UTHCPC Continuum of Care Plan

Principle/Values:

UTHCPC supports the following principles related to care across the continuum.

1. Mental illness requires ongoing care across the continuum
2. Care should be provided in the least restrictive setting based on individual patient needs.
3. Relapse is anticipated to some degree and should be managed in an effort to prevent re-hospitalization when possible.
4. Caregivers and family members play a vital role in supporting their significant others who are diagnosed with mental illness.
5. The independence and self-determination of the patient is supported.
4. Discharge planning begins at time of admission.
5. Referral to self-help groups is valued.
6. Confidentiality of our patients is honored. When our efforts to protect patient confidentiality impacts family members, we will do our best to explain to our policies.
7. Discharges should be planned early in the treatment stay
8. Patient preferences are honored when at all possible.

Care across the continuum:

UTHCPC provides care across the continuum. Entry into the system begins during the preadmission assessment. Following the assessment, the patient is referred to less intense treatment settings and or is admitted. If admitted, the patient is treated, and then referred to less intensive treatment settings upon discharge. This might include partial and outpatient programs, referral to MHMRA, or private therapists or treatment settings. When referred to UTHCPC outpatient programs the patient may enter, exit, and reenter different levels of care at any time during the year based on specific patient needs. Communication between caregivers is of utmost importance as the patient moves from one level of care to the other in our settings.

Purpose of the Plan:

This plan is written to provide guidelines for the multidisciplinary staff members of UTHCPC so that through the description of common standards, there will be uniformity in the quality of care provided to our patients.

Referral of patients to UTHCPC:

UTHCPC receives referrals from NPC, MHMRA, and local area hospitals as well as self-referrals. The hospital receives voluntary and involuntary clients. Communication with referral sources occurs prior to the assessment of patients through review of written documentation and telephoned information about potential patients.

Admission Process:

Patients are assessed prior to admission. Criteria for both outpatient and inpatient care are reviewed at time of admission.

Patients are referred to less restrictive settings based on the preadmission evaluation. Patients who are deemed too medically ill at time of admission are referred to area medical hospitals.

Patients are informed (by social service staff members) at time of admission about the continuum of care. They are informed about the partial and outpatient programs and about the importance of continuing a plan of care post discharge to prevent readmission.

Assessment/Treatment:
The treatment team reviews patient history upon arrival to the inpatient or outpatient program. In the process of assessing patient the team gathers information about course of illness. An effort is made to determine what meds and treatment patient received prior to admission. Nursing staff, medical staff and pharmacy participate in the review and reconciliation of medications the patient was taking prior to admission. Effort is made to validate information given when needed through interview of guardians, and parents.

Discharge planning process:
Initial discharge plans are documented on the psychosocial assessment, which is online (Should we add a time frame for doing so?). Updates to discharge plan are included in social service progress notes. The social service clinician is responsible for keeping the patient up to date about discharge plans. The patient participates in the planning through participation in rounds.

Treatment teams are encouraged to keep planning documents so that all team members are aware of the anticipated discharge date. In this way, all treatment staff is kept aware of patient discharge plan so that all can answer patient and family member questions about the tentative discharge plans.
Discharge plans are documented in the treatment plan section of the chart. The patient participation in this process is documented on the treatment plan. The discharge summary includes reference to the discharge plan.

Referral Process:
Patients are referred to housing and for follow up treatment. All patients receive a written discharge instruction sheet, which describes follow up recommendations. Nurses review medications and medical clinic referrals. Social service staff members review aftercare appointments and housing recommendations. The physician reviews discharge plans with the patient in rounds. Discharge instruction documents are reviewed with the patient at time of discharge. Significant others and family members receive discharge instruction when possible. Printed information about medications is provided in English and Spanish as needed. A discharge packet with lists of self-help groups, online patient information and resource lists is given to all patients at time of discharge.

Coordination of Post Discharge treatment plans: Social Services Clinicians and medical staff members interface with agencies, hospitals, MHMRA to coordinate the planning process.

Housing:
Personal care Homes: UTHCPC only refers to licensed personal care homes.
Shelters: Homeless patients are referred to shelters. An attempt is made to refer to shelters appropriate for the patient.
Patients who live independently or with family members are provided transportation and referrals for community resources that will offer ancillary services and augment their income.
Transportation: The mode of transportation is determined by using the following process:

Patient is transported to their destination by taxi if:
Patient is not ambulatory and /or on fall precautions.
Patient is at baseline but remains extremely disoriented and/ or unable to process simple directions
and:
Patient has no family, friends, or facility to transport them (Clinician must verify with a written authorization for each contact)

A case management team is not involved with patient (i.e. MCOT, ACT Team, Deblin, etc)

Patient's discharge destination is not on or within 6 blocks of the Metro Bus Line.

If the patient qualifies for transport via Taxi, they are sent directly to their placement utilizing this mode of transportation.
If they do not qualify per the criteria, they are given bus tokens and directions/bus routes to their destination. Other arrangements such as Commercial Bus Lines, planes, etc. have been used for patients who live outside the area. A receiving family member/friend is contacted to meet the patient at their destination.
If there is some unusual circumstance that does not apply to the above criteria, the issue is brought to the treatment team for examination of the options that are available. The Social Service Clinician brings the team's recommendation to the Director of Social Service.

<u>Follow up treatment:</u>

<u>UTHCPC OUTPATIENT Services:</u> All patients who are eligible for service at UTHCPC outpatient are provided an opportunity to be referred there for follow up. Once they begin treatment, patients are followed over time. Based on intensity of treatment needed they are able to move from more intensive to less intensive treatment options based on their condition.

<u>MHMRA Target population clients:</u>
___Patients who are defined, as target population by MHMRA definition and who/or are open clients are
Referred to MHMRA
__ Patients who are defined as target population by MHMRA who are not open clients are referred to the
Crisis Center for MHMRA
__ Target population patients who do not have immediate access to MHMRA and are placed on waiting list
May be referred to UTHCPC Partial or IOP program if they are eligible.

<u>MHMRA Non Target Population clients</u>:
__ If patient is voluntary, non target, non resource, and is without a compromising medical condition, patient
Is referred to Crisis Residential for inpatient step down or the crisis counseling center for outpatient
Services depending on level of need.
__Noncompliant, non-resource, non-target population patients who have a GAF score under 50 and/or have
Over __admits in 12 months are referred to MCOT.
__ Non target patients who have compromising medical conditions are referred to MLK.

<u>TCADA Services:</u>
Social Service Clinicians screen each patient during the process of collecting information for the patient's psychosocial.
If the screen indicates a substance abuse problem, the patient is referred to a representative of the Houston Council on Alcohol and Drugs for a TCADA screening and if needed, a full assessment. Following the assessment the patient's needed level of care is determined, using TCADA criteria.

A referral is made for the appropriate level of care.

Medical care post discharge:
___All patients with medical conditions are given referral to a medical practitioner.
___Ben Taub clinics: A large number of patients are referred to Hospital district clinics.
Effort is made to seek Gold cards for patients who are referred to Hospital district system.
An attempt is
Made to seek red cards for access to emergency services when needed.

Follow-up Services:
UTHCPC Outpatient services: Patients are free to return to UTHCPC at any time based on clinical reed.
MCOT referred patients: COC will provide follow up and check status post referral
Juvenile Unit: JDC staff provides follow up through programs sponsored by JDC.
MHMRA clinic referred patients:
Private providers: Patients with resources can access private physicians, therapists, and programs.

Communication/Coordination between Caregivers:
Social Service Clinicians coordinate the needs of the patient with various caregivers to help the patient have a successful post discharge experience. Communication is frequently needed among several agencies simultaneously and family members need to be included in the process. The patient often leaves inpatient care with multiple follow up appointments.

Health Information Management (HIM):
HIM provides services for internal and external customers.

- **HIM is instrumental in providing information for continuum of patient care to:**
- **HCPC:** Admissions Packets, for patients readmitted to HCPC within 30 days, MTP, Initial Nursing Assessment, Advance Directives and Occurrence History,
- **UTH HCPC Out Patient:** IPE, MTP, IPA, all Consents and Advance Directives
- **MHMRA Clinics:** Discharge Summary, IPE AND Lab
- **NPC:** Discharge Summary
- **Adult Forensic:** Discharge Summary
- **Ben Taub:** Discharge Summary
- **TRC:** Discharge Summary, IPE, Lab
- **ON line clinical documents provide staff the information necessary to coordinate care across the inpatient and outpatient continuum.**

HIM has many functions such as:
- Protecting and maintaining the confidentiality of patient information.
- Assemble discharged patients information and place in permanent folder.
- Analyze information in chart for deficiencies.
- Generate deficiency reports weekly for the various disciplines.
- Release information to those with proper authorization or to those entities the law requires no authorization in order to release.
- Information is released to patients, guardians, attorneys TRC, after care facilities secret services and many others.

- **Responsible for compliance issues for the following:**
- Responsible for providing charts for chart review and reporting results to the Medical Records Committee and the PICC. (JCAHO Requirement)
- Provide a monthly report on delinquency rate (Must be less than 40% to be complaint with JCAHO)
- Provide coding services for professional services.
- Responsible for auditing of coders (Peer Audit)