Warm Handoff Discharge Planning Guide

Purpose

The Oregon Performance Plan (OPP) and OHA require a warm handoff will be presented as part of the discharge planning process for individuals (18 and older) with an SPMI diagnosis.

Warm handoff discharge planning and documentation requirements are in OAR 309-032-0850 through OAR 309-032-0890. OHA has committed in the OPP to provide quarterly data on the number of individuals with SPMI that discharged from an acute care psychiatric hospital and received a warm handoff and have an appropriate housing plan.

Performance outcome measures

In the OPP, OHA committed to the following goals:

- 60% receive a warm handoff by 6/30/2017
- 75% receive a warm handoff by 6/30/2018
- 85% receive a warm handoff by 6/30/2019

As of December 2018, only 30% of adults with SPMI received a warm handoff before discharge from an acute care psychiatric facility (ACPF). While this percentage has been going up over the last few months, we were still far from achieving our goals. Metrics for Warm Handoffs will be part of OHA's Behavioral Health Quality and Performance Improvement Plan (BHQPIP).

Definitions

"Warm Handoff" means the process of transferring a patient from an acute care psychiatric hospital to a community provider at discharge, that involves face-to-face meetings with the patient, either in person or through the use of telehealth, and coordinates the transfer of responsibility for the patient's ongoing care and continuing treatment and services.

- A warm handoff shall either (a) include a face-to-face meeting with the community provider and the client, and if possible, the hospital staff, or (b) provide a transitional team to support the client as a bridge between the hospital and the community provider, and ensure that the client connects with the community provider.

"Telehealth" means a technological solution that provides two-way, video-like communication on a secure line.

"Transitional Team" means one or more persons whose professional role is to support the client, serve as a bridge between the hospital and a community provider, and ensure that the client connects with a community provider.

"Community Provider" means an employee for a community-based entity that is responsible for planning and delivery of services for persons with a mental health diagnosis

"Housing Plan" means the plan to address the patient's need for immediate housing upon discharge.

"Serious and Persistent Mental Illness (SPMI)" means the current DSM diagnostic criteria for at least one of the following conditions as a primary diagnosis:

1. Schizophrenia and other psychotic disorders;

2. Major Depressive Disorder;
3. Bipolar Disorder;
4. Anxiety disorders, limited to Obsessive Compulsive Disorder (OCD) and Post Traumatic Stress Disorder (PTSD);
5. Schizotypal Personality Disorder; or
6. Borderline Personality Disorder.

Data collection method

OHA contracted with HealthInsight Assure to review patient records of all individuals age 18 years or older discharged with an SPMI diagnosis on OHP. This review includes nine acute care psychiatric hospitals. HealthInsight Assure will collect data to determine whether or not the individual was offered and received a warm handoff and had a housing plan prior to discharge. OHA identifies patients through MMIS claims data and provides names to HealthInsight Assure for chart reviews.

Acute Care Psychiatric Hospitals list

1. ASANTE ROGUE REGIONAL MEDICAL CENTER
2. BAY AREA HOSPITAL
3. CEDAR HILLS (UBH)
4. GOOD SAMARITAN REGIONAL MEDICAL CENTER– Corvallis
5. PEACE HEALTH SACRED HEART MEDICAL CENTER
6. PROVIDENCE PORTLAND MEDICAL CENTER
7. PROVIDENCE ST VINCENT MEDICAL CENTER
8. SALEM HOSPITAL
9. ST CHARLES MEDICAL CENTER
10. UNITY CENTER FOR BEHAVIORAL HEALTH

Documentation requirements (OAR 309-032-0870)

Documentation to support linkages to timely and appropriate community services upon discharge needs to include:

- The plan to address the patient's need for a follow-up visit with a community mental health provider within seven days of the anticipated discharge date
- The plan to address the patient's need for immediate housing upon discharge

For individuals with SPMI, the discharge plan shall also include:

- Whether a warm handoff was offered and whether one occurred, and the community provider that was involved in the warm handoff process
- Whether the patient declined a warm handoff

Review exclusions

1. Discharge to incarceration facility
2. Transfer or discharge to medical facility or unit
3. Discharge to Oregon State Hospital
4. Death
5. Left AMA
6. Unable to locate record
7. Record received was for a non-psychiatric admission

Warm handoff exceptions

If the patient refuses any help with discharge planning, code as patient refused warm handoff.
If the patient refuses treatment, in general, code as patient refused warm handoff.

Process examples

Warm handoff Criteria:

1. Must occur prior to discharge – there is no specified timeframe that requires a warm handoff to occur at the time of discharge, which means it can occur within any of the days leading up to discharge
2. Must be face-to-face (in-person or via telehealth)
3. Must involve the client and a community provider

Examples of a community provider:

- A staff member or a volunteer for an organization that helps people transition from the hospital to the community, a community case manager, a peer provider, or a residential provider
- A community provider is NOT a personal friend or relative of the client or an employee of the hospital where the patient is receiving treatment

Examples of transitional team members:

- An Assertive Community Treatment (ACT) team, a peer, a volunteer for an organization that helps people transition from the hospital to the community

Examples of acceptable warm handoffs:

- A staff person from the mental health provider where the patient is already engaged in services comes to see the patient prior to discharge; they meet face-to-face to discuss next steps upon discharge; this face-to-face encounter should be counted as a warm handoff
- A residential provider comes to the hospital to screen the patient for placement in their program; they meet face-to-face with the patient so the provider can learn more about the patient and share how their program can meet the patient's needs; two days later the patient discharges to that program; the face-to-face encounter should be counted as a warm handoff
- An Intensive Care Coordinator (ICC) from the patient's CCO either comes to the facility or connects with the patient via telehealth to introduce themselves to the patient; the ICC shares available resources to support their discharge, etc.; this face-to-face or telehealth encounter should be counted as a warm handoff

Examples of acceptable housing plans:

- Patient referred to short-term residential housing facility
- Patient provided means to transport to temporary housing with a plan for continued engagement
- Patient provided means to transport to a community provider to discuss housing options
- Patient discharged to pre-admit housing, permanent stable community housing

Examples of unacceptable housing plans:

- Patient's need for immediate housing was not addressed, or housing plan was not documented
- No description of home

Best practice recommendations

1. Develop a process and a place in the patient chart for documenting consistently in the discharge summary to help standardize the documentation process
2. Adapt the discharge plan to identify elements needed to achieve the warm handoff process and housing plan to help ensure all requirements are addressed during the documentation process

3. Utilize the term "warm handoff" in your discharge summary and clearly address the following:
    a. Was a warm handoff offered as part of the discharge planning process?
    b. Did the warm handoff occur face-to-face or via telehealth and who was involved?
    c. Did the patient decline a warm handoff? If so, what efforts were made to engage the patient?
4. Document barriers to achieving a warm handoff, such as patient refusal, community provider was not available or was unwilling to meet face-to-face, etc.
5. Document instances where a housing plan was offered but the patient chose to remain homeless, including efforts to engage the patient in discussion of housing options
6. Use a discharge planning check-list during the discharge planning process

Questions to assist in meeting warm handoff discharge planning requirements

- Does the patient have a qualifying SPMI diagnosis at the time of discharge?
- Is the patient an adult (18 or older)?
- What housing is available to the individual and is it appropriate?
- Is there a plan to meet the patient's need for immediate housing upon discharge?
- Was the patient offered a warm handoff?
- Did the patient decline a warm handoff? If so, what efforts were made to engage the patient?
- Did the warm handoff occur? If so, when?
- Who was involved in the warm handoff process?
- Did the warm handoff occur face-to-face or via telehealth? If so, did hospital staff connect with the outpatient provider, collaborate on discharge planning, and ensure the patient had an appointment post-discharge?
- If the face-to-face requirement was not met, was the patient connected to a community provider prior to discharge in some other way?
- Were there barriers to achieving a warm handoff? If so, what type of barriers resulted in not being able to achieve a warm-handoff?

If you have any questions regarding warm handoff, please contact Lisa Peetz, Adult Mental Health Program Coordinator, at lisa.m.peetz@dhsoha.state.or.us