VALUE BEHAVIORAL HEALTH of PENNSYLVANIA
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Successful Transitions from Inpatient to Ambulatory Care
Components of Discharge Management Planning (DMP)
Reviewer's Instructions

The following tool can be used when conducting internal chart reviews of Discharge Management Plans. The first section contains elements as designated by the state as mandatory while the last four are best practices that VBH-PA would like to see contained in the chart.

Discharge Planning Element	Comments
Discharge Management Plan (DMP) was present in chart	Was there evidence in the chart (hard copy or electronic format) of a summary of instructions for the member to follow upon discharge to address the actual or potential needs of the member? Although the actual tool or format may vary across facilities, some type of consolidated plan should be available for reference as to the next steps for the member to follow after leaving the inpatient setting. Verbal instructions are NOT acceptable.
Documentation that the member was given a copy of the DMP	Was there a notation that the member was provided with a written copy of the discharge plan to have for reference? Yes or No This documentation in the chart will include the dated signature of the member that the plan was received OR signature of staff and date that it was refused by the member. Any signatures and dates should match the date of discharge. It is not acceptable for the clinical staff to only write a progress note that a copy of the plan was provided to the member as this does not include evidence that it was actually received by the member and reviewed for understanding of the follow up care.
Documentation, on the DMP, that medications taken prior to admission were evaluated with instructions regarding continuation or discontinuation at discharge	Was medication reconciliation documented on the DMP? Was there a notation of the medications being taken by the member prior to admission on the DMP? If yes, was there an assessment at the time of discharge as to the disposition of each of these medications upon leaving the inpatient setting, such as continuation, discontinuation, changes noted, etc.? If the member was not on medications at the time of admission, there must be a notation on the DMP stating that.
Documentation of all medications prescribed at discharge including:	For each of the elements noted below, is there a clear and legible notation that would be easily understood by the member?
• Drug Name	Was there notation of the drug name (either in brand or generic format or both) for each medication prescribed at the time of discharge?
• Dosage	Was there notation of the dosage of medication that was prescribed for each medication at the time of discharge? The dose is the amount of drug taken at any one time and can be expressed as the weight of the drug (250 mg), volume of drug solution (10mL, 2 drops), the number of dosage forms (1 capsule, 1 suppository) or some other quantity (such as 2 puffs). The route of administration will be included, such as oral, topical, nasal, rectal, etc. This element is not required for a passing score on the line item.
• Schedule	Was there notation of the dosage regimen including the frequency which the drug doses are to be given? Examples would include 2.5 mL twice a day, one tablet three times a day, one injection every four weeks, etc. Abbreviations such as tid, bid are not acceptable in the member discharge materials as they are likely to not be clearly understood by the member.

• Reason for Medication	Was there notation of the rationale/indications for each of the prescribed medications to assist in making it clear to the member the reason for taking each prescribed medication? A generic note that "medication education was provided" is not acceptable Educational handouts located in the chart will only be accepted as fulfilling this measure if they are part of the DMP or the member's signature and date are also present on the form. Examples could include: • "Prolixin-for schizophrenia" • "Cogentin- for side effects of Prolixin".
Follow-Up Visit Scheduled Between 0-14 Days	Was there a notation of a follow up visit **scheduled** within the 14 day time period? • Day 0=the day of discharge • Day 1=the day after discharge
Follow-Up Visit Documentation Includes the Following Elements:	
• Provider / Clinic Name / Address	Was there a notation of the provider name and each of the following: • Street name , street number, and city • All be present to receive credit
• Appointment Date and Time	Was there notation of the appointment date and time for reference by the member?
• Provider Phone Number	Was there notation of the full phone number, including the area code and number?
There must be documentation in the DMP that the follow-up visit is for behavioral health therapy or medication management. The following types of documentation are acceptable	Was there notation to distinguish the difference between behavioral health follow up appointments and physical health or other appointments? • A notation that the provider is a behavioral health clinician (LCSW, Psychiatrist, Psychologist, IOP, PHP, etc.). • A notation that the visit is for therapy or medication management
Documentation of scheduled ACT may be included in lieu of an outpatient appointment provided it meets the criteria above	Same as above
Additional Best Practice Elements (VBH Recommended)	
Evidence that Discharge Planning began upon admission	Was there a notation, within 72 hours of admission, that the inpatient facility initiated discussions/assessments of the potential discharge at the time of the admission assessment?
Barriers to follow-up treatment were identified and addressed with the member	Was there a notation that the member was asked about potential barriers that could impact their ability to follow through on their outpatient treatment following discharge, such as transportation, child care, adequate housing, financial concerns, physical health issues etc.? If yes, list the barriers identified and any potential interventions that were identified to address the barrier.
Evidence of coordination of care between Inpatient Provider and the members current Outpatient Provider/BCM	Was there a notation that the inpatient facility staff were able to connect with the outpatient provider/BCM to coordinate care? This could include documentation in the chart of a phone call exchange of information, a letter of referral, exchange of medical records, etc.
Evidence that viable natural supports were explored	Was there a notation in the chart that the inpatient facility staff asked the member about available natural supports after leaving the inpatient setting? This includes the availability if family, friends, clergy, peer support, non-provider community support, etc.