

## CONNECTICUT VALLEY HOSPITAL OPERATIONAL PROCEDURE MANUAL

<b>SECTION I:</b>	<b>PATIENT FOCUSED FUNCTIONS</b>
<b>CHAPTER 2:</b>	Assessment
<b>PROCEDURE 2.7:</b>	<b>Discharge Planning</b>
<b>REVISED:</b>	06/2009; 01/2013; 10/ 13; 09/12/16; 02/18
<b>Governing Body Approval:</b>	11/13; 09/15/16; 04/18

**PURPOSE:** To ensure the completion of the collaborative discharge process.

**SCOPE:** All clinical staff

### **POLICY:**

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:**

#### **Discharge Planning Practices for All Divisions**

It is the responsibility of clinical social workers to assure the development of an appropriate discharge plan, and that linkages with appropriate community agencies have been established.

- A. Coordination with family/significant others, community providers and the local Mental Health Authority/network is essential to the discharge planning process. Strong linkage and coordination of treatment and rehabilitation efforts must be achieved by a team of professional staff including hospital personnel, community providers, the individual, advocates, conservators, family and/or significant others to assure continuity of care.
- B. Ongoing assessment of discharge planning and recommendations are documented in the Psychosocial Assessment, the Individualized Treatment Plan and social work progress notes. This documentation should reflect the individual's and significant others' involvement in the discharge planning process, progress towards discharge, barriers, and/or issues that require ongoing treatment in a hospital setting, and recommendations regarding the optimal level of care.

- C. Coordination with community providers is managed through the interdisciplinary treatment team process. Discharge meetings occur regularly with representation from the Local Mental Health Authority (LMHA), or appropriate providers.
- D. An individual may choose to return to their own community or a new community upon discharge. The Local Mental Health Authority (LMHA) or Mental Health Network is responsible for service coordination and provision within the geographic area that the patient chooses to live in.
- E. A critical aspect of discharge planning involves assisting the individual in locating safe, permanent stable housing. This planning involves discussions with the individual regarding housing and /or residential options in a desired geographic location. Individual choice is highly valued and wherever possible, the individual is offered a variety of options within the level of care or housing sought after or desired.

In the General Psychiatry divisions an emergency shelter should not be considered to be an acceptable permanent housing disposition following inpatient psychiatric care. In the rare circumstance where all other options have failed, the DMHAS Medical Director can authorize discharge to an emergency shelter.

- F. The discharge planning process also includes the coordination of tangible services such as entitlements. The determination of the patient's entitlement needs is an essential part of the clinical social work assessment and plan. It is crucial to know a patient's financial status upon admission to prevent potential delays in the discharge process. Individual entitlements such as Medicaid, Cash Benefits, or Basic Needs applications vary among service populations. Clinical social workers are ultimately responsible for the timely and accurate securing of entitlements, as part of discharge planning.
- G. Critical care components of discharge planning to be addressed, include, but are not limited to; case management, housing, psychiatric follow-up, substance abuse follow-up, medical follow-up, vocational referral, socialization and leisure issues, legal issues, family and other.
- H. Upon discharge, a written plan ([CVH-2](#) for GPD or [CVH-2a](#) for ASD/BH) is provided to each individual (or legal representative) and their continuing care provider. Copies can be provided to family and/or significant others upon request by the individual served.

### **DISCHARGE PLANNING FOR SPECIFIC PATIENT POPULATIONS**

For Individuals Committed by the Psychiatric Security Review Board (PSRB) (CGS 17-257):

The discharge process involves Temporary Leave (TL) Planning. When it has been determined that the individual has demonstrated readiness for community placement, Temporary Leave planning is initiated by the treatment team, forensic monitor, and LMHA. The plan is then reviewed with the Forensic Review Committee, and if approved it becomes the basis for a Temporary Leave application completed by the forensic monitor, with input from the LMHA and treatment team. The PSRB may require a hearing to review the individual's progress and the application. If the PSRB approves the application all necessary conditions are formalized in a Memorandum of Decision.

A Conditional Release Plan is an extension of the Temporary Leave plan, after the patient has demonstrated successful adjustment to the community. The PSRB authorizes the conditional Release through a Memorandum of Decision before a patient may be discharged from the hospital.

#### Individuals Admitted with and Acquired Brain Injury (ABI):

Discharge planning for individuals with Acquired Brain Injury (ABI) requires coordination by the clinical social worker with the Department of Social Services (DSS) who oversees the ABI waivers and private contractors. Families or conservators are actively involved in this process. The discharge plan involves attention to individual's cognitive rehabilitation and related support service needs.

#### Individuals served by The Department of Developmental Services (DDS):

Discharge planning for individuals served through the Department of Developmental Services will be coordinated through the clinical social worker. Any identified discharge obstacles are reported through the Chief of Social Work for resolution by the DDS/DMHAS work group.

#### Individuals Ages 18-25, Young Adults Services (YAS)

All individuals between the ages of 18-25 will be assessed for potential referral to the statewide YAS program. For those individuals already served by YAS, the clinical social worker coordinates discharge planning with YAS.

#### Local Mental Health Authorities (LMHA)

Each of Connecticut's 169 cities and towns are incorporated into defined geographic areas for the delivery of mental health and addiction services. There are twenty-three defined catchment areas, each of which is assigned to a designated LMHA. The LMHA is responsible for the planning, development, implementation, and oversight of clinical, rehabilitation, and support services for individuals living in their catchment area or in DMHAS facilities. Services are typically provided through outpatient mental health centers or privately run programs subsidized by DMHAS.

Local Mental Health Authorities (LMHAs) are expected to actively participate with CVH treatment teams in planning both inpatient and aftercare services. The goal is to have the Local Mental Health Authorities collaborate with the arrangement of all transitional and community services required for the continuity of care of the individual in treatment.