

Collaborative Discharge Protocols for Community Services Boards and State Hospitals Adult & Geriatric

Department of Behavioral Health and Developmental Services

The following protocol is designed to provide consistent direction and coordination of activities required of state hospitals and community services boards (CSBs) in the development and implementation of discharge planning. The activities delineated in these protocols are based on or referenced in the Code of Virginia or the community services performance contract. In these protocols, the term CSB includes local government departments with a policy-advisory CSBs, established pursuant to § 37.2-100 of the Code of Virginia, and the behavioral health authority, established pursuant to § 37.2-601 et seq. of the Code of Virginia.

Shared Values:

Both CSBs and state hospitals recognize the importance of timely discharge planning and implementation of discharge plans to ensure the ongoing availability of state hospital beds for individuals presenting with acute psychiatric needs in the community.

While the Code of Virginia assigns the primary responsibility for discharge planning to CSBs, discharge planning is a collaborative process that must include state hospitals.

Joint participation in treatment planning is the most advantageous method of developing comprehensive treatment goals and implementing successful discharge plans. The treatment team, in consultation with the CSB, shall ascertain, document and address the preferences of the individual and his surrogate decision maker(if one has been designated) in the needs assessment and discharge planning process that will promote elements of recovery, resiliency, self-determination, empowerment and community integration. The treatment team shall address the preferences of the individual or surrogate decision maker to the greatest degree practicable in determining the discharge placement. However, this may not be applicable for certain forensic admissions due to their legal status.

NOTE: see attached Appendix A for timeframes related to referrals for community-based services, residential applications and other reporting requirements for CSBs with a defined threshold of state hospital bed utilization. These requirements also include timeframes for certain state hospital activities.

DEFINITIONS

Acute admissions or acute care services: Services that provide intensive short-term psychiatric treatment in state mental health hospitals.

Surrogate decision maker: A person permitted by law or regulations to authorize the disclosure of information or give consent for treatment and services, including medical treatment, or participation in human research, on behalf of an individual who lacks the mental capacity to make these decisions. A surrogate decision maker may include an attorney-in-fact, health care agent, legal guardian, or, if these are not available, the individual's family member (spouse, adult child, parent, adult brother or sister, or any other relative of the individual) or a next friend of the individual (defined in 12VAC35-115-146).

Case management CSB: The public body established pursuant to § 37.2-501 of the *Code of Virginia* that provides mental health, developmental, and substance abuse services within each city and county that established it and in which an adult resides or in which surrogate decision maker resides. The case management CSB is responsible for case management and liaising with the hospital when an individual is admitted to a state hospital, and for discharge planning. If the individual or surrogate decision maker chooses for the individual to reside in a different locality after discharge from the state hospital, the CSB serving that locality becomes the receiving CSB and works with the case management CSB, the individual, and the state hospital to effect a smooth transition and discharge. The case management CSB is ultimately responsible for the completion of the discharge plan. Reference in these protocols to CSB means case management CSB, unless the context clearly indicates otherwise.

Case management CSB designations may vary from the definition above under the following circumstances:

- When the individual's living situation is unknown or cannot be determined or the individual lives outside of Virginia, the case management CSB is the CSB which completed the pre-screening admission form.
- For individuals who are transient or homeless, the CSB serving the catchment area in which the individual is living or sheltered at the time of pre-screening is the case management CSB.
- When a CSB other than the pre-screening CSB is continuing to provide services and supports to the individual, then the case management CSB is the CSB providing those services and supports.
- For individuals in correctional facilities, in local hospitals or Veteran's Administration facilities or in regional treatment/detox programs, the case management CSB is the CSB serving the catchment area in which the individual resided prior to incarceration, or admission to local hospitals, Veterans Administration facilities, or regional detox programs

Comprehensive treatment planning meeting: The meeting, which follows the initial treatment meeting and occurs within seven days of admission to a state hospital. At this meeting, the individual's comprehensive treatment plan (CTP) is developed by the treatment team in consultation with the individual, the surrogate decision maker, the CSB and, with the individual's consent, family members and private providers. The purpose of the meeting is to guide, direct, and support all treatment aspects for the individual.

Co-occurring disorders: Individuals are diagnosed with more than one, and often several, of the following disorders: mental health disorders, developmental disability, or substance use disorders. Individuals may have more than one substance use disorder and more than one mental health disorder. At an individual level, co-occurring disorders exist when at least one disorder of each type (for example: a mental health and substance use disorder or developmental disability and mental health disorder) can be identified independently of the other and are not simply a cluster of symptoms resulting from a single disorder.

Discharge plan or pre-discharge plan: Hereafter referred to as the discharge plan, means an individualized plan for post-hospital services that is developed by the case management CSB in accordance with § 37.2-505 and § 16.1-346.1 of the Code of Virginia in consultation with the individual, surrogate decision maker and the state hospital treatment team. This plan must include the mental health, developmental, substance abuse, social, educational, medical, employment, housing, legal, advocacy, transportation, and other services and supports needed by the individual, consistent with subdivision A.3 of § 37.2-505, following an episode of hospitalization and must identify the public or private providers that have agreed to provide these services and supports. The discharge plan is required by § 37.2-505, § 16.1-346.1, and § 37.2-508 of the Code of Virginia.

Primary substance use disorder: An individual who is clinically assessed as having one or more substance use disorder per the current Diagnostic and Statistical Manual of Mental Disorders (DSM) with the substance use disorder being the “principle diagnosis” (i.e. the condition established after evaluation to be chiefly responsible for the admission; the individual may not have a mental health disorder per the current DSM or the mental health disorder is not the principle diagnosis).

State hospital: A hospital, psychiatric institute, or other institution operated by the Department that provides acute psychiatric care and treatment for persons with mental illness

Treatment team: The group of individuals responsible for the care and treatment of the individual during the period of hospitalization. Team members shall include, at a minimum, the individual receiving services, psychiatrist, a psychologist, a social worker, and a nurse. Hospital. CSB staff shall actively participate, collaborate, and consult with the treatment team during the individual’s period of hospitalization. The treatment team is responsible for providing all necessary and appropriate supports to assist the CSB in completing and implementing the individual’s discharge plan.

Treatment plan: A written plan that identifies the individual’s treatment, educational/vocational and service needs and states the goals, objectives and interventions designed to address those needs. There are two sequential levels of treatment plans:

1. The “initial treatment plan,” which directs the course of care during the first hours and days after admission; and
2. The “comprehensive treatment plan (CTP),” developed by the treatment team with CSB consultation, which guides, directs, and supports all treatment of the individual.

Treatment plan review (TPR): Treatment planning meetings or conferences held subsequent to the CTP meeting.

1. Collaborative Responsibilities Following Admission to State Hospital

	State Hospital Responsibilities	CSB Responsibilities
1.1	State hospital staff shall assess each individual upon admission and periodically thereafter to determine whether the state hospital is the most appropriate treatment site.	As active participants in the discharge process and consultants to the treatment process, CSB staff shall participate in discussions to determine whether the state hospital is the most appropriate treatment hospital.
1.2	<p>State hospital staff shall contact the CSB within one business day of admission to notify the CSB of the new admission.</p> <p>State hospital staff shall also provide a copy of the admissions information/face sheet, including the name and phone number of the social worker assigned and the name of the admitting unit, to the CSB within one calendar day of admission.</p> <p>1. For individuals admitted with co-occurring SMI and DD disorders, the hospital social work director (or designee) will communicate with the CSB discharge liaison to determine specifically who the CSB will identify to take the lead in discharge planning (MH or DD services).</p>	<p>Upon notification of admission, CSB staff shall begin the discharge planning process for both civil and forensic admissions. If the CSB disputes case management responsibility for the individual, the CSB shall notify the state hospital social worker immediately upon notification of admission.</p> <ol style="list-style-type: none"> 1. For every admission to a state hospital from the CSB's service area that is currently not receiving services from that CSB, the CSB shall develop an open case and assign case management responsibilities to the appropriate staff. 2. For individuals with co-occurring SMI/DD disorders, the CSB MH and DD Directors will identify and inform the CSB liaison whether the DD support coordinator or MH case manager will take the lead in discharge planning. 3. The individual assigned to take the lead in discharge planning will insure that the other relevant parties (DD support coordinator, providers, etc.) are engaged with the state hospital social work director within two business days of the admission. CSB staff shall establish a personal contact with the individual to initiate collaborative discharge planning.

1.3	<p>State hospital staff shall make every effort to inform the CSB of the date and time of the CTP meeting at least two business days prior to the scheduled meeting.</p> <p>The CTP meeting shall be held within seven calendar days of the date of admission.</p>	<p>CSB staff shall make arrangements to attend or otherwise participate in the CTP and TPR meetings. If the CSB staff is unable to physically attend the CTP or TPR meeting, the CSB may request arrangements for telephone or video conferencing.</p> <p>In the event that the arrangements above are not possible, both parties shall make efforts to discuss the individual's progress within two business days.</p> <p>Note: While it may not possible for the CSB to attend every treatment planning meeting, participation in person or via phone conference is expected. This is the most effective method of developing comprehensive treatment goals and implementing successful discharge plans.</p>
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2. Needs Assessments & Discharge Planning

Joint Responsibility of the State Hospital & CSB		
2.1	<p>The treatment team and CSB shall document and address the preferences of the individual and their surrogate decision maker in the comprehensive assessment and discharge planning process in a manner that will promote elements of recovery, self-determination, empowerment, and community integration.</p>	
	State Hospital Responsibilities	CSB Responsibilities
2.2	<p>The state hospital social worker shall complete the social work comprehensive assessment prior to the CTP or within seven calendar days of admission for each individual. This assessment shall provide information to help determine the individual's needs upon discharge.</p> <p>The treatment team shall document the individual's preferences in assessing their unique needs upon discharge.</p>	<p>Discharge planning begins on the initial pre-screening form and continues throughout hospitalization. In completing the discharge plan, the CSB shall consult with members of the treatment team, the individual, the surrogate decision maker and (with consent) family members or other parties to determine the preferences of the individual upon discharge. The discharge plan shall:</p> <ul style="list-style-type: none"> • include the anticipated date of discharge from the state hospital; • identify the services needed for successful community placement and the frequency of those services; and • specify to the public or private providers that have agreed to provide these services.

2.3		The CSB shall initiate discharge planning at the time of admission. The discharge plan shall address the discharge needs identified in the comprehensive social work assessment in addition to other pertinent information within the clinical record.
2.4	As an individual's needs change, the hospital social worker shall document changes in the comprehensive social work assessment, in the hospital social worker's progress notes and through scheduled meetings with the CSB.	If the individual's needs change or as more specific information about the discharge plan becomes available, the CSB staff shall update the discharge plan accordingly.

Joint Responsibility of the State Hospital & CSB

2.5	<p>The treatment team in collaboration with the CSB shall ascertain, document, and address the preferences of the individual and the surrogate decision maker as to the placement upon discharge.</p> <p>The preferences of the individual and the surrogate decision maker shall be addressed to the greatest degree practicable in determining the optimal and appropriate discharge placement. When a disagreement related to the discharge of the individual occurs, the CSB, individual, surrogate decision maker and hospital shall attempt to resolve the disagreement through the regions' established dispute resolution process.</p> <p>NOTE: There may be limitations to individual choice for certain forensic admissions due to their legal status.</p>
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2.6 If the individual has an DD and a co-occurring SMI diagnosis, the CSB MH and DD directors will identify and inform the CSB's designated MH or DD liaison, who will notify the state hospital social work director whether the DD or MH case manager will take the lead in discharge planning and work collaboratively with the CSB mental health discharge liaison on eligibility-planning activities and state hospital discharge procedures.

CSB DD responsibilities include the following:

Assessment/Screening to determine diagnostic and functional eligibility for a DD Waiver for individuals not on waiver waitlist or receiving waiver services.

- If applicable, secure a Medicaid Waiver slot place on the waiver wait list for the individual receiving services;
- Initiate the referral to REACH;
- Complete all documentation required for Medicaid waiver slots;
- Participate in the development and updating of the discharge plan;
- Attend and participate in treatment team meetings, discharge planning meetings and other related meetings;
- Assist in coordinating assessments with potential providers;
- Assist in scheduling tours/visits with providers for the individual and surrogate decision maker;
- Assist with locating and securing needed specialists who will support individual in the community once they have been discharged, i.e., doctors, behavioral support;
- Provide support during the transition to community services;
- Facilitate the transfer of case management responsibilities to the receiving CSB or private provider according to the Support Coordination/Case Management Transfer Procedures for Persons with Developmental Disability.
- Assure that an individual with decision making authority is provided an opportunity to be present in all discharge planning meetings.

State hospital responsibilities include:

- Upon identification that the individual admitted to the state hospital has a co-occurring diagnosis of SMI/DD, the hospital social worker director will notify the liaison/case manager for the CSB;
- Notify the designated CSB lead for discharge coordination in advance of relevant meetings so attendance can be arranged;
- Assist the case managers to compile the necessary documentation to implement the process for waiver and/or bridge funding.
- Serve as a consultant to the DD case manager as needed;
- Assist with coordinating assessments with potential providers;
- Assist with scheduling tours/visits with providers for the individual and surrogate decision maker.

3. Readiness for Discharge

State Hospital Responsibilities

3.1 The treatment team shall rate the clinical readiness for discharge for all individuals at least bimonthly using the following scale:

Clinical Readiness for Discharge Ratings

1. Clinically Ready for Discharge:

- a. Has met treatment goals and does not need inpatient psychiatric treatment.
- b. Not guilty by reason of insanity (NGRI) with up to 48 hour privilege level.
- c. NGRI under a temporary custody order and at least one forensic evaluator has recommended conditional or unconditional release and there is a pending court date.
- d. NGRI on revocation status and the treatment team and CSB recommend conditional or unconditional release and there is a pending court hearing.
- e. Has met treatment goals and does not need acute inpatient psychiatric treatment, but is reluctant to participate in discharge planning.

2. Almost Clinically Ready for Discharge

- a. Needs additional inpatient care to fully address clinical issues and/or there is concern about adjustment difficulties.
- b. Can take community trial visits to assess readiness for discharge; may have the civil privilege level to go on overnight temporary visits.
- c. NGRI with unescorted community visits privilege.

3. Not Clinically Ready for Discharge:

- a. Requires treatment and further stabilization in an acute inpatient psychiatric setting.
- b. NGRI and does NOT have unescorted community visits privilege.

4. Significant clinical instability limiting privileges and engagement in treatment:

- a. not psychiatrically stable
- b. requires constant 24 hour supervision in an acute inpatient psychiatric setting.
- c. presents significant risk and/or behavioral management issues that require psychiatric hospitalization to treat.
- d. Acutely psychotic and can benefit from inpatient psychiatric care to address symptoms.

NOTE:

Discharge planning begins on admission and is continuously active throughout hospitalization independent of the clinical readiness for discharge rating

	State Hospital Responsibilities	CSB Responsibilities
3.2	The state hospital social worker shall notify the CSB in writing, in person or through the use of technology within one business day when the treatment team determines that the individual is clinically ready for discharge or state hospital level of care is no longer required or, for voluntary admissions, when consent has been withdrawn.	Once it has received notification of the individual's readiness for discharge, the CSB shall take immediate steps to implement the discharge plan.
3.3	Once the CSB has finalized the discharge plan, the state hospital shall discharge the individual as soon as possible.	
3.4	Notification of Ready for Discharge (RFD) and Placement on the Extraordinary Barriers to Discharge List (EBL): The state hospital social worker shall provide notification when an individual is RFD and/or is placed on the EBL to that individual's discharge liaison, the discharge liaison's immediate supervisor, the CSB behavioral health director or equivalent, the CSB executive director, the state hospital social work director, the state hospital director, and the designated Central Office acute care consultant. The notifications shall be made to the parties noted above in accordance with the time frames defined in Appendix A of this protocol.	
Joint Responsibility of the State Hospital & CSB		
3.5	<p>To the greatest extent possible, the treatment team, the CSB staff, the individual and their surrogate decision maker shall be a part of the decision making process regarding the individual's clinical readiness for discharge.</p> <p>The hospital social worker is responsible for communicating decisions regarding the individual's clinical readiness for discharge to the CSB staff with documentation of the contact noted in the individual's medical record.</p> <p><i>Dispute Process</i></p> <ol style="list-style-type: none"> 1. When disagreements regarding clinical readiness for discharge occur, the CSB and the treatment team shall make a reasonable effort to resolve the disagreement. If both parties are unable to come to a resolution during the treatment team meeting, the CSB shall notify the state hospital social work director, in writing, within three calendar days of receiving the discharge readiness notification of their disagreement with the treatment team's designation of the individual's clinical readiness for discharge. 	

Joint Responsibility of the State Hospital & CSB

	<p>2. The hospital social work director (or designee, should the director be unavailable) shall initiate a resolution effort to include at least one face-to-face meeting with the state hospital and CSB staff at a level higher than the treatment team. This meeting shall occur within three business days of receipt of the CSB’s written disagreement.</p>	
	<p>3. If the disagreement remains unresolved, the state hospital social work director shall initiate a request in writing to the DBHDS Director of Acute Care Services (or designee) for resolution within one business day of the meeting outlined in step 1.</p> <p>4. The Director of Acute Care (or designee) shall consult with a clinical representative from the CSB and the state hospital (as designated by the CSB executive director and state hospital director) within three calendar days of the receipt of the CSB’s written request for resolution. After such consultation, the Director of Acute Care (or designee) shall provide written notice of the decision to the CSB executive director and state hospital director. Notification of the decision shall be provided within five calendar days of the receipt of the social work director’s written request for resolution.</p> <p>5. During the dispute process outlined above, the CSB shall formulate a discharge plan that can be implemented within 3 business days if the decision is in support of clinical readiness for discharge.</p> <p>6. Should the Director of Acute Care (or designee) determine that the individual is clinically ready for discharge and the CSB has not developed a discharge plan to implement immediately, then the enforcement measures set out in VA code, subdivision A.3 of § 37.2-505 shall apply.</p>	
3.6	<p>State hospital staff shall collaborate with CSB staff as needed in finalizing the discharge plan.</p> <p>NOTE: While the primary responsibility for making the initial referral to all private providers, including nursing homes and assisted living facilities (ALFs), is the responsibility of the case management CSB, state hospital staff may assist in the referral process.</p>	
3.7	<p>Each state hospital and CSB shall develop and implement a process for resolving transportation issues that will result in discharge within 72 hours of the being determined to be RFD when transportation is the only remaining barrier to discharge.</p>	
	<p>State Hospital Responsibilities</p>	<p>CSB Responsibilities</p>
3.8		<p>In the event the CSB experiences extraordinary barriers and is unable to complete the discharge within 14 calendar days of notification of the clinical readiness for discharge, the CSB shall document in the CSB discharge planning notes why the discharge cannot occur within 14 days of notification. The note shall describe the barriers to discharge (i.e. reason for placement on the Extraordinary Barriers to Discharge or EBL) and the specific steps being taken by the CSB to address the barriers.</p>

Joint Responsibility of the State Hospital & CSB

3.9 At a minimum, the hospital and CSB staff shall review on a monthly basis those individuals rated a 1 or 2 on the clinical readiness for discharge scale. To ensure that discharge planning is occurring at a reasonable pace, the CSB shall provide an updated discharge planning progress that shall be documented in these monthly meetings. The regional utilization structures shall review at least monthly the placement status of those individuals with extraordinary barriers to discharge at a state hospital.

The Director of Acute Care Services (or designee) shall monitor the progress of those individuals with extraordinary barriers to discharge.

4. COMPLETING THE DISCHARGE PROCESS

Joint Responsibility of the State Hospital & CSB

4.1 State hospital staff shall initiate applications for Medicaid, Medicare, SSI/SSDI and other financial entitlements. Applications shall be initiated in a timely manner per federal and state regulations prior to actual discharge. To facilitate follow-up, the hospital social worker shall notify the CSB of the date and type of entitlement application that is submitted and include a copy of the entitlement application with the discharge documentation that is provided to the CSB

	State Hospital Responsibilities	CSB Responsibilities
4.2	<p>The treatment team shall complete the discharge information and instructions form. Prior to discharge, the state hospital staff shall review the discharge information and instructions form with the individual and surrogate decision maker and request his/her signature. Distribution of the discharge information and instructions shall be provided to all next level of care providers no later than one calendar day post discharge.</p> <p>NOTE: Individual review of the discharge information and instruction form may not be applicable for certain forensic admissions due to their legal status.</p>	<p>To reduce re-admissions to state hospitals, CSBs, in conjunction with the treatment team, shall develop and complete when clinically indicated, a safety and support plan as part of the individual's final discharge plan.</p> <p>NOTE: Safety and support plans are generally not required for court ordered evaluations, restoration to competency cases, and jail transfers. However, at the clinical discretion of the treatment team or the CSB, the development of a specialized safety and support plan may be advantageous when the individual presents significant risk factors and for those individuals who may be returning to the community following a brief incarceration period.</p> <p>EXCEPTION: Due to having a risk management plan as part of the conditional release plan, NGRI acquittees do not need a safety and support plan.</p>

	State Hospital Responsibilities	CSB Responsibilities
4.3	The state hospital medical director shall be responsible for ensuring that the physician's discharge summary is provided to the case management CSB (and state prison, regional, or local jail when appropriate) to the greatest extent possible, within 14-and no later than 30 calendar days of the actual discharge date.	
4.4		<p>CSB staff shall ensure that all arrangements for psychiatric services and (to the greatest extent practicable) medical follow-up appointments are in place prior to discharge.</p> <p>CSB staff shall ensure the coordination of any other intra-agency services, (e.g. employment, outpatient services, residential, etc.) and follow up to applications for Medicaid submitted by the state hospital.</p>
4.5		The CSB case manager, primary therapist, or other designated clinical staff shall schedule an appointment to see individuals who have been discharged from a state hospital within seven calendar days of discharge or sooner if the individual's condition warrants.
4.6		The CSB case manager, discharge liaison, or other designated staff shall schedule an appointment with the CSB (or other) psychiatrist within seven calendar days of discharge when the discharging individual is on psychiatric medications.

5. TRANSFER OF CASE MANAGEMENT CSB RESPONSIBILITIES

	State Hospital Responsibilities	CSB Responsibilities
5.1	<p>The hospital social worker shall indicate in the progress notes any intention that is clearly expressed by the individual and the surrogate decision maker to change or transfer case management CSB responsibilities and the reason(s) for doing so.</p> <p>This shall be documented in the individual's medical record and communicated to the case management CSB.</p>	<p>Transfers shall occur when the individual receiving services or his surrogate decision maker decides (on behalf of the individual) the individual will relocate to another CSB service area.</p> <p>If the individual or his surrogate decision maker decides (on behalf of the individual) the individual will relocate, the case management CSB shall immediately notify the CSB affected by the potential placement.</p> <p>The case management CSB must complete and forward a copy of the out of catchment referral form to the receiving CSB prior to the individual's discharge</p> <p>Individuals who are enrolled in CSB DD services may have different protocols for transfer of case management responsibilities.</p> <p>NOTE: Coordination of the possible transfer shall, when possible, allow for discussion of resource availability and resource allocation between the two CSBs prior to advancement of the transfer.</p>
5.2		<p>Exceptions to the above may be granted when the CSB, individual served, and their surrogate decision maker wish to keep services at the case management CSB while living in a different service area.</p>

	State Hospital Responsibilities	CSB Responsibilities
5.3		<p>At a minimum, the case management CSB and the CSB accepting responsibility for services shall collaborate prior to the actual discharge date. The case management CSB is responsible for completing the discharge plan, conditional release plan, and safety and support plan and for the scheduling of follow up appointments.</p> <p>The CSB accepting responsibility for services also must be actively involved in the development of the discharge plan and the safety and support plan. The arrangements for and logistics of this involvement are to be documented in the discharge plan, safety and support plan, monthly discharge note and the individual's medical record.</p> <p>The case management CSB shall, upon notice of transfer, provide the CSB accepting responsibility for services with a copy of all relevant documentation related to the treatment of the individual.</p>
5.4		<p>If the two CSBs cannot agree on the transfer of case management responsibility within three calendar days of notification of intent to transfer, they shall seek resolution from the Director of Acute Care Services (or designee). The case management CSB shall initiate this contact.</p>

6. SHELTER AND TEMPORARY PLACEMENTS

	State Hospital Responsibilities	CSB Responsibilities
6.1	<p>If discharge to a shelter is clinically recommended and the individual has capacity and has expressed a preference or willingness to transition to a shelter, and/or an unwillingness to accept housing elsewhere, the hospital social worker shall document this recommendation in the social work progress notes. The hospital social worker shall notify the director of social work when CSB consultation has occurred. The director of social work shall review the plan for discharge to a shelter with the medical director (or their designee). Following this review, the medical director (or designee) shall document endorsement of the plan for discharge to a shelter in the individual's medical record.</p>	<p>For individuals with a primary diagnosis of mental illness or co-occurring diagnosis of mental illness and developmental disability, discharge to a shelter may be part of the individual's discharge plan only if it is clinically recommended and the individual has expressed a preference for shelter placement.</p>
6.2	<p>In the case of out of catchment shelter placements, state hospital staff shall consult both the case management CSB and the CSB accepting responsibility for services and both must agree to the placement and service provision arrangements. The hospital social worker is to provide both CSBs with notification as directed in 5.1.</p>	<p>Both the case management CSB and the CSB accepting responsibility for providing case management services shall follow the same procedures as outlined in Section 5 for out of catchment placements.</p> <p>For individuals who are transient or homeless, the CSB serving the catchment area in which the individual is living or sheltered at the time of pre-screening is the case management CSB.</p>

APPENDIX A

Admission and Discharge Requirements For State Hospital Census Management

- 1) **Each CSB** shall develop and implement the following procedures to supplement the existing Discharge Protocols for State Hospitals and CSBs.
 - a) Notification to Discharge Planner of Admission to a State Hospital: The emergency services clinician shall notify the CSB discharge planner of every admission to a state hospital within 24 hours of the issuance of the temporary detention order (TDO).
 - b) Documentation of Private Hospital Bed Search Prior to State Hospital Admission: The emergency services clinician shall complete an approved tracking form documenting all private hospital contacts prior to seeking a bed of last resort at a state hospital and transmit the form to the receiving state hospital along with the preadmission screening form.
 - c) Notification of Discharge Planning Personnel: Each CSB shall provide the Director of Acute Care Services at DBHDS with the names of CSB personnel who are providing discharge planning services for individuals in state hospitals, their role and title, and the FTE equivalency for the hours each staff spends in discharge planning.
- 2) **Each region** is expected to develop and implement the following procedures.
 - a) List of Available Community Resources: The CSBs in each region shall develop a process for communicating and updating a list of available CSB and regional housing resources funded by DBHDS for individuals being discharged from state hospitals using the attached format. The resource listing should include willing private providers. CSBs shall review and update the list at each regional discharge planning meeting to ensure that all resource options are explored for individuals who are Ready for Discharge (RFD) and/or on the Extraordinary Barriers List (EBL).
 - b) State Hospital Standardized Data Review: By the 16th of each month, DBHDS will provide each regional manager with standardized data for the preceding month that includes, by CSB, the monthly bed use per 100,000 population. CSBs in each region shall incorporate a review of this data at its regional discharge planning meetings, mental health council meetings, emergency services council meetings, and the executive director meeting. The meeting minutes of each council or group shall reflect this review and any actions taken in response to this review.
 - c) Resolution Process for Outstanding Issues: In order to facilitate solution oriented communications and establish timely and effective problem solving processes, CSBs in each region shall establish a regional bidirectional process, with time frames, and clearly defined steps for notification, discussion, and resolution of issues at the CSB, state hospital, and Central Office levels.
- 3) **All state hospitals and any CSB with an average daily census of nine (9) beds or more per 100,000 adult and geriatric population** shall implement the procedures outlined below. DBHDS shall calculate CSBs' average daily census per 100,000 for adults and the geriatric population for the individuals with the following legal statuses: civil temporary detention order, civil commitment, court mandated voluntary, voluntary, and NGRIS with 48 hour unescorted community visit privileges. If a CSB's bed use is at or below the established threshold of an average daily census of eight (8) beds or less per 100,000 adult and

geriatric population, they will be exempted from these requirements at the time of the quarterly review. If an exempt CSB's average monthly bed use for the prior quarter is above the established threshold, they will have a "grace period" of the next three months to reduce their bed use. If the exempt CSB is unsuccessful in meeting this threshold over this six-month period, they will be expected to comply with the requirements in Section C. During the third week of quarter, DBHDS will review each CSB's use of beds per 100,000 adult and geriatric population for the prior three months to determine if the CSB meets the threshold for complying with the requirements in this section.

- a) Notification of Ready for Discharge (RFD) and Placement on the Extraordinary Barriers to Discharge List (EBL): The state hospital social worker shall provide notification when an individual is RFD and/or is placed on the EBL to that individual's discharge liaison, the discharge liaison's immediate supervisor, the CSB behavioral health director or equivalent, the CSB executive director, the state hospital social work director, the state hospital director, and the designated Central Office acute care consultant. The notifications shall be made to the parties noted above in accordance with the time frames described below.
 - i) *RFD Notification*: Every Wednesday, the state hospital social worker will use encrypted email to provide notification of every individual who is RFD but will not be discharged within 72 hours.
 - ii) *EBL Notification*: Within one business day of an individual being placed on the EBL, the state hospital social worker shall use encrypted email to provide notification of the individual's placement on the EBL.
 - (a) All involved CSB and state hospital personnel shall use encryption to communicate about RFD or EBL. No communication about RFD or EBL should occur by fax or US mail.
- b) Transportation Requirement: Each state hospital and CSB shall develop and implement a process for resolving transportation issues that will result in discharge within 72 hours of the individual being determined to be RFD when transportation is the only remaining barrier to discharge.
- c) Referral Time Frame Requirements: Each CSB shall develop and implement a process for meeting the following referral requirements.
 - i) *CSB Mental Health Services and Housing*: For each of the services listed below, the state hospital treatment team shall review the discharge needs. If referrals for these services are needed for the individual, the hospital social worker shall refer the individual to the case management CSB for assessments for eligibility for these services within two business days of the treatment team identifying and agreeing with the need for the service or resource. Once the referral is made, the CSB has eight business days to complete the assessment with the individual. The CSB shall share the outcome of the assessment and the date when the services will be available with the hospital treatment team immediately upon completion of the assessment.
 - (1) Psychosocial Rehabilitation
 - (2) Case Management
 - (3) Mental health skill building
 - (4) Permanent Supportive Housing
 - (5) PACT/ICT

(6) Other residential services or placements operated by the CSB or Region

ii) *Not Guilty by Reason of Insanity acquittees (NGRIs)*

- (1) The state hospital shall complete and submit a packet requesting an increase in privilege level within 10 business days of the treatment team identifying the individual as being eligible for an increase in privilege level.
- (2) The CSB shall review, edit, sign, and return to the state hospital, a Risk Management Plans for an individual adjudicated NGRI within five business days so as to not delay progression through the graduated release process.
- (3) The CSB shall develop and transmit to the state hospital a conditional release plan within 10 business days of being notified that the individual has been recommended for conditional release.

iii) *Guardianship*

- (1) Within two business days of the treatment team determining that an individual needs a guardian, the hospital social worker shall notify the discharge planner of the need. Within two business days of this notification, the CSB shall explore potential individuals to serve in that capacity.
- (2) If the CSB cannot locate a suitable candidate who agrees to serve within 10 business days, steps shall begin toward securing public guardianship.
- (3) These activities start and continue regardless of patient's discharge readiness level.

iv) *Developmental Disability Services:*

- (1) Within two business days of admission of an individual with a developmental disability with a moderate, severe, or profound developmental disability, the CSB shall determine and report to the hospital if the individual is receiving DD services, has a waiver, is on a waiver waiting list, or should be screened for waiver.
- (2) Within five business days of admission, a REACH referral must be completed for anyone with a developmental disability diagnosis who is not already being followed by REACH.
- (3) When indicated based on above information, the VIDES shall be completed within 10 business days of admission.
- (4) When requested referrals or assessments are not completed within five business days of the request, the state hospital director will contact the CSB executive director to resolve delays in the referral and assessment processes.

v) *Assisted Living:*

- (1) When the individual's ability to live independently is unclear, the state hospital shall see that an Independent Living Skills (ILS) assessment is made and is completed within five working days of the referral. Referrals for ILS (when indicated) should be made when the individual is at Discharge Ready Level 2.

- (2) As soon as a supervised assisted living facility setting is being considered, CSB shall obtain releases from the individual or substitute decision maker to contact potential facilities and begin initial contacts regarding bed availability and willingness to consider the individual for placement. This process shall be started prior to the individual being determined to be RFD.
- (3) The state hospital will complete the UAI when the individual is Discharge Ready Level 2. UAI will be completed within five business days of the individual being found Discharge Ready Level 2.
- (4) CSB shall send referral packets to potential placements (identified above) within two business days after individual is rated as Ready for Discharge. Multiple applications are to be sent simultaneously.

vi) *Nursing Home:*

- (1) As soon as a supervised nursing home setting is being considered, CSB shall obtain releases from the individual or substitute decision maker to contact potential facilities and begin initial contacts regarding bed availability and willingness to consider the individual for placement.
 - (2) State hospital will complete the UAI when the individual is Discharge Ready Level 2. UAI will be completed within five business days of being found Discharge Ready Level 2.
 - (3) Within two business days of being found Discharge Ready Level 1, the state hospital shall send the packet to Ascend for Level 2 nursing home screening.
 - (4) Applications shall be sent to potential nursing homes identified above within two business days of Level 2 response from Ascend.
- d) Requirement for Notification of Changes in Discharge Planning Personnel: Each CSB shall notify the Director of Acute Care Services when changes are made to the list of personnel providing discharge planning services or adjustments made to the hours spent in providing discharge planning.