

Department of Health and Social Services

DHSS Policy Memorandum 66

Subject: Discharge/Transition Practices/Guidelines Language in DHSS Grants,
Contracts and State Plans

I. Purpose:

The purpose of this Memorandum is to provide uniform standards for the incorporation of discharge/transition planning practices/guidelines in all State Plans, Federal grants, sub-grants and contracts with vendors originating within the Delaware Health and Social Services (DHSS). A goal of the guidelines is to facilitate communication among DHSS divisions/facilities/providers/consumers and create a more coordinated/streamlined process for an individual's transition into the community or transition/movement among programs. The establishment of partnerships among entities who commit resources to the plan can result in a cost savings, a more effective utilization of resources and a positive impact on the life and well-being of the individual.

II. Background:

A joint committee made up of representatives of the Delaware Interagency Council on Homelessness (DICH) and the Delaware Commission on Community Based Alternatives for Individuals with Disabilities met in 2007 to explore their mutual interests and recommendations and to address the discharge and transition planning needs of vulnerable populations in Delaware. The resulting document entitled Exemplary Practices in Discharge (Transition) Planning (Appendix A) was intended to assist state and other government agencies, local communities, service providers, individuals receiving services, their family members, significant others and friends to develop and implement the most effective discharge planning systems possible.

III. Definition:

Individual: Within this policy DHSS recognizes that an individual, 18 or older, can mean both the client and, in some cases, a person who has legal standing to make decisions for the client.

IV. Scope:

This policy extends to all Divisions, facilities, and other entities of the Department of Health and Social Services and applies to all Federal grants, subgrants, State Plans and contracts as they relate to direct services to our consumers. Each Division will develop internal procedures to ensure their clients/consumers' needs are met. These are model guidelines that are not intended to take the place of or be in conflict with already established regulations governing Long Term Care (LTC) facilities, hospitals and other institutions originating within DHSS.

V. Responsibilities:

Ensure that all documents covered under Section III (Scope) are prepared in accordance with this policy and include the following elements of discharge/transition guidelines:

- The discharge/transition planning process shall begin at the time of an individual's admission to an institution, LTC facility, hospital or any other restricted environment
- The discharge/transition planning process is also triggered when a referral is made to a DHSS Division or when there is a change in services; or a change in the individual's level of care or care needs; or change of financial status.
- Notice to the DHSS Division regarding the need for a discharge/transition plan shall be made immediately upon the information of a change in circumstance/ level of care. Timely planning is essential to a quality discharge/transition plan.
- A discharge/transition plan must include consumer involvement and reflect the individual's preferences and choices. The plan is more likely to be successful when the individual has a sense of ownership of it.
- A discharge/transition plan shall encourage individuals to be as independent and self-sufficient as possible, in keeping with their abilities.
- The planning process will examine all available and appropriate resources for housing, health care, mental health and substance abuse treatment, income supports, individual safety needs, employment, education, training, self management of money and other resources and support networks.

- A plan shall feature partnerships among all entities, public and private, that can facilitate an individual's transition with supports and services in the community.
- A plan shall examine the use of non-traditional resources, when necessary.
- A plan must detail the expectations and scope of responsibility of each partner.
- The plan will take into account the recommendations made by the Delaware Governor's Commission on Building Access To Community Based Services and the Delaware Interagency Council on Homelessness as they pertain to housing, health care, mental health and addictions treatment, transportation, education and employment.
- The plan shall incorporate on-going, comprehensive assessment of the individual
- The plan must identify any unmet needs and gaps in service to inform and promote future planning and budgeting of needs and services. An interim plan will be put in place, while other services are being developed.

The decision of an individual to leave a program or facility against professional advice will not stand as a bar to apply/re-apply for future services.

Failure to comply with the responsibilities as outlined in the policy will result in a review by the applicable DHSS division administration and action up to and including termination of the contract (in instances where the relationship is contractual) and appropriate corrective/disciplinary action (when the lapse is internal to DHSS).

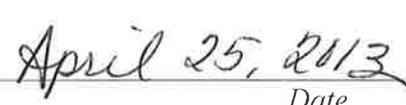
VI. Effective:

This policy becomes effective upon the date of signature.

This policy shall supersede all previous policy memorandum related to this stated subject.

If any part of this policy memorandum is in conflict with any Federal or State laws, Executive Orders or mandates of the Budget Director, that part only shall become null and void; the balance of the policy shall remain in effect until superseded.


Rita M. Landgraf, Secretary


Date

PM 66
Discharge/ Transition Practices/ Guidelines Language in DHSS Grants, Contracts and State
Plans

Appendix A: Exemplary Practices In Discharge (Transition) Planning

EXEMPLARY PRACTICES IN DISCHARGE PLANNING

A Delaware policy statement, developed by the Delaware Interagency Council on Homelessness and the Delaware Commission on Community-Based Alternatives for Individuals with Disabilities.

EXEMPLARY PRACTICES IN DISCHARGE PLANNING

Introduction:

A joint committee made up of representatives of the of the Delaware Interagency Council on Homelessness (DICH) and the Delaware Commission on Community Based Alternatives for Individuals with Disabilities met during 2007, to explore their mutual interests and recommendations and to address the discharge and transition planning needs of vulnerable populations in Delaware who are at risk for homelessness. The statements that follow represent the consensus of that committee.

The committee used a document as a template that was originally developed by the U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, 5600 Fishers Lane Rockville, MD 20857. That document, entitled *Exemplary Practices in Discharge Planning*, was organized into four categories:

1. Roles and Responsibilities
2. Elements of an Effective Discharge Plan
3. Collaboration and Partnership Issues
4. Cost and Funding Issues.

We have elected to organize Delaware's policies regarding discharge planning using the same format. These policies are intended to assist state and other government agencies, local communities, service providers, individuals receiving services, their family members, significant others and friends to develop and implement the most effective discharge planning systems possible.

The committee recognizes that there is a need for an implementation work group to develop procedures and infrastructure to manage certain elements of the discharge planning policy. Specifically, funding and management infrastructure will be needed to establish information systems and tracking as they are described herein. Similarly, protocol for selecting, training, and assigning team leaders, and a system for managing that process over time, will need to be developed. Finally, a mechanism for tracking the ongoing needs of persons who can be expected to need transition/discharge planning over the course of their lives will require management infrastructure. It is our intent to designate an implementation work group that will provide specific procedural direction in these areas.

I. ROLES AND RESPONSIBILITIES IN EXEMPLARY DISCHARGE PLANNING

A. Mission

Delaware Mission for Discharge Planning and Assessment: We will develop an assessment/discharge planning process that identifies the individualized supports and services needed to live successfully in the community for any Delaware citizen with a disability, condition, or problem related to life transition.

Guiding Principle: The lives of all individuals change; therefore individuals will have different support needs at different times in their lives and mechanisms need to be in place to provide for on-going planning.

B. Community Responsibility

Exemplary discharge and transition planning should be done in partnership among state and other government agencies, local communities, institutions and other long-term care facilities, and individuals, with designated community agencies having the primary responsibility for re-entry. This process will address the needs of all individuals with disabilities or other qualifying conditions who are moving out of institutions or other long-term care facilities, or who are transitioning from one level of care to another, as well as individuals who are transitioning between life phases, placing them at risk for homelessness and other poor outcomes. Persons transitioning between life phases may include, but are not limited to, youth exiting services as they enter adulthood, individuals who have been the victims of domestic violence, persons leaving military services, and older adults who need assistance to maintain community tenure.

- 1. Broad Involvement of Stakeholders:** Support from state government services, providers, agencies, family members and/or significant others and friends needs to be paramount in discharge planning. The planning process should be provided in an organized, consistent, and comprehensive fashion that addresses the needs of the individual and the resources that are (or are not) available to meet those needs.
- 2. Consideration of the Full Range of Individual Needs:** The assessment and discharge planning process will take into account the needs of the individual in the areas of housing, health care, employment, mental health and substance abuse treatment, income supports, education, and individual safety needs.
- 3. Connection to Community Resources and Services:** Institutions and other long-term care providers, hospitals, correctional centers, and

other similar programs and facilities have the responsibility for connecting individuals in their care to the individual's local community and its available resources. An exemplary process should also address the transitional needs of persons defined in Section B (above) and will include individuals with disabilities and other qualifying conditions who live in a community setting and who wish to move to a less restrictive setting. It will also include, but not be limited to, persons who are undergoing a transition between life phases that could lead to homelessness or other poor outcomes, such as youth exiting services as they enter adulthood, individuals who have been the victims of domestic violence, persons leaving military services, and older adults who need assistance to maintain community tenure. The process should also assist the state and other government agencies in the identification of gaps in resources and services that pose barriers to effective discharge planning. This is best accomplished through active partnerships with the agencies that will provide the primary support and services to individuals in the community. Community agencies and institutions and other long-term care facilities, have the responsibility of communicating and following through to ensure that the individual is offered all the services and supports necessary to live as independently and self-sufficiently as possible in the community.

- 4. Transient Individuals:** In instances in which the individual is transient, the discharging institutions and other long-term care facilities will attempt to connect the individual to the most appropriate community and to ensure that discharge planning has been carried out with the cooperation of the receiving community before the individual is discharged.
- 5. Choice and Self-Determination:** Whether in an institution or other long-term care facility, a community-based setting, or undergoing a transition between life phases, service delivery should focus on the preferences of the individual and his/her goals. Individual choice and self-determination respects the experience and knowledge of the individual by valuing these four principles: freedom, authority, support and responsibility.
- 6. Identification of Gaps:** The discharge planning/assessment process will identify unmet needs and gaps in service, and will lead to the creation of a database of comprehensive individual profiles that will enable greater collaboration, coordination, and planning among government agencies and programs, private sector providers, and natural support systems to facilitate successful community living. In addition the database will be utilized to promote future planning of budget needs and services.

C. Team Approach to Discharge Planning

In exemplary discharge planning, a team approach involving all people with significant discharge and transition responsibilities is essential. A team approach should facilitate efficient communication and effective use of resources.

1. Teams emerge from partnerships among individuals and their natural supports, advocates, community providers, state and other government agencies, and institutions and other long-term care facilities, and commit to a plan of care, support, housing, and treatment of the individual that will maximize the individual's chances for successful community living. The plan of care clearly establishes responsibility for identified deliverables and projected timeframes.
2. Team composition is flexible and can include persons serving in the following capacities:
 - a. Individual*
 - b. Family member(s) or other supporters
 - c. Community case manager*
 - d. Institution/ long-term care facility representative*
 - e. Mental health and substance abuse specialists
 - f. Housing specialist
 - g. Entitlement/income specialist
 - h. Criminal justice system representative
 - i. Health care system representative
 - j. Payer representative
 - k. Education specialist
 - l. Employment specialist
 - m. Advocate
 - n. Peer supporter

*Indicates core members of a discharge planning team. While a team might have many members, not every team member needs to be present at meetings with the individual. The composition of each team should be based on the unique needs, strengths and preferences of the individual.

3. Team members must have the ability to commit the resources of the organization which they represent. Issues of eligibility for entitlements (such as eligibility for Medicaid under all relevant waivers and plan amendments) should be identified and addressed as part of the planning process. Team members should identify all resources and

entitlements that can be applied for prior to discharge, and should agree upon the point of responsibility and timeframes for completing all such applications (such as Social Security, Medicaid, housing subsidies, etc.)

D. The Importance of the Team Leader

The team leader is the person with the primary responsibility for the re-entry coordination of the individual into the community. The team leader will be determined depending on the setting from which the individual is being discharged and the discharge goals. The team leader collaborates with the other members of the team to ensure that the individual has the necessary resources and supports available to assist with the re-entry.

1. The team leader is responsible for following up with the individual to ensure the implementation of the discharge plan, including the need for ongoing assessment.
2. The team leader identifies the other members of the team, secures their participation, and ensures communication among the team.
3. The team leader has conflict resolution authority among the team.
4. While in many instances a community-based case manager will serve as the team leader, the position is flexible and subject to community determination.
5. The team leader is an individual who is able to work well with and gain the trust of the individual.
6. A system will be established for resolving any disputes that may arise regarding the appointment of a team leader.
7. The assessment/discharge planning process will identify the long-term needs of the individual, including future points at which she/he may need additional assistance, and should specify who will take responsibility for assisting the individual with future planning.

E. Information Systems and Tracking

The discharge planning/assessment process will identify unmet needs and gaps in service, and will lead to the creation of a database of comprehensive individual profiles that will enable greater collaboration, coordination, and planning among government agencies and programs, private sector providers, and natural

support systems to facilitate successful community living. In addition the database will be utilized to promote future planning of budget needs and services. A well-designed management information system supports the discharge planning process by improving communication, facilitating access to resources, and tracking completion of the discharge plan.

1. One integrated planning format should be adopted and utilized for all services and supports while allowing and promoting person-centered goals and interests.
2. Information systems should be developed to link the community with institutions and other long-term care facilities.
3. Information should be aggregated to identify trends to aid in the planning for future services, supports, and areas of concentration such as access to housing, transportation and employment.
4. Information systems and tracking procedures should feature safeguards and consent agreements that protect confidentiality and civil rights.
5. Funding sources need to devote adequate resources to ensure the development of effective information systems.
6. Provisions for measurable plan outcomes need to be incorporated into care planning and aggregated to demonstrate effectiveness over time.
7. A single designated agency should be appointed and should have the responsibility for coordinating the activity of all the institutions and other long-term care facilities and community providers involved in a community system of re-entry and ongoing care. This agency will act as the clearinghouse and primary impetus for the collection and organization of data.

F. Incentives and Flexibility

Exemplary systems offer incentives both to individuals and providers as well as allow for flexibility in meeting individual needs.

1. Incentives that emphasize performance and outcomes and encourage agency collaboration and participation need to be developed.
2. Exemplary discharge planning systems and community re-entry procedures are flexible, allowing and promoting appropriate latitude for responding to individual need.

3. Exemplary discharge planning systems recognize that the lives of all individuals change and those individuals will have different support needs at different times in their lives. Mechanisms need to be in place to provide for on-going planning.

G. Government and Other Funding Agencies

Government and other agencies responsible for funding community placement and ongoing community services have the responsibility for utilizing resources as efficiently as possible. The Delaware Interagency Council on Homelessness (DICH), established by Executive Order 65, and Delaware's Commission on Community-Based Alternatives for Individuals with Disabilities (CCBA), established by Executive Order 50 will be responsible for monitoring the implementation of the discharge planning system.

This process works best when all state agencies with an interest in community re-entry collaborate. Executive, legislative, and judiciary branches of government should all be involved in the discharge planning process.

Advocacy groups have an important role to play in ensuring the integrity of the discharge planning system. Advocacy groups have the responsibility to monitor the state governments to ensure that they fulfill their responsibilities.

1. The Funding agencies have the responsibility for ensuring the development and implementation of discharge policy.
2. Effective discharge planning is based on successful, replicable models and evidence-based practices that have been tested in various communities and states.
3. Discharge planning is more effective when state administrations make it a priority and involve multiple state agencies, especially those with responsibilities for housing, human services, and criminal justice.
4. The DICH and the CCBA will have the responsibility for monitoring the implementation of effective discharge policy and planning.

II. ELEMENTS OF THE DISCHARGE PLAN

A. Individual Involvement and Cultural Competence

The most important element of the re-entry plan is individual involvement and buy-in. When the individual feels a sense of ownership of the plan, the individual is more likely to follow it.

1. Exemplary discharge plans are developed with individuals and feature the most extensive input possible from individuals.
2. Exemplary discharge plans are written in the form of a contract between the individual, service providers, institutions and other long-term care facilities, and the community representative.
3. Exemplary discharge plans are culturally competent and consider the important issues in race, ethnicity, religion, gender and sexual orientation.
4. Exemplary discharge plans are conscious of factors such as the relationship between genetics and medication; the role of eye contact, language, social space, and body language in a culture and the relationship of these elements to diagnosis; and the culture's view of mental illness and stigma.
5. Professionals who assist in the development of exemplary discharge plans are culturally competent and achieve a "good fit" between the individual and the clinician.

B. Housing, Health Care, and Treatment

For a discharge plan to be successful, it needs to facilitate the individual finding and maintaining housing, health care, treatment, access to transportation and employment or education opportunities, based on their individual plan.

The assessment/discharge planning process will take into account the recommendations made by the Delaware Governor's Commission on Community Based Alternatives for Individuals with Disabilities and the Delaware Interagency Council on Homelessness as they pertain to housing, health care, mental health and addictions treatment, transportation, education, and employment. The implementation of these recommendations is critical to effective discharge planning. Without the resources recommended in the referenced reports, there are not enough resources, and the resources are not sufficiently varied, to provide appropriate community placement alternatives for persons with disabilities and other qualifying conditions and life situations.

1. Exemplary discharge plans identify and secure a variety of housing options, recognizing that the needs and preferences of individuals vary and change over time as conditions and interest change.

2. Exemplary discharge plans stem from an assessment of a community's housing stock and partnerships between housing and service providers. Given these resources, under no circumstances should an individual be discharged to the streets.
3. A significant increase in the stock of affordable, supportive housing is necessary for successful community re-entry. The stock of affordable, accessible housing units must be consistently identified and maintained.
4. On-going, comprehensive assessment, undertaken in collaboration with the individual and emphasizing the individual's strengths and preferences, is essential to the discharge and community re-entry processes.
5. Exemplary discharge plans provide for the mental and physical health needs of the individual on a level of parity.
6. Exemplary discharge plans ensure substance abuse and mental health treatment, and other therapies as defined by the plan, such as occupational or physical therapy as needed.

C. Income, Employment, and Entitlements

Exemplary discharge plans encourage individuals to be as independent and self-sufficient as possible.

1. Exemplary discharge planning builds in a system of empowerment with educational supports in self-management and tools for individuals and their natural supports to gain competencies in self-management.
2. Exemplary discharge plans ensure that individuals receive all the entitlements for which they are eligible.
3. Exemplary discharge plans examine the possibility of employment, education and training.
4. Exemplary discharge plans ensure appropriate management of money and other resources.

D. Personal Support and Life Skills Education

Individuals have better opportunities for a successful and permanent community re-entry if they can develop adequate support systems. Exemplary discharge planning facilitates the development of this support.

1. Exemplary discharge plans feature case managers with small caseloads who work with individuals and agencies to ensure that the discharge plan is followed or revised as necessary.
2. Exemplary discharge plans ensure the development of support networks.
3. Exemplary discharge plans involve family members, friends and other supporters as appropriate or requested.
4. Peer support groups can be very helpful to community re-entry, and discharge plans should make use of these resources whenever appropriate.
5. Exemplary discharge plans feature education, as needed, in community-based life skills, and self-directed care.

E. Timing of the Plan

Discharge planning has to begin immediately upon an individual's admission to an institution or other long-term care facility and/or any other restricted environment. For persons who will be transitioning between life phases, transition planning should begin as early as possible to ensure that the individual will have the maximum amount of choice and time to prepare financially, emotionally and in all other relevant ways to make the transition.

As the majority of stays in hospitals and other institutions and other long-term care facilities are relatively short-term, it is critical that discharge planning begins when the individual enters the institution or other long term care facility.

F. Difficult Cases

For some individuals, non-compliance or relapse may be part of their community re-entry experience. Exemplary discharge planning recognizes and anticipates these possibilities.

1. Exemplary discharge planning recognizes that, for a variety of reasons, difficult cases happen. Some individuals will choose to become disconnected from the system and some agencies will occasionally refuse to offer services to certain individuals.
2. Exemplary discharge planning anticipates these difficulties and attempts to develop alternative resources to meet potential and likely needs. These resources might include outreach programs, Safe

Havens, jail diversion programs, alternative programs developed in unused areas of state hospitals, and other innovative programs.

3. Exemplary discharge planning ensures that if individuals leave a program or facility against medical advice, they will be able to return to the system and resources will be available.

III. COLLABORATION AND PARTNERSHIPS

A. Levels of Collaboration

A variety of forms of partnerships and collaboration can achieve an effective discharge planning system. It is the responsibility of each team to determine which level works best in its own situation. Exemplary discharge planning recognizes a continuum of collaboration. It ranges from shared information and memoranda of understanding to blended staffs and joint financial agreements. Exemplary discharge planning utilizes each level as appropriate.

B. Developing Partnerships

The major benefit of partnerships is that successful ones expand the amount of resources available to individuals engaged in community re-entry.

1. In most cases, the network of partnerships in collaboration will begin with agreements between a few agencies and will grow, over time, to include all agencies and institutions and other long-term care facilities necessary to the system.
2. Exemplary partnerships involve agencies in the areas in which they have demonstrated expertise.
3. An exemplary discharge planning system features a review mechanism to ensure that the procedures and structures established to facilitate collaboration do not obstruct or impede the collaboration.
4. Exemplary discharge planning promotes individual-oriented outcome or impact measures.

C. Thinking "Outside the Box"

In developing partnerships to facilitate community re-entry, it can be helpful to explore relationships with non-traditional allies as well as those with entities which have an obvious interest in discharge planning (providers of housing, substance abuse treatment, mental health care, or support services). These

relationships can result in new resources and fresh perspectives for discharge planning.

1. Exemplary discharge planning systems feature partnerships among all entities that can facilitate a individual's re-entry into the community. Examples of such entities include, but are not limited to, community providers, housing agencies, family services agencies, Business Improvement Districts, private foundations, advocates, the media, and criminal justice organizations. The scope of "the box" often extends beyond a local community to the regional, state, or national levels.
2. Exemplary collaboration sometimes involves agencies or institutions and other long-term care facilities that have had a competitive or adversarial relationship in a common endeavor that creates new understandings and cooperation while reducing historic tensions.

D. Written Agreements

Written agreements provide a necessary underpinning for successful collaborations. These agreements clearly delineate roles and responsibilities and ensure the correct functioning of collaborations if they are impacted by personnel transitions.

1. Exemplary collaboration is built on written agreements between agencies and institutions and other long-term care facilities, and other entities essential to effective discharge planning. These agreements take the form of memorandums of understanding (MOUs), contracts, or instruments of agreement, as appropriate.
2. Exemplary agreements are usually reflective of an agency or institution, or other long-term care facilities' mission statement, are time-limited, feature an evaluation component, and are drafted with input from staff who will be responsible for implementing the agreement.

E. Community Resources and Systems Integration

Systems integration can reduce the duplication of services and administrative functions, thus increasing the amount of resources available to support an individual's re-entry into the community. Support for systems integration is included in a community's official policy documents.

1. Effective discharge planning procedures and policies are supported by all relevant community planning documents, including the Consolidated

Plan, Continuum of Care, and mental health and public housing authorities' strategic plans.

2. Effective discharge planning systems make use of all available resources, including, but not limited to, state, local and federal resources.

IV. FUNDING AND COST ISSUES

A. Funding Considerations

In order for discharge planning to be successful, it needs adequate funding for the resources and programs deemed likely to be most successful in assisting an individual's re-entry into the community of their choice where applicable.

1. In order for discharge planning to be effective, there should be an establishment and implementation of MOUs that clearly articulate roles, the level of resources, including funding expectations, and program accountability that promote a successful discharge.
2. Funding agencies should support those practices and services that have been proven effective in assisting individuals to re-enter and remain in the community of their choice where applicable.
3. Comprehensive strategic planning facilitates budgeting and allocation of resources that promotes individuals to remain in or re-enter into the community.
4. In order to establish consistency in a community's discharge planning system, funding agencies need to ensure that the strategic plan is fully implemented.

B. Partnerships

By developing effective partnerships, system fragmentation can be eliminated, promoting a seamless continuum across systems.

1. The establishment of partnerships among agencies in a discharge planning system can result in cost savings and the more effective use of existing resources.
2. It is essential that each agency in a partnership commit resources including personnel, funding, or in-kind services.

C. Research and Evaluation

Evidence based research should document and support best practices in discharge planning.

1. To ensure that best practices are adopted and receive adequate funding.
2. Performance of discharge planning should be measured through program evaluation.
3. Trends identified by analyses of performance measures should be utilized to promote best practices in discharge planning.

D. Stakeholder Responsibilities

All stakeholders, based on a thorough needs assessment, are responsible for establishing funding priorities for discharge planning.

1. Stakeholders should assist in identifying the needs of the community and communicate them to the administrative and the legislative branches of government.
2. Stakeholders should develop an assessment evaluating the effectiveness of each component of the discharge planning system and as part of the process be reviewed quarterly.
3. The savings achieved through the use of exemplary practices should be reinvested in the discharge planning system and in creating additional community resources.