

CT DMHAS # 7: Discharge/Coordination/Continuity of Care Policies Department of Mental Health and Addictions Services

Continuum of Care: Discharge Planning

Purpose:

The Department of Mental Health and Addictions Services' (DMHAS) discharge process begins at the admission to any of the inpatient sites and is a interdisciplinary function that is coordinated by the unit Clinical Social Worker or assigned clinician to insure seamless continuity of care. At the beginning of each admission the Local Mental Health Authority (LMHA) where the individual is currently living, is notified that the person has been admitted. The expectation is that there will be a treatment team meeting with the LMHA staff within the first two weeks, where goals and plans for discharge, if feasible, are discussed.

Policy Statement:

All patients admitted to and treated by DMHAS inpatient staffs are assured upon discharge that comprehensive plans are in place that address their housing, treatment, financial, medical and other more specialized needs. In addition, patients should expect to be an integral and active part of all recovery treatment planning, including any discharge planning processes, and that such planning occur from the time of their admission. Additionally all patients treated by DMHAS staff can expect to be offered choices including where they would like to live and that any concerns about such plans are considered and/or addressed prior to discharge.

Procedure:

1. Upon admission each patient is evaluated by a Psychiatrist, Registered Nurse (RN), Clinical Social Worker, Rehabilitation Therapist, Psychology (as indicated) and other medically defined ancillary professions in the form of a multidisciplinary treatment team. The results of these evaluations are utilized to formulate a preliminary treatment and discharge plan. Each admissions office working with the inpatient units will contact the LMHA notifying them that the individual has been admitted and request any community information that can be made available. All such information and evaluations identified at admission, would allow for appropriate inpatient treatment progressing to a successful discharge. This information would include the individual's strengths, preferences and personal goals as identified in the 14 domains of the Client Assessment of Strengths, Interests, and Goals (CASIG) or other functional assessment. These comprehensive tools are used to identify issues affecting the patient's life which can assist in the development of the discharge plan. The issues that were related to the admission in the community (not taking meds, delusional activities etc.,) must be addressed during the inpatient stay and be referenced during the development of the treatment plan.
2. On a weekly basis the issues relating to discharge plans of patients are reviewed at the treatment team. Any barriers to a successful discharge are identified immediately.
3. Discharge plans may be modified anytime the patients' clinical condition changes or based on additional information from the community.
4. Discharge planning includes the wishes and concerns of the patients, family or significant others and their conservators and other interested individuals approved by the hospitalized person. These interested individuals are included in discharge planning meetings as

indicated. Patients have the right to include advocacy in the discharge planning process such as advocates from the Connecticut Legal Rights Project or Melissa's Project or Protection and Advocacy.

5. Each Social Work Progress note must document recommendations and current barriers to discharge planning, and specific progress towards the patients' individualized discharge plan (including items such as support, vocational, and community treatment services, housing and status of finances, etc.) As with all treatment team discussions, where an advocate is involved, documentation that they were notified of the changes should be noted.
6. The Local Mental Health Authority and/or community providers are included in the discharge process from the time of admission and are also to be included in ongoing treatment team meetings and discharge planning meetings as indicated.
7. As the patient approaches discharge, a planning meeting is held, to insure that all elements within the discharge process are in place and that the patient is truly ready for discharge and all plans are finalized. The Liaison from the LMHA provides the transition many individuals need to move back to the community and may arrange to have day visits and some overnight stays.
8. The Clinical Social Worker insures that the patient is given discharge instructions, and that the referral information is completed for the receiving LMHA.