

DMC-ODS Discharge Services

Santa Cruz County Behavioral Health

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Quality Improvement

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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

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

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.

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.

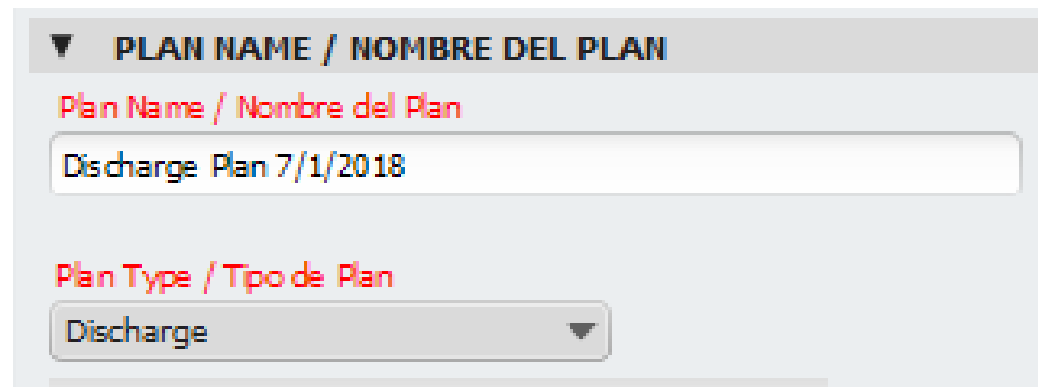
pause for questions

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.



The screenshot shows a software interface for creating a plan. It features a section titled "PLAN NAME / NOMBRE DEL PLAN" with a sub-label "Plan Name / Nombre del Plan" in red. Below this is a text input field containing "Discharge Plan 7/1/2018". Another sub-label "Plan Type / Tipo de Plan" in red is positioned above a dropdown menu that currently displays "Discharge".

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.*

The screenshot shows a web form with two sections. The first section, titled 'AUTHORIZATION DATES / FECHAS DE AUTORIZACION', contains three date input fields. The first field, labeled 'Authorization Date / Fecha de Autorizacion', has the date '06/07/2018' entered and is highlighted with a yellow box. The second field, labeled 'Authorization End Date / Fin de Autorizacion', has the date '09/04/2018' entered. The third field, labeled 'Next Review Date / Siguiente Fecha de Revision', has the date '08/21/2018' entered. The second section, titled 'LANGUAGE / IDIOMA', contains a question: 'Was this treatment plan discussed in a language other than English / Se discutió este plan de tratamiento en un idioma que no sea el inglés'. Below the question are two radio button options: 'No' (which is selected) and 'Yes'.

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.

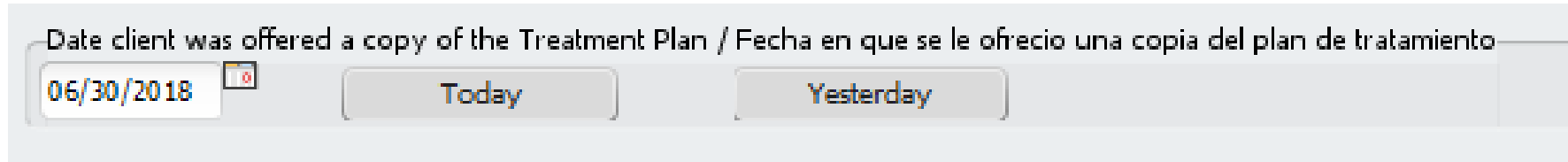
▼ PARTICIPANTS / PARTICIPANTES

Plan Participants / Participantes del Plan

	Role	Staff ID	Participant Name	Plan Author	Notification	Signature
1	CLIENT (CL)		Betty Garbo	No (N)	No (N)	Sign ✓
2	CERTIFIED PRIM...			Yes (Y)		Sign ✓
3						Sign

Avatar - Discharge Plan

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



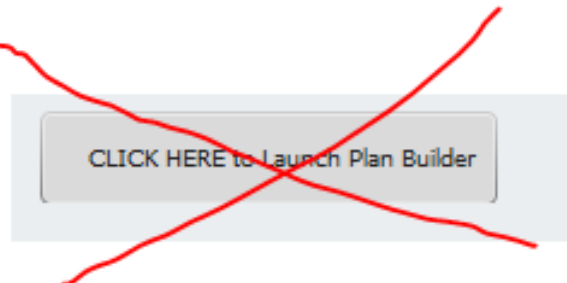
Date client was offered a copy of the Treatment Plan / Fecha en que se le ofrecio una copia del plan de tratamiento

06/30/2018 Today Yesterday

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

My Readiness for Discharge and Expected Success for Ongoing Recovery: Client's self-evaluation and summary of progress toward meeting treatment plan goals and objectives during the course of treatment. Including those met, partially met and those not yet addressed.



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

My Healthy Choices: My identified healthy choices and coping skills that will be utilized to support this recovery plan.

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)*

The image shows a screenshot of a software interface for creating a discharge plan. It features two identical, vertically stacked form sections. Each section contains three text input fields: 'Trigger #:', 'Name/Description:', and 'Prevention Plan to Avoid Relapse:'. Below the second section, there is a horizontal bar with three buttons: 'Revert', 'Save', and 'Cancel'. The buttons are green with white text. The entire form is enclosed in a light green border.

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

My Support Plan Upon Discharge: Describe your support plan upon discharge. (List the meetings, people and organizations that will support you relapse prevention/recovery lifestyle.)

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)*

Plan for Use of Support #1
Support Type (name of person, meeting, group, activity):
Frequency + Location: (when, where and how often):
Warning sign for not maintaining this support:

Plan for Use of Support #2
Support Type (name of person, meeting, group, activity):
Frequency + Location: (when, where and how often):
Warning sign for not maintaining this support:

Plan for Use of Support #3
Support Type (name of person, meeting, group, activity):
Frequency + Location: (when, where and how often):
Warning sign for not maintaining this support:

Plan for Use of Support #4

Revert Save Cancel

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

My Additional Discharge Information: Add information as applicable; Current ASAM needs to support recovery; address medications if applicable.

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

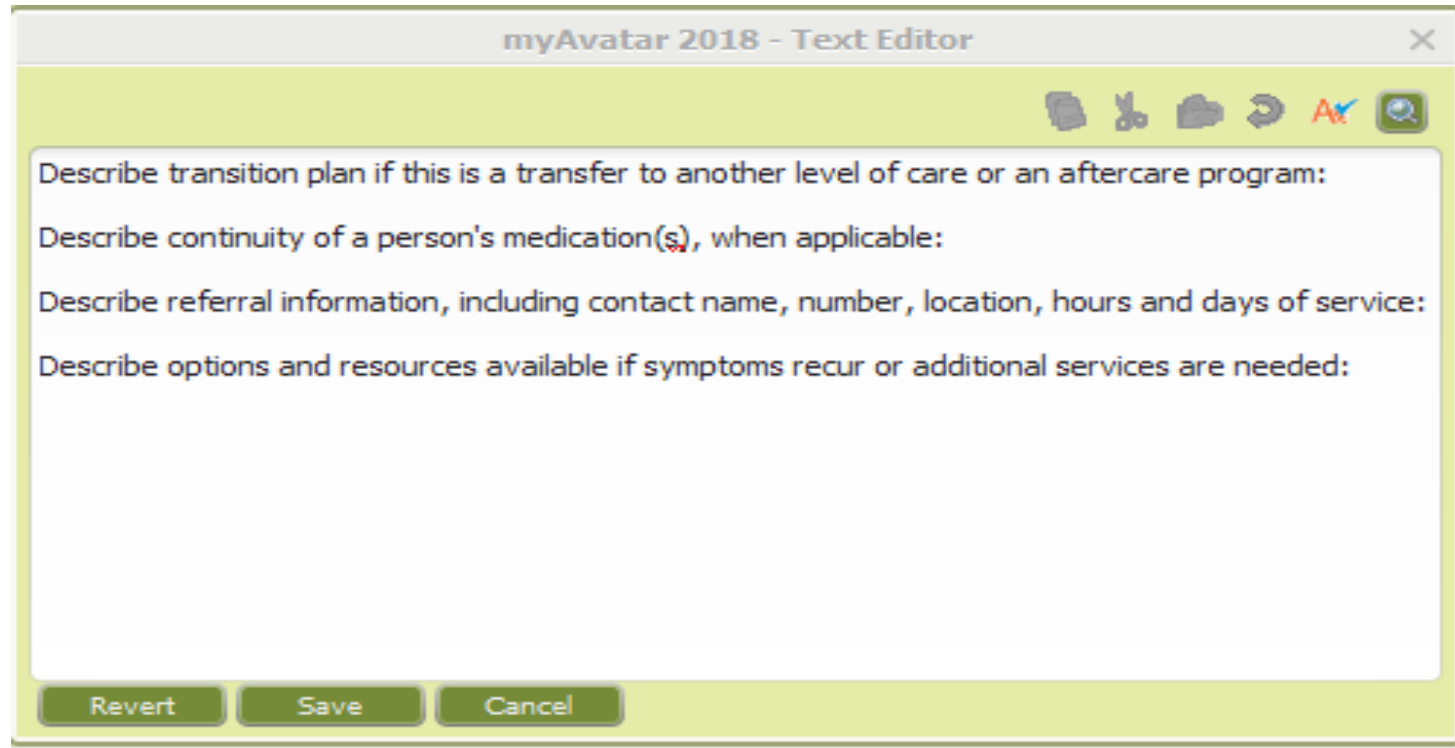
To access:

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



myAvatar 2018 - Text Editor

Describe transition plan if this is a transfer to another level of care or an aftercare program:

Describe continuity of a person's medication(s), when applicable:

Describe referral information, including contact name, number, location, hours and days of service:

Describe options and resources available if symptoms recur or additional services are needed:

Revert Save Cancel

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

As a person in recovery, I understand that neglecting my recovery plan will jeopardize my ability to maintain my recovery. I know that addiction is a chronic condition. I know how important it is that I maintain a recovery plan that includes a strong support system with people who care for me.

Anticipated Date of Discharge

06/30/2018

Today

Permission to contact: This treatment program has my permission to contact me during the next 12 months as a follow-up to my treatment and recovery.

Yes

No

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.

Client
Signature
& date 6/30/18

Primary
Counselor
Sig & date

Treatment Plan Status / Estado del Plan

Draft

Final

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 last 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.

Avatar – Treatment/Discharge Summary form

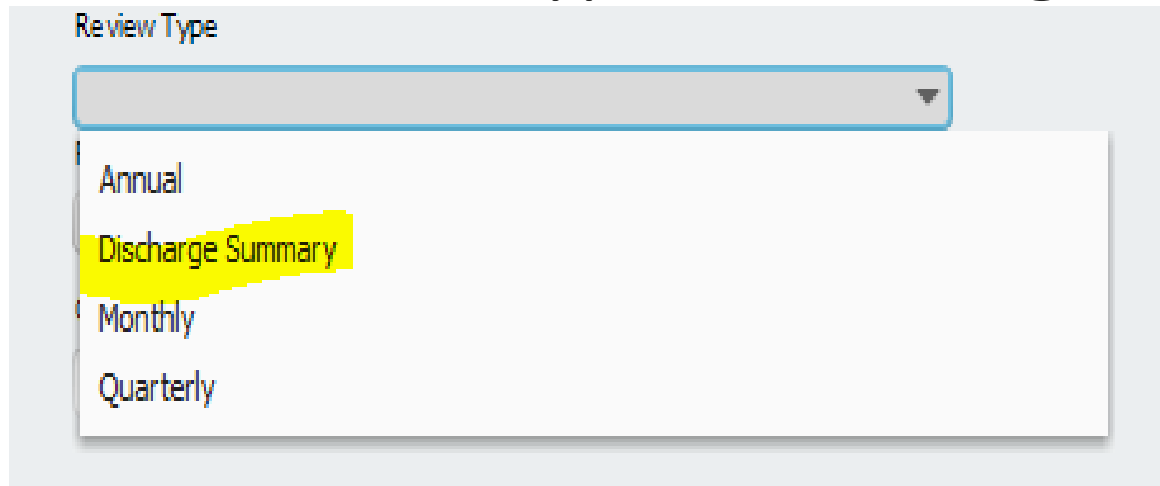
1. DMC-ODS Discharge Summaries are documented in the “Treatment/Discharge Summary form.”
 - a. No signature and date requirement

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)

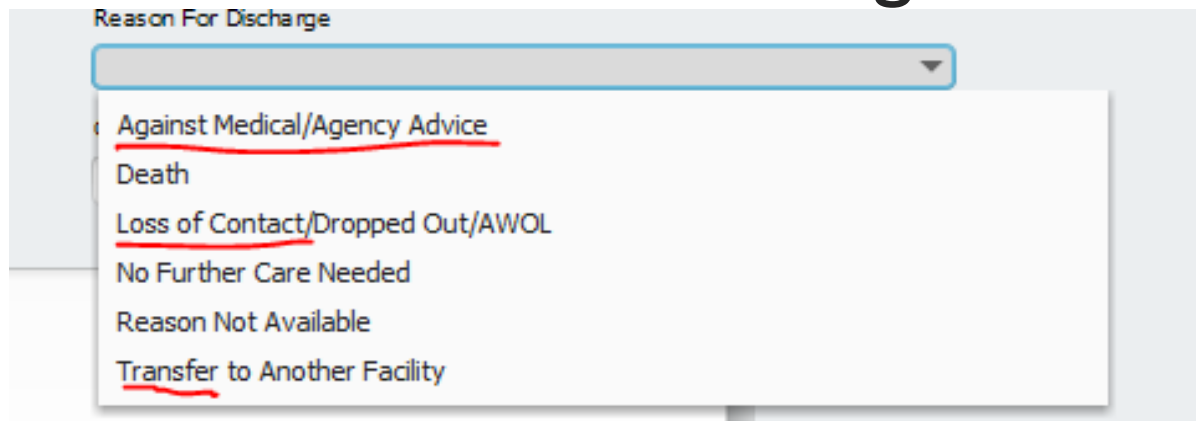
5. Select Review Type as Discharge Summary



Review Type

Annual
Discharge Summary
Monthly
Quarterly

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



Reason For Discharge

Against Medical/Agency Advice
Death
Loss of Contact/Dropped Out/AWOL
No Further Care Needed
Reason Not Available
Transfer to Another Facility

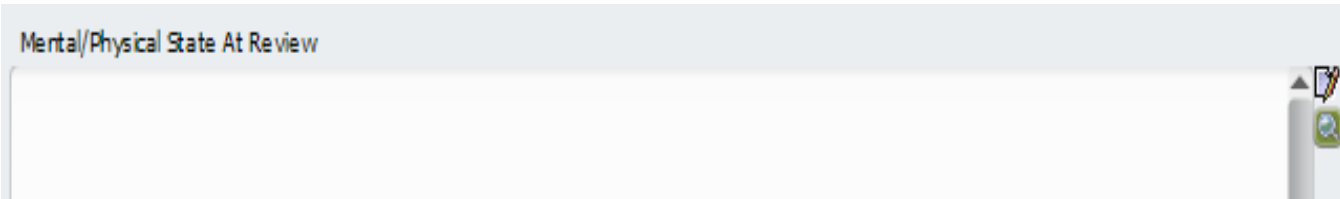
Avatar – Treatment/Discharge Summary (con't)

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.

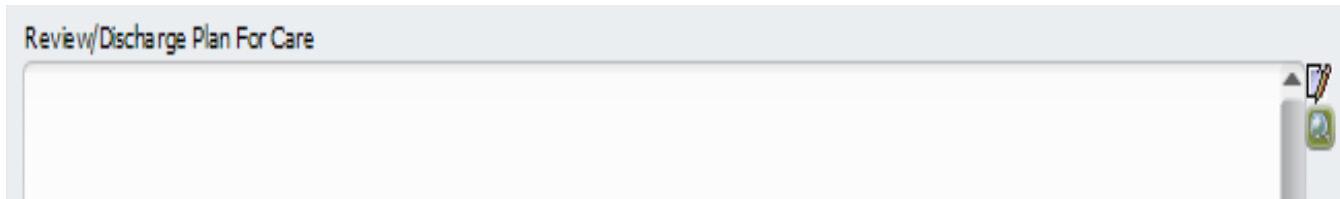
Review Of Client's Treatment

A screenshot of a software interface showing a text input field. The field is empty and has a light gray border. On the right side of the field, there are two small icons: a magnifying glass and a green circular icon with a white checkmark.

Mental/Physical State At Review

A screenshot of a software interface showing a text input field. The field is empty and has a light gray border. On the right side of the field, there are two small icons: a magnifying glass and a green circular icon with a white checkmark.

Review/Discharge Plan For Care

A screenshot of a software interface showing a text input field. The field is empty and has a light gray border. On the right side of the field, there are two small icons: a magnifying glass and a green circular icon with a white checkmark.

Avatar – Treatment/Discharge Summary (Con't)

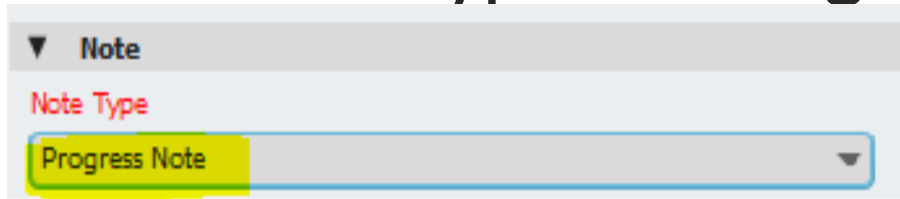
8. Enter Notifications, Transportation and Follow up information as indicated. This section will be individualized depending on the professional and personal relationships involved in client's care.

The screenshot shows a software interface for the 'Notification, Transportation and Follow Up' section. It contains several form fields and radio button options:

- Notification, Transportation and Follow Up** (Section Header)
- Notified Family/Sponsor Of Discharge**: Radio buttons for No, N/A, Yes.
- Notification Comments**: A text area with a scroll bar and a small icon.
- Transportation And Equipment Verified**: Radio buttons for No, N/A, Yes.
- Transportation Comments**: A text area with a scroll bar and a small icon.
- Reviewed Aftercare Instructions And Orders**: Radio buttons for No, N/A, Yes.
- Aftercare Comments**: A text area with a scroll bar and a small icon.
- Reviewed Aftercare Resources And Insurance Coverage**: Radio buttons for No, N/A, Yes.
- Community Resources Comments**: A text area with a scroll bar and a small icon.
- Follow Up Appointment Scheduled**: Radio buttons for No, N/A, Yes.
- Follow Up Comments**: A text area with a scroll bar and a small icon.
- Date Of Appointment**: A date picker with 'T' and 'Y' buttons.

Avatar – Treatment/Discharge Summary (Con't RED Items)

9. Select Note Type as “Progress Note”



A screenshot of a software interface showing a dropdown menu. The menu is titled "Note" and has a sub-label "Note Type". The option "Progress Note" is selected and highlighted in yellow.

10. Enter narrative in **Review/Discharge Note** field:

Review/Discharge Note (SUD discharges must include duration of episode [admit dt - disch dt], summary of treatment and expected prognosis, client's expected success outcome after treatment.)

- 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

Add/Edit Referral

Registered Referral	Referral To (Individual's Name)	Referral Organization	Other/Unregistered Referral Organization
No	Recovery Refuge		Insight Medication Center

Registered Referral
 Yes No

Referral To (Individual's Name)

Other/Unregistered Referral Organization

Referral Street Address

Referral City

Referral State

Referral Organization

Referral Zip Code

Referral Phone

Referral Comments

Discharge Progress Note

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

- ❖ OP/IOP and NTP: Use discharge planning service code when there is a last F2F session with client and A001 non-billable service code when there is not a last F2F session with the client.
- ❖ OP Discharge Planning Service Code= Over 21 A1439/ U21 A2439
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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