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

Department of Behavioral Health and Developmental Services

The attached protocol is designed to provide consistent direction and coordination of those 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 department~~s~~ with a policy-advisory CSB~~s~~, 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 authorized representative if one has been designated in the needs assessment and discharge planning process that will promote elements of recovery, self-determination, empowerment and community integration. The treatment team shall address the preferences of the individual or authorized representative 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: In anticipation of the implementation of an electronic health record (EHR) at the state hospitals in 2014-15, references to the Secure Site Discharge Database (SSDD) have been removed from this document. Until such time as the EHR is operational at each state hospital with CSB access, the SSDD will continue to be the database used to document an individual's needs, discharge plan, safety and support plan, discharge planning notes, and the Barriers to Discharge.

DEFINITIONS

Acute admissions or acute care services: Services that provide intensive short-term psychiatric treatment in state mental health hospitals for a period of less than 30 days after admission.

Authorized representative: 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. An authorized representative 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 a minor's parent~~,~~ or authorized representative resides. The case management CSB is responsible for case management, liaison with the hospital when an individual is admitted to a state hospital, and discharge planning. If the individual, the parents of a minor receiving service, or authorized representative chooses to reside in a different locality after discharge from the state hospital, the 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.

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 authorized representative, 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, intellectual 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 (e.g., mental health and substance use disorder, intellectual 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, authorized representative 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.

A completed or finalized discharge plan means the document on which all of the services to be received upon discharge are shown, the providers that have agreed to provide those services are identified, the frequency of those services is noted, and a specific date of discharge is entered.

Extended treatment: Refers to length of stay for a period of 30 days or more after admission that offers intermediate or extended treatment in a state hospital for individuals with severe psychiatric impairments, emotional disturbances, or multiple service needs.

Involuntary admission: An admission of an adult or minor that is ordered by a court through a civil procedure pursuant to § 37.2-814 – 37.2-819 or § 16.1-346.1 of the *Code of Virginia*.

Minor: An individual who is under the age of 18 years. Any minor must have a legal guardian unless emancipated by a legal process. A minor who is 14 years of age or over must give consent for admission and treatment issues.

Primary substance use disorder: An individual who is clinically assessed as having one or more substance use disorders per the current 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 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. While not actual members of the facility treatment team, 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~~s~~ in completing and implementing the individual's discharge plan.

Treatment plan: A written plan that identifies the individual's treatment, educational, 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.

I. 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 an appropriate treatment site. Inappropriate admissions including individuals with a primary diagnosis of substance abuse will be reported to the CSB discharge liaison within one calendar day.	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 an appropriate treatment facility.
1.2	State hospital staff shall contact the CSB within one calendar day of admission to notify the CSB of the new admission. 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. 1. For individuals who are discharged prior to the CTP, the treatment team is responsible for completing the discharge instructions in consultation with the CSB. 2. For individuals admitted with co-occurring SMI/ID/DD disorders, the hospital social work director will communicate with the CSB MH and ID directors to determine specifically who will take the lead in discharge planning.	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. 1. For individuals who are discharged prior to the CTP, CSB responsibilities post discharge will be reflected in the discharge instructions. 2. 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**.** 3. For individuals with co-occurring SMI/ ID/DD disorders, the CSB MH and ID Directors will identify and inform the state hospital social work director whether the ID or MH case manager will take the lead in discharge planning. 4. The individual assigned to take the lead in discharge planning will insure that the other relevant parties (DD case manager, providers, etc.) are engaged with the state hospital social work director within seven calendar days of the admission. 5. CSB staff shall establish a personal contact (face-to-face, telephone, etc.) at least once for an acute hospitalization, at least monthly for individuals receiving extended treatment, and within 30 days prior to the individual's discharge.

	State Hospital Responsibilities	CSB Responsibilities
1.3	State hospital staff shall make every effort to inform the CSB of the date and time of the CTP meeting at least two calendar days prior to the scheduled meeting. The CTP meeting shall be held within seven calendar days of the date of admission.	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. In the event that the arrangements above are not possible, both parties shall make efforts to discuss the individual's progress within two calendar days. Note: While it may not be possible for the CSB to attend every treatment planning meeting, attendance at treatment planning meetings is the most advantageous method of developing comprehensive treatment goals and implementing successful discharge plans.

II. Needs Assessments & Discharge Planning

Joint Responsibility of the State Hospital & CSB		
2.1	The treatment team and CSB shall document and address the preferences of the individual and his authorized representative in the comprehensive assessment and discharge planning process in a manner that will promote elements of recovery, self determination, empowerment, and community integration.	
	State Hospital Responsibilities	**CSB Responsibilities**
2.2	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. The treatment team shall document the individual's preferences in assessing their unique needs upon discharge.	Discharge planning begins on the initial pre-screening form and continues on the CSB-discharge plan document. (*This form is in the process of being revised. Until the process is complete, we will continue to use the existing document).* In completing the discharge plan, the CSB shall consult with members of the treatment team, the individual, the authorized representative, and with consent, family members or other parties in determining the preferences of the individual upon discharge. The discharge plan shall: • 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.

	State Hospital Responsibilities	CSB Responsibilities
2.3		The CSB shall initiate the discharge plan within ten calendar days 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 facility 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	The treatment team in collaboration with the CSB shall ascertain, document, and address the preferences of the individual and the authorized representative as to the placement upon discharge. The preferences of the individual and the authorized representative shall be addressed to the greatest degree practicable in determining the optimal and appropriate discharge placement. ***NOTE:*** This may not be applicable for certain forensic admissions due to their legal status**.**	
2.6	If the individual has an ID/DD and a co-occurring SMI, the CSB MH and ID directors will identify and inform the state hospital social work director whether the ID 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 ID/DD responsibilities include the following:** Assessment of the individual for Medicaid Waiver eligibility; • If applicable, securing either a Medicaid Waiver slot or Money Follows the Person funding for the individual receiving services; • Initiating the referral to REACH; • Completion of all documentation required for Medicaid waiver slots; • Participation in the development and updating of the discharge plan; • Attendance and participation at treatment team meetings, discharge planning meetings and other related meetings; • Assistance coordinating assessments and shadowing of potential providers; • Assistance scheduling tours/visits with providers for the individual and authorized representative; • Assisting to locate and secure needed specialists who will support individual in the community once they have been discharged, i.e., doctors, behavioral support; • Providing support during the transition to community services; • Facilitation of 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 Intellectual Disability.* • Assure that an individual with decision making authority is present in all discharge planning meetings.	

Joint Responsibility of the State Hospital & CSB	
	State hospital responsibilities include: • Upon identification that the individual admitted to the state hospital has a co-occurring diagnosis of SMI/ID/DD, the hospital social worker director will notify the MH Director for the CSB (or their designee); • 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 ID/DD case manager as needed; • Assist with coordinating assessments and shadowing of potential providers; • Assist with scheduling tours/visits with providers for the individual and authorized representative.

III. Readiness for Discharge

State Hospital Responsibilities	
3.1	The treatment team shall rate the clinical readiness for discharge for all individuals at least monthly 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. 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. resistant to discharge and refuses to engage in discharge process d. NGRI with unescorted community visits privilege. 3. **Not Clinically Ready for Discharge:** a. Participates in treatment (engaged, adherent with medications, groups. etc.), but unable to function independently of 24 hour supervision in an inpatient psychiatric setting. b. Not yet able to take independent passes or take trial passes to a supervised placement but may have unescorted grounds privileges if available at the facility. c. NGRI- does NOT have unescorted community visits privilege.

	State Hospital Responsibilities	
	4. **Significant clinical instability limiting privileges and engagement in treatment:** a. not psychiatrically stable b. Requires constant 24 hour supervision in an inpatient psychiatric setting. c. presents significant risk and/or behavioral management issues d. Acutely psychotic. **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 calendar 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.	
	Joint Responsibility of the State Hospital & CSB	
3.4	To the greatest extent possible, CSB staff, the individual and the authorized representative shall be a part of the decision making process regarding the individual's clinical readiness for discharge. 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. **EXCEPTION**: For individuals under the jurisdiction of criminal justice regulations, discharge notification will occur within one calendar day of discharge to the jail. ***Dispute Process*** 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, then 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. 2. The hospital social work director 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 five calendar days of receipt of the CSB's written disagreement. 3. If the disagreement remains unresolved, the state hospital social work director shall initiate a request in writing to the assistant commissioner for behavioral health (or designee) for resolution within three calendar days of the meeting outlined in step 1.	

Joint Responsibility of the State Hospital & CSB		
	4. The assistant commissioner for behavioral health (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 assistant commissioner for behavioral health (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. 5. During the dispute process outlined above, the CSB shall formulate a discharge plan that can be implemented within 21 calendar days of the CSB's receipt of the discharge readiness letter. 6. Should the assistant commissioner for behavioral health (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.	
3.5	State hospital staff shall collaborate with CSB staff as needed in finalizing the discharge plan. ***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 and/or initiate the referral process.	
	State Hospital Responsibilities	**CSB Responsibilities**
3.6		In the event the CSB experiences extraordinary barriers and is unable to complete the discharge within 30 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 30 days of notification. The note shall describe the barriers to discharge and the specific steps being taken by the CSB to address the barriers.
Joint Responsibility of the State Hospital & CSB		
3.7	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 note at least monthly. 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 assistant commissioner for behavioral health (or designee) shall monitor the progress of those individuals with extraordinary barriers to discharge.	

IV. 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 facility social worker shall notify the CSB of the date and type of entitlement application that is submitted.	
	State Hospital Responsibilities	**CSB Responsibilities**
4.2	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, AR and/or legal guardian 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. **NOTE:** Individual review of the discharge information and instruction form may not be applicable for certain forensic admissions due to their legal status.	To reduce re-admissions to state hospitals, CSBs, in conjunction with the treatment team, shall develop and complete, as clinically determined, a safety and support plan as part of the individual's final discharge plan. **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. **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.
4.3	The state hospital medical director shall be responsible for ensuring that the 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		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.

	State Hospital Responsibilities	CSB Responsibilities
		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.
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, primary therapist, or other designated clinical staff shall schedule to the greatest extent practicable individuals discharged from a state hospital with continuing psychotropic medications needs to be seen by the CSB psychiatrist within seven calendar days of discharge, or sooner if the individual's condition warrants.

V. TRANSFER OF CASE MANAGEMENT CSB RESPONSIBILITIES

	State Hospital Responsibilities	CSB Responsibilities
5.1	The hospital social worker shall indicate in the progress notes any intention that is clearly expressed by the individual and the authorized representative to change or transfer case management CSB responsibilities and the reason(s) for doing so. This shall be documented in the individual's medical record and communicated to the case management CSB. **EXCEPTION**: This process may be accelerated for discharges that require rapid response to obtain admission to the community placement e.g., nursing care facilities.	Transfers shall occur when the individual receiving services or his authorized representative decides to relocate to another CSB service area. If the individual or his authorized representative decides to relocate, the case management CSB shall notify the CSB affected by the potential placement. The case management CSB must complete and forward a copy of the out of catchment referral form to the receiving CSB. ***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**.**

	State Hospital Responsibilities	CSB Responsibilities
5.2		Exceptions to the above shall be granted when the CSB, individual served, and his authorized representative agrees to keep services at the case management CSB while living in a different service area.
5.3		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. The case management CSB shall maintain census responsibility for no less than 30 calendar days after the individual's discharge. The CSB accepting responsibility for services also must agree with the discharge plan and be actively involved in the development of 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. 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.
5.4		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 assistant commissioner for behavioral health (or designee). The case management CSB shall initiate this contact.

VI. SHELTER AND TEMPORARY PLACEMENTS

	State Hospital Responsibilities	CSB Responsibilities
6.1	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, 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.	For individuals with a primary diagnosis of mental illness or co-occurring diagnosis of mental illness and intellectual disability, discharge to a shelter shall be part of the individual's discharge plan if it is clinically recommended, and the individual has expressed a preference for shelter placement.
6.2	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. The hospital social worker is to provide both CSBs with notification as directed in 5.1. The hospital social worker is to provide both CSBs with notification as directed in 5.1.	Both the case management CSB and the CSB accepting responsibility for providing case management services shall follow the same procedures as outlined in Section V for out of catchment placements.