Plan for Care.



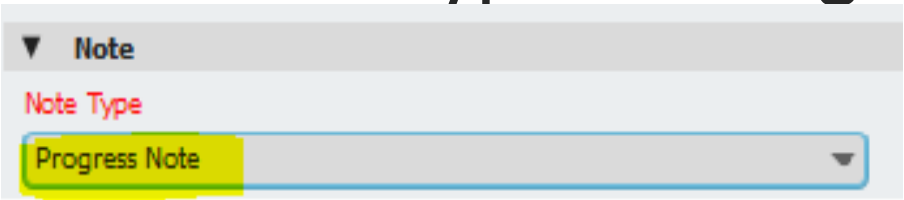
# Avatar – Treatment/Discharge Summary (Con't)

8. Enter Notifications, Transportation and Follow up information as indicated. This section will be individualized depending on the professional and personal relationships involved in client's care.

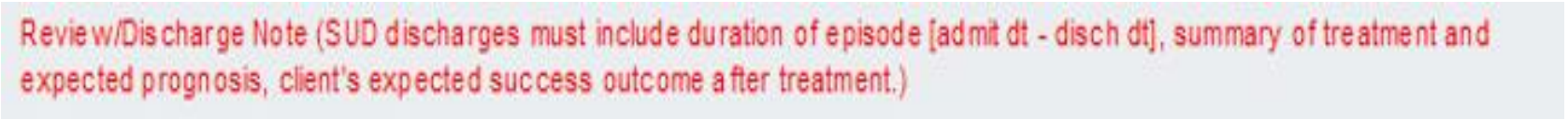


# Avatar – Treatment/Discharge Summary ( Con'tRED Items)

9. Select Note Type as "Progress Note"



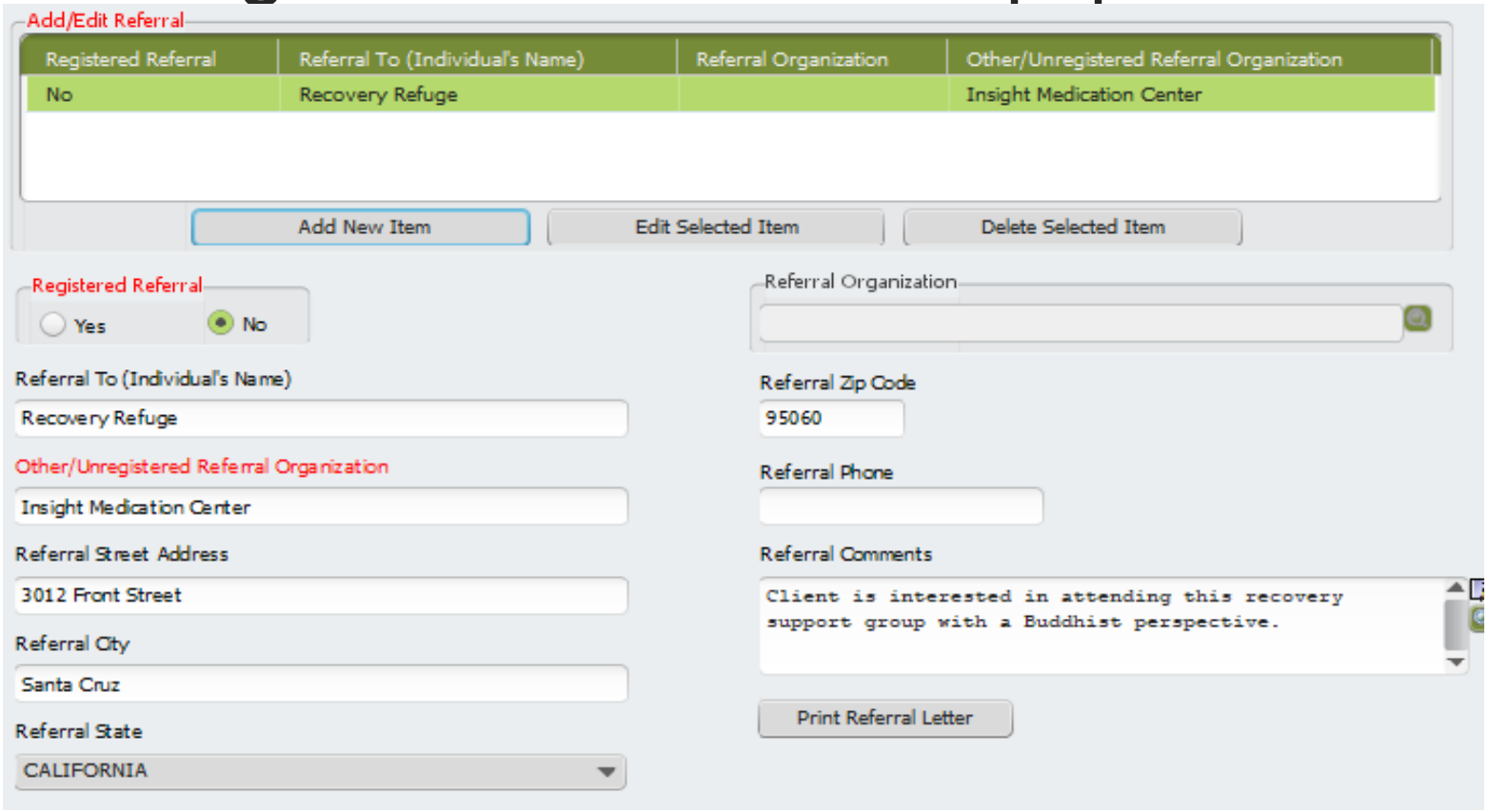

10. Enter narrative in Review/Discharge Note field:




- Duration of episode (admit date-discharge date)
- Summary of treatment & expected prognosis
- Client's expected success outcome after discharge

# Avatar – Treatment/Discharge Summary (con't)

11. Include Referrals provided to client by
- adding new item row for each referral
- entering information that auto populates in row



# Discharge Progress Note

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❖NTP Discharge Planning Service Code= A1339

❖ Residential Weekly note: A001, ADD discharge note content to last weekly summary OR write a separate note for discharge summary (A001).

Note content: updated ASAM reassessment results, length of treatment duration, client's readiness for discharge & prognosis, completion of the appropriate discharge form, name referrals to aftercare services and ongoing medication management if applicable.

Case management service code used when there is coordination of care/linkage activities *prior to discharge* from program.

# Avatar – Other Discharge functions

1. Complete progress notes
2. Complete scanning of paper records into Avatar chart
3. Cal-OMS Discharge/ Cal-OMS Youth Discharge form
4. Discharge form

# So what about Case Management Services?

**Discharge placement Coordination:**

1. Outreaching next level of care provider to coordinate a clients transition out of one program and admission into another.
2. Coordinating a transfer to a higher level of care (within same provider location).
3. Monitoring progress with service linkage to ensure client access to service and the service delivery system. (Client not heard back from next service provider regarding intake appointment.)

**Discharge Service Coordination:**

1. Making a referral to services – medical, mental health, educational, vocational, etc.
2. Following up on the referral to establish services – monitoring access to services
3. Arranging for transportation, clothing voucher, housing based on needs
4. Assist with linking client to new PCP (help with arriving at appointment, filling out paperwork, communicating needs).
5. Monitoring discharge readiness based on ASAM reassessment

# Review – service providers

Licensed Practitioner of the Healing Arts (LPHA) - must have current good standing license/registered status.

- Physician
- Nurse Practitioner
- Physician Assistant
- Registered Nurse
- Registered Pharmacist
- Licensed Clinical Psychologist
- Licensed Clinical Social Worker (LCSW)
- Licensed Marriage and Family Therapist (LMFT)
- Licensed Professional Clinical Counselor (LPCC)
- Licensed Eligible Practitioner working under the supervision of licensed clinician (ASW, AMFT, APCC)

Registered SUD Counselor (must complete certification process within the 5 year requirement)

Certified SUD Counselor (must have current good standing certification status)

* All direct service staff (master program “trainees”, volunteers, or other groups) must be a Registered SUD Counselor at a minimum to provide direct client services.

# Final Questions

# Thank You