Warm Handoff Discharge Planning Guide

Purpose

OHA requires a warm handoff to be presented as part of the discharge planning process for individuals (18 and older) with an SPMI diagnosis discharging from an acute care psychiatric hospital (OAR 309-032-0870). Warm handoffs create a personal connection to the community that can translate into increased engagement and improved treatment outcomes.

For a warm handoff to be successful, collaboration must occur between the acute care psychiatric hospital and community partners. Community Mental Health Programs (CMHP) are required to assist individuals with care coordination and warm handoff process (OAR 309-019-0150). Coordinated Care Organizations (CCOs) also have a responsibility for ensuring the provision of a warm handoff [CCO 2.0 Contract, Exhibit M, 17(e)].

Performance outcome measures

Metrics for Warm Handoffs are 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 be offered to all adults with SPMI as part of the discharge planning process that involves a face-to-face meeting, either in person or through the use of telehealth, and includes either
    - (a) A community provider, the patient, and if possible, hospital staff, or;
    - (b) A transitional team, the patient, and if possible, the hospital staff to support the patient, to serve as a bridge between hospital staff and a community provider, and to ensure the patient connects to a 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

Currently, OHA contract 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 ten 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. This requirement is included in the CCO Contract, Exhibit M, and will transition to the CCOs in the future.

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

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

Warm handoff criteria:

- 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.
- Must be face-to-face (in-person or via telehealth).
- Must involve patient and a community provider.

Documentation requirements (OAR 309-032-0870)

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

- The discharge summary and plan to address the patient's need for a follow-up visit with a community mental health provider within seven days after 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.

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)?
- Is there a plan to meet the patient's need for immediate housing upon discharge?
- Who should be involved in the warm handoff?

Process examples

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 discusses available resources to support their discharge, etc.; this face-to-face or telehealth encounter should be counted as a warm handoff.
- A staff person or volunteer from a mental health provider to which the patient is being referred comes to see the patient or engages with the patient via telehealth prior to discharge.

Examples of a patient declining a warm handoff:

- A patient declines any help with discharge planning. Staff have re-approached them, and the patient continues to decline assistance with discharge planning. Staff documents their efforts to engage the individual in the discharge planning process, which includes a warm handoff, and documents that the patient declined a warm handoff.

- A patient accepts assistance with discharge planning but declines to meet face-to-face or via telehealth with the community provider. Staff have re-approached them, and the patient continues to decline meeting with the community provider prior to discharge. Staff documents their efforts, and the patient's choice to decline a warm handoff.

Examples of acceptable housing plans:

- Patient referred to short-term residential housing facility and assisted in getting to the 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.
- A referral to a homeless shelter without any follow-up plan regarding transitional or permanent housing options.

Best practice recommendations for Acute Care Psychiatric Facilities

1. 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.
2. 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 in-person or face-to-face via telehealth and who was involved?
    c. Did the patient decline a warm handoff? If so, what efforts were made to engage the patient?
3. Document barriers to achieving a warm handoff, such as community provider was not available or was unable or unwilling to meet face-to-face, either in person or by telehealth.
4. If the face-to-face requirement was not met, document whether the patient was connected to a community provide prior to discharge in some other way.
5. Clearly document any post-discharge appointments with both mental health ***and*** primary care providers.
6. 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.

Best practice recommendations for Community Providers

1. Educate agency and program staff regarding warm handoff requirements.
2. Develop procedures for connecting hospital staff with the appropriate community provider to engage in the warm handoff and work with hospital staff to address any potential barriers. If lack of secure telehealth capacity is the issue, the community provider or the hospital staff should contact Lisa Peetz at OHA to discuss possible solutions. (See also, OHA's Confidentiality Toolkit at https://www.oregon.gov/oha/HSD/AMH/docs/Tool-Kit-091820.pdf).
3. Include warm handoff on your team's transition planning list and readily identify who from your agency will be responsible for coordinating with the hospital.

4. Inform hospital staff how (in-person, face-to-face via telehealth) and when you plan to engage with the individual.
5. Inform hospital staff regarding the outcome of your attempt to engage with the individual.
    a. Did the individual engage? Did your contact with the individual meet the criteria and purpose of a warm handoff?
    b. Is there information that needs to be clarified or concerns that need to be addressed prior to discharge?
    c. Did the individual decline to engage? If so, what attempts were made to engage the individual?
6. Document information in 5a – 5c in agency records regarding the individual.

Best practice recommendations for Coordinated Care Organizations (CCOs)

1. Include warm handoff requirements and expectations in contracts with hospitals and community providers. Include qualitative and quantitative expectations regarding participating in and documenting warm handoffs for adults with SPMI.
2. Educate contract hospital(s) and contract provider(s) and CCO care coordination staff regarding warm handoff requirements. Provide written guidelines and training opportunities regarding the expected outcomes.
3. Inform contract hospital staff and contract providers how the CCO will receive and report data about warm handoffs and how the CCO will evaluate their responsibilities for warm handoffs, and what actions the CCO will take if goals are not met.
4. Include warm handoffs on your care coordinator's transition planning list and readily identify who from your CCO will be responsible for coordinating with the hospital and community providers to assure warm handoffs occur.
5. Develop procedures for connecting hospital staff with the appropriate community provider (including Choice contractor) to engage in the warm handoff process and work with hospital staff and contract providers to address any potential barriers. If lack of secure telehealth capacity is the issue, the community provider or the hospital staff should contact Lisa Peetz at OHA to discuss possible solutions. (See also, OHA's Confidentiality Toolkit at https://www.oregon.gov/oha/HSD/AMH/docs/Tool-Kit-091820.pdf).
6. If the CCO care coordinator is involved in the warm handoff for an individual, in any capacity, have the care coordinator document the following information in the CCO records regarding the individual.
    a. Did the individual engage? Did contact with the individual meet the criteria and purpose of a warm handoff? Who was involved in the warm handoff?
    b. Is there information that needs to be clarified or concerns that need to be addressed prior to discharge?
    c. Did the individual decline to engage? If so, what attempts were made to engage the individual?

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