Continuity of Care: Improving Communication and Transitions between Inpatient and Outpatient Treatment in the South Carolina Department of Mental Health

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I. Introduction to Mental Health system and description of need:

The South Carolina Department of Mental Health (SCDMH) system is made up of both inpatient and outpatient settings to support the recovery of South Carolina citizens with mental illness. The inpatient system includes two hospitals dedicated to serving adults with severe and persistent mental illness, including an inpatient forensics unit. Additional inpatient units serve children and those in need of substance abuse treatment. SCDMH also operates 4 nursing homes and the state sexually violent predator program. On the outpatient side, SCDMH operates 17 community mental health centers with 42 clinics located throughout the state's 46 counties.

When a patient transitions between the inpatient and outpatient settings, it is important to ensure continuity of care so that the receiving system can fully address the individual's needs. As stated by Naylor and Keating (2008), "The large gaps in care that exist for patients and their caregivers during critical transitions can lead to adverse events, unmet needs, low satisfaction with care, and high rehospitalization rates" (p. 60). This requires communication between systems, including information about current treatment in the other system, challenges experienced, existing supports, and information as to what has historically helped the individual improve.

Patients receiving care in the inpatient system are doing so because this is the least restrictive setting to ensure the safety and well-being of themselves or others who could be harmed by actions related to their symptoms. The primary focus of hospitalization is on maintaining safety and stabilizing their illness to allow them to return home. Research suggests that a successful post-hospital care transition depends on the patient's ability to manage the discharge care plan upon returning home (Agency for Healthcare Research and Quality, 2014). Formal discharge planning remains a role of the hospital staff, and content of recommendations

are often medically focused. In the SCDMH system, written discharge recommendations contain few variations. They typically include a statement that the individual is "encouraged to take prescribed medications and keep all scheduled outpatient appointments." A directive to notify their doctor of any symptoms or side effects from medications and/or to abstain from alcohol and drug use may also be included, if applicable.

The outpatient system, on the other hand, serves individuals at varying levels of functioning and stability, and is designed for ongoing support and progress as well as to minimize the need for a return to inpatient care. In the SCDMH system, the 17 Mental Health Centers (MHCs) offer similar services, yet are serving quite dissimilar communities, each with different needs and resources. Each MHC is therefore uniquely structured and managed in order to best meet the particular characteristics of its catchment area. For this reason, the outpatient clinics play a vital role in the provision and de facto design of discharge plan content. Including MHC input into earlier stages of this process can keep these plans specific and make them more likely to result in sustained improvement. There must be a process in place to bridge the gaps created by between-system differences and coordinate transitions when they occur.

As mental health care underwent a shift in emphasis toward community-based services rather than long-term hospitalization, the need was recognized for improved coordination between these two systems (Tidwell and Associates, n.d.). It was realized that the outpatient system could address these gaps, and a Hospital Liaison (HL) position was designed and implemented at each Center to meet this need. However, the inpatient and outpatient systems have experienced considerable changes over the past 25 years. Additionally, changes have been made in the responsibilities and practices of the liaison position at many outpatient clinics, including Charleston Dorchester Mental Health Center (CDMHC), resulting in lessened

efficiency and decreased consistency of benefit. By updating this position and its function, efficiency can be improved to the benefit of the entire SCDMH system and those to whom they provide care, thus improving the ability of the agency to achieve its central mission.

In order to identify improvements needed to the HL position, I began with a review of the structure of the overall SCDMH system. I reviewed the history of the position and how the duties have been performed in the past. I gathered information from the management and front-line personnel of the inpatient and care coordination systems. I then performed a review of the current duties and staffing patterns at CDMHC. Additionally, I surveyed the HLs of all 17 MHCs, via telephone and written questionnaires, with the objective of identifying similarities and differences (see Appendix C). Doing so allowed me to incorporate successful components of each and to identify the tasks most productive in achieving the core objectives of this position. I also reviewed publications for healthcare industry standards and recommendations.

II. History and previous systems

Some degree of informal liaison work between inpatient and outpatient care has been in place for decades. The first full-time HL was installed at CDMHC in 1989. A consultant later reviewed this need and provided recommendations for changes, and the HL position was refined in order to best create a link between systems. In the early 1990s, SCDMH began looking to create innovative programs which enhance the ability of long-term patients to experience successful and sustained transitions from inpatient care into the community, reducing incidence of re-hospitalization. This initiative, called Toward Local Care (TLC), greatly enhanced the value of communication between the inpatient and outpatient systems. The rollout of the TLC initiatives accelerated the expansion of designated HL positions to all MHCs.

Studies have shown that continuity of care is strengthened through the utilization of a HL (Tidwell and Associates, n.d.). The creation of this designated position resulted not only in reduced length of stay and readmission rates, but also improved adherence to outpatient treatment upon discharge. Additionally, the improved communication process between these two subsystems led to the recognition of further ways to improve coordination, including the development of a pre-release pass system, utilization of case conferences, a tracking system to address breaks in continuity of care, and a policy to address discharge of homeless individuals (Tidwell and Associates, n.d.).

The HL position initially had the primary role of acting as the conduit for communication between the hospitals, MHC staff, and Community Residential Care Facility (CRCF) administrators. Responsibilities in the initial design included

- screening of patients, helping to assess follow-up plans and placement, and open outpatient charts for the patients while hospitalized;
- sharing information between MHC and hospital staff on patient progress;
- maintaining statistics appropriate for admission and discharges;
- recommending policy for new community-based programs;
- reviewing, amending, and updating appropriate memorandums of agreement;
- determining breaks in continuity of care and recommend solutions;
- orienting hospital staff to the MHC and orienting MHC staff to the hospitals; and
- developing innovative training programs between MHC and hospital staff.

As this position was re-created throughout the outpatient system, many of the ancillary duties identified above were dropped while maintaining the core role of helping the discharge process

to work more quickly and effectively. The HL was emphasized not to be a recreation of outpatient clinician or hospital social worker, but rather a link between the two service entities.

Initially, the CDMHC HL evenly split time between the inpatient and outpatient environments, spending 2 days per week visiting in 3 Columbia-area hospitals. The practice was to first check in with the lead Social Workers, who would have lists prepared of which patients needed to be screened. Liaisons would also participate in staffings with the inpatient treatment teams and would attend monthly meetings with inpatient staff which included case presentations. Gathered information was entered into a database called AVATAR, which was initially an inpatient billing system. The intent of the entry of this data was to improve continuity of care and track what would be needed to achieve a successful community placement. However, the system was unable to fulfill this original intent, so mandatory use was discontinued in 2009. HLs for a short time were also allowed to document directly into the clinical inpatient record, allowing not only the inpatient team but other Liaisons to have access to this assessment information. However, this practice was halted prior to the year 2000 due to credentialing issues. For some time afterward, paper forms called Facility/Liaison Communication Sheets (FLCS) were completed with this data, with protocol that copies were to be left in the inpatient staff office, ostensibly to be shared (see Appendix B). Adherence to this practice was inconsistent and has been largely disregarded. Reports from current state HLs indicate less than 25% use these forms in any capacity, with 25% utilizing some self-developed but unshared tracking system, and 50% reporting no tracking of screening data. No alternative process is currently being used to share this screening documentation.

III. Current system at CDMHC and other MHCs

Currently, the CDMHC HL visits the SC state hospital inpatient unit twice per month for the purpose of screening. Given that the travel time between Charleston and Columbia equals nearly 4 hours round-trip, these visits consume full days, of which less than half of the actual work hours are spent in active review and screening of hospitalized patients.

Across MHCs there is considerable inconsistency in how the HL position is utilized. In a survey of HLs throughout the state, the amount of time spent in HL duties averaged approximately 10 hours per month, with individual responses ranging from 4 to 20 hours monthly. The frequency of screening visits to a SC state hospital averaged one visit per month (equal to the designated minimum frequency), with a range from no screening visits at all to two times each month. Much of the variation appears to be directly tied the commuting distance from the hospitals, with some closer MHCs not only maintaining more frequent routine visits but reporting some willingness to add screening times off-schedule when requested by the hospitals. Although more data is needed to confirm this relationship, such a correlation would indicate travel time as a barrier to screening visits.

Interestingly, videoconferencing appears to be rarely utilized despite availability to do so. Only 1 of 8 MHCs reported consistently screening via videoconference, with 3 others reporting rare use of this technology. Fifty percent (50%) of respondents indicated they do not ever utilize videoconferencing for screening. Use did not correlate to hospital proximity.

IV. Staffing patterns (current)

Data collected indicate that 100% of state HLs maintain one or more additional roles, with 75% of these having some involvement in TLC programming. CDMHC's liaison is more

diversified than most, with approximately 40 % of time spent as HL and accompanying duties as follows (time allocated in parentheses): CRCF Liaison (25%); Child OOH Placements (25%); TLC Coordinator (5%); and Supervised Apartments (5%). Despite this, it appears there is adequate time available to perform these tasks, though time allotted to each may change. Additionally, there is an administrative staff person who has clinical experience in housing programs who also has current duties relating to two housing programs, including an apartment program. This staff member currently spends approximately 10% of her time per month on housing-related functions, but up to 90% of her time is allocated to the scheduling of psychiatric appointments. The ratio of time spent on each set of duties may also have potential to change.

V. Indications of best practices in research literature

As stated in the Health Policy Brief (2012), care transitioning should be a continuous process. Their recommendation is for "transition coaches," a role possible to incorporate into the HL position, to follow a patient for 4 weeks following discharge. Eric Coleman's *Care Transitions Intervention* (2007) suggests a focus during the transition on ensuring patients know their schedule of outpatient follow-up appointments; their medications and a system for managing them; and, how to identify and respond to "red flags" which indicate their condition is worsening. Transition contacts start in the hospital and may include follow-up in the home and via telephone. Furthermore, the Joint Commission (2013) recommended assisting with "reconciliation" of medication changes and including the patient's pharmacists, if possible (p. 4). The literature emphasizes improving communication by utilizing interpersonal rather than merely written communication whenever possible and including family participation, when appropriate. Finally, according to the American Medical Directors Association (2010), the HL

should ensure all necessary discharge documentation makes it into the patient's outpatient medical record.

VI. Integrating two systems: Clinical and Care Coordination

In identifying the best process for coordinating transitions between the inpatient and outpatient treatment systems, it is important to consider what has been helpful historically, maintain the integral components of what currently exists, and address gaps in the existing process. A development in the mental health system which directly impacts the allocation of transition tasks is the spinning off of linking functions, referred to as Targeted Case Management (TCM) services, previously provided by clinicians. In contrast to therapeutic services, these involve helping patients access needed resources and services in the community. In January 2013, SCDMH created a new division called the Office of Clinical Care Coordination dedicating staff solely for this purpose. In this new arrangement, each division is authorized to provide only the type of services under their purview; employees are prohibited from providing both clinical services and care coordination. This presents a complication in developing an optimal HL system, given that as noted previously, roles of the HL include both screening via assessments and linking with supports which enhance the ability to maintain community tenure.

It is unrealistic to have a HL system based exclusively in one of these domains. There are clinical components to the interactions the HL has with both the patient and the treatment team. Even beyond pure assessment skills and knowledge of mental health disorders, the interaction with the hospitalized individual benefits from the HL having clinical training. The same is true for coordinating with family members and preparing them for the return home of their loved ones. In an equal manner, successful placement hinges on the identification and linking to resources, often including residential placements and or entitlement systems, which fall squarely

within the field of care coordination. Indeed, research and experience show that mental health patients have multiple and complex health and social needs reaching beyond the field of psychiatric care and mental health, making the function of a Care Coordinator (CC) integral to the maintenance and quality of their recovery; the SCDMH website identifies, "helping patients transition to the community from inpatient settings," as being of particular importance. Given the necessary inclusion of functions from both departments, it makes sense to have staff from each program contributing to the process, despite some inherent complications.

There have already been steps taken in recognition of the need to include Care Coordination in this process. This year, the state office of Clinical Care Coordination began establishing at the two primary state hospitals centralized CCs whose duties include providing the initial TCM comprehensive needs assessment, which will then be forwarded to local CCs for further action.

One structural factor requiring consideration in the final design is the supervisory structure of the Care Coordination team. CCs are part of DMH but are regionally hired and supervised rather than linked to one MHC. As a result, the CCs serving CDMHC are supervised by a Regional Coordinator who is not part of, nor directly accountable to, the supervisory structure of CDMHC. Thus, accountability and the ability to incorporate CCs into this design must also involve agreement by Care Coordination management.

Given the participation of both departments, it is important to identify which will drive the process. In this situation, it appears most appropriate that the clinical HL take this central role. The HL is based locally, rather than regionally, and therefore the most directly linked and accountable to each MHC. This being the ideal arrangement is even reflected in a statement on the SCDMH website, noting, "The CC is part of every CMHC's clinical team, helping to bridge

the communication gap between numerous providers" (http://www.state.sc.us/dmh/history_addendum.html). This acknowledges that the vital inclusion of care coordination should be viewed as an augmentation of the existing clinical system.

VII. Proposed restructuring

Given the available information, it is recommended that the HL and all housing functions be consolidated into a single department. The staff dedicated to performing these duties should be supervised by a single supervisor who would be tasked with the oversight of the housing and liaison programs. This change has already been started with the establishment of a Housing Coordinator position and shifting lines of supervision to place the current HL under this Coordinator's purview. These two individuals are housed in the same office but supervised by different managers, making this arrangement less coordinated than it could be. Additionally, the scheduling tasks being performed by the administrative staff member could be performed by many people, but few administrative staff have the base knowledge and clinical experience to be able to also enhance performance of the MHC's housing and liaison missions. A concurrent initiative is underway to overhaul the scheduling system, and in conjunction with these changes additional scheduling personnel are anticipated to be hired or reassigned from other areas. Also, a grant was just awarded to expand the CDMHC housing programs, and administrative tasks relating to housing programs are likely to increase. It is therefore recommended that additional time in the administrative staff person's responsibilities be allocated to housing and liaison support, with the commensurate amount of scheduling duties shifting to the newly establishing scheduling team. An increase of ½ day per week will be appropriate at the start, but should additional hours be needed it is recommended that this transition continue. Initially, supervision can remain unchanged, with only oversight of housing/liaison-related duties being designated to

the Housing Coordinator; however, should the balance of responsibilities shift in favor of non-scheduling duties, primary supervision of this position should be reassigned to the Housing Coordinator.

In order to create synergy with TCM functions, it is recommended that the Care Coordination team identify a single CC to have primary responsibility for TCM functions for those awaiting discharge from the SCDMH hospital system. Supervision of this CC would remain with the Regional Care Coordination Team Leader, who will collaborate with the Housing Coordinator to ensure the departments operate together effectively. While Care Coordination can be initiated by the social workers at the hospital by requesting the required comprehensive needs assessment, the referral for CC at the local level should either flow through or be copied to the HL to ensure the continuity within this system. The Director of G. Werber Bryan Hospital in Columbia as well as a supervising Social Worker concur that the HL should be the central figure in these referrals.

If housing needs exist, the HL will evaluate appropriateness for placement in either a Mental Health housing program or a CRCF. If the patient needs linking to a CRCF or an apartment, the HL will coordinate with the CC who will perform these linking services. Generally speaking, all activity considered appropriate billable activity within the Care Coordination department would be performed by the CC.

As mentioned earlier, technology appears considerably underutilized in the liaison process. Videoconferencing could be increased to reduce time spent commuting between hospitals and MHCs. By more fully utilizing videoconferencing, screening can shift from availability once or twice per month to a virtually on-demand resource. It is also possible that telepsychiatry equipment could be used to broaden this to create "virtual treatment teams" for

participation in inpatient clinical reviews. Enhancement of tracking via technology is also an integral piece of this improvement process, resulting in improved record-keeping and reduced duplication of effort between MHCs when screening patients outside of designated catchment areas. Initially, a local database for tracking admitted patients should be created, utilizing some fields from the FLCS, including name, date of birth, date of admission, outpatient clinician, and hospital/unit/social worker. Additional information to be noted should include residential arrangements, placement and treatment issues which may present as barriers to discharge, and identified care coordination needs. This database can also be used to track completion of transition tasks upon discharge.

It is anticipated that in the future, SCDMH Inpatient Services will move toward an Electronic Medical Records (EMR) system to replace the existing paper records. Ideally, SCDMH will implement an EMR system which interfaces with the existing outpatient EMR system. If all HLs were granted access for documenting their screening efforts, then a dedicated section would optimally be created for this function. These contacts would then be easily tracked and accessed by inpatient staff as well as other liaisons, enhancing communication and increasing efficiency. However, given the uncertainty of details and timeline for this change, an ideal alternative to this proposed system is for an internet-based database system to be developed allowing for all liaisons to access screening data. The use of Microsoft's SharePoint or a similar program would allow for secure, internet-based access to this information. This program is already owned by SCDMH and is being utilized for other purposes, so SCDMH IT personnel are already proficient in its use. The Program Coordinator with SCDMH responsible for HL oversight agrees that this is a favorable alternative to reinstating use of the FLCS.

It is generally accepted that the discharge process should start at onset of admission. To this end, the HL should be aware of all admissions and be fully aware of all admissions and their circumstances at the onset of inpatient treatment, including existing residential arrangements. Identifying and documenting this information at the onset will allow the system to be more responsive in establishing a supportive arrangement prior to discharge.

The duties of the HL should also be expanded to reflect the role as a supportive clinical transitioner throughout the discharge process as suggested in Coleman's CTI model, rather than solely in communicating between the inpatient and outpatient systems (Health Policy Brief, 2012). Expanded activity would include engaging with family/caregivers in order to prepare them for how they might enhance the individual's potential for success upon discharge. Liaison services would also not abruptly cease at the day of discharge. Rather, the HL would communicate with the assigned primary clinician to confirm successful resuming of outpatient care, receipt of inpatient discharge paperwork, and access to prescribed medications. Those services that can be billed as clinical services can be provided by either the HL or the primary clinician, but the responsibility for confirming their completion would belong to the HL. The potential for the HL to perform the Initial Clinical Assessment to open a new patient to outpatient care on the day of discharge should also be explored.

VIII. Additional Resources

CDMHC has an entitlement specialist on staff for the purpose of assisting those eligible for Medicaid or Social Security Disability benefits in navigating the process of getting approved for these benefits. Interestingly, this staff member has no involvement in helping to get these benefits arranged for those being discharged from the hospital. There is an entitlement specialist system in place at the state level for this purpose. However, these employees can only complete

a portion of the certification process, as individuals with benefits suspended due to hospitalization become eligible for resuming benefits only after providing written confirmation of discharge. Additionally, there have been notable instances of this system failing to adequately ensure that all necessary arrangements are completed. Of the MHCs surveyed, only 38% report having local entitlement specialists, and 25% report needing to intervene in establishment of entitlements despite the expectation that these be arranged by the hospital entitlement specialists. Given CDMHC's investment in local entitlement personnel, it appears worthwhile to incorporate their expertise in finalizing these processes to ensure income and insurance start as soon as possible upon discharge.

IX. Costs

The primary costs associated with this plans have to do with allocation of resources. The primary staff member designated for these functions will not change, so no additional costs related to this position will be incurred. In fact, lower costs should result due to increased efficiency and lower incidence of readmission to inpatient care. All other costs will be related to adding contributions of other existing staff; the Housing Coordinator position already has been added, and costs related to redirecting administrative participation should be minimal due to anticipated changes in the CDMHC scheduling system. The development of tools to enhance performance, such as a local database, will have no cost, and any future state-wide database would have only the cost of IT staff time spent to create the framework, which would have both expense and benefit distributed throughout the SCDMH system.

X. Timeframes for implementation is as follows:

Action Step	Target Date
Begin implementation, communication of design to all participants	April 1, 2015
Begin increased utilization of videoconferencing	April 1, 2015

Establishment of single CC for HL process	May 1, 2015
Increase by 10% of admin staff time designated to HL, Housing	May 1, 2015
Consolidation of supervision under Housing Coordinator	July 1, 2015
Creation of a local database (Excel)	July 1, 2105
HL participation in hospital treatment teams	July 1, 2015
HL expanded duties, including intake and post-discharge follow up	October 1, 2015
Creation of statewide database (SharePoint)	December 1, 2015

XI. Evaluation

Though other factors are significant in measuring transition outcomes, a recent Joint Commission review in 2013 found that most providers evaluate their transitions processes by evaluating their impact on readmissions data (JC citation, 2013). This same measure should be applied to these changes. Data can be tracked once a local database is implemented.

XII. Items for further evaluation/conclusion

In addition to a SCDMH Hospital Liaison, CDMHC also has a clinical supervisor who acts as the liaison with hospitals in the Charleston area. The local liaison primarily acts to problem-solve coordination between CDMHC and inpatient units and Emergency Departments at these hospitals. During these hospitalizations the primary clinician tends to maintain involvement and is the point of contact for arranging follow-up upon discharge. The local liaison does not routinely engage in discharge planning except in circumstances where this process has not functioned properly. Given the overlap in function, a shift of these duties to this HL may merit consideration.

Though many changes have been made over the years to the HL position, it remains a vital part of the treatment process. By revisiting the primary principles that first led to HL development, incorporating best practice techniques, improving tracking and accessibility of

information, and better utilizing existing resources and technology to increase efficiency, the HL can help CDMHC to improve overall care and reduce incidence of rehospitalization.

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Appendix A: Definitions of Terms/Acronyms

Care Coordination:	New name for Targeted Case Management service providers
Catchment Area:	The specific geographic area for which a particular institution, especially a mental health center, is responsible
CC:	Care Coordinator
CDMHC:	Charleston Dorchester Mental Health Center
CRCF:	Community Residential Care Facility
EMR:	Electronic Medical Records
FLCS:	Facility/Liaison Communication Sheet
HL:	Hospital Liaison
IT:	Information Technology
LOC:	Level of Care
MHC:	Mental Health Center
OOH:	Out of Home placements, for children
SCDMH:	South Carolina Department of Mental Health
TCM:	Targeted Case Management
TLC:	Toward Local Care

Appendix B: Facility/Liaison Communication Sheet Form

Facility/Liaison Communication Sheet (11-03)

Patient Name:	CID:	DOB:	Age:	Episode:
Adm Date:	Facility:		LOS: □ DC	Date of DC:
County:	County of Origin:		MHC:	
HL:			Social Worker:	

Placement And Treatment Issues

Date: _____

□ Psychosis	□ Substance Abuse
□ Self Abusive/Suicidal Gestures	□ Wanders □ Organic/Dementia
□ Physical Aggression Others	□ Runs Away/Transient
□ Physical Aggression Property	□ Medication Noncompliance
□ Sexual Acting Out	□ Treatment Noncompliance
□ Known by Law Enforcement	□ Social Skills Deficit
□ Hx of Incarceration (Violent Offenses)	□ ADL Skills Deficit
□ Legal Issues	□ Mental Retardation
□ Sets Fires	□ Medical Health Problems
□ Exhausted options/multiple placements	□ Incontinence
□ Pt rejects placements	□ Family Concerns
□ Pt refuses to leave hospital	□ Pt Sabotages

Facility Communication to Liaison: Date: _____

Liaison needs to see: ____ Patient ____ Social Worker ____ Other ____ Medical Record

□ Needs placement	□ Assist in MR Certification
□ Needs Treatment Services	□ Follow up with Social Worker/Case Manager
Recommended Placement #1 _____	Placement #2 _____

Outcome of Liaison Screening: Date/Update: _____

Liaison Interviewed: ____ Patient ____ Social Worker ____ Read Medical Record ____ Other: _____

□ Concur with DC Plan	□ Investigate placement options
□ Continue to follow up with Social Worker	□ Negotiate placement with other CMHC
□ Identify case manager	□ Staff case at CMHC
□ Investigate treatment options	□ Initiate case resolution procedure
Recommended placement #1:_____	
	Placement #2:_____

Actions for Social Worker to Complete:

□ Establish financial platform	□ Clarify legal issues
□ Establish entitlements	□ Establish medical supply costs
□ Establish Nursing Home Certifications	□ Contact community to arrange screening

Notes:

1.	Secure Inpatient	6.	Supervised Apt	11.	Rooming House	16.	Supervised Apt Living Youth
2.	Structured CRCF	7.	Family/SO	12.	Halfway House	17.	Therapeutic Foster Care Youth
3.	Level II CRCF	8.	Independent Living	13.	Nursing Home	18.	High Management Group Home Youth
4.	Standard CRCF	9.	Shelter	14.	Jail/DOC/DJJ	19.	Moderate Management Group Home Youth
5.	Homeshare	10.	VA Facility	15.	MR Placement	20.	Residential Treatment Facility Youth

21. Other

Appendix C: Hospital Liaison Questionnaire

The following questions were distributed to all SCDMH HLs:

1. Does your MHC have multiple liaisons? Do you have multiple roles at your MHC? If so, what are your other roles?
2. How many hours per week/month do you spend in your HL role?
3. At what frequency do you have face-to-face visits screening visits at the state hospitals?
4. Do you use videoconferencing for screening at the hospitals?
5. Do you screen only patients in your catchment area or also screen patients from other areas?
6. Does the Care Coordination team have a role in your liaison process, and if so, who performs what liaison duties?
7. How consistent have you found your clinical perception of readiness for discharge to match that of the inpatient treatment team?
8. What resources do you have/utilize in arranging local placements, including navigation of entitlement systems?
9. How do you document and track your screening activity? Do you use the Facility/Liaison Communication Sheet form?