CHI St. Anthony Hospital

ER Discharge Planning for Mental health Treatment Patients

POLICY

It is the intent of this policy to ensure that suicidal/homicidal and acutely psychotic Emergency Department patients who obtain a County Designated Mental Health Provider exam by Community Consoling Solutions (CCS) are offered and encouraged to bring in support persons so that they are supported at discharge by a network of family or friends.

The patient will be given a pamphlet describing this policy and a medical release form will be used to allow the patient to sign consent for us to communicate to a third party of their choosing.

1. Discuss with the patient if they would like to identify a family member, friend, or other support person ("lay caregiver") who will provide assistance to the patient following their discharge from the hospital. Particularly vulnerable patients, such as those hospitalized for mental illness should be encouraged to designate a support person to aid in their post-discharge care. If a lay caregiver is identified, note the designation in the patient's medical record.
    a. For a patient who is younger than 14 years of age, the lay caregiver is a parent or legal guardian of the patient.
    b. For a patient who is younger than 18 years of age but at least 14 years of age, the lay caregiver is the patient's parent or legal guardian unless the legal guardians refuse or there are clear clinical indications to the contrary such as sexual abuse by the guardian or evidence of emancipation. To the extent a legal guardian is not designated as the lay caregiver due to clinical indicators, those reasons should be noted in the medical record. A patient aged 14 to 18 may also designate a lay caregiver of their choice.
2. If a lay caregiver is identified, encourage the patient to sign an authorization to disclose relevant protected health information. Note in the medical record if the patient authorization is obtained. Information to share with the patient and lay caregiver prior to discharge should include, but not limited to:
    a. The hospital's criteria and reasons for initiating discharge.

b. The patient's diagnosis, treatment recommendations, and outstanding safety issues.
c. Risk factors for suicide and what steps to take if danger exists, such as ridding the home of firearms/other means of self-harm and creating a plan to monitor and support the patient.
d. The patient's prescribed medications including dosage, explanation of side effects and process for obtaining refills, as applicable.
e. Available community resources including case management, support groups, and others.
f. The circumstances under which the patient or lay caregiver should seek immediate medical attention.

3. CCS will conduct a risk assessment of the patient's risk of suicide.
4. CCS will conduct a needs assessment to understand the long-term needs of the patient. The assessment should include questions regarding the patient's income, housing situation, insurance, and aftercare support, among others. The lay caregiver should be included in this conversation, if applicable.
5. CCS will coordinate the patient's care and transition to outpatient treatment. Providers should share the post-discharge treatment plan with the patient and lay caregiver and provide an explanation of:
    a. The next level of care, how it differs from hospitalization, and what the patient should expect from outpatient treatment.
    b. Contact information for the outpatient care including address and phone number of the site/provider.
6. CCS will schedule follow-up appointment for no later than seven days after discharge.
    a. If a follow-up appointment cannot be scheduled within seven days, document the applicable barriers in the patient's medical record.
7. As necessary, CCS will provide instructions or training to the patient and lay caregiver prior to discharge. Instructions should address how to provide assistance to the patient and may include securing and administering medications, safety plans, name and location of follow-up appointment and community resources, or any other anticipated assistance relating to the patient's condition.
8. Notify the designated lay caregiver in advance of patient discharge or transfer.

References: ORS 441.053, OAR 836-053-1403