

Transition Process & Continuity of Care Guidelines: ADULT RESIDENTIAL SERVICES STANDARDS

PURPOSE: The following Standards are designed to facilitate continuity of care for adult clients receiving, or eligible to receive, residential services funded and/or certified by the NYS Office of Mental Health or the NYS Office of Mental Retardation and Developmental Disabilities. Specifically, these Standards are meant to address issues for adult clients who are:

- Psychiatrically hospitalized,
- Brought to an emergency department for a psychiatric evaluation,
- Discharged from a residential facility (client initiated, staff initiated, or mutually agreed upon discharge), and/or
- Unable to return to or maintain their previous living situation (regardless whether it is funded or certified by NYS OMH or NYS OMRDD).

These Standards are consistent with the Codes, Rules, & Regulations of the State of New York including, but not necessarily limited to, Part 595 (Operation of Residential Programs for Adults – NYS Office of Mental Health), Part 87 (Standards for Family Care Homes) and Part 686 (Operation of Community Residences (NYS Office of Mental Retardation and Developmental Disabilities).

1. PSYCHIATRIC HOSPITALIZATION

General Principles

In most circumstances residents who are psychiatrically hospitalized will return to their previous living situation.

Collaborative decision-making is the goal; inpatient providers, residential services staff, outpatient providers, and the patient should reach consensus on whether to discharge the resident from residential services or change the level of care of residential services during the course of hospitalization. In those instances where a hospitalized client is unable to return to the previous living environment within the specified time period (45 days, as detailed below) and the residential slot is filled, residential providers will work with inpatient providers on a case-by-case basis and prioritize that person for future admissions if the individual is able to return to that residential service provider. Plans may involve placement in a transitional residence so as not to delay discharge. Readmission of individuals discharged from a residential program as a result of a hospitalization will be prioritized to an appropriate level of residential care through the Single Point of Access (SPOA).

Specific Guidelines

A. RESIDENTIAL PROVIDERS WILL:

- “hold” the bed for at least 45 days unless it is mutually agreed upon by inpatient, outpatient, residential providers and the resident that the resident will not be returning to the program.

As soon as it is determined by the inpatient provider that the resident will be hospitalized for at least two weeks, the resident’s entire treatment/rehabilitation team shall meet with the resident (or at a minimum all treatment team members will be asked for input) and, where appropriate, family members to discuss the anticipated length of extended hospitalization as determined by the inpatient treatment team, the likelihood of the resident returning to the program, and the consequences of continuing to hold the resident’s bed for a minimum of 45 days or a maximum of 90 days as allowed by regulation. (Please note that individual family care providers are not bound by these regulations and may not wish to hold the bed.)

In making the decision to hold a bed, the following factors shall be considered:

- (1) The resident's current condition and response to current treatment;
 - (2) The resident's history of re-compensation from past episodes of acute illness;
 - (3) The impact on the community of holding a bed beyond two weeks that could be used by another eligible individual (including persons who are in hospital beds and are awaiting admission); and
 - (4) The impact of lost revenue to the residential provider as a result of not being able to bill Medicaid for holding beds.
- Prior to discharge back to residential settings, inpatient providers will solicit and receive current information from both residential services and clinical providers.
 - It is particularly important for residential providers to give inpatient units *specific/explicit* information about trial visits as soon as they are completed (via the "Trial Visit Feedback Form"). If the client does not currently meet criteria for admission, residential providers will instruct inpatient staff on the specific behavioral indicators that are preventing acceptance into the program and a transition plan will be developed together.

B. PSYCHIATRIC INPATIENT PROVIDERS WILL:

- Communicate regularly and involve residential staff in discharge planning and updates regarding treatment progress.
- Communicate as far in advance as possible the potential discharge date.
- Consider referring patients to a partial hospitalization program to help transition patients from inpatient units to a residential setting

In those instances where the hospitalization of a resident coincides with the residential provider's decision to discharge them from a program (due to the resident's behavior posing an immediate and substantial threat to the health and well being of the resident or other individuals or creates a serious and ongoing disruption to the therapeutic environment of the residential program), the residential provider will collaborate with the current outpatient treatment provider, the current inpatient treatment provider, case managers and/or service coordinators, and other residential services providers to arrange for an appropriate disposition. Inpatient social workers will take the lead in facilitating referrals, but all others who are involved will be expected to be actively engaged in planning. If an alternative placement is not identified in a timely manner, in order to not unduly delay the inpatient discharge, the situation will be discussed at the next SPOA Special Review with the goal of developing a discharge plan.

Referrals for mental health residential service providers will go to SPOA; referrals for MR/DD residential service providers will go to the DDSO's Central Entry.

Inpatient social workers are encouraged to contact SPOA and the DDSO Access Team for accessing Case Management and Service Coordination services for those individuals who demonstrate a need for these services and who do not already have this level of service.

Psychiatric inpatient providers may request MR/DD agencies to provide staff to assist in the supervision of clients who are hospitalized from their residential services. Reasonable attempts will be made by MR/DD providers in an attempt to honor this request.

Although individuals hospitalized more than 30 days are not eligible to receive Medicaid Service Coordination through the DDSO, inpatient psychiatric providers can request that the Medicaid Service

Coordinator remains involved in disposition planning for longer than 30 days. (The DDSO should be contacted in the event the Service Coordinator refuses that request.)

2. PSYCHIATRIC EMERGENCY DEPARTMENTS

General Principle

In most circumstances when residents are seen in a psychiatric emergency department (ED) and not hospitalized they will return to their previous living situation.

Specific Guidelines

- A. Residential staff will call the ED prior to the resident's arrival in the ED to inform them of the reason for the ED visit and share pertinent information regarding precipitating events and history.
- B. Assessment in the ED will include communication with and input from residential staff. Prior to discharging, ED personnel will consult with residential staff, inform them of the result of the evaluation, and discuss the disposition plan.
- C. Residential staff will call the on-call residential services administrator when they have concerns about the discharge plan. In those cases, residential staff will inform ED staff of the reason for the delay in accepting the discharge plan. In most cases, the on-call administrator will call the ED within 30 minutes to further discuss the disposition plan.
 - During after-hours *and* in extenuating circumstances, ED staff will *consider* boarding the resident until a mutually agreeable disposition can be arranged.
- D. Psychiatric ED staff may request MR/DD agencies to provide staff to assist in the supervision of clients who are in the ED from their residential services. Reasonable attempts will be made by MR/DD providers in an attempt to honor this request.

3. NOTICES OF INTENT TO TERMINATE RESIDENCY¹

General Principles

Consistent with Part 595.9 of the Codes, Rules & Regulations of NYS, mental health residential providers will ensure that a discharge planning process begins upon admission and continues throughout an individual's stay. In most circumstances, the process leads to a jointly planned discharge. In some cases, a change in the individual's medical condition, psychiatric conditions, behavior or capacity for self preservation will lead to a determination that the individual needs a higher or different level of care. In these cases, unless the conditions for a precipitous discharge (see Item 4 below) are met, written notices of intent to terminate residency will be given to the individual. In addition, the outpatient provider will be notified and expected to participate with the residential provider to help the client maintain residency or move to an alternative residential setting or level of care.

¹ Please note this section refers to mental health residential services providers only. Residences operated and/or regulated by the DDSO have different guidelines under which they operate.

Specific Guidelines

- A. Prior to initiating a preliminary 30-day notice, the residential provider will have provided counseling and training in an attempt to help the individual change unacceptable behavior and meet the responsibilities of residency. In doing so, the residential provider will have notified the outpatient provider and sought their assistance in helping the individual to change behavior.
- B. If the individual's behavior has not changed, the residential provider must give the individual a written 30-day notice of the intent to terminate residency. That notice must include the reason(s) for discharge and identify a specific corrective action plan that needs to occur to avoid the discharge. The individual, residential provider and outpatient provider will collaborate in establishing the plan and monitor its implementation. In most cases, the formality of this notice provides the motivation for change and the individual remains in residence.
- C. If there is no change by the end of the first 30 days, the residential provider must give the individual a written final notice of the intent to terminate residency within 30 days, which shall set forth the reason(s) for discharge and outline potential residential and service options. The outpatient provider will be notified of the final notice and be expected to collaborate with the residential provider in locating a safe alternative residential option for the individual and for providing on-going treatment.

4. PRECIPITOUS DISCHARGES

General Principles

Unplanned and/or rapid discharges from residential services providers will be avoided whenever possible. However, in recognition of the fact that they do occur, the following specific guidelines are offered to help minimize the difficulties for the resident and enhance the communication among providers.

As soon as the possibility of an unplanned or rapid discharge becomes evident, the residential service provider will notify all other involved providers and initiate a collaborative dialogue regarding the development or revision of a behavior plan and/or alternate living arrangements.

Specific Guidelines

- A. In instances where a residential provider intends to immediately discharge a resident (due to the resident's behavior posing an immediate and substantial threat to the health and well being of the resident or other individuals or creates a serious and ongoing disruption to the therapeutic environment of the residential program) and this decision does not coincide with hospitalization, residential providers will work with the case manager/service coordinator, outpatient treatment providers, and other pertinent parties to find a reasonably safe place for immediate placement prior to discharge.
 - SPOA and/or the DDSO Placement Coordinator will be notified of this situation.
- B. When there is a case manager or service coordinator already involved with the individual, the case manager or service coordinator will take the lead and coordinate disposition planning, in collaboration with outpatient treatment providers, the most recent residential service provider, and other pertinent parties.
- C. In instances where the case manager or service coordinator disagrees with the primary therapist or ED staff's recommendation, supervisors will be consulted. In addition, the SPOA Coordinator, DDSO

Placement Coordinator, and the Supervising Clinical Consultant for the Monroe County Office of Mental Health will be available for consultation.

- D. In instances where the clinical provider disagrees with the residential service provider's recommendation, the clinical provider will clearly detail their concerns to the residential provider.
 - For mental health residential service providers the ultimate decision to discharge a resident under the circumstances described in paragraph A above will be the responsibility of the residential service provider.

5. INDIVIDUALS REFUSING PLACEMENT

General Principle

The County strongly encourages individualized person-centered planning.

Specific Guidelines

- A. When individuals refuse to either return to their former placement or refuse to be placed in a setting judged to be an appropriate level of care by the professionals involved in the case, all pertinent parties will come together for a planning session as soon as possible. One forum for this is the SPOA Special Review where the goal is to determine the course of action by the conclusion of the meeting. However, in many cases a more timely dialogue will need to be initiated to address the specific situation.

6. DIFFICULT TO PLACE CLIENTS

General Principles

The public provider system has a responsibility to offer treatment to individuals in the community who are eligible for services. Certain individuals, by virtue of their past behavior or current functioning, are difficult to place into residential services settings and/or outpatient treatment facilities. Nevertheless, the provider community needs to accommodate the treatment needs of these individuals.

Specific Guidelines

- A. In recognition of the difficulties that such clients present, especially when one treatment provider is predominantly responsible for the services, providers are encouraged to collaborate with one another and establish joint (i.e., "risk sharing") treatment plans.
- B. When inpatient providers are unable to discharge clients to a residential setting because of past behavior and/or current functioning, the provider community will need to develop a "community plan" for that individual. The process of developing such community plans will be facilitated by the SPOA Coordinator with input from the County Office of Mental Health.

Trial Visit Feedback Form

Name of Client: _____

Program Visited (agency & location): _____

Date of Trial Visit: ___/___/___ Length of Visit: _____

OUTCOME OF VISIT:

Areas where client performed well in meeting expectations of the residential setting
(participation, interaction with clients & staff, willingness to accept rules, chores, financial responsibilities, willingness to following medication schedule, etc.): _____

Areas where client showed difficulty in meeting the expectations of the residential setting:

Summary / Conclusions (including plans for next steps and/or areas of specific behavioral changes required to admit to the program):

Feedback sent to: _____

At fax number: _____ Date: ___/___/___

Name of Residential Staff completing this form: _____

Phone number: _____

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6/23/04