

## **CONNECTICUT VALLEY HOSPITAL OPERATIONAL PROCEDURE MANUAL**

<b>SECTION I:</b>	<b>PATIENT FOCUSED FUNCTIONS</b>
<b>CHAPTER 2:</b>	Assessment
<b>PROCEDURE: 2.38</b>	<b>Community Integration and Discharge</b>
<b>REVISED:</b>	06/04/15; Reviewed 02/18
<b>Governing Body Approval:</b>	06/11/15; 04/18

### **POLICY:**

Taking into account the limits of court imposed confinement; the hospital actively pursues the appropriate discharge of persons deemed discharge ready by their treatment team who are receiving services. The hospital pursues the provision of services in the most integrated, appropriate setting that is consistent with each person's needs and to which they can be reasonably be accommodated, taking into account the resources available to the State and the needs of others with psychiatric disabilities. The hospital also takes into account the informed choice of the individual or his/her conservator with authority, or other legal representative, if applicable, including whether the placement is opposed.

Treatment planning is a collaborative endeavor between clinicians and patients. Treatment planning will also focus on discharge, and discharge planning should be based on an approach that "sets the bar high" at the most integrated setting and works down when necessary, rather than requiring the individual to work up a ladder and earn opportunities for independence and self-determination. Individuals will be encouraged to pursue education, employment, valued roles, and social activities in their communities.

Discharge planning is a collaborative clinical process that begins at the time of admission and continues throughout the individual's hospitalization. The preferences of the individual and his/her family, significant others and conservators are identified and incorporated into the discharge planning process. All treatment plans should include the individual's strengths, personal preferences, and goals. Challenges to a successful discharge are also identified. This process ensures the safety, well-being and continuity of care for the individual in the least restrictive setting possible.

Clinical social workers maintain a knowledge base of community support services and provide oversight to the discharge planning process. The discharge planning process is documented in the psychosocial history and assessment, clinical social work progress notes and the individualized treatment plan.

### **PROCEDURE:**

It is recognized that training, supervision and accountability are required to operate a system that promotes timely community integration. In order to create an environment that promotes and supports such a system, the hospital has procedures that address the following objectives related to hospital discharge-planning, transition from hospital to outpatient status, and timely community integration:

1. Planning for discharge to the most integrated community setting begins upon admission to the inpatient service and treatment planning shall address the particular considerations for each individual bearing on discharge and identify barriers to discharge.
2. At every treatment plan review the treating physician will document in the chart and discuss with the patient the specific factors that the physician is considering to determine the patient's current clinical need for hospital level of care and the patient's readiness for discharge. Such factors should include the patient's physical and mental status, results of medical/psychological tests, the patient's cognitive and behavioral status, the patient's functional capacities, and evaluative explorations or treatment protocols yet to be completed. The physician will also document in the chart the treatment interventions the hospital will provide to address each factor in order to discharge the patient from the hospital in a timely manner once the patient is deemed discharge ready by the treatment team. Extrinsic factors which present barriers to discharge, such as the patient's willingness to leave the hospital or the availability of a residential placement must be documented in the chart. While these barriers may impact the patient's actual discharge, they are not relevant to the physician's decision about the patient's clinical state of readiness for discharge.
3. Discharge planning must be directed toward the most integrated, least restrictive environment appropriate for each individual, maximizing the individual's opportunity to interact with persons who do not have disabilities and take into account the informed choice of the individual or his/her conservator with authority, or other legal representative,, if applicable. When addressing discharge planning, treatment teams shall begin with the presumption that supportive housing, which is housing with supportive services that can be adjusted to meet the individual's needs, is the most integrated setting generally. Treatment teams will then explore whether supportive housing is the most integrated setting appropriate for the needs of the individual. The rationale for discharge to a setting other than supportive housing shall be clearly documented in the chart and supported by clinical findings or otherwise that confirm the person's inability to reside in supportive housing.
4. Individuals who no longer need hospital level of care, as determined by the individual's treatment team, shall be discharged as expeditiously as possible. It is recognized that, in some cases, treatment teams may not have control of certain systemic barriers, and teams must bring these cases to the attention of supervisors in a timely manner. Those persons who are not discharged within ninety (90) days shall have a right to a case conference within ten days (10) with the DMHAS Medical Director. The objective of the case conference shall be to review and overcome, where possible, impediments to discharge.
5. When a treatment team determines that an individual no longer needs hospital level of care, the team will chart the person as discharge ready, specify the least restrictive community living arrangement appropriate for that individual, the specific barriers to discharge to that setting, and a schedule for implementing the discharge plan, taking into account the resources available to the State and the needs of others with mental disabilities and the individual's or his/her legal representative's informed choice.