

DIVISION OF MENTAL HEALTH AND DEVELOPMENTAL SERVICES  
SOUTHERN NEVADA ADULT MENTAL HEALTH SERVICES  
SCOPE: HOSPITAL SOCIAL SERVICES

---

SUBJECT: Discharge Planning and Aftercare  
Plan

EFFECTIVE DATE: 06/2012

REVIEW DATE: 06/2014

APPROVED BY: /s/Susan Kingsbury, LCSW  
Department Head, Social Services

SUPERCEDES: Department procedure dated 08/01/05, 08/07, 11/08, 01/10, 07/10

---

**I. PROCEDURE**

It shall be the procedure of Southern Nevada Adult Mental Health Services Hospital Social Services to provide discharge planning to all patients in the Psychiatric Observation Unit (POU) and on the inpatient units.

**II. PURPOSE**

The purpose of discharge planning and aftercare is to identify and describe the services and support systems that are appropriate to meet the patient's psychosocial needs and that will be effective on the day of discharge.

**III. PROTOCOL FOR DISCHARGE PLANNING:**

A. POU social workers shall first interview the patient gathering information for completion of the Psychosocial Assessment 2008 in Avatar, which is completed within 24 hours of admission to POU and 72 hours of admission for inpatient units. The social worker shall document specific steps to be completed by the time of discharge, which may include affirming housing and identifying the need for referrals to community services and a working discharge plan, within 72 hours of admission, as part of the Inpatient Treatment Plan. Inpatient social worker shall document every 7 days until discharge in the treatment plan steps taken to develop the discharge plan, referral services and barriers to discharge. Housing will be confirmed and documented. In the event the patient refuses to allow contact about housing, the social workers shall document attempts, refusal, and efforts to gather information from the patient about the arrangements made by the patient. Weekly progress notes will also be entered in AVATAR for each patient, continuing to document the process of discharge planning.

B. Social Workers shall:

1. Patient interviewed by social worker to identify psychosocial needs.

2. Family members, significant others, friends, roommates, Guardians, apartment/hotel managers, and other support contacted to verify housing placement, and outpatient service needs. An attempt to obtain consent should occur at first contact.
3. Social workers shall complete a thorough exploration with patient, family, friends, intra agency and inter agency supports for housing, outpatient programs to help meet patient's needs identified in the patients discharge goals and plans and written in the treatment plan.
4. Family/significant others shall be invited as soon as possible, with consent from patient, to Treatment Team meetings.
5. Social workers shall make a referral at the beginning of admission for a Service Coordinator when the patient, family, social worker and treatment team members identify the patient needs more support and assistance. The referral form is located on the server in the Social Services folder. The following criteria should be considered: history of rapid readmits (3+ in 1 year), history of multiple failed or unsuccessful housing placements, history of Axis I, SMI, substance abuse/gambling relapses and failed drug treatment programs, serious suicide or homicidal attempt(s); physical or emotional frailty putting patient at risk for safety without community placement; history of lack of treatment and medication compliance.
6. Once a Service Coordinator is assigned, it shall be the responsibility of the social worker to invite them to the treatment team meeting to discuss the patient's progress in treatment and confirm a discharge plan.
7. Patients may also be referred to Mohave Mental Health for Case Management. All Mohave referrals must have Medicaid. A referral form is on the SNAMHS server, and as with Service Coordination, a referral should be made as early into a patient's hospital stay as possible.
8. Co-occurring patients with an SMI and a substance abuse/dependency diagnosis being referred to Total Recovery need to be identified as soon as possible. Referral forms will need to be completed. These forms are located on the SNAMHS server.
9. Social workers shall identify with patient the SNAMHS Medication Clinic, Mojave Medication Clinic or VA Clinic the patient will be referred to and discuss the outpatient counseling available, as well as medication follow up.

10. Insured patients shall be given provider choices for outpatient treatment. Efforts should be made to schedule an outpatient appointment with a week, not greater than two weeks from discharge. An ROI releasing the provider's discharge summary shall be obtained prior to discharge for patients identified as being followed by psychiatric providers outside of SNAMHS.
11. For patients being referred to home health agencies and skilled nursing facilities, a list of providers shall be maintained in the department and accessed online. Patients/guardians (families as appropriate) shall be made aware of the available resource lists. There will be documentation in a weekly progress note when a HHA or SNF list is requested or declined. The patient/guardian preference for referral shall be noted in a weekly progress note.
12. Social workers shall provide each patient with a copy of the Discharge Instructions. Instructions shall include appointments made and/or how the patient can access the services. The instruction form can be found on the SNAMHS server in the Social Services folder. An original signature copy needs to be placed in the medical record, and a copy given to the patient.
13. Social workers shall complete prior to the discharge date and document in weekly progress notation all contacts and referrals with intra agency and community programs and shall document the discharge planning process with the patient and multidisciplinary treatment team, in weekly treatment plan updates as well as in weekly Progress Notes.
14. Patients who are being discharged on a court commitment shall either leave on "conditional" or "unconditional" leave. The social worker shall contact HIS department and inform the identified staff who completes court commit discharges to initiate the 1 page leave form for Hospital Director or designee to sign. The signed conditional release form shall be given to HIS for filing in Family court prior to discharge.
15. If the patient's family has been involved in the discharge process and the patient consents the social worker shall contact family member(s) and inform them of the aftercare plan and discharge date.
16. Should the patient have a guardian, the guardian must be informed about the Discharge Plan and date of discharge. Should a patient be committed, this plan shall be sent, in writing, to the guardian.
17. Social workers shall write a discharge summary that day or the next working day, in the progress notation following patient discharge which shall include:

- Complete description of referrals to treatment and community resources including date(s) and times and addresses of service providers.
  - Document that a Community Resource Guide was given to the patient.
  - Description of community based housing arrangements and prior communication and exchange of information.
  - Economic/financial status of application for social security benefits, Medicaid, Clark County rent voucher.
  - Brief description of family and significant others involvement with the patients discharge, and briefly address anticipated problems after discharge and suggested resources and interventions.
  - Transportation resources provided, day bus pass given, bus schedules, and map quest to get to referral appointments.
  - Brief bio-psychosocial description of status of patient on day of discharge.
18. In addition to a discharge progress note, the social worker shall complete a LOCUS and the SSAP (date and core measure tab) in Avatar.
19. When a patient is discharged from SNAMHS inpatient hospital and admitted to a medical facility in the community, the SNAMHS social worker shall initiate contact the day or following day of discharge with the social worker or staff member responsible for discharge at the other facility. The social worker shall inform the staff member of the legal status, discharge plan to return or not to return to Rawson-Neal Hospital or community placement i.e. rehabilitation, nursing home etc. Social worker shall keep ongoing contact with the medical facility as appropriate.

## **V. REFERENCES:**

- A. Joint Commission Interpretative Guide for Discharge Planning, B133, B134, B135
- B. CMS standards for discharge planning
- C. Social Worker Algorithm for Discharge Planning and Aftercare

## **VI. ATTACHMENTS:**

- A. Locus
- B. Conditional Release form
- C. Unconditional Release form