



Report to the Legislature

**State Hospital Ward Sizes, Discharge Practices, and Community  
Placement Issues**

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# **State Hospital Ward Sizes, Discharge Practices, and Community Placement Issues**

## **Legislative Report**

### **1. Introduction**

During the past several years there has been significant attention and concern expressed by the Governor, the State Legislature, the Department of Social and Health Services (DSHS) and advocates in regard to staff and patient safety in Washington's state hospitals as well as the capacity of the community system to meet the complex needs of individuals with severe mental health issues as indicated by excessive lengths of stay and differential discharge planning practices.

The Governor prioritized staff and patient safety through the performance monitoring and improvement aspects of the GMAP process by requiring that staff injuries and seclusion and restraint data be presented and addressed during 2007/2008. DSHS/HRSA completed a comprehensive analysis in 2007 of direct care staffing resources at Western State Hospital (WSH) and Eastern State Hospital (ESH) based on a comparative "best practices" model implemented in another state in response to a Federal lawsuit.

In 2008 the Legislature expressed significant interest by instructing DSHS to report back on optimal recommendations as follows:

- (i) Ward sizes at Eastern and Western State Hospitals and patient case mix by ward;*
- (ii) Discharge practices for state hospitals to include the Child Study and Treatment Center and;*
- (iii) Community placements to include placements for adults and children.*

The Legislature directed the Department to engage a nationally known expert as well as include representatives from the Regional Support Networks (RSNs) in the review and development of recommendations for discharge practices and community placements.

In July and August of 2008, Health & Recovery Services Administration (HRSA)/Mental Health Division (MHD) organized meetings with administrative and clinical leadership of the state hospitals and representatives of the Regional Support Networks. The meetings were facilitated by Dr. Jeffrey Geller. Dr. Geller is a national psychiatric expert in the subject of active psychiatric treatment and the civil rights of persons receiving treatment in state psychiatric hospitals and related facilities. This report utilizes information gathered during these meetings. In addition, the report utilizes information collected through other recent studies completed in the past several years in the areas of residential capacity, housing, and utilization management.

This report represents one important aspect of the comprehensive long-range planning that DSHS/HRSA is engaged in for Washington's state psychiatric hospitals. Strategic long range planning and known psychiatric best practice asks the question of the appropriate bed size for a state psychiatric hospital as well as geographic access as population trends change over time.

It would appear that the size and scope of Western State Hospital civil beds should be considered for long-term planning recommendations specific to decentralization and geographic redistribution.

Additionally, the expert recommendations made by this report regarding “community placements” are priority goals of DSHS/HRSA in regard to standardized discharge planning practices and reducing excessive lengths of stay for patients deemed clinically ready for discharge. DSHS/HRSA intends to engage in a partnership dialogue within the RSN contract negotiations process over the next two years as resources permit.

Another related aspect of strategic systems planning is the alignment of the evidenced based clinical practices provided in the state psychiatric hospitals with community clinical, support, and peer services based on the provisions of Washington’s “mental health waiver” and state only funds in unison with the individual’s acuity and treatment and recovery plan. DSHS/HRSA envisions a public partnership dialogue that will encompass all stakeholders for the purpose of improving the relationship between and among the state psychiatric facilities, the community outpatient delivery system, RSNs, providers, allied systems and partners, consumers, families, and advocacy groups.

## **2. Ward Sizes and Patient Case Mix:**

During 2007, the MHD and the state psychiatric hospitals completed a comprehensive study of direct care staffing requirements. Neither the Center for Medicaid and Medicare Services certification process nor the Joint Commission accreditation process has specific and identified staffing requirements for state psychiatric hospitals serving adults and children. Both processes do identify operational and safety requirements in order to obtain and sustain certification and accreditation. These requirements impact staffing levels and qualifications.

The August 2007 comprehensive Direct Care Staffing Review and Recommendations Report of MHD was based on the state hospital ward staffing model achieved by a state in 1999 as a successful response to a Department of Justice lawsuit. This model became known as the “Virginia model” and has been used as a baseline by other states since that time based on the fact that the Federal Court involved with the Virginia case accepted the specifics of the staffing model as a standard.

The workgroup facilitated by Dr. Geller in 2008 recommended further development of the assumptions of the Virginia model to address operational factors not previously considered. A key concept toward the newly evolving staffing paradigm is to address patient acuity, which is typically higher on admission wards, by establishing treatment team ward staffing based on variables related to admissions, discharges, and the number of transfers in and out of the ward on a weekly basis.

<b>Recommendation</b>
#1: Move toward adoption of standards for staffing all wards and populations which addresses acuity by looking at ward census and patient flow. Key principles of the proposed model include: <ul style="list-style-type: none"><li>a. Standard ward size for all populations not to exceed 24 patients per ward.</li><li>b. Staffing and caseload are adjusted by patient flow issues providing greater staffing for wards with high levels of admissions.</li></ul>

Details on the assumptions of the model are included in Appendix 1 which is the full report from Dr. Geller. Further development of this approach will require a detailed analysis of current state hospital staffing and ward census patterns against the proposed staffing model to assess the financial impacts. It should be noted that the model which calls for a minimum of 24 patients per ward will not only have expected additional costs but will also result in less total capacity as currently wards average approximately 30 patients. A cost benefit analysis was not conducted for this report at this time as there are strategic questions in regard to the number of total beds needed in Washington now and in the future, the future geographic distribution of state psychiatric hospital capacity, and the known demands on the state budget at this time. Clearly a cost/benefit analysis as well as cost offset assessments should be a fundamental part of strategic long term planning.

### **3. Discharge Practices and Planning**

During 2007 and 2008, the MHD and the state psychiatric hospitals placed a higher priority on timely discharges for patients deemed “ready for discharge” by their treatment teams. A study on Inpatient Psychiatric Utilization Management practices in 2007 identified a lack of consistency and standardization in RSN and state hospital practices, lack of adequate information for effective utilization management processes, and barriers to timely state hospital discharges. The Executive Summary of this report is attached as Appendix 2.

A review of recent data from the state hospitals highlights the challenges resulting from the variable practices:

1. The length of stay at Washington’s state hospitals is high and there is significant variation between WSH and ESH.
  - a. 47% of the civil patients at WSH have been in residence for over 1 year in contrast to 21% at ESH.
  - b. Over 11 civil state hospital wards are being used for individuals who have been in residence longer than 1 year.
  - c. Both facilities have high percentages of older adults in residence over 1 year (WSH = 52% / ESH = 42%).
2. In FY 08, RSNs paid \$2.7 million in funds intended for community services to pay for patient days of care at the State Hospitals which exceeded bed allocations.
3. In FY 08, each civil bed at ESH served an average of 4 patients while each civil bed at WSH only served an average of 2 patients.
4. On any given day, there are approximately 150-170 people ready for discharge at Western State Hospital.

- a. Of these, approximately 120 are between the ages of 18-59 with grounds privileges that allow them to leave their unit unsupervised.
- b. The remainder includes a number of older adults in need of a specialized long term care setting that can accommodate behavioral issues.

The issue of patients who are ready for discharge remaining at the state hospitals is a factor of importance to the RSNs and community hospitals. RSNs are at risk of paying for patients in excess of their contracted allocations. In recent years, there have been many times where there was a “back-up” of patients committed under 90/180 day court orders to the state hospitals who remained in community hospital beds due to a lack of census capacity at the state hospitals. While there is currently no waiting list, this concern has been significant in the western region of the state where the wait list has at times exceeded 40 individuals on any given day. This issue may also be exacerbated again with upcoming ward closures scheduled for May and October of 2009.

<b>Recommendations:</b>
#2: Address the barriers for individuals who are “ready for discharge” but backed up at the state hospitals by adapting a standardized discharge case planning tool and protocols that are clear, straightforward, and efficient. Use of the tool and process should become a requirement of the state hospitals and a contractual requirement of the RSNs in 2010-2011. An example of protocols developed and implemented in the State of Virginia are included as Appendix 5.
#3: In accordance with the recommendation of the 2007 Utilization Management study, establish a statewide standardized utilization management protocol for both acute and extended inpatient admissions and continuing stays using a single utilization management vendor. This would include management of all community and state hospital utilization. Consider expansion to include standardized utilization management for other high cost limited resources such as intensive psychiatric residential treatment and crisis triage beds.
#4: Review the financial incentives/penalties related to state hospital utilization and realign the incentives/penalties structure from looking broadly at utilization to a more focused approach on areas with individuals who remain at the state hospitals long after being determined ready for discharge.

A standardized discharge planning approach would be implemented as a partnership approach among the consumer, state hospital treatment team, and the RSN’s discharge planning liaison. This approach would be based on a comprehensive assessment of the consumer’s needs, strengths, and preferences and the RSN’s community based plan to support a successful community placement. DSHS believes that immediate focused effort to address discharge barriers and improve utilization management would create enough capacity to significantly reduce or eliminate the state hospital waiting list for the next few years.

While the concepts of standardization have been discussed with RSNs and recommended by Dr. Geller and by the Utilization Management study, it is not clear that there will be consensus in moving forward to adopt standardized utilization management (UM) and discharge practice approaches. DSHS/HRSA intends to have a goal of standardized discharge planning practices included as a function of the RSN contracts during the next two years.

#### **4. Community Placements for Adults and Children.**

Gaps in adequate community placements for adults and children have been an ongoing challenge for the Washington Mental Health system. A study by the Public Consulting Group in 2004 highlighted the need for expansion of community evaluation and treatment capacity as well as other residential capacity, crisis diversion beds, and the need for Program of Assertive Community Treatment (PACT) teams. The study also specifically called out a need for enhanced resources for specialty populations such as individuals with dementia or traumatic brain injuries requiring long term care settings that could manage behavioral issues associated with these populations. One area of progress since the study was done is the implementation of 10 PACT teams throughout the state which came on line during fiscal year 2008.

In 2007, a Washington State Mental Health Housing Plan developed by Common Ground reiterated the importance of having a range of housing options including licensed residential facilities, community based housing with adequate service supports, and crisis respite beds. The plan also identified the importance of Permanent Supportive Housing (PSH) as part of the continuum and identified the unique funding needs (e.g. rent subsidies, landlord incentives) for these programs which cannot be paid for with traditional service dollars. The executive summary for the Mental Health Housing Plan is attached as Appendix 4.

A complicating factor in Washington is the significant shortage of community psychiatric inpatient beds. A review of data from the American Hospital Association Annual Survey Database & US Census Data shows that Washington lags behind other states in the number of community hospital psychiatric inpatient beds per 100,000 population:

- Washington ranked 51st of all the states and the District of Columbia
- Washington's per capita average was 66% below the national average

This issue impacts families in need of acute treatment throughout the state and is exacerbated when it comes to specialized resources for children. Currently families with children in need of a placement in one of Washington's limited CLIP beds are faced with waiting times averaging up to 100 days. As noted above, maximizing the extremely limited resources in Washington for acute psychiatric care requires developing adequate capacity and service levels in the community to ensure timely placement when individuals are ready for discharge from the most intensive resources.

<b>Recommendations:</b>
#5: Directly support the development of additional Permanent Supportive Housing units by exploring options for securing rent subsidies, operating subsidies (e.g. landlord incentives, risk mitigation funds), and determining whether additional funding for PSH case management and crisis services can be met through current RSN allocations.
#6: Support the DSHS Aging and Disability Services Administration plan for increasing the capacity of the geriatric Expanded Community Services (ECS) program to serve state hospital

patients requiring enhanced behavioral support services in long term care settings.

#7: Continue statewide implementation of Fidelity Based PACT teams and consider adapting the model to address specialized state hospital populations (e.g. personality disorders.)

#8: Continue to monitor and explore options for promoting expansion, or at minimum maintaining capacity, of services which can manage individuals with acute behavioral issues in community settings including Evaluation and Treatment Centers, Crisis Triage Centers, and Children's Long Term Inpatient programs.

### **5. Expected System Impacts:**

While a formal cost analysis has not been conducted, it is clear that there will be additional costs to implement the recommendations noted above. The expected potential benefits of these approaches include:

- Reduction in the need for future increases to the number of state hospital beds
- Reduction to state hospital staff and patient injuries
- Reduction in the use of seclusion and restraints at the state hospitals
- Increase in active treatment and discharge planning resulting in shorter average lengths of stay and increased turnover/utilization of beds for individuals with acute mental health needs
- Improvements in timely access to high cost and scarce involuntary treatment beds
- Improvements in intensity of community support services resulting in reduced criminal justice involvement with acute mental health consumers
- Improvements to consumer recovery by shortening psychiatric hospital stays and providing community service levels which will reduce recidivism

**Appendix 1**

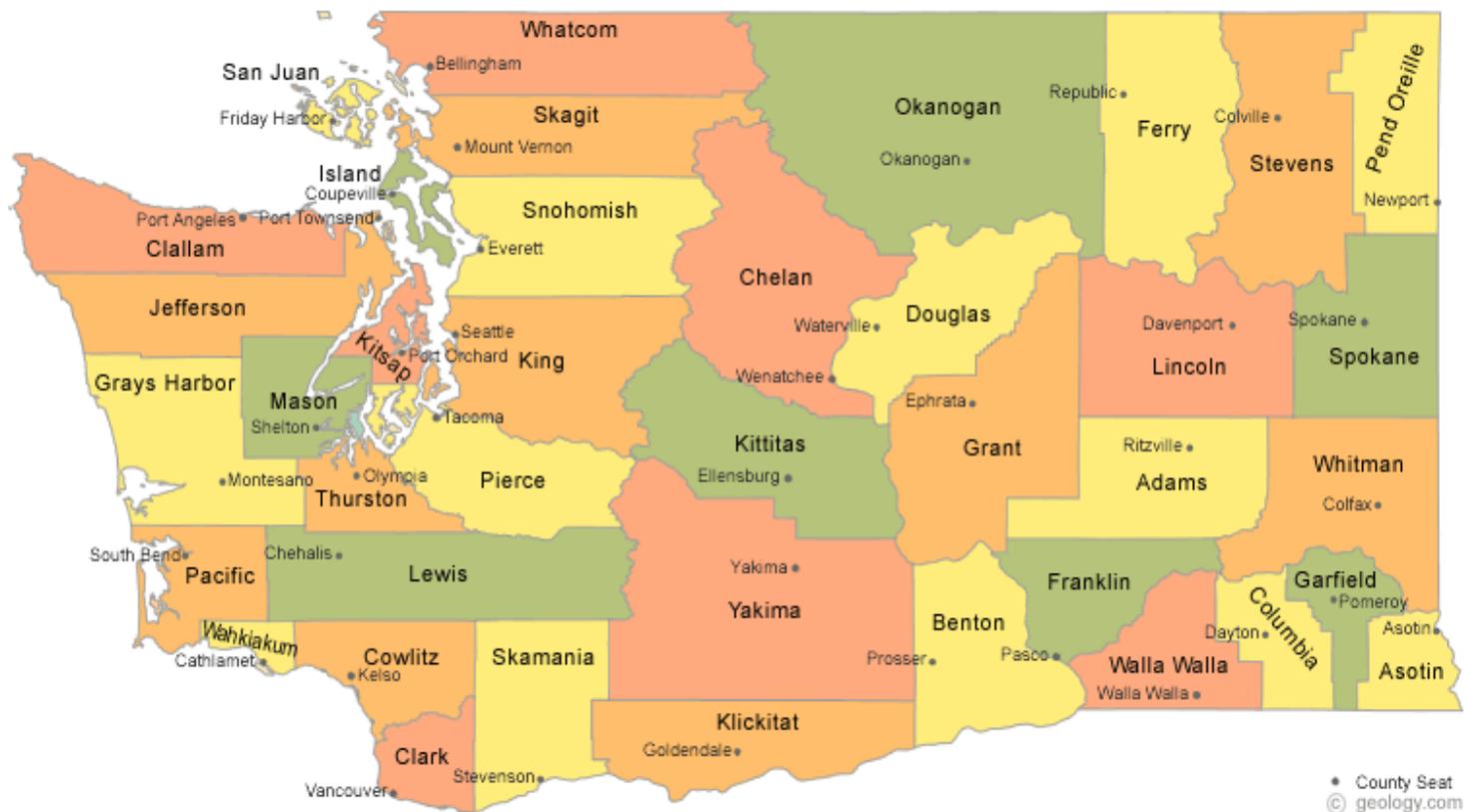
**Washington State's Psychiatric Hospital and Community Services:  
An Evaluation of Staffing, Operations and Interfaces**

**Dr. Jeffrey Geller**

**December 2008**

WASHINGTON STATE'S PSYCHIATRIC HOSPITAL  
AND COMMUNITY SERVICES: AN EVALUATION  
OF STAFFING, OPERATIONS AND INTERFACES

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## EXECUTIVE SUMMARY

On August 11, 2008 a meeting was held of representatives from Western State Hospital, Eastern State Hospital, Child Study and Treatment Center and Central Office to address ward staffing issues and state hospital bed capacity. On August 12, 2008, a meeting was held with the above personnel and representatives of the Spokane RSN, the Kings County RSN, and community providers to address community placements and state hospital discharge practices. This report is an outcome of these meetings.

### WARD STAFFING

Based on a set of 10 assumptions: 1) absolute cap of 24 patients/ward; 2) no more than 2 Treatment Teams/ward; 3) a Treatment Team can cover 2 wards at a factor of 1.2; 4) “forensic” work is: competency to stand trial evaluation, criminal responsibility evaluation, and “Flips”; 5) admission function staffed by a dedicated psychiatrist, nurse and social worker; 6) psychiatrist partners with a medical physician; 7) a psychiatrist’s absences are covered by a psychiatrist who does not cover another team full-time, i.e., is not “cross coverage”; 8) psychiatry or social work vacancies are not covered by existing staff who already have full-time caseloads; 9) forensic evaluations are not done by ward-based Treatment Team staff; and 10) the “Core Treatment Team” is composed of the patient, psychiatrist, nurse and social worker.

**Psychiatrist’s** caseload calculated as follows:

$$\text{Caseload} = 24 \text{ patients} - \frac{(\text{Admissions} \times 1.4)}{\text{week}} - \frac{(\text{Transfers in})}{\text{week}} + \frac{(\text{Transfers out} \times 0.6)}{\text{week}} - (\text{ADC below 18 years old} \times 0.3)$$

**Social Work’s** caseload calculated using the same formula.

**Nursing** staff requirements calculated using Hours Per Patient Day (HPPD) and the Percentage RN.

The Formula for HPPD is: 
$$\text{HPPD} = \frac{\text{Total nursing staff} \times 8 \text{ hours}}{\text{Ward Census}}$$

Conversion factor of 1.8 to determine the number of staff necessary to fill one FTE 7 days per week, 365 days per year.

Required HPPD at Washington state hospitals is:

<u>Ward Type</u>	<u>HPPD</u>
Adult wards	6.0
Child wards	9.0

Required percentage of that staff that must be RN’s is:

<u>Ward Type</u>	<u>Percentage RN’s</u>
Adult wards	35%
Adolescent wards	25%
Child wards	20%

Required minimum ratio of direct care staff is:

<u>Ward Type</u>	<u>Minimum Ratio</u> (1 <sup>st</sup> & 2 <sup>nd</sup> shift)	<u>Minimum Ratio</u> (3 <sup>rd</sup> shift)
Adult ward-acute	1:5	1:5
Adult ward-intermediate/ long-term	1:5	1:6
Adolescent ward	1:4	1:4
Child ward	1:4	1:4

**Medical Physician's** caseload is calculated as follows:

$$\text{Caseload} = 48 \text{ patients} - \frac{(\text{Admissions} \times 1.4)}{\text{week}} - \frac{(\text{Transfers in})}{\text{week}} + \frac{(\text{Transfers out} \times 0.6)}{\text{week}} - (\text{ADC who are functional geropsychiatry} \times 0.3)$$

**Psychologists** are not assigned to Treatment Teams. Psychologists perform consultations.

**Rehabilitation Staff** are 6 per 24-bed unit.

## STATE HOSPITAL BED CAPACITY

Washington State cannot close any WSH or ESH beds at this time. The recommended total number of civil beds for Washington State is 869 beds (647 WSH beds, 222 ESH beds).

## STATE HOSPITAL DISCHARGE PRACTICES

State hospital discharges are fundamentally affected by state hospital admission practices and commitment processes. Currently, RSN's feel: they have no impact on length of stay (LOS); there are probably more patients than clinically/medically/legally necessary going from 72-hour to 14-day commitment; almost assuredly more patients than clinically/medically/legally necessary are going from 14-day to 90-day commitment; and RSN's are paying more for state hospital (SH bed) days than they would with a tighter system of oversight and their active participation in discharge planning.

Consider system improvement through:

- RSN has 24-hour availability itself or by contract.
- Difficult to manage/recidivist patients have crisis plans.
- DMHP evaluation has requirements for consultation with RSN 24 hr/day and authorization for 72-hour payment not 20 days.
- All psychiatric hospitals notify RSN within 24-hours of admission of every admission from RSN.
- RSN participates in discharge planning and decision to petition for 14-days.
- Payment for 72-hours – 14-days based on RSN determination of medical necessity.
- RSN participates in deciding on petition for 90-day commitment.
- RSN participates in decision to petition for 180-day commitment.
- Any patient who hits 180 days is placed on long-term inpatient list (LTIL).
- All patients on LTIL are reviewed by State Hospital Readiness for Discharge Committee on a scheduled basis.

Resources to accomplish this include:

- ESH RSN's may need 1-2 Case Manager Liaison positions to be present at ESH .
- WSH needs to designate a person to provide the admission information to RSN's 7 days/week.
- RSN's need to have capacity to responds to DMHP's, community hospitals, state hospital's 24 hrs/day, 7-days per week.
- Education sessions for Judges.

Discharge practices themselves require major modifications. The process must move from its current state of being an adversarial process to one that is a true partnership. Consider use of the *Needs Upon Discharge* and the *Discharge Plan* processes. The state hospital treatment team is responsible to develop the needs upon discharge; the RSN is responsible to provide the method/means by which the RSN will meet each need.

The RSN can request the discharge of any of the RSN's inpatients at the state hospital at anytime the RSN believes it can safely serve the patient out of the state hospital.

## **COMMUNITY PLACEMENTS**

There are many indicators that Washington's current community-based bed capacity is insufficient to meet Washington State's needs.

The need for supervised beds in the community can be lowered by:

- Improved acute treatment of new or recent cases.
- Improved treatment and rehabilitation in the hospital of long term cases.
- Improved Utilization Management (UM) of persons in staffed residences.
- Readily accessible, affordable housing for persons who can live in their own dwellings.

### ***Future Directions***

System improvements:

- Step-down capacity in all RSN's.
- Effective community-based UM of all residential beds.
- Fully functioning PACT teams, i.e., at capacity and effective.
- Targeted discharge and community tenure efforts for specifically identified populations.
- Community education to deal with stigma.
- Clarification and management of permanent placements and of transitioned placements.
- Funding for development of target residential beds, i.e., for specific needs, rather than "general" residential beds.

## WASHINGTON STATE'S PSYCHIATRIC HOSPITAL AND COMMUNITY SERVICES: AN EVALUATION OF STAFFING, OPERATIONS AND INTERFACES

On August 11, 2008 I facilitated a meeting of representatives from Western State Hospital, Eastern State Hospital, Child Study and Treatment Center and Central Office to address ward staffing issues and state hospital bed capacity. On August 12, 2008 I facilitated a meeting of the above personnel and representatives of the Spokane RSN, the King County RSN, and community providers to address what's needed in the way of community placements and state hospital discharge practices. What follows are the results of these meetings.

### **WARD STAFFING**

The examination of ward staffing at Washington State's three state hospitals is based on a set of 10 assumptions<sup>1</sup>:

1. Absolute cap of 24 patients/ward (based on nursing staff expert opinion).
2. No more than 2 Treatment Teams/Ward.
3. A Treatment Team can cover 2 wards at a factor of 1.2.
4. "Forensic" work is:
  - Competency to stand trial evaluation
  - Criminal Responsibility evaluation
  - "Flips"
5. Admission office or admission function is staffed by a dedicated psychiatrist, nurse and social worker.
6. Psychiatrist partners with a medical physician.
7. A psychiatrist's time off, sick time, or other absences are covered by a psychiatrist who does not cover another team full-time, i.e., coverage is not arranged through "cross coverage".
8. Psychiatry or social work vacancies are not covered by existing staff that already have full-time caseloads. Need to use outside sources: contracts, locum tenens, fee-for-service, etc.

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<sup>1</sup> These assumptions are derived from my own work over the past three decades which has included employment at state hospitals from ward psychiatrist to medical director; work as a consultant to U.S. Department of Justice and states (state mental health authority and state attorneys general) which has taken me to 26 states and territories and to approximately 75 state hospitals; work at community mental health centers providing direct care to patients; overseeing an entire system of public mental health services as a DMH Area Medical Director; provision of education and training to residents, state hospital staff, peers; service on relevant Boards; research and publication; and interactions with colleagues in all disciplines.

9. Forensic evaluations are done by a Forensic Team not by Ward-based Treatment Team staff.
10. The “Core Treatment Team” is composed of the patient, psychiatrist, nurse and social worker.

### ***Psychiatrists***

The caseload for a psychiatrist at any Washington state hospital is calculated as follows:

$$\text{Caseload} = 24 \text{ patients} - \frac{(\text{Admissions} \times 1.4)}{\text{week}} - \frac{(\text{Transfers in})}{\text{week}} + \frac{(\text{Transfers out} \times 0.6)}{\text{week}} - (\text{ADC below 18 years old} \times 0.3)$$

This formula takes into account the various factors that affect the psychiatrist’s actual workload.

### ***Social Work***

The caseload for a social worker at any Washington state hospital is calculated using the formula above.

### ***Nursing***

Consistent with 1) the methodology first developed by the USDOJ expert in the Hawaii State Hospital Civil Rights of Institutionalized Persons Act (CRIPA) case and then used in the Virginia CRIPA cases, and 2) Washington State’s DHHS report of August 17, 2007, calculating direct care nursing staff requirements uses two formulas: Hours Per Patient Day (HPPD) and the Percentage RN.

HPPD is a numerical tool used to indicate nursing resources required to provide a minimum average of nursing care hours per patient. HPPD is calculated with the following factors:

- The number of direct care nursing staff required on a ward or unit in a 24/7 setting
- 8 hours worked per day by one nursing staff
- Ward census

The formula for HPPD is: 
$$\text{HPPD} = \frac{\text{Total nursing staff} \times 8 \text{ hours}}{\text{Ward Census}}$$

Since a nursing staff works 40 hours, but an 8-hour shift for 7 days is 56 hours, and a nurse uses vacation, personal and sick time (there’s regional variation in this usage), we need a conversion factor of 1.8 in Washington State to determine the number of staff necessary to fill one FTE 7 days per week, 365 days per year.

Required direct care nursing staff is calculated with the following factors:

- 1.8 coverage factor
- The average number of patients by ward type
- The minimum HPPD
- 8 hours worked per day by one nursing staff

The resulting formula for required direct care nursing staff is:

$$\text{Required Staffing} = \frac{1.8 \text{ coverage factor} \times \text{Avg. \# pts. per ward type} \times \text{HPPD}}{8 \text{ hours}}$$

The consensus of participants on August 11, 2008 for the HPPD at Washington state hospitals is:

<u>Ward Type</u>	<u>HPPD</u>
Adult wards	6.0
Child wards	9.0

Once the required number of staff is determined for a ward, there is a second requirement for the percentage of that staff that must be Registered Nurses (RN). The consensus of participants on August 11, 2008 for Washington state hospitals is:

<u>Ward Type</u>	<u>Percentage RN's</u>
Adult wards	35%
Adolescent wards	25%
Child wards	20%

Further, there is a minimum ratio of direct care staff (defined as Mental Health Technicians MHT) + Licensed Practical Nurses (LPN) that must be assigned to the ward and present at work at all times. These minimums are per consensus of participants.

<u>Ward Type</u>	<u>Minimum Ratio (1<sup>st</sup> &amp; 2<sup>nd</sup> shift)</u>	<u>Minimum Ratio (3<sup>rd</sup> shift)</u>
Adult ward-acute	1:5	1:5
Adult ward-intermediate/ long-term	1:5	1:6
Adolescent ward	1:4	1:4
Child ward	1:4	1:4

In these calculations, one always rounds up to the whole person.

Whether the first 1:1 staffing (“specials”) can come out of existing ward staff, or must be an added staff person is dependent upon whether or not the ward can maintain its minimum ratio with one staff and one patient removed from the ratio. If yes, then the 1:1 can come from the assigned staff already on the ward; if not, a staff must be added to the coverage for the first 1:1.

Finally, in consideration of the needs for nursing staff, there was consensus of the participants on August 11, 2008 that Washington state hospitals should use the RN Manager Model and not the Program Manager Model.

### ***Medical Physician***

The caseload for a medical physician at any Washington state hospital is calculated as follows:

$$\text{Caseload} = 48 \text{ patients} - \frac{(\text{Admissions} \times 1.4)}{\text{week}} - \frac{(\text{Transfers in})}{\text{week}} + \frac{(\text{Transfers out} \times 0.6)}{\text{week}} - (\text{ADC who are functional geropsychiatry} \times 0.3)$$

This formula takes into account the various factors that affect the medical physician's actual workload.

### ***Psychology***

Psychologists are not assigned to Treatment Teams. Psychologists perform consultation functions to Treatment Teams, including 1) Behavioral and 2) Neuropsychology. Psychologists perform forensic evaluations, conduct group therapy, and provide 1:1 psychotherapy. Psychologists are not assigned to tasks that do not require an advanced clinical degree, e.g., Program Manager. The number of psychologists should be calculated such that no less than 50% of a psychologist's work time is in direct patient evaluation and treatment.

### ***Rehabilitation Staff***

This category includes occupational, vocational, recreational staffs including OT staff, Voc staff, Rehab staff, Music Therapist, Drama Therapist, Teacher, Recreational/Activities Therapist, etc.

Calculating 10 patients per group and 4 groups per day, 5 days per week, with Rehab staff each leading 4 groups per day, there should be 6 Rehabilitation staff per 24 beds. Some of this time should be on weekends and holidays.

Rehabilitation staff are assigned to Treatment Teams as liaisons between the core Treatment Team and the Psychosocial Rehabilitation (PSR) Mall.

### ***Other Considerations***

- ❖ This model takes into account acuity.
- ❖ This model holds true no matter what the nature of the population on the ward, e.g., admission/acute, intermediate, long-term, geriatric, forensic, child/adolescent.
- ❖ This model allows for consistency across all Washington State public psychiatric hospitals.
- ❖ This model holds true independent of the program model at the hospital (although the Treatment Mall Model is highly recommended).

## Staffing Matrix

Using the principles outlined in this report, the following table is provided to show the required staff for a 24-bed unit.

General Staffing of a 24-bed unit<sup>2 3</sup>

Discipline	Acute Unit Staff on-site	Intermediate/Long-Term Unit Staff on-site
Psychiatrist	2	1
Psychologist <sup>4</sup>	1	0.5
Social Worker	2	1
Nursing		
First Shift		
RN <sup>5</sup>	3	2
LPN	1	1
MHT <sup>6</sup>	5	4
Second Shift		
RN	2	2
LPN	1	0
MHT	6	5
Third Shift		
RN	1	1
LPN	0	0
MHT	5	4
Rehab <sup>7</sup>	6	6
Medical Physician	1	0.5

<sup>2</sup> These numbers are modified based on formulas provided in this report.

<sup>3</sup> Nursing staff numbers need to be multiplied by 1.8 to determine the number of employees for 24 hour, 7-day week coverage.

<sup>4</sup> Allotted to 24-bed unit for this model, but would function as a central consult service.

<sup>5</sup> One RN on first shift is charge nurse and is not counted in HPPD.

<sup>6</sup> First 1:1 coverage can come from direct care staff (MHT's + LPN's) as long as direct care staff to patient ratio remains at or above minimum, and the HPPD remains at or above minimum. If not, an additional staff is required.

<sup>7</sup> Assigned to 24-bed unit for this matrix, but would function centrally through Treatment Mall and be liaisons between Treatment Team and Mall Staff.

## **STATE HOSPITAL BED CAPACITY**

WSH had 677 civil beds

ESH has 222 civil beds

TOTAL 899 civil beds

WSH closed 30 civil beds

WSH now has 647 civil beds

ESH has 222 civil beds

TOTAL 869 civil beds

State has plans to reduce WSH census to 587 civil patients (10/1/09)

State has plans to reduce ESH census to 192 civil patients (1/1/09)

It was the unanimous conclusion of the participants on August 12, 2008 that Washington State cannot close any WSH or ESH beds at this time. The recommended total number of civil beds for Washington State is 869 beds (647 WSH beds, 222 ESH beds).

This number of civil beds plus the number of forensic beds places Washington State in the beds per 100,000 population range of 12-19 with other states such as IL, MA, NC and PA. Further, Washington State would have fewer beds per 100,000 population than about 20 states, including CT, MD, NJ, NY and VA.

## STATE HOSPITAL DISCHARGE PRACTICES

### *Admissions and Commitments*

State hospital discharges are fundamentally affected by state hospital admission practices and commitment processes. The following describes current practices and suggested modifications to these practices.

- *Current Practices*

#### Process

- 72-hour authorization involuntary treatment act (ITA) carries with it 20-day authorization for payment
- RSN representative most often not present at any meeting to decide on petition for 14-day commitment.
- RSN representation virtually never present at any meeting to decide on petition for 90-day commitment.
- RSN doing no active UM between commitment points.

#### Outcomes

- RSN's feel they have no impact on LOS.
  - Probably more patients than clinically/medically/legally necessary going from 72-hour to 14-day commitment.
  - Almost assuredly more patients than clinically/medically/legally necessary going from 14-day to 90-day commitment.
  - RSN's paying more for SH bed days than they would with a tighter system of oversight and active participation in discharge planning for inpatient treatment.
  - Unnecessary tension between RSN's and SH's. This should be a partnership.
- *Future Actions*

#### Civil Commitment

- ❖ *Community*
  - RSN has 24-hour availability itself or by contract.
  - Difficult to manage/recidivist patients have crisis plans accessible to RSN, DMH, SH, hospital ER
  - DMHP evaluation
    - Requirements for consultation with RSN 24 hr/day
    - Authorization for 72-hour payment not 20 days
- ❖ *72-hour*
  - Psychiatric hospital (community or state hospital) notifies RSN within 24-hours of admission of every admission from RSN

- RSN has representative at the table to do discharge planning and participate in decision to petition for 14-days
- Payment for 72-hours – 14-days based on RSN determination of medical necessity
- Hospital does initial treatment plan (ITP)
- ❖ 14-day
  - Hospital develops master treatment plan (MTP)
  - MTP includes discharge plan
  - MTP states expected discharge date with rationale
  - RSN has representative at team meeting to participate in deciding on petition for 90-day commitment
- ❖ 90-day
  - Hospital has done reviews of MTP, i.e., treatment plan reviews (TPR)
  - RSN has representative at TPR not less than monthly
  - RSN participates in decision to petition for 180-day commitment
  - Modification of anticipated discharge date as necessary
- ❖ 180-day
  - Any patient who hits 180 days is placed on long-term inpatient list (LTIL)
  - All patients on LTIL are reviewed by SH Readiness for Discharge Committee (a centralized function for entire hospital) on a scheduled basis
  - Treatment Teams continue to do TPR's
  - RSN continues to be present at TPR's no less than monthly

#### Ancillary Actions

Review, and modify 20-day payment authorization as necessary to achieve above.  
May require statutory change?

#### Possible Resources

ESH RSN's may need 1-2 Case Manager Liaison positions to be present at ESH (community positions, not hospital positions)

WSH needs to designate a person to provide the admission information to RSN's 7 days/week

RSN's need to have capacity to respond to DMHP's, community hospitals, & state hospital's 24 hrs/day, 7-days per week.

Education sessions for Judges

#### ***Discharge Practices***

Discharge practices themselves require major modifications. The process must move from its current state of being an adversarial process to one that is a true partnership.

To this end, I suggest Washington State consider a discharge practice model developed by Virginia and its expert consultants in response to the USDOJ CRIPA lawsuit. In this model the

discharge process is considered to have two distinct components: the *Needs Upon Discharge* and the *Discharge Plan*. The state hospital treatment team is responsible to develop the needs upon discharge; the RSN is responsible to provide the methods/means by which the RSN will meet each need.

The needs and plan are each divided into categories:

- Psychiatric/Therapeutic
- Substance Abuse
- Medical
- Medication
- Housing
- Daily Living
- Financial
- Legal
- Supervision
- Transition
- Crisis
- Other

Note that each of these is evaluated separately. Supervision requirements are considered in light of all other factors.

Practically, this is done by the state hospital treatment team completing all sections of the Needs Upon Discharge form. This form is emailed or faxed to the RSN or designated agency. The RSN/agency has a specified time, e.g., 3 business days to return the completed and signed Discharge Plan to the Treatment Team Social Worker for inclusion into the patient's state hospital medical record.

Any component can be modified on the Update form as the patient's needs change or the available resources change.

The RSN or designee should be able to request the discharge of any of the RSN's inpatients at the state hospital at anytime the RSN believes it can safely serve the patient out of the state hospital. If the attending psychiatrist disagrees and is unwilling to discharge the patient (this is certainly a psychiatrist performing well within the standard of care) then the hospital Medical Director or designee should review the case and offer a second opinion. If that opinion supports discharge, the Medical Director must sign the discharge order if the attending psychiatrist remains unwilling to do so.

## COMMUNITY PLACEMENTS

### *Current Situation*

There are many indicators that Washington's current community-based bed capacity is insufficient to meet Washington State's needs:

- WSH and ESH have significant numbers of patients ready for discharge that are unable to leave simply because "there's no place for them to go."
- Washington State closed 150 beds, then had to open 150 beds and can only close 30 beds now.
- Only Chelan, Douglas, King and Pierce Counties offer step-down or community re-entry beds as part of their crisis services.
- PACT remains in its early phase-in period. There are 2 PACT teams state-wide, each with capacity of 90 persons. SE currently has 62 assigned clients with 45 enrolled; DESC has 69 assigned with 49 enrolled. In both programs, housing has been deemed a significant barrier.
- Outreach and stabilization services in individuals' homes or in other appropriate places in the community are not occurring uniformly.
- Transitioning out of staffed community residences to independent living is not occurring with reasonable frequency. For the 13 months June 2007 through June 2008, 54 individuals in the Spokane County Regional Support Network moved to independent living. Of these, 27 (50%) came from one ARTF (Sunshine). Leaving Sunshine ARTF aside, there were only 2 discharges to independent living per residence in 13 months.
- Washington State is not enforcing federal Medicaid requirements when persons are "evicted" from a nursing home. Hence, seniors are "deposited" in community hospital ER's with no place to go.

### *How many beds?*

The number of beds can be expressed as an equation:

Residential Bed Need =

Current Unmet Need +  $\frac{\text{Incidence of new cases needing residential level of care (RLC)}}{\text{year}}$  +  
(point in time to fix capacity)

$\frac{\text{Incidence of exiting cases needing RLC}}{\text{year}}$  -  $\frac{\text{incidence of moves out of RLC}}{\text{year}}$  -

$\frac{\text{Deaths in RLC}}{\text{year}}$

The need for supervised beds can be lowered by:

- Improved acute treatment of new or recent cases.
- Improved treatment and rehabilitation in the hospital of long term cases.
- Improved utilization management of persons in staffed residences.
- Readily accessible, affordable housing for persons who can live in their own dwellings.

The bed needs will be raised by:

- Not doing the above.
- Better medical care resulting in lower annual death rate of mental health residential clients.

### *Future Directions*

The community-based system, as it is currently construed and operated, does not appear to be fundamentally meeting the goals of the legislatures and public as a result of:

- **Regional variability**  
From RSN to RSN and from west to east there is no consistent model that incorporates what an RSN shall provide across the continuum of residential service; how an RSN relates to the state hospital in terms of admissions and discharges; what the nature and degree of symptomatic mental illness is that is expected to be dealt with in the community; what services are provided for dually diagnosed individuals (Mental Illness/Substance Abuse, Mental Illness/Developmental Disabilities, and Mentally Ill/Medically Ill); and the broad array of crisis services.
- **Competing incentives and disincentives**  
There are clinical reasons for the use/nonuse of a state hospital, fiscal reasons, policy reasons, ideological reasons, and public safety reasons. In Washington State, these are more misaligned than in many states. For example, what is the fiscal disincentive for an RSN to direct its more difficult to manage patients to a state hospital and hold up their discharge?
- **Lack of accountability for discharges**  
Currently, there's neither central nor regional accountability for the number of discharges per year, the length of an RSN's "ready for discharge" list at the state hospital, an RSN's rate of repeated state hospital admissions in less than 30 days, linkage plans (services after discharge), or community providers actively participating in discharge planning.

Washington State needs to

- Create step-down capacity in all RSN's
- Develop an effective community-based UM of all residential beds
- Implement fully functioning PACT teams, i.e., at capacity and effective
- Target discharge and community tenure efforts for persons with
  - Axis II diagnosis and problematic behaviors
  - Firesetter/careless smoking
  - Cognitive impairment, e.g., Huntington's, TBI, Dementia
  - Sex offending behaviors
  - Criminal histories
  - Histories of noncompliant medically
  - Undocumented status
  - Geriatric status and problematic behaviors

- Provide community education to deal with stigma such as “NIMBY” (not in my back yard).
- Clarify those placements that are permanent and those that are transitional. Count and track each.
- Fund the development of target residential beds based on identified specific need. No “general” residential beds at this point.
- Develop and implement a system of clear accountability, measurable outcomes, and sound fiscal relationships.

## GLOSSARY

ADC:	Average daily census
Conversion Factor:	Number needed to calculate number of nurses necessary to have full-time coverage 24/7. For this report, conversion factor is 1.8.
CRIPA:	Civil Rights of Institutionalized Persons Act
Direct Care Staff:	MHT's + LPN's
FTE:	Full time equivalent
Functionally geropsychiatry:	Under age 65 with neurocognitive impairment requiring placement on a geriatric unit, e.g., dementia, traumatic brain injury, Huntington's disease
HPPD:	Hours per patient day. Refers to nursing staff requirements.
LPN:	Licensed Practical Nurse
LTIL:	Long Term Inpatient List
Mall:	Centralized PSR programming. Can be in one location or multiple locations and is not located in same space as the ward where the patients sleep.
MHT:	Mental Health Technician
PSR:	Psychosocial Rehabilitation
RLC:	Residential Level of Care
RN:	Registered Nurse
SH:	State hospital
Social Worker:	Person with a master's degree in social work, i.e., MSW
USDOJ:	United States Department of Justice

## **Appendix 2**

### **Washington Inpatient Utilization Management Project University of Washington at Harborview Medical Center**

#### **Executive Summary**

**July 2007**

# Washington Inpatient Utilization Management Project

## EXECUTIVE SUMMARY

As part of its Systems Transformation Initiative (STI), the Mental Health Division (MHD) contracted with University of Washington at Harborview Medical Center (HMC) to undertake a study of current utilization management (UM) practices in state and community hospitals that care for Medicaid and other state-funded consumers. For purposes of this study, UM is defined as the standards and procedures used to ensure appropriate use of publicly funded mental health resources statewide. This summary represents the key findings and recommendations of the study.

A key factor in recovery-oriented systems is that services are available to individuals that are oriented toward recovery. UM principles are based on a continuum of care being available to an individual. We articulate these principles in the report with the concept:

**“Giving the right service, in the right place, for the right amount of time.”**

### Utilization Management Tools

Four instruments were identified as potentially suitable to use as a standardized tool for determining medical necessity for hospital admission and continued length of stay review. They represent best practices in that they have known psychometric properties. This is not a comprehensive list, but rather an introduction to a limited number of commercial and public domain products available. Commercial products include InterQual<sup>1</sup> and Milliman Care Guidelines.<sup>2</sup> Public domain products include Level of Care Utilization System (LOCUS) (Adult Psychiatric and Addiction Services, 2000)<sup>3</sup> and Brief Medical Necessity Scale.<sup>4</sup>

### Review of Utilization Management in Washington State

The state MHD manages two state hospitals that provide inpatient psychiatric services for adults: Western State Hospital (WSH) and Eastern State Hospital (ESH). Additionally, the MHD manages the Child Study and Treatment Center (CSTC) for children who require inpatient level of care. MHD has a contractual relationship with 13 Regional Support Networks (RSNs) to manage community outpatient services as well as provide utilization oversight of the psychiatric beds in community hospitals. Key informants from each of these entities were interviewed or surveyed to provide information about current UM practices. In addition, descriptive data on patients currently served at state hospitals were compiled from databases maintained by the MHD through the Health and Recovery Services Administration (HRSA) of the state Department of Social and Health Services (DSHS).

1 A sample of their product may be viewed at the following website: <http://www.interqual.com>.

2 Milliman: <http://www.milliman.com>. Washington State Milliman Consultant: [vance.clipson@milliman.com](mailto:vance.clipson@milliman.com).

3 Sowers, W., George, C., & Thompson, K. (1999). Level of care utilization system for psychiatric and addiction services (LOCUS): A preliminary assessment of reliability and validity. *Community Ment Health J*, 35, 545-563. A sample of their product may be viewed at the following website: <http://www.comm.psych.pitt.edu/finds/LOCUS2000.pdf>.

4 Roy-Byrne, P., Russo, J., Rabin, L., Fuller, K., Jaffe, C., Ries, R., et al. (1998). A brief medical necessity scale for mental disorders: Reliability, validity, and clinical utility. *J Behav Health Serv Res*, 25, 412-424.

## **Comparisons with Other States**

As part of this study, we contracted with the TriWest Group to compare Washington State with Arizona, Colorado, New Mexico and Pennsylvania in the areas of: organization of the states' managed care systems, organization of involuntary treatment systems, and approaches to UM in community and state hospitals. Their detailed findings and recommendations are in Section VI of this report and in Appendix J. In brief, the comparison states review revealed several key themes:

- Unlike comparison states, the RSNs in Washington State do not directly contract with inpatient providers. Because of this, Washington's RSNs have fewer tools to manage inpatient utilization and expenditures.
- Washington State's current policy of holding RSNs accountable for all involuntarily admitted individuals, regardless of Medicaid status, challenges effective UM practices at the RSN level and is a system not found in other comparison states. Additionally, unlike other states reviewed here, Washington's ITA does not provide for outpatient court-ordered care.
- Unlike Washington, a number of comparison states have customized and comprehensive medical necessity criteria in place as guidelines for accessing inpatient care. None have been scientifically tested for validity or reliability so their actual utility is unclear.
- Like Washington State, comparison states do not have standardized UM procedures in place at their state hospitals.

## **Summary Key Findings**

### **Lack of Consistency**

- Results of key informant interviews revealed a lack of consistency in carrying out UM functions throughout the state.
- Multiple key informants identified the need for centralized UM leadership.
- Key informants representing community hospitals and RSNs expressed the need for a reliable and valid instrument for UM functions.
- UM data reporting methods are not consistent.

### **Need for More Data**

- Multiple key informants report having questions that could be addressed if data were available.
- Analyses of administrative data raised questions about why some individuals have unusually long stays at state hospitals and why 27% of discharges from state hospitals are readmitted within one year of discharge, yet data to answer these questions were not available.

### **Barriers to Timely State Hospital Discharges**

- Discharge barriers occur at all levels which prevent or slow discharge to the community, such as lack of placements for specialized populations, lack of structured residential placement, and lack of housing and services for unfunded consumers.
- RSNs are not penalized for consumers that remain in state facilities unless they exceed their allotted bed census—this may act as a disincentive for RSNs to develop community services.

- Discharge barriers are not being tracked and reported in a systematic way.

## **Recommendations**

### **Standardization of UM Processes, Data, and Leadership**

- 1) Standardize UM criteria for pre-authorization and length of stay review. HRSA/MHD is launching a new initiative to standardize the processes, clinical elements, and forms which the RSNs use for authorization and concurrent review. This will go into effect on August 1, 2007. Additionally, RSN authority to conduct utilization review (UR) is being reasserted and standardized across the state (WAC 3880-550-2600). We recommend that the standardization be extended to include objective criteria and this data be systematically collected.
- 2) Whatever instrument(s) are selected, it is essential that they provide data that can be maintained and analyzed by the MHD. For this to occur, the raw data must be freely available to the MHD.
- 3) Uniformly track data on discharge barriers across the state hospitals. A suggested list of key discharge variables for tracking and reporting to the MHD is offered in Appendix J.
- 4) The MHD is poised to develop a new data system interface with Provider One. This should be used to collect standardized data on initial admission authorizations, continued stay reviews, and discharge barriers for both community and state hospitals.
- 5) Statewide medical expertise is essential to a successful UM program. Consideration should be given by the MHD to hiring a Director of Inpatient Care Management or a Chief Medical Officer versed in public behavioral health UM.

### **Close Resource Gaps, Resolve Data Inconsistencies**

- 6) The ability to effectively manage inpatient hospital length of stay will continue to be challenging. Serious study of each RSN's hospital diversion and discharge options must be conducted in order to forecast needed areas of development. The 2002, 2004, and 2005 Public Consulting Group, Inc. (PCG) studies are still relevant and can be used as an immediate source of identified needs.
- 7) Conduct a root cause analysis of why, at times, there are discordant data reports between the MHD and some RSNs.

<sup>5</sup> Brown, T., & Brimmer, K. (2002). *Projecting the need for inpatient and residential behavioral health services for adults served by the Mental Health Division*: Public Consulting Group, Inc.; State of Washington, Department of Social and Health Services, Mental Health Division.

Brown, T., & Brimmer, K. (2004). *Capacity and demand study for inpatient psychiatric hospital and community residential beds: Adults & children*: Public Consulting Group, Inc.; State of Washington, Department of Social and Health Services, Mental Health Division.

*PALS community placement assessment*. (2005). Public Consulting Group, Inc.; State of Washington, Department of Social and Health Services, Mental Health Division.

### **Enhance Management Processes for State Hospital Admissions and Discharges**

- 8) A Dispute Resolution and Consumer Appeals panel should be established at each state hospital. Panel membership should include consumers and reflect recovery principles, as well as include RSN and hospital staff.
- 9) A new model that better aligns incentives for the development of community based options needs to be developed. Many of the resource options for long-term hospitalized patients are not under the control of the RSNs, such as adult family homes and skilled nursing facilities. For patients who do not meet the diagnostic criteria for MHD/RSN enrollment, other divisions of DSHS should share fiscal responsibility for continued hospital stay.
- 10) RSNs should take a more assertive role in reviewing each individual being considered for admission to the state hospitals on 90 or 180-day court orders.

### **Conduct Further Study**

- 11) We recommend further study of the subset of state hospital patients whose extended stays account for a disproportionate number of bed days as it could inform efforts directed at reducing long lengths of stay.
- 12) We also recommend further study of individuals who are re-admitted to state hospitals or who enter community hospitals in the year following discharge from a state hospital. This is especially the case for individuals who are readmitted to inpatient hospital care multiple times in a one-year period. Further study could be done by analyzing information integrated from multiple databases and/or through a well-constructed annual chart review of those with re-hospitalizations. In either case, we recommend that readmissions be closely tracked and that this information be used to inform planning efforts to improve service to such individuals.

## **Appendix 3**

### **Mental Health Housing Action Plan- Common Ground**

#### **Executive Summary**

**October 2007**



# **Mental Health Housing Action Plan**

## **Executive Summary**

**October 2007**

**Prepared by:**

**Common Ground**

**With assistance from:**

**Building Changes** *(formerly known as AIDS Housing of Washington)*

## **Executive Summary**

The Mental Health Housing Action Plan is a component of the System Transformation Initiatives, a package of budget and policy initiatives, passed in the 2006 Legislative Session. The Plan addresses one critical element of the high utilization of Eastern and Western State Hospitals: the lack of appropriate community-based housing for people with mental illnesses.

## **Underlying Philosophy**

Stable housing is an integral element of recovery for every individual with a mental illness. In a recovery-based system, there is an increased emphasis on consumer choice and a preference for housing models that promote independence. Every community in Washington State needs a range of housing options. Among the most effective housing alternatives that respond to the tenets of recovery is permanent supportive housing (PSH). There is solid evidence that providing community-based PSH is a cost-effective alternative to the revolving door of the street, shelter, emergency rooms, psychiatric hospitals, jails, and prisons.

## **Target Population**

People currently served by the public mental health system (primarily adults with schizophrenia, bipolar disorder, or major depression and children with serious emotional disturbances) are the target population for this housing, including those receiving Medicaid-supported services through the Prepaid Inpatient Health Plans (PIHP) contracts with RSNs and those receiving crisis response, Program of Assertive Community Treatment (PACT) services, or Program for Adaptive Living Skills (PALS) alternative services through state-only funds contracted through RSNs.

In 2007, the estimated unmet need for community-based housing for people served in the public mental health system is approximately 5,000 units. This number includes single adults, families where a parent has a mental illness or a child has a serious emotional disturbance, and seniors.

Initially, the majority of units will be created in RSNs with the largest populations of people with mental illnesses and the highest utilization of state hospitals. Approximately 65–70 percent of the units are targeted for single adults, 20–25 percent for families, and 10–15 percent for seniors.

Approximately 70 percent of the units will target people who are served by the public mental health system and are homeless, many of whom are individuals or families with a history of cycling through the streets, shelters, hospital emergency rooms, jails, and/or local and state hospitals. The definition of homeless includes people who are on the street, in a shelter or transitional housing, or who are discharged from a state or local institution without housing.

## **Gaps and Barriers**

The RSNs, providers, and consumers who contributed to this plan agree that the key barriers to securing housing for people with mental illnesses include: a lack of affordable housing stock; insufficient case management services; histories of poor credit or felony convictions; cultural and

language barriers; insufficient prevention and crisis management services; and incompatible or uncoordinated policy and resource decisions among public agencies at the state and local level. The Plan includes strategies to address these barriers.

### **Housing Model**

This Plan addresses the largest gap in the housing options for people with mental illnesses, the lack of PSH available and affordable to mental health consumers. The Plan proposes 760 units of PSH to be created and placed in service between 2007 and 2010, including 500 units developed through acquisition and rehabilitation or new construction, and 260 units leased from existing housing stock and made affordable with rent subsidies. The Plan also proposes an additional 1,600 units of PSH by 2015, including 1,050 units acquired, rehabilitated or built, and 550 units that are leased from existing housing stock.

The basic model combines an apartment or single-family home leased by the consumer with flexible supporting services. Services are titrated to meet individual needs and are provided in home and community settings. Features of successful PSH models include: case manager caseloads of 1:8–1:15; consumer and landlord access to case management staff 24/7; landlord access to risk mitigation funds that cover any excess costs related to renting to people with mental illnesses; and consumer access to short-term respite care, if the consumer’s illness spikes, without loss of his or her apartment.

One type of PSH that has been demonstrated to be successful for people whom the more traditional housing and service models have failed is Housing First. The model moves people directly into housing and then begins engagement for supporting services. While there is a rich package of services available, participation is not required to secure housing.

Because the Plan proposes over 700 units come from existing housing stock, there is a need for landlord incentives to address traditional barriers for people with mental illnesses. Key elements include landlord access to service staff 24/7, option of master leasing units to a mental health provider, and access to a risk fund that pays for any extra costs related to unit damage or higher than expected turnover and/or eviction costs. An operating subsidy/landlord incentive/risk mitigation fund is included in the Plan.

### **2007–2010 Financing Requirements for 760 Units**

The estimated capital financing for the bricks and mortar of 500 units is \$115 million (at an average cost per unit of \$220,000 in 2007; estimated costs are adjusted for inflation through 2010). Approximately 60 percent of the capital funds for the 500 units are committed. There are sufficient capital dollars available within current allocations to support the remaining capital costs, **if** rent subsidies and service funds are secured to assure affordability of the housing for people with limited incomes over the 40–50 year period required by public capital financing sources.

The total cost of rent subsidies for 760 units is estimated at \$7.3 million, based on an annual subsidy of \$6,500 per unit. There may be sufficient rent subsidy available within existing resources to cover these. However, the subsidy sources are oversubscribed and housing for people with mental illnesses must compete with housing for many other deserving populations. The Plan assumes that 65 percent of the 760 units will receive rent subsidy from existing sources, leaving a gap of \$2.8 million for the remaining 35 percent (260 units). The cost of operating subsidies (a.k.a. landlord incentives/risk mitigation funds) for excess costs related to renting to mental health consumers is modeled at \$3.8 million for the 2007–2010 period and based upon \$1,200/unit per year.

The residents of all 760 units will require supporting services, estimated at \$14.9 million for 2007–2010. The range of service costs in PSH projects is \$3000 to \$15,000 per year in 2007. In this Plan, the services costs are modeled using \$8,000 per year for single adults and \$10,000/year for families.

For those units housing people with PACT (450 units) or some of PALS alternative services (30 out of 100), current funding is sufficient to support the PSH model. The remaining 280 units require \$2.69 million worth of supporting services. Determining how much of that is available within current funding levels for RSNs is beyond the scope of this Plan. However, it is clear that 1) RSNs/providers do provide PSH to some PIHP consumers now; 2) providing services in home and community settings, as required for PSH, does replace some or all clinic-based mental health services for the consumer (all in the case of PACT); 3) the cost of providing home or community-based services is higher than for clinic-based services; and 4) there are not sufficient service dollars available for people in the target population who are not enrolled or not yet enrolled in the PIHP, PACT, or PALS alternative services.

### **2011–2015 Financing Requirements for 1,600 Units**

The 1,600 units proposed to be created in 2011–2015 will require additional capital, rent subsidy, and service dollars, both from increases in existing sources and from new sources. Two sources that may provide more resources for PSH and should be explored are the Criminal, Educational, Penal, and Reformatory Institution Trust Fund (CEP&RI) and the .1 percent local sales tax for mental health services. The estimated capital cost for the 1,050 units proposed by 2015 is \$284 million. The estimated costs for operating and maintaining 760 units created between 2007–2010 and phasing in an additional 1,600 units over the 2011–2015 period are estimated at \$26.5 million. The estimated service cost to maintain the 760 units and phase-in an additional 1,600 by 2015 is \$55 million. The operating subsidy/landlord incentive/risk mitigation fund for the total 2,360 units phased in by 2015 is \$14 million.

### **Implementation Steps**

Key 2007–2008 action steps to implement the Plan include:

- Promote the creation of PSH at the RSN and local level by providing best practice information on models, partnerships, and financing; funding technical assistance to build the capacity of RSNs to support and mental health providers to develop and manage PSH;

building new partnerships and resources for PSH; and proposing additional funding where appropriate.

- Ensure PHP benefit design includes flexible modality for services in home and community settings and that the rate is sufficient to cover costs.
- Suggest standards for RSNs to determine the number of crisis respite beds needed to cover both step-down (from hospital settings) and step-up (from community-based housing) needs. Identify additional funding for crisis respite beds if necessary.
- Identify any additional service dollar needs to meet PSH model requirements for units to be placed in service by 2010. Identify additional operating or rent subsidy requirements for units to be placed in service by 2010. Finalize the landlord risk mitigation program and financing requirements. Consider developing a joint PSH funding proposal with CTED for 2009 Governor and Legislature consideration.
- Explore the use of the Charitable, Educational, Penal, and Reformatory Institutions Trust fund to support the creation of more PSH for mental health consumers.
- Review the physical building conditions and services in all licensed residential facilities funded for mental health consumers statewide and ask RSNs to establish long-term plans for maintaining, rehabilitating and/or replacing units with PSH.
- Develop a closer working relationship with CTED's Housing Division. Opportunities for closer collaboration include, at least, adding MHD housing staff to key housing advisory committees; coordinating technical assistance and pilot project funding for PSH; adding MHD consultation into the CTED funding decisions on projects with units for people with mental illnesses; investigating opportunities to more effectively tap state Housing Trust Fund, 2060 Operating and Maintenance funds, State Housing Grant Assistance Program (HGAP) and other CTED resources; and investigating options to allow people leaving state hospitals, without housing options, to be eligible for homeless housing units.
- Capitalize on the opportunities offered through the Governor's Mental Health Transformation Grant to further the design and delivery of the landlord incentive package and peer support for PSH.
- Collect data at RSN/provider level and publish an annual statewide report on the housing status and tenure of all consumers served in the public mental health system.

## **Appendix 4**

### **Summary of Meeting with RSNs on Discharge Barriers**

**July 2008**

## Summary of Meeting with RSNs on Discharge Barriers - July 24, 2008

Issue	Not Working well	Working Well	Possible Solutions	
Capacity Issues	The nearest inpatient psychiatric bed is 100 miles away from Wenatchee. This has forced us to become creative.		Short Term:	
	Funding for E&T is in doubt, have had high turnover of E&T psychiatrists. Community needs more short term crisis stabilization beds across populations for children, adults and older adults. Placement is a big issue.	Crisis services have reduced need for ITA beds in our county		
		Boarding is not an issue, only one or two a year (month?)		
	Children's beds are in another time zone			
	Single bed certification and boarding. 25% of the people detained in King County are boarded in Emergency Departments and Emergency units—many as the result of serious medical complexity and are hard to discharge once they get into hospital. Backlog of 90/180 day holds in local hospitals. Discharge practices vary. One hospital aggressive with d/c planning for 90/180 day consumers, other two not so much.			
	Losing beds as population increases, lack of inpatient beds. There's a potential for increased grievances and critical incidents related to capacity issues.			
	Single Bed certifications, Steven's hospital in Everett rumored to be closing their psychiatric beds.			
	VA no longer serving older vets as they shift resources to Iraq/Afghan war vets. Increasing use of single-bed certifications. Today we have 6 single bed certifications at the crisis facility. At any one time we will have 2-6 people on single bed certifications in the hospital. There is a statewide lack of inpatient beds, people are travelling further.			Long Term
	Single bed certifications: one community hospital does not want to see boarding. We cannot force them to board without ESH approval. In any event. Boarding or ESH hospital is likely not the best client care for acute consumers.	Thanks legislature for support of ET dollars		
	Single bed certifications upset our major inpatient provider (St Petes) more than anything else. They note that they are not an ITA facility; They state that they will not tolerate this much longer and they threaten a lawsuit.			
Census remains a problem. ESH still functions as an acute care hospital 44% of our patients are on 72 and 14 day holds				
Have recently received a clear directive that we cannot care for dementia patients Wards must close until persons are discharged. There are 60 people over 65 in this category. Two of three temporary wards are slated for closure				
Notes that capacity is strained often by inappropriate placements. Many times these people should not be in a state hospital as they would be better served by other treatment modalities. People should be served in the community. Vital time is spent on discharge planning due to lack of community resources that would be spent more productively by providing therapeutic care to patients.				
Difficulty finding placements ultimately reduces capacity.				

Issue	Not Working well	Working Well	Possible Solutions
Cross systems consumers: Co-Occurring DDD Dementia TBI	Huge numbers of folks with dementia in psychiatric facilities. Decompartmentalization needs to occur so that systems can work together. System needs to be looked at from the ground-up, beds at all levels.		Short term
	There are no specialty nursing homes in Clark County. There is no sub-acute facility, no place of last resort.		
	Nursing bed shortage means that dollars that could go to serve behavioral health consumers are limited		
	Housing shortages, programs are not flexible, history of WSH involvement may close off housing opportunities		
	There needs to be special licensure for secure long term care for individuals with dementia/TBI. One county has an ITA rate 430% above the state average—this is likely due to the detention of demented consumers		Long Term
	VA no longer providing services to older veterans. HCS placements in local nursing homes such as Georgian House wind up taxing the system as they wind up shifting them to MH system care—taxing MH beds. It seems like WSH has become the final resting place of persons with dementia because there is no-other/more appropriate place for them.		
	Step downs from WSH often difficult in these cases		
	Half of the “charges” we spend are likely the result of DD or Dementia Consumers taxing our system		
	Beds for long term custodial care do not exist. MH has become the default system for crisis serving CD, DD, and ADSA consumers—we frequently get into issues with DDD over crisis plans for DD consumers in the E&T		
	Nursing home and AFH licensing restrictions are impacting us		
	Complex consumers with DD issues are often hard to discharge		
	Children with multiple needs are hard to discharge, Children’s Administration struggling to place non-clip kids.		
We have received a clear directive from the Joint Commission that we cannot provide custodial care for dementia patients or we will lose certification, wards must be closed until all patients with dementia are discharged. 60 people over 65 in this category, 2 of 3 temporary wards slated for closure.			
Time spent on discharge planning for such consumers takes away treatment time from other patients			
Skilled nursing facility rules don’t align well with discharge procedures. Difficult to find placements.			

Issue	Not Working well	Working Well	Possible Solutions	
10.77 & 71.05	Forensic flips create a major problem for us. We have 14 beds available at WSH hospital and forensic flips place a tremendous burden on them.	Crisis services have reduced need for ITA beds in our county	Short term	
	County crisis services have done a good job reducing ITA's. Local hospital has ceased to operate as an E&T, leaving the freestanding E&T as the local resource for ITA's. Hard to find ways to pay for E&T.	Boarding is not an issue, only one or two a year (month?)		
	Barriers between legal, treatment and financial parts of system.			
	More than 50% of hospitalizations are involuntary. Many of these are due to the concept of "poor faith voluntaries." 25% of persons ITA'd are in non-E&T facilities under "Single Bed Certifications." Forensic flips have placed a major burden on King County. Many of the problems related to WSH capacity is due to forensic patients flipping over to civil beds			
	One county is 430% above the state average for ITAs (likely due to demented consumers being detained.) We have several undocumented aliens "stuck at WSH hospital due to lack of resources on discharge.			
			Long Term	
	VA no longer taking anyone but "good faith voluntaries." This increases the number of ITAs as less restrictives dwindle.			
	Increased percentage of ITA costs, we are unable to manage ITA costs	Thanks legislature for support of ET dollars		
	Noted difficulty in placing/finding housing for persons with histories of Fire Starting/sexual offenses/remote history of high profile crimes			
	While we feel we have enough forensic beds at WSH, we are aware that the Court System places pressures on the King County Census. 50% of the waitlist are King Consumers, 50% are Dementia consumers.			
	WSH Hospital is driven by 10.77 and 71.05. State may be unique in the way that competency evaluations are performed. Cites study that notes determinations of incompetency usually range between 10-40%. 75% of forensic consumers ultimately determined incompetent. They then go into a competency restoration siècle. Many are then flipped to the civil side but prove difficult to discharge. Fix would lie in jail diversion projects. (Note, this is dependent on other systems			

Issue	Not Working well	Working Well	Possible Solutions	
Non Medicaid funds/state dollars			Short term	
	Hard to maintain E&T, due to the size of unit, beds have been cut down from 16 to 12. It's hard to maintain costs with the small size. Local funds limited, had a 1.6 mil sales tax that will go away shortly. Difficult to recruit and hang on to E&T doctors.			
	It s hard to get consumers out of PALS. We pay costs out of state funds, some consumers prefer to stay in PALS beds because they do not pay room and board there. No incentive for them to leave.			
	Charges for WSH beds eat at state dollars. Dollars don't cover the responsibilities of state only contracts.			
	Charges at WSH are a concern			
	2-3 consumers at PALS do not want to move out because they don't pay room and board.			
			Long Term	
	There is a large discrepancy between state only money and requirements of a state only contract.			
	Non Medicaid funds vs. non Medicaid needs are apparent. We are still one RSN that provides non-Medicaid services, but our ability to prevent hospitalizations ins being limited as costs shift to inpatient.			
	Constant struggle with penalties for WSH, we've had to pay 2 million in penalties.			
	E&T's bleed off non-Medicaid funds. There is a challenge as IMD regs mandate facilities of 16 beds or less, so we don't have the economies of scale of a larger facility.			
	Notes the drain on state funds			
	N/A			
N/A				

Issue	Not Working well	Working Well	Possible Solutions
Housing	Housing is tight in Wenatchee, 3 year waiting list for public housing, 1.6% vacancy rate. People seem to be moving to Wenatchee due to lack of resources in other states.		Short term
	Placement is a big issue, no specialty nursing homes.		
	Housing and Nursing homes are needed.		
	We face housing shortages; existing programs lack flexibility when dealing with the mentally ill.		
	Need more ARTFs, there needs to be special licenses for secure long term care. Housing is a critical issue.		Long Term
	Drift due to people being sent to WSH and staying in the area.		
	Spending lots of money for housing.		
	Not In My Backyard sentiment makes it difficult to place people with histories of fire starting, sex offenses, and/or history of high profile crimes.		
	Housing a major issue in discharging, people want to stay at PALS. We need housing for hard to place persons.		
	Need therapeutic foster care.		
	Need step down resources		
	On any given day 100 people are ready for discharge, but these individuals still have major needs, there simply isn't housing available for them		
Difficult to find placements, AFHs are relied on, skilled nursing facility rules don't align well with discharge procedures			

Issue	Not Working well	Working Well	Possible Solutions
Children's Issues	Kids need varied types of placements rather than long term beds.		Short term
	All ages, including kids, would benefit from short term crisis beds. Access to psychiatrists and primary care doctors is a huge problem.		
	There is no overarching set of values and principles for all of the state agencies. Child serving agencies do not share visions, there is no collocation of services, sharing of dollars, and frequently they wind up working at odds with each other. Regarding the issue of beds, beds for what? What are the treatment models? Overprescribing and poor prescribing for kids suspected. With great distances for inpatient beds it cumulatively adds to the difficulty for discharges. Parents may be unable to participate due to lack of involvement from Children's Administration agency.		
	Kids in general: there aren't enough respite or therapeutic foster beds. Hard to find foster care, let alone therapeutic foster care.		Long Term
	Psychiatric time hard to come by, hard to find providers willing to work with complicated cases.		
	We experience drift due to a number of children's and DD facilities being located in our county. DD and Children's region overlay a number of counties. There are a number of group homes for hard to serve children and DD consumers. There is a lack of medical services for our consumers; we end up paying for care we shouldn't be paying for.		
Many Children are difficult to discharge, Relations between RSN's vary with some having minimal involvement, others being highly creative, There is a lack of therapeutic foster care and step-downs for 18 year old kids.			
There are 90 beds now; there is a need for step down resources and a dearth of resources for non-Medicaid kids. Of the 70% involuntary population, 20% are non-Medicaid w/o public mental health. Children with multiple needs lack resources on discharge. Collaboration with Children's Administration is difficult due to their lack of resources—they have difficulty placing non CLIP kids. CLIP kids have even greater barriers.			

## **Appendix 5**

### **Discharge Protocols for Community Services Boards and State Mental Health Facilities**

**November 2001**

# **Discharge Protocols for Community Services Boards and State Mental Health Facilities**

The attached protocols are designed to provide consistent direction and coordination of those activities required of state facilities 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 Continuity of Care Procedures in the Community Services Performance Contract. In these protocols, the term CSB includes local government departments with policy-advisory CSBs, established pursuant to §37.1-195 of the *Code of Virginia*, and behavioral health authorities, established pursuant to §37.1-242 et seq. of the *Code of Virginia*.

## DEFINITIONS

*The following words and terms, when used in these protocols, shall have the following meanings, unless the context clearly indicates otherwise.*

**Acute Admissions or Acute Care Services** means services that provide intensive short term psychiatric treatment in state mental health facilities for a period of less than 30 days after admission.

**Case Management CSB** means a citizen board established pursuant to 37.1-195 of the *Code of Virginia* that serves the area in which an adult resides or in which a minor's parent, guardian or legally authorized representative resides. The case management CSB is responsible for case management, liaison with the facility when an individual is admitted to a state facility, and discharge planning. If an individual, the parents of a minor receiving service, or legally authorized representative chooses to reside in a different locality after discharge from the facility, the community services board serving that locality becomes the case management CSB and works with the original case management CSB, the individual receiving services, and the state facility to effect a smooth transition and discharge. Reference in these protocols to CSB means Case Management CSB, unless the context clearly indicates otherwise.

**Comprehensive Treatment Planning Meeting** means the meeting, which follows the initial treatment meeting and occurs within seven (7) days of admission to a state mental health facility. At this meeting, the individual's Comprehensive Treatment Plan (CTP) is developed by the Treatment Team in consultation with the individual, the legally 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 individuals receiving services.

**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 § 37.1-197.1 and § 16.1-346.1 of the *Code of Virginia* in consultation with the state mental health facility Treatment Team. This plan describes the community services and supports needed by the individual being served following an episode of hospitalization and identifies the providers of such services and supports. The discharge plan is required by § 37.1-197.1, § 16.1-346.1 and § 37.1-98 of the *Code of Virginia*. A completed or finalized discharge plan means the *Discharge Plan Form (DMH 1190C or DMH 1190)* 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.

**Dual Diagnosis** means an individual who has been clinically assessed as having both a serious mental illness and:

1. a diagnosis of mental retardation as defined in § 37.1-1 of the *Code of Virginia*, (the accepted acronym for this population is MI/MR) **OR**,
2. A co-occurring/co-existing substance abuse or addiction disorder, per criteria in the current *Diagnostic and Statistical Manual of Mental Disorders (DSM)*, designated by the American Psychiatric Association.

**Extended Rehabilitative Services** means services provided for a period of 30 days or more after admission that offer intermediate or long term treatment in a state facility for individuals with severe psychiatric impairments, emotional disturbances, or multiple service needs (e.g. persons who are mentally ill and deaf).

**Involuntary admission** means an admission of an adult or minor that is ordered by a court through a civil procedure according to § 37.1-67.3 or § 16.1-346.1 of the *Code of Virginia*.

**Legally Authorized Representative** means a person permitted by law or regulations to give informed consent for disclosure of information and give informed consent to treatment on behalf of an individual who lacks the mental capacity to make such decisions.

**Minor** means an individual who is under the age of eighteen years.

**Pre-admission screening** means a face-to-face clinical assessment of an individual performed by a CSB to determine the individual's need for inpatient care and to identify the most appropriate and least restrictive alternative to meet the individual's need.

**Primary substance abuser** means an individual who is clinically assessed as having one or more substance abuse or dependence disorders per the current DSM; and the individual does not have an Axis I Mental Health disorder per the current DSM.

**State Mental Health Facility or State Facility** for purposes of these protocols means a state mental health facility under the supervision and management of the Commissioner of the Department of Mental Health, Mental Retardation, and Substance Abuse Services.

**Treatment Team** means the group of individuals that is 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, a psychiatrist, a psychologist, a social worker, and a registered 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 and is responsible for the preparation and, where appropriate, the implementation of the discharge plan.

**Treatment Plans** mean written plans that identify the individual's treatment, training, and service needs and stipulate 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 individuals receiving services.

**Treatment Plan Review (TPR)** means treatment planning meetings or conferences held subsequent to the Comprehensive Treatment Plan meeting.

## I. ADMISSION TO STATE FACILITIES

	Facility Responsibilities	CSB Responsibilities
1.1		<p>Section 37.1-197.1 of the <i>Code of Virginia</i> states that Community Services Boards (CSBs) are the single points of entry for publicly funded mental health, mental retardation, and substance abuse services. Section 37.1-67.1 of the <i>Code of Virginia</i> also stipulates that it is the responsibility of CSBs to perform a face-to-face pre-admission screening that confirms the appropriateness of admission to a state facility.</p> <p><b>NOTE:</b> The <i>Code of Virginia</i> Sections 19.2-169.6, 19.2-176, 19.2-177.1 for Adults and Section 16.1-275 under the Juvenile provisions do not require NGRIs, Mandatory Parolees, or transfers from jail for treatment, evaluation or restoration to be prescreened by a CSB unless the individuals is being admitted for emergency treatment under a TDO pursuant to the above mentioned sections.</p>
1.2	<p>Upon admission, if the person is not able to make the necessary decisions (lacks the capacity to make an informed decision) regarding treatment and discharge planning and there are no family members available, state facility staff shall arrange for substitute consent as appropriate.</p>	

	<b>Facility Responsibilities</b>	<b>CSB Responsibilities</b>
1.3	<p>The state facility Treatment Team and Utilization Review Department, and, as appropriate the Forensic Coordinator, shall assess each individual upon admission and periodically thereafter to determine whether the state facility is an appropriate treatment site. These assessments shall be made available to the Case Management CSB for purposes of treatment and discharge planning.</p> <p><b>RECOMMENDED PRACTICES:</b></p> <ol style="list-style-type: none"> <li>1. For individuals with the dual diagnosis of MR/MI, both the admitting Mental Health Facility and the region’s Mental Retardation Training Center should confer to determine which institution can best serve the individual’s needs.</li> <li>2. If the individual with a dual diagnosis of MR/MI is sent to a State Mental Health Facility under a Temporary Detention Order (TDO), consultation prior to or participation at the commitment hearing is expected of: <ol style="list-style-type: none"> <li>a. The Admitting Facility</li> <li>b. The Catchment Area’s Training Center</li> <li>c. The Case Management CSB’s Mental Health Services Staff</li> <li>D. The Case Management CSB’s Mental Retardation Services Staff.</li> </ol> </li> </ol>	<p>As active participants in the discharge process and consultants to the treatment process, CSB staff shall participate in assessments to determine whether the state facility is an appropriate treatment site.</p> <p><b>RECOMMENDED PRACTICE:</b></p> <p>It should be the CSB’s responsibility to notify its service area’s state MH and MR facility of any known individual with the dual diagnosis of MR/MI who is receiving local inpatient services either through Temporary Detention Order, Civil Commitment or Voluntary Admission and who may require additional treatment in a state facility.</p>
1.4	<p>Facility staff shall contact the Case Management CSB by telephone within 24 hours of admission, or for weekends and holidays on the next working day, to notify the CSB of the new admission. In addition to contact by the Social Worker, Facility staff shall also fax a copy of the admissions face sheet, including the name and phone number of the Social Worker assigned and the name of the admitting ward, to the CSB within one (1) working day of admission.</p> <p><b>NOTES:</b></p> <ol style="list-style-type: none"> <li>1. For all forensic admissions, Facility staff shall provide the CSB with a patient information sheet within one (1) working day of admission.</li> </ol>	<p>Upon notification of admission, CSB staff shall begin the discharge planning process. If the CSB disputes case management responsibility for the individual, the CSB shall notify the facility Social Worker immediately upon notification of admission.</p> <p><b>NOTES:</b></p> <ol style="list-style-type: none"> <li>1. CSB staff is not responsible for completing the discharge planning forms for individuals admitted to a State Mental Health Facility and who are discharged prior to the CTP. However, CSB responsibilities post discharge will be reflected in the Discharge Instructions - Form 226. (Please see Attachment 3)</li> </ol>

	<b>Facility Responsibilities</b>	<b>CSB Responsibilities</b>
1.4	<p>2. Treatment Teams are not responsible for completing the Needs Upon Discharge Form for any individual admitted to a State Mental Health Facility and who is discharged prior to the CTP. However, the Treatment Team is responsible for completing the Discharge Instructions (Form 226).</p> <p><b>RECOMMENDED PRACTICE:</b> When reporting admissions to the CSBs, facility staff should specify those individuals admitted to a state facility with a primary diagnosis of substance abuse.</p>	<p>2. For all forensic admissions, the CSB shall participate in the treatment and discharge process in accordance with these protocols.</p> <p>3. For every admission to a State Mental Health Facility for individuals from the CSB's service area that are currently not served by that CSB, the CSB shall develop an open case and assign Case management responsibilities to the appropriate staff. (Please see SFY 2002 Community Services Performance Contract Section 5.3.5)</p> <p><b>RECOMMENDED PRACTICE:</b> For each admission, the CSB should make every effort to establish a personal contact (face-to-face, telephone, etc.) at least weekly for acute admissions and at least monthly for those individuals receiving extended rehabilitative services.</p>
1.5	<p>The Treatment Team shall, to the greatest extent possible, accommodate the CSB when scheduling CTP and Treatment Plan Review (TPR) meetings. Facility staff shall inform the CSB of the date and time of the Comprehensive Treatment Plan (CTP) meeting at least 48 hours prior to the scheduled meeting.</p> <p><b>NOTE:</b> The CTP meeting shall be held within seven (7) calendar days of the date of admission.</p> <p><b>RECOMMENDED PRACTICES:</b></p> <ol style="list-style-type: none"> <li>1. Facilities should develop centralized scheduling for all CTP and TPR meetings. This process should be automated to allow for the posting of an e-mail calendar that would also provide advance notice for all treatment planning meetings. This e-mail calendar should be accessible to all the CSBs served by the facility.</li> <li>2. Special consideration shall be made for scheduling and discharging individuals admitted with a primary substance abuse diagnosis, with attention focused on diversion efforts and other community alternatives.</li> </ol>	<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, it is CSB's responsibility to notify the Facility Social Worker and request arrangements for telephone or video conferencing accommodations.</p> <p>In the event that the above mentioned are not possible, it is the responsibility of the CSB staff to contact the Treatment Team or Facility Social Worker to discuss case specifics prior to receipt of the <i>Needs Upon Discharge Form</i>.</p> <p><b>NOTES:</b></p> <ol style="list-style-type: none"> <li>1. While it may not be possible for the CSB to attend every treatment planning meeting, it is understood that attendance at treatment planning meetings is the most advantageous method of developing comprehensive treatment goals and implementing successful discharge plans.</li> <li>2. A basic principle is that all individuals who are clinically ready for discharge should be seen face-to-face by CSB staff before they are discharged from the state facility.</li> <li>3. For those individuals receiving extended rehabilitation services (those in a state</li> </ol>

	Facility Responsibilities	CSB Responsibilities
1.5		<p>facility for 30 days or more), CSBs shall ensure attendance in person at no less than one CTP or TPR meeting within 45 calendar days prior to the discharge of the individual.</p> <p>4. For those individuals receiving acute care services (those in a state facility for less than 30 days), CSBs shall ensure attendance at no less than one CTP or TPR meeting prior to the discharge of the individual unless:</p> <ul style="list-style-type: none"> <li>a. The individual is discharged before the CTP; or</li> <li>b. Based on the clinical judgment of CSB staff, a face-to-face contact is not necessary (e.g. the CSB has seen the individual within the past 60 days as a consumer of its services), the CSB has documented this determination in the patient's medical record, and the CSB has had communication (i.e., teleconference or video conference) with the individual and the Treatment Team that explains and discusses this determination.</li> </ul>
1.6	The state facility in collaboration with CSB staff shall arrange for telephone and video conferencing accommodations for CSB staff, legally authorized representatives and family members who are invited to attend meetings but are unable to attend in person.	

## II. NEEDS ASSESSMENTS & DISCHARGE PLANNING

	Facility Responsibilities	CSB Responsibilities
2.1	<p>The Treatment Team, with CSB consultation, shall ascertain, document and address the preferences of the individual or his legally authorized representative in the needs assessment and discharge planning process that will promote elements of recovery, self-determination and community integration.</p>	
2.2	<p>The Facility Social Worker shall complete a Psychosocial Assessment prior to the CTP for each individual receiving services. This assessment shall serve as one basis for determining the individual's needs upon discharge from the state facility. The Treatment Team shall document the individual's preferences in assessing the needs upon discharge from the state facility. Although the entire Treatment Team and CSB staff shall participate in evaluating the individual's needs, the Facility Social Worker (or designee) is responsible for documenting these needs on the <i>Needs Upon Discharge Form (DMH 1190F)</i> section of the Comprehensive Treatment Plan. (Please see Attachment 1)</p> <p><b>NOTES:</b></p> <ol style="list-style-type: none"> <li>1. For individuals with an MR/MI diagnosis who may be eligible for services under the Medicaid Waiver, the following shall be established:               <ol style="list-style-type: none"> <li>a. That Facility staff has conducted a current psychological assessment.</li> <li>b. That Medicaid eligibility has been determined and confirmed.</li> </ol> </li> </ol>	<p>CSB staff shall initiate discharge planning upon the individual's admission to a state facility. Discharge planning begins on the Initial Pre-Screening form and continues on the <i>Discharge Plan Form (DMH 1190C)</i> section of the CTP. (Please see Attachment 1). In completing the <i>Discharge Plan</i>, the CSB shall consult with members of the Treatment Team, the individual receiving services, his legally authorized representative, and, with his consent, family members or other parties in determining the preferences of the individual upon discharge. The Discharge Plan shall be developed in accordance with the <i>Code of Virginia</i> and the Community Services Performance Contract and shall:</p> <ul style="list-style-type: none"> <li>• include the anticipated date of discharge from the state facility;</li> <li>• identify the services needed for successful community placement; and</li> <li>• specify the public or private providers that have agreed to provide these services.</li> </ul> <p><b>NOTES:</b></p> <ol style="list-style-type: none"> <li>1. For individuals with an MR/MI diagnosis, CSB Division Directors for Mental Health and Mental Retardation (or designees) shall conduct both case review and an assessment of the CTP to ensure intra-agency coordination.</li> <li>2. For individuals with an MR/MI diagnosis who may be eligible for services under the Medicaid Waiver, the following shall be established:               <ol style="list-style-type: none"> <li>a. That a Level of Functioning (LOF) assessment has been completed by the CSB.</li> </ol> </li> </ol>

	Facility Responsibilities	CSB Responsibilities
2.2		<p>b. That the Inventory for Client and Agency Planning (ICAP) has been completed.</p> <p><b>RECOMMENDED PRACTICE:</b> For those individuals who are deaf, hard of hearing, late deafened, or deaf-blind, the CSB should coordinate the discharge planning effort with the Regional Deaf Coordinator.</p>
2.3	<p>The <i>Needs Upon Discharge</i> form shall be filled out as completely as possible by the Facility Social Worker (or designee) at the CTP meeting. If the CSB is not present at the CTP meeting, facility staff shall fax a copy of the <i>Needs Upon Discharge</i> form to the CSB within one (1) working day of the CTP meeting.</p>	<p>At the initial CTP meeting, CSB staff shall fill out as completely as possible the <i>Discharge Plan</i> section of the CTP and sign the CTP. If CSB staff is unable to attend the meeting, they shall send a copy of the <i>Discharge Plan</i> to the Facility Social Worker within three (3) working days of the initial CTP meeting (or receipt of the <i>Needs Upon Discharge Form</i>). The <i>Discharge Plan</i> must address each need identified on the <i>Needs Upon Discharge</i> section of the form.</p>
2.4		<p>The <i>Discharge Plan</i> cannot be filled out in the absence of the <i>Needs Upon Discharge</i> form. If the <i>Needs Upon Discharge</i> form is not available at the initial CTP meeting or within one (1) working day:</p> <ul style="list-style-type: none"> <li>• CSB staff shall notify the Treatment Team leader and Facility Social Worker.</li> <li>• If the <i>Needs Upon Discharge</i> form is not made available upon notification of the problem, the CSB staff shall notify the CSB Mental Health Director (or designee) who shall notify the Facility Social Work Director of the problem.</li> <li>• If the facility does not address the delinquencies, the CSB Executive Director shall contact the Facility Director in writing within two (2) working days of notification by the CSB Mental Health Director (or designee).</li> <li>• If completion of the <i>Needs Upon Discharge</i> form remains problematic, the CSB Executive Director shall notify the Assistant Commissioner for Facility Management in writing of the problem and include supporting documentation.</li> </ul>

	<b>Facility Responsibilities</b>	<b>CSB Responsibilities</b>
2.5	<p>The <i>Needs Upon Discharge</i> form shall be initiated at the first CTP meeting and updated at subsequent TPR meetings. As an individual's needs change, the Facility Social Worker shall document changes on the <i>Needs Upon Discharge</i> section of the CTP and in the Facility Social Worker's progress notes.</p>	<p>The <i>Discharge Plan</i> form shall be initiated at the first CTP meeting and updated at subsequent meetings. 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 to address changes to the Needs Assessment.</p> <p><b>RECOMMENDED PRACTICE:</b> Where applicable, CSB Mental Health, Mental Retardation and Substance Abuse staff should work jointly in the development and execution of the discharge plan.</p>
2.6	<p>In the event that a CSB fails to initiate the <i>Discharge Plan</i> form within three (3) working days of the initial CTP or receipt of the <i>Needs Upon Discharge Form</i> and other information from the state facility:</p> <ul style="list-style-type: none"> <li>• The Treatment Team Leader or designee shall notify the Director of Social Work and the Facility Director in writing of the problems and issues associated with the development or completion of the <i>Discharge Plan</i>.</li> <li>• If the CSB fails to initiate the <i>Discharge Plan</i> form upon notification of the problem, the Facility Social Work Director shall notify the CSB Mental Health Director (or designee) of the problem and document the contact in the individual's medical record.</li> <li>• If the CSB does not address the delinquencies, the Facility Director shall contact the CSB Executive Director in writing within two (2) working days of notification by the Treatment Team requesting a meeting with the Executive Director and Mental Health Director (or designee) in an effort to resolve the problems and issues associated with the development or completion of the <i>Discharge Plan</i>.</li> <li>• If the development or completion of the Discharge Plan by the CSB remain problematic, the Facility Director shall notify the Assistant Commissioners of</li> </ul>	

	<b>Facility Responsibilities</b>	<b>CSB Responsibilities</b>
2.6	Facility Management and of Administrative and Regulatory Compliance in writing of the problem and include supporting documentation.	
2.7		<p>As part of the individual's medical record, the CSB shall provide weekly discharge planning notes for individuals being treated on state facility admission wards. Discharge planning notes document the CSB's progress in discharging the individual. For those individuals being treated on other wards, discharge planning notes are required every 30 days.</p> <p><b>NOTES:</b></p> <ol style="list-style-type: none"> <li>1. For those individuals found Not Guilty by Reason of Insanity (NGRI) who are being treated on civil wards, a discharge planning note is required weekly on admission wards and every 30 days on other wards. As the individual receives unescorted overnight community visits then discharge planning notes will be required every 14 days.</li> <li>2. A CSB presence at the state mental health facility is not required for the completion of discharge planning notes. Discharge planning notes may be forwarded to the facility by secure e-mail, facsimile or mail.</li> </ol>

### III. INDIVIDUALIZED TREATMENT PLANNING

	Facility Responsibilities	CSB Responsibilities
3.1	The Treatment Team, in consultation with CSB staff, shall develop an individualized treatment plan that is designed to lead to discharge. The Treatment Team shall, with the individual's and the CSB's input and recommendations, develop goals that will indicate the end of the treatment phase at the facility.	
3.2	Individuals receiving services, legally authorized representatives and, with the individual's consent, family members and private providers who will be involved in providing services shall be included in the treatment planning process and shall be asked to sign the treatment plan if present at treatment team meetings.	
3.3	The behaviors and skills that the individual will need to be successful in the designated discharge site shall drive treatment in a manner that will promote a successful discharge and avoid unnecessary readmission.	
3.4	With the individual's consent, facility staff, in collaboration with CSB staff, shall notify family members by telephone of dates and times of the Treatment Team meetings whenever possible.	
3.5	<p>The Treatment Team, with CSB consultation, shall ascertain, document, and address the preferences of the individual or his legally authorized representative as to the placement upon discharge.</p> <p style="text-align: center;"><b>NOTE:</b></p> <p>This may not be applicable for certain forensic admissions due to their legal status.</p>	

## IV. READINESS FOR DISCHARGE

	Facility Responsibilities	CSB Responsibilities
4.1	<p>When the individual receiving services achieves the treatment goals identified in his CTP, the Treatment Team, with CSB consultation, may determine that the individual is clinically ready for discharge if the individual is medically stable and state facility level of care is no longer required or, for voluntary admissions, when consent has been withdrawn; and for <b>children and adolescents</b> any of the following:</p> <ul style="list-style-type: none"> <li>• The minor is unlikely to benefit from further acute inpatient psychiatric treatment; or</li> <li>• The minor has stabilized to the extent that inpatient psychiatric treatment in a state facility is no longer the least restrictive treatment intervention; or</li> <li>• If the minor is a voluntary admission, the legal guardian, or the minor if he is age 14 or older, has withdrawn consent for admission.</li> </ul>	
4.2	<p>Decisions regarding discharge readiness shall be made at CTP or TPR meetings.</p> <p>The CSB staff and the individual or his legally authorized representative shall be a part of the decision making process in determining whether or not the individual is ready for discharge</p> <p>The Treatment Team shall notify the Facility Director (or designee) when an individual is determined ready for discharge. If the CSB staff has not participated in the CTP or TPR meeting when an individual was determined to be ready for discharge, the Facility Social Worker is responsible for communicating decisions regarding discharge readiness to the CSB staff. The Facility Social Worker shall, by telephone contact the CSB within one (1) working day of the meeting and provide notification of readiness for discharge and document the call in the patient's medical record. This contact is to be followed by a written notification to the CSB.</p> <p style="text-align: center;"><b>NOTE:</b></p> <p>The Facility Social Workers shall notify the Social Work Director or Forensic Coordinator and the CSB of any individual receiving forensic services who has been identified by the Treatment Team as clinically and legally ready for discharge to a correctional center or facility.</p> <p style="text-align: center;"><b>RECOMMENDED PRACTICE:</b></p> <p>For those individuals being served on extended rehabilitation wards at state facilities, and for whom recovery is delayed due to the extent of their illness, the anticipated date of discharge should be assessed at least every 90 days.</p>	

	Facility Responsibilities	CSB Responsibilities
4.3		<p>If the CSB agrees that the individual is ready for discharge, it shall take immediate steps to finalize the <i>Discharge Plan</i> within no more than ten (10) working days. The individual shall be discharged from the facility as soon as possible but in no more than 30 calendar days of the notification except as provided for in Section 4.6, when the CSB experiences extraordinary barriers making it impossible to complete the discharge within 30 calendar days of notification.</p> <p><b>NOTES:</b></p> <ol style="list-style-type: none"> <li>1. A basic principle is that all individuals who are clinically ready for discharge should be seen face-to-face by CSB staff before they are discharged from the state facility. <ol style="list-style-type: none"> <li>1. For those individuals receiving extended rehabilitation services (those in a state facility for 30 days or more), CSBs shall ensure attendance in person at no less than one CTP or TPR meeting within 45 calendar days prior to the discharge of the individual.</li> </ol> </li> <li>3. For those individuals receiving acute care services (those in a state facility for less than 30 days), CSBs shall ensure attendance at no less than one CTP or TPR meeting prior to the discharge of the individual unless: <ol style="list-style-type: none"> <li>a. The individual is discharged before the CTP; or</li> <li>b. Based on the clinical judgment of CSB staff, a face-to-face contact is not necessary (e.g. the CSB has seen the individual within the past 60 days as a consumer of its services), the CSB has documented this determination in the patient's medical record, and the CSB has had communication (i.e., teleconference or video conference) with the individual and the Treatment Team that explains and discusses this determination.</li> </ol> </li> </ol>

	<b>Facility Responsibilities</b>	<b>CSB Responsibilities</b>
4.4	State facility staff shall collaborate with CSB staff as needed in finalizing the <i>Discharge Plan</i> .	<p style="text-align: center;"><b>NOTE:</b></p> <p>It is the sole responsibility of the CSB to make individual referrals to private providers, including Assisted Living Facilities (ALFs). The Case Management CSB may request that facility staff assist the referral process as needed.</p> <p style="text-align: center;"><b>RECOMMENDED PRACTICE:</b></p> <p>For Acute Admissions, CSBs and Treatment Teams will accelerate the discharge process to shorten the time frames recommended and ensure continuity for existing community supports.</p>
4.5		<p>After discharge, if the individual is not able to make the necessary decisions regarding treatment in the community, CSB staff shall arrange for substitute consent as appropriate.</p> <p style="text-align: center;"><b>RECOMMENDED PRACTICE:</b></p> <p>Whenever possible, substitute consent needs to be in place by the date of discharge.</p>
4.6		<p>In the event the CSB experiences extraordinary barriers, including insufficiency of state funding and the lack of community infrastructure (including willing providers), making it impossible to complete the discharge within 30 calendar days of notification, the CSB must submit written notification to the Facility Director and the Commissioner of DMHMRSAS documenting why the discharge cannot occur within 30 days of notification. The documentation must describe the barriers to discharge and the specific steps being taken by the CSB to address them.</p> <p>This documentation shall be submitted no later than 30 calendar days from the notification of readiness for discharge. This shall be documented in the individual's Discharge Plan and the CSB discharge planning notes that are part of the individual's medical record.</p>
4.7	Facility and CSB staff shall review on a monthly basis those cases that have been submitted to the Facility Director and the Commissioner of DMHMRSAS as impossible to discharge within 30 days and document the CSB's progress in addressing barriers to ensure that discharges are occurring at reasonable pace.	

	<b>Facility Responsibilities</b>	<b>CSB Responsibilities</b>
4.8	<p>If the CSB agrees that the individual is ready for discharge but has neither completed nor implemented the discharge plan:</p> <ul style="list-style-type: none"> <li>• The Treatment Team Leader/Designee shall notify the Director of Social Work and the Facility Director in writing of the problems and issues associated with the CSB's completion of the <i>Discharge Plan</i>.</li> <li>• The Facility Director shall contact the CSB Executive Director in writing within two (2) working days of notification by the Treatment Team, and</li> <li>• If discharge efforts by the CSB remain problematic, the Facility Director shall notify the Assistant Commissioner for Facility Management and the Assistant Commissioner for Administrative and Regulatory Compliance in writing of the problem and include supporting documentation.</li> </ul>	
4.9		<p>If the CSB disagrees that the individual is clinically ready for discharge, the Executive Director shall notify the Facility Director and Treatment Team in writing within 10 working days of the notification of readiness for discharge. Also, the CSB staff must document the disagreement in the CSB discharge planning notes section of the patient's medical record within 30 calendar days of said notification.</p>
4.10	<p>When disagreements regarding readiness for discharge occur, the CSB and the state facility are expected to make a reasonable effort to resolve the disagreement before sending a written request for resolution to DMHMRSAS. This effort is to include at least one face-to-face meeting with state facility and CSB staff at a level higher than the Treatment Team with written documentation of the meeting's contents included in the individual's medical record.</p>	
4.11	<p>In the event that a resolution is not forthcoming, the party disagreeing with the individual's clinical readiness for discharge is responsible for initiating a request in writing to DMHMRSAS under the conditions specified in Attachment 5.3.4 of the Community Services Performance Contract.</p>	

## V. COMPLETING THE DISCHARGE PROCESS

	Facility Responsibilities	CSB Responsibilities
5.1	<p>Facility staff in collaboration with CSB staff shall initiate applications for Medicaid, Medicare, SSI/SSDI and other financial entitlements (e.g., indigent medications). Applications shall be initiated in a timely manner prior to actual discharge when possible. For individuals receiving extended rehabilitation services at the facility, the application process shall begin not less than 30 days prior to the anticipated date of discharge. Each team member is responsible for timely and comprehensive reports as required for the applications. To facilitate follow-up, the Facility Social Worker shall notify the CSB of the date and type of entitlement application that is submitted. This will also be reflected in the <i>Needs Upon Discharge</i> section of the individual's <i>Discharge Plan</i>.</p>	
	<p>The Treatment Team shall prepare the <i>Discharge Information and Instructions-Form #226</i> (Attachment 3) and obtain the physician's review and signature prior to discharge. At the actual time of discharge, facility staff shall review the <i>Discharge Information and Instructions</i> sheet with the individual or his legally authorized representative and request his signature.</p> <p><b>NOTE:</b> Individual review of the <i>Discharge Information and Instructions</i> may not be applicable for certain forensic admissions due to their legal status.</p> <p><b>RECOMMENDED PRACTICE:</b> A psychiatrist shall evaluate the patient and document the evaluation in 24 hours or less before the time of discharge.</p>	<p>To reduce re-admissions to state mental health facilities, CSBs shall develop, as appropriate and on an individual basis, a crisis intervention plan that is part of the final <i>Discharge Plan</i>. (See Attachment 2 for template design)</p> <p><b>NOTES:</b></p> <ol style="list-style-type: none"> <li>1. Crisis plans are not required for individuals who have been acquitted as Not Guilty by Reason of Insanity (NGRI).</li> <li>2. Similar documentation is included in the court documents and approved by the Forensic Review Panel.</li> <li>3. Crisis Plans are not required for Court Ordered Evaluations, Restoration to Competency cases, and Jail Transfers.</li> <li>4. For individuals with the dual diagnosis of MR/MI, an individualized behavior management or a crisis plan must be part of the <i>Discharge Plan</i>. These plans must work in conjunction with any pre-existing MR/MI protocols developed between the facility and its service area.</li> </ol> <p><b>RECOMMENDED PRACTICES:</b></p> <ol style="list-style-type: none"> <li>1. CSB staff should ensure that all arrangements for Psychiatric services and medical follow-up appointments are in place prior to discharge.</li> <li>2. CSB staff should ensure the coordination of any other intra-agency services, e.g., employment, outpatient services, residential, etc.</li> </ol>

	<b>Facility Responsibilities</b>	<b>CSB Responsibilities</b>
5.3	The Facility Medical Director shall be responsible for ensuring that the <i>Discharge Summary</i> is provided to the case management CSB within fourteen (14) calendar days of the actual discharge date.	
5.4		The CSB case manager, primary therapist, or other designated staff shall schedule an appointment to see individuals who have been discharged from a state mental health facility within seven (7) calendar days of discharge or sooner if the individual's condition warrants.
5.5		Individuals discharged from a state mental health facility that have missed their first appointment with the CSB case manager, primary therapist, psychiatrist, or day support program shall be contacted no later than 24 hours after the missed appointment. Written documentation shall be provided of efforts to see the person face-to-face no later than seven (7) calendar days after the missed appointment.
5.6		Individuals discharged from a state mental health facility with continuing psychotropic medications needs shall, to the extent practicable, be scheduled to be seen by the CSB psychiatrist within seven (7) calendar days post discharge, or sooner if the individual's condition warrants. In no case shall this initial appointment be scheduled longer than 14 calendar days following discharge.

## VI. TRANSFER OF CASE MANAGEMENT CSB RESPONSIBILITIES

	Facility Responsibilities	CSB Responsibilities
6.1	<p>The Facility Social Worker shall indicate in the progress notes any intention expressed by the individual receiving services or his legally authorized representative to change or transfer Case Management CSB responsibilities and the reason(s) for doing so.</p> <p>Prior to any further discussion with the individual, his legally authorized representative, family, or other parties, Facility Staff shall contact both the Case Management CSB and the CSB affected by the individual's intention to transfer so that they may begin discussion. This shall be documented in the individual's medical record.</p>	<p>Transfers shall occur when the individual receiving services or his legally authorized representative decides to relocate to another CSB service area.</p> <p><b>RECOMMENDED PRACTICE:</b> Coordination of the possible transfer should allow for discussion of resources availability and resource allocation between the two CSBs prior to advancement of the transfer.</p>
6.2		<p>Transfer of Case Management CSB responsibility shall be handled according to DMHMRSAS policies and procedures as discussed in Section 4.5 of the <i>Procedures for Continuity of Care Between Community Services Boards and State Psychiatric Facilities</i>.</p>
6.3		<p>Exceptions to the above shall be granted only when the CSB and individual receiving services or his legally authorized representative agree to keep services at the Case Management CSB while living in a different service area.</p>
6.4	<p>Facility Staff shall provide written notification to the current and new case management CSB at least 48 hours before the final TPR meeting. The Treatment Team shall to the greatest extent possible accommodate both CSBs when scheduling the final TPR meeting.</p>	<p>Case Management services must be provided by the new CSB promptly upon notification of transfer. This shall be effective no later than one week prior to the date of discharge.</p> <p>At a minimum, the new Case Management CSB shall attend the final Treatment Plan Review (TPR) meeting prior to the actual discharge date. The CSB of origin shall stay involved with the case for no less than 30 calendar days post discharge. The arrangements for and logistics of this involvement are to be documented in the <i>Discharge Plan</i>.</p> <p><b>NOTE:</b> The criteria delineated in this section shall also apply to individuals with the dual diagnoses of MH/SA and MR/MI regardless of vendor, Medicaid Waiver eligibility or placement site.</p>

	<b>Facility Responsibilities</b>	<b>CSB Responsibilities</b>
6.4		<b><i>RECOMMENDED PRACTICE:</i></b> The CSB of origin should, upon notice of transfer, provide the new CSB with a copy of all relevant documentation related to the treatment of the individual.
6.5		If the two CSBs cannot agree on the transfer of case management responsibility before the individual is discharged, they shall seek resolution from the Assistant Commissioner for Facility Management and the Assistant Commissioner for Administrative and Regulatory Compliance. The CSB of origin shall initiate this contact.