Washington State
Department of Social
& Health Services

# DSHS STATE HOSPITAL DISCHARGE PROTOCOL FOR DDA ENROLLED CLIENTS AT STATE PSYCHIATRIC HOSPITALS

## PURPOSE AND SCOPE

This protocol sets forth the process by which the Developmental Disabilities Administration (DDA) and the Behavioral Health Services Integration Administration (BHSIA) will work toward discharge of individuals from state psychiatric hospitals who are enrolled with DDA and committed under Chapter 71.05 RCW, *Mental Illness*. This protocol is complementary to and is not intended to substitute for or otherwise replace procedures set forth in policy.

## DEFINITIONS

**Active Discharge List** means the list of patients who have been determined to be clinically ready for discharge and both parties have signed the Patient Achieved Discharge (PAD) form.

**Clinically Ready for Discharge** means that the patient has met their discharge criteria as established in the treatment plan prescribed by the treating psychiatrist.

**DDA Client** means an individual who is currently enrolled with the Developmental Disabilities Administration.

**DDA Mental Health Program Manager** means a DDA headquarters employee assigned to manage DDA's mental health program.

**DDA Mental Health Case Resource Manager** (MH-CRM) means the DDA regional field services employee responsible for facilitating the development of community resources for individuals enrolled with DDA being discharged from Western or Eastern State Hospital.

**DDA Clinical Team** means those employees of DDA who are responsible for facilitating the development of community resources, including residential services, vocational services, and other appropriate supports for DDA enrolled individuals who are at Western or Eastern State Hospital. This typically involves the appropriate DDA regional Field Services Psychologist or Psychology Associate and the DDA regional Mental Health Case Resource Manager, but in some cases may involve other DDA staff.

**Discharge Planning** means services provided to patients by the assigned Habilitative Mental Health (HMH) Treatment Team and the DDA regional Clinical Team that are designed to secure the timeliest possible clinically indicated discharge from the hospital. Discharge planning is a joint effort and begins immediately upon the patient's admission to the hospital.

**DBHR** means the Division of Behavioral Health and Recovery in the BHSIA.

**HMH Treatment Team** means the staff of Western State Hospital (WSH) or Eastern State Hospital (ESH) Habilitative Mental Health programs who are responsible for development and implementation of patient treatment plans for patients on the HMH units, and whose duties include, but are not limited to, consultation regarding the provision of HMH treatment for DDA enrolled clients who are placed on other hospital units.

**Initial Discharge Criteria** or **Discharge Criteria** means objective and measurable criteria developed by the assigned HMH Treatment Team and the DDA Clinical Team that reflect the desired level of psychiatric stability and the behavioral changes necessary for the patient to be determined to be clinically ready for discharge.

**Initial Treatment Plan** or **Treatment Plan** means an individualized plan established within ten (10) business days of admission that provides individualized behavioral intervention strategies and treatment goals targeted to address the issues that led to the client's hospitalization. The treatment plan is done in consultation with the appropriate DDA staff, the RSN hospital liaison, the patient, their legal representative (if any), or appropriate family members, service providers and any other natural supports identified by the patient, and with the patient's consent.

**DBHR Program Manager** means a DBHR headquarters employee who is responsible for administering the BHSIA's collaboration with the DDA.

**Regional Support Network (RSN)** means a county, combination of counties or other member entities under contract with BHSIA. The RSNs administer all mental health service activities within their jurisdiction, using available resources. Refer to WAC 388-865-0200 for details.

**Social Worker (SW)** means the state hospital Social Worker.

## PROCEDURES

### A. TREATMENT AND DISCHARGE PLANNING

1. Within ten (10) business days of state hospital admission, the assigned HMH Treatment Team, DDA Clinical Team, the patient and their legal representative (if any), family, and residential providers (if any) will meet to develop a treatment plan. The RSN representative, if there is one, may also participate. This initial

plan will include a review of issues that may have led to the hospitalization, measurable criteria for each goal identified on the treatment plan, individualized treatment strategies, and a discharge plan that reflects measurable discharge criteria. The discharge plan shall include objective and measurable behavioral requirements that the patient must meet, including addressing the reason for hospital admission, before they can be considered for return to the community.

2. The hospital SW or designee will forward a copy of the treatment plan, including the proposed discharge criteria, to the DDA Mental Health Case Resource Manager (MH-CRM) within three (3) business days after the initial treatment plan meeting.

3. If a patient requires review by the End of Sentence Review Committee (ESRC) prior to discharge, or other placement barriers exist and placement is expected to be difficult, the patient must be informed that they may experience delays in discharge.

4. Subsequent treatment planning conferences shall occur in accordance with state hospital policy or may be held more frequently if indicated by individual patient needs. DDA staff and state hospital staff are expected to participate in these treatment planning conferences. State hospital staff will provide reasonable notice of all treatment conferences to relevant participants, including the patient's legal representative (if any), family members and advocates (with the patient's consent), and DDA staff.

5. The conferences shall consider any needed changes to the initial treatment plan as a result of the ongoing assessment. If a patient is not making progress towards discharge, changes in the strategies will be considered and the treatment plan will be updated to reflect the change in strategy or the rationale why no change is made. The patient will be encouraged to participate in any and all of their treatment conferences and will be informed of changes in the strategies, discharge criteria, and placement efforts.

6. At the conclusion of each treatment planning conference, the MH-CRM or other DDA designee will document agreement or disagreement with the discharge criteria in a Service Episode Record (SER) in CARE. The MH-CRM will email a copy of the SER to the HMH staff.

7. The MH-CRM will provide written documentation for the hospital chart concerning the status of discharge planning and barriers to discharge and, if applicable, DDA eligibility redetermination status on a monthly basis. The MH-

CRM will document this in a SER in CARE noting any specific areas to address, and e-mail a copy of the SER to the HMH staff.

8. DDA patients who have had an eligibility determination since June 1, 2005, do not require another eligibility determination. However, if a DDA eligibility redetermination is needed, or anticipated to be needed, as part of discharge planning, DDA will initiate this process within thirty (30) days of admission or as soon as clinically appropriate following admission. For patients whose psychiatric status must be stable in order to proceed with the eligibility redetermination, this step may be delayed until such time that the treating hospital psychiatrist makes a determination that the patient is stable enough to proceed with the eligibility redetermination process.

## B. PATIENT ACHIEVED DISCHARGE (PAD)

1. When the patient is considered clinically ready for discharge per the treatment plan, two representatives from both the HMH Treatment Team and the DDA Clinical Team shall sign the hospital's *Patient Achieved Discharge (PAD)* form, indicating their agreement that the patient has met their clinical discharge criteria. If the PAD is not signed by DDA, the MH-CRM will document the reason(s) why in a SER and send copies to the CRM and DDA Psychologist within in five (5) business days.

2. Upon the signing of the PAD form by both the HMH and DDA, the assigned hospital SW will place the patient's name on the active discharge list. For the purposes of this protocol, designating a patient as "clinically ready for discharge" does not mean that all appropriate community supports and services have been secured for the patient's discharge.

3. If the patient will be living in a non-DDA funded setting, the hospital will work with the intended service provider and applicable team members to determine a discharge transition plan and timeline for community placement. If the patient will be receiving DDA funded residential services, refer to Section E, DDA Funded Residential Services.

4. A patient's name may be removed from the active discharge list when all parties who signed the PAD form agree that the patient is no longer clinically ready for discharge. Any disagreement may be referred for dispute resolution. Refer to Section I, Dispute Resolution.

## C. FINAL DISCHARGE MEETING AND TRANSITION

1. When the appropriate community supports are in place, the assigned HMH Treatment Team, the DDA Regional Clinical Team, and the patient's other community service providers will meet in a timely manner, consistent with the patient's needs, to finalize discharge preparation. The RSN representative, if any, may also participate.

2. The final discharge meeting must be held sufficiently in advance of discharge to reasonably ensure that all appropriate preparations and supports for discharge are in place.

3. Discharge preparations will include, but are not limited to, the following actions:

   a. The assigned hospital SW will provide a copy of the discharge and after care plan to the MH-CRM and the residential services provider.

   b. The hospital psychiatrist will provide a list of current medications, including dosages, routes, and times, along with a supply of current medications in accordance with hospital policy.

   c. The hospital psychiatrist will provide a copy of the most recent Monitoring of Side Effects Scale (MOSES) or other side-effect monitoring tool.

   d. The SW will make an effort to assure that the patient is discharged with current picture identification and social security card.

   e. The SW will facilitate referrals for necessary financial and SSI eligibility paperwork.

   f. Dates and times for scheduled mental health intake and other appointments as appropriate will be coordinated by the hospital SW.

   g. Review of the patient's Cross System Crisis Plan (CSCP), Positive Behavior Support Plan (PBSP) and other treatment materials as needed to facilitate community transition.

## D. DISCHARGE

1. No DDA enrolled patient will be discharged from the state hospital to a community setting without a written Cross System Crisis Plan (CSCP).

a. Individuals discharged to a Residential Habilitation Center (RHC) or a correctional facility will not be required to have a CSCP.

b. Prior to the patient's discharge, the CSCP will be developed or revised jointly by the HMH Treatment Team, the DDA Clinical Team, the RSN representative (if any), DDA and mental health community service providers, DOC representative (if any), the patient's legal representative (if any), and family members (with consent from the patient). Teleconferencing will be available for participants as needed.

c. The MH-CRM is responsible to complete the final version of the CSCP.

2. In accordance with DDA policy, if a DDA enrolled patient has a Positive Behavior Support Plan (PBSP) or is determined to need one, the PBSP shall be consistent with the CSCP.

3. DDA staff, and others as appropriate, will provide individualized training to community service providers prior to discharge.

4. It is the expectation that pre-placement visits by the community service provider to the hospital and the patient to the community service provider will be arranged to familiarize the patient with their prospective living situation. If no transitional visits are scheduled, the MH-CRM will document the reason(s) for the exception in a SER.

5. The HMH Treatment Team, in consultation with the DDA Clinical Team and a RSN representative, will review the patient's current diagnostic status and determine whether to refer to the RSN for outpatient follow up. If a decision is made not to refer to the RSN, the HMH Treatment Team will work with the DDA Clinical Team staff to identify appropriate community mental health services as needed.

6. If a decision is made to refer to the RSN for intake, prior to the patient's discharge, the SW will either make the RSN appointment or ensure that the residential service provider has scheduled the appointment.

7. Within thirty (30) days of discharge, a copy of the medical discharge summary will be provided to the MH-CRM and to the RSN representative (if any).

## E. DDA FUNDED RESIDENTIAL SERVICES

1. For patients who will be transitioning to a DDA funded residential service (e.g., Supported Living, Adult Family Home, etc.), the following guidelines shall be followed:

   a. Once a patient meets discharge criteria, the SW will obtain copies of the documents listed in Attachment A, *State Hospital Documentation for DDA Residential Service Referral Packets,* from the hospital records and send these to the MH-CRM within three (3) business days for inclusion in the referral packets.

   b. The MH-CRM must include in the referral packet relevant records as identified in Attachment A, *State Hospital Documentation for DDA Residential Service Referral Packets.*

   c. The MH-CRM will confirm with the regional Community Protection Program (CPP) Coordinator whether the patient meets CPP criteria or must be referred for review by the Regional Community Protection Program Committee. DDA staff will follow the procedures described in DDA Policy 15.01, *Community Protection Program Identification and Eligibility*. Referral packets cannot be sent until the CPP designation is determined.

   d. DDA shall follow DDA Policy 4.02, *Community Residential Services: Referral and Acceptance,* and distribute referral packets to all appropriate residential service providers within the patient's region. DDA will also pursue out-of-region referrals if no providers are available in the home region, clinically appropriate treatment is available in another region, or to accommodate patient choice.

   e. The MH-CRM will notify the SW of the potential provider's response within two business days of receipt. The SW will document this information in the patient's hospital chart, as it becomes available.

      i. The SW will identify and make appropriate referrals to attempt to resolve any known outstanding legal issues/warrants. Information concerning any legal issues/warrants which are unresolved at the time of discharge will be provided to the MH-CRM and residential services provider for follow up.

ii. The SW will complete all necessary notifications including notice to prosecuting attorneys, local and state law enforcement agencies, Department of Corrections, and victim/witness notifications.

iii. The HMH will initiate a discharge review when required by RCW 71.05.232 and hospital policy.

f. If community placement does not occur within ninety (90) days following the placement of the person on the active discharge list, the MH-CRM must document in a SER what actions have been taken to address any existing barrier(s) and the status of those efforts.

## G. End of Sentence Review Committee – Chapter71.09 Consideration

1. Patients with a criminal history of sex offense convictions may require a review by the End of Sentence Review Committee (ESRC) prior to discharge. The ESRC will review the case and determine whether to refer the patient to the ESRC 71.09 Sexually Violent Predator Subcommittee for further evaluation and consideration of obtaining a forensic psychological evaluation. Refer to Chapter 71.09 RCW for more information.

2. The 71.09 Forensic Psychological Evaluation may be used as the authorized risk assessment required for all clients considered for and placed in the DDA Community Protection Program, if the report meets the requirements of DDA Policy 15.01, *Community Protection Program: Identification and Eligibility.*

3. If the decision is made by the ESRC to obtain a forensic psychological evaluation:

   a. The SW will facilitate the gathering of required hospital records that are maintained on the unit and follow hospital policies for providing the necessary documentation to the BHSIA representative to the End of Sentence Review Committee (ESRC).

   b. The evaluation must be received and reviewed by the DDA Clinical Team prior to finalizing any discharge plan.

## H. CROSS SYSTEMS COMMITTEE

The DBHR Program Manager and the DDA Mental Health Program Manager will provide a report to the Cross Systems Committee at each meeting concerning the number of persons who have remained in the hospital for more than ninety (90) days following placement in active discharge status, and the barriers related to discharge.

## I. DISPUTE RESOLUTION

1. Dispute Resolution is a process that is designed to help resolve differences between DDA and BHSIA related to issues that may arise through the implementation of this discharge protocol. DDA and BHSIA encourage the use of this process to resolve differences that inevitably will occur. Primary areas in which disputes might occur include, but are not limited to, the following:

   a. Establishing patient discharge criteria;

   b. Patient's achievement of discharge criteria;

   c. The clinical relevance of a patient related incident subsequent to their having met discharge criteria, but not yet discharged from the hospital; and

   d. Resolution of discharge barriers not related to any of the above.

2. Any dispute regarding implementation of this discharge protocol will first be attempted to be resolved between the applicable parties without the use of the dispute resolution process.

3. Prior to submitting a dispute resolution request, the requesting party must first notify the other party of their concerns and intent to request dispute resolution.

4. If the parties are unable to resolve the dispute, the state hospital HMH Program Manager, or designee or the DDA Mental Health Case Resource Manager, or designee will submit the dispute to the DBHR Program Manager and the DDA Mental Health Program Manager.

5. In the event that they cannot resolve the dispute within ten (10) business days of its submission to them, the issue will be submitted by the DBHR Program Manager and the DDA Mental Health Program Manager to the Deputy Assistant Secretaries of the BHSIA and the DDA for their consideration. The Deputy Assistant Secretaries will review all relevant issues.

6. In the event that the Deputy Assistant Secretaries cannot resolve the issue within ten (10) business days, the issue will go to the Assistant Secretaries of BHSIA and DDA.

7. The final resolution to any dispute will be made by the Assistant Secretaries of BHSIA and DDA within thirty (30) business days of referral.

8. The recommended resolution of the dispute at any level will be sent in writing to the appropriate individuals.

## EXCEPTIONS

No exceptions to this protocol may be granted without the prior written approval of the DDA and BHSIA Deputy Assistant Secretaries.

Approved: _____ Date: 1/21/2014
Victoria Roberts
Deputy Assistant Secretary
Behavioral Health and Service Integration Administration

Approved: _____ Date: 1/16/2014
Donald Clintsman
Deputy Assistant Secretary
Developmental Disabilities Administration

*Attachment A – State Hospital Documentation for DDA Residential Service Referral Packets*

## ATTACHMENT A

# State Hospital Documentation for DDA Residential Service Referral Packet

1. **The following documents must be included in the referral packet:**

   - ☐ Transmittal letter or form that includes hospital staff and contact information
   - ☐ Face Sheet
   - ☐ Two most recent Treatment Plans and Addendums
   - ☐ Medical Administration Record (MAR) for the preceding 90 days
   - ☐ Current MOSES or other side-effect monitoring tool, if available, for preceding 90 days
   - ☐ Current/most recent Psychiatric Assessment
   - ☐ Current/most recent Psychosocial Assessment
   - ☐ Current Nursing Assessment
   - ☐ Current/most recent History and Physical
   - ☐ Nursing progress notes for the preceding 90 days
   - ☐ Physician progress/clinical notes for the preceding 90 days
   - ☐ Current Functional Assessment, if one exists
   - ☐ Current Positive Behavior Support Plan, if one exists
   - ☐ Copy of Court Order (Conditional Release (CR) or Least Restrictive Alternative (LR/LRA), if applicable

2. **Additional documentation that may be requested of the state hospital prior to the patient's discharge:**

   - ☐ Lab Reports
   - ☐ Psychological evaluations and/or other testing completed
   - ☐ Medical Reports (e.g., consults, surgical reports, physical problems that need community follow-up, etc.)
   - ☐ Behavioral data tracking (e.g., charts, graphs, etc.)
   - ☐ Seclusion/restraint logs for the preceding 90 days
   - ☐ Additional court papers (e.g., warrants quashed)
   - ☐ Immunization Record
   - ☐ TN Testing Results
   - ☐ Copy of Advanced Directives (for healthcare and psychiatric care)