

**DSHS PROTOCOL FOR DISCHARGE OF DDD PATIENTS FROM
STATE PSYCHIATRIC HOSPITALS**

1. **Purpose and scope:** This protocol sets forth the process by which the Division of Developmental Disabilities (DDD) and the Mental Health Division (MHD) will work toward discharge of individuals who are enrolled with DDD and committed under RCW 71.05 from state psychiatric hospitals. This protocol is complementary to and is not intended to substitute for or otherwise replace procedures set forth in policy.

2. **Definitions:**

The following terms appearing in this agreement are defined as follows:

- a. **“Active Discharge List”** means the list of patients who have been determined to be clinically ready for discharge.
- b. **“Clinical Readiness for Discharge”** means that the patient has met his or her discharge criteria as established in the treatment plan prescribed by the treating psychiatrist.
- c. **“DDD Client”** means an individual who is currently enrolled with the Division of Developmental Disabilities.
- d. **“DDD Mental Health Program Manager”** means a DDD headquarters employee assigned to manage DDD’s mental health program.
- e. **“DDD Mental Health Resource Manager”** means the DDD regional field services employee responsible for facilitating the development of community resources for individuals enrolled with DDD being discharged from Western or Eastern State Hospital.
- f. **“DDD Regional Mental Health Team”** means those employees of DDD who are responsible for facilitating the development of community resources, including residential services, vocational services, and other appropriate supports for DDD enrolled individuals who are at Western or Eastern State Hospital. This typically involves the appropriate DDD regional field services psychologist and the DDD regional mental health resource manager, but in some cases may involve other DDD staff.
- g. **“Discharge Planning”** means services provided to patients by the assigned hospital treatment team and the DDD regional mental health team designed to secure the timeliest possible clinically indicated discharge from the hospital. Discharge planning involves both the assigned hospital treatment team and the DDD regional mental health team and begins immediately upon the patient’s admission to the hospital.
- h. **“HMH Treatment Team”** means the staff of Western State Hospital or Eastern State Hospital 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 in regard to provision of HMH treatment for individuals enrolled with DDD who are placed on other units.

- i. **“Initial Discharge Criteria”** or **“Discharge Criteria”** means criteria developed by the assigned hospital treatment team and the DDD regional mental health 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. These criteria will be objective and measurable.
- j. **“Initial Treatment Plan”** or **“Treatment Plan”** means an individualized plan established within seven 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 DDD staff, the RSN hospital liaison, patient, his/her guardian or 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.
- k. **“MHD Program Administrator”** means a headquarters employee of the Mental Health Division who is responsible for administering the Mental Health Division’s collaboration with the Division of Developmental Disabilities.
- l. **“Regional Support Network” (RSN)”** means a county, combination of counties or other member entities under contract with DSHS Mental Health Division (MHD). These RSNs administer all mental health service activities within their jurisdiction, using available resources. (See WAC 388-865-200 for details.)

3. Treatment Planning: Implementation/ Discharge Expectations:

- a. Within seven business days of state hospital admission, the assigned hospital treatment team, DDD staff, RSN representative, the patient and his/her legal representative or guardian, if any, family, and residential providers, if any, will meet to develop a treatment plan. 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 before he/she can be considered for return to the community and the recommended level of care upon discharge.
- b. Discharge criteria shall represent a clear message to the individual concerning when he/she can expect to be discharged. If a patient has multiple placement barriers and placement is expected to be difficult, the patient shall be informed that he/she may experience delays in discharge.
- c. The next treatment planning conference shall occur within the time frame specified by hospital policy, or may occur earlier, if indicated by individual patient needs. State hospital staff will provide reasonable notice of all treatment conferences to relevant participants, such as, residential and vocational providers, legal representative or guardians, if any, family members and advocates. This conference shall consider any needed changes to the initial treatment plan as a result of the ongoing assessment. DDD, RSN representative, and state hospital staff are expected to participate.
- d. Subsequent treatment conferences shall occur in accordance with state hospital policy, and may be updated more frequently if indicated by individual patient needs. If an individual 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 individual will be encouraged to participate in any and all of his/her treatment conferences and will be informed of changes in the strategies, discharge criteria, and placement efforts.

- e. The DDD mental health resource manager will provide documentation for the hospital chart on at least a monthly basis concerning the status of discharge planning and, if applicable, DDD eligibility redetermination status. The method used to provide the documentation will be in accordance with hospital policy and/or practice.
- f. If a DDD eligibility redetermination is needed, or anticipated to be needed, as part of discharge planning, DDD will initiate this process as soon as practicable following admission. For individuals 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.

4. When the patient has met his/her discharge criteria:

- a. He or she will then be considered “clinically ready for discharge.” The assigned hospital treatment team, RSN/mental health liaison, if RSN funding or services will be utilized, and the DDD Regional Mental Health Team shall sign the “Patient Achieved Discharge” (PAD) form, Appendix 1, indicating their agreement that the patient has met his/her clinical discharge criteria.
- b. Upon the signing of the PAD form, the assigned hospital social worker 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.
- c. A patient’s name may be removed from the active discharge list when all parties who signed the PAD agree that the person is no longer clinically ready for discharge. Any disagreement may be referred to the dispute resolution process in Section 10.

5. Funding Approval:

- a. The MHD/DDD treatment team identifies the patient’s community support needs and explores all potential funding sources including RSN, other, and DDD funding. The DDD Mental Health Program Manager will notify the MHD Program Administrator, the assigned hospital social worker and program manager, in writing, when the requisite new funding is authorized. If receipt of this information is considered clinically appropriate by the hospital treatment team, the individual will be informed about such funding.
- b. If new DDD funding is determined to be unavailable, disapproved, or otherwise not authorized, during the pendency of the settlement agreements in the *Allen and Marr* lawsuit, the DDD Mental Health Program Manager shall notify WPAS within seven business days of such determination.

6. When a patient is placed on the active discharge list, and if DDD funds the hospital outplacement, the following steps to discharge shall include but are not limited to the following:

- a. The assigned hospital social worker will obtain copies of the following items from the hospital records to be sent to DDD within three business days for inclusion in the referral packets:
 - i) A transmittal letter or form including contact information for the hospital;
 - ii) The two most recent treatment plans, including current behavior support plan;
 - iii) The preceding three months of progress notes, including physician notes);
 - iv) The current psychosocial assessment;
 - v) The current psychiatric assessment;
 - vi) The current nursing assessment;
 - vii) The current MOSES;
 - viii) The current medication list; and
 - ix) The current medical assessment.
- b. The DDD Mental Health Resource Manager will use best efforts to obtain and include in the referral packet other relevant records as identified in the STATE HOSPITAL REFERRAL PACKET CHECKLIST FOR DDD ENROLLED PATIENTS, Appendix 2.
- c. DDD shall distribute packets to all appropriate providers in their regions as per DDD policy, and shall also pursue out-of-region placement if no providers are available in the home region, clinically appropriate treatment is available in another region, or to accommodate patient choice.
- d. The DDD Mental Health Resource Manager will notify the assigned hospital social worker of the prospective providers to whom the packets have been distributed within three business days of a packet being sent to a provider.
- e. The community residential provider will notify DDD within 10 business days of receiving the referral whether they decline the referral or accept it for further evaluation, in accordance with DDD Policy 4.02. The DDD Mental Health Resource Manager will notify the assigned hospital social worker of the potential provider's response within two business days of receipt. The potential provider and the DDD Mental Health Resource Manager must agree on a timely process to complete the referral. The DDD Mental Health Resource Manager will notify the assigned hospital social worker within two business days of DDD's acceptance of a proposal by a provider or of a provider's decision not to serve an individual. This process is repeated until a provider has been secured and approved. The assigned hospital social worker will document each step of the process in the individual's hospital chart, as it becomes available.

- f. The assigned hospital social worker may arrange for a hospital visit between a provider who has received a referral packet and the patient. The following staff shall be invited and encouraged to attend if needed: HPA, treatment coordinator, vocational and recreational staff, hospital RN or designee, DDA1, IC3, ward physician, Clinical Director, Program Manager, SW, DDD Mental Health Resource Manager, and the RSN representative. The purpose of this meeting is to allow the potential provider an opportunity to meet the patient and the staff who can advise the potential provider of effective treatment strategies for working with the individual.
- g. If the funding for the proposed placement is from a source other than DDD, hospital staff will coordinate with the appropriate team members to facilitate community placement.

7. Discharge when there are significant community barriers to placement:

- a. When discharge from the hospital is made more difficult because of criminal and/or other public safety concerns, or other reasons, the assigned hospital treatment team, the RSN representative, and the DDD Regional Mental Health Team will apprise the patient/legal representative/guardian, if any, and family of the identified barriers to discharge. The assigned hospital treatment team, RSN liaison, and the DDD Regional Mental Health Team shall identify specific barriers and work to resolve these as quickly as possible. Activities shall be documented in the patient's chart.
- b. Additional steps needed to address potential discharge barriers may include, but are not limited to, the following:
 - i) DDD Mental Health Resource Manager will authorize a risk assessment as needed for patients with significant histories of sexually intrusive behavior or violence that may require additional supervision or counseling services to be served in a less restrictive community setting.
 - ii) The assigned hospital social worker will initiate a discharge review when required by RCW 71.05.232 and hospital policy.
 - iii) The assigned hospital social worker will complete all necessary notifications including notice to prosecuting attorneys, local and state law enforcement agencies, Department of Corrections, and victim/witness notifications.
 - iv) The assigned hospital social worker will notify and provide necessary documentation for hospital's End of Sentence Review Committee (ESRC) and Risk Review Board.
 - v) The assigned hospital social worker 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 DDD Mental Health Resource Manager and residential services provider for follow up.
- c. If community placement does not occur within 90 days following the placement of the person on the active discharge list, the HMH Program Manager shall provide written notification to the MHD Program Administrator and the DDD Mental Health Program Manager of efforts to

address any existing barrier(s) and the status of their efforts to resolve the barrier(s). The assigned hospital social worker shall keep the patient and his/her legal representative/guardian, if any, and family apprised of the progress.

- d. Upon notification, the MHD Program Administrator and the DDD Mental Health Program Manager shall review the status and take any appropriate action to try and resolve any existing barrier(s). The MHD Program Administrator and the DDD Mental Health Program Manager will keep the DDD mental health resource manager and the assigned hospital social worker apprised of their progress.
- e. The MHD Program Administrator and the DDD 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 90 days following placement in active discharge status, and the barriers related to discharge.

8. Final Discharge Meeting:

- a. When the appropriate community supports are in place, the assigned hospital treatment team, RSN representative, and the DDD Regional Mental Health Team, as well as other community providers will meet in a timely manner, consistent with the individual patient's needs, to finalize discharge preparation.
- b. The final discharge meeting shall be held sufficiently in advance of discharge to reasonably ensure that all appropriate preparations for discharge are in place.
- c. Discharge preparations will include but are not limited to:
 - i) Assigned hospital social worker will provide a copy of the discharge and after care plan to the regional DDD Mental Health Resource Manager and residential service provider.
 - ii) 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.
 - iii) Hospital psychiatrist will provide a copy of most recent MOSES (medication side effects scales).
 - iv) Assigned hospital social worker will make an effort to assure that the patient is discharged with current picture identification and social security card.
 - v) Assigned hospital social worker will facilitate completion of necessary financial paperwork.
 - vi) Date and times for scheduled mental health intake and other appointments as appropriate will be arranged.
 - vii) Review of Cross System Crisis Plan (CSCP), Positive Behavior Support Plan (PBSP) and other treatment materials as needed to facilitate community transition.

9. Discharge protocol:

- a. No DDD enrolled patient will be discharged from the state hospital to a community setting without a cross system crisis plan. Individuals discharged to a Residential Habilitation Center (RHC) or prison will not be required to have a CSCP. The CSCP will be developed or revised by the assigned hospital treatment team, RSN representative, the DDD Regional Mental Health Team, DDD and mental health community providers, DOC representative (if any), the patient's legal representative/guardian (if any), and family members (with consent from the patient) prior to the patient's discharge. Teleconferencing will be available for participants as needed. A member of the crisis team to which the patient will be discharged will be notified of the meeting and should be encouraged to attend or participate by teleconference. In accordance with DDD policy, if a DDD enrolled patient has a positive behavioral support plan or is determined to need one, the PBSP shall be consistent with the CSCP.
- b. Prior to discharge from the hospital, the RSN representative will ensure that a copy of the CSCP has been provided to the crisis team. In addition, DDD staff, and others as appropriate, will provide individualized training to community provider staff prior to discharge.
- c. Pre-placement visits by the patient to the community will be provided if recommended for a successful discharge.
- d. State hospital staff, in consultation with the RSN liaison and the DDD mental health team will review the patient's current diagnostic picture and determine whether to refer to the RSN for outpatient follow up. If a decision is made not to refer to the RSN, the assigned hospital treatment team will work with the DDD Regional Mental Health Team staff to ensure appropriate follow-up.
- e. If a decision is made to refer to the RSN for intake, the hospital social worker will assure that the appointment has been made prior to discharge.
- f. Within 30 days of discharge, a copy of the medical discharge summary will be provided to the DDD Mental Health Resource Manager and to the RSN liaison.

10. Exceptions:

Exceptions to this protocol may granted upon the joint approval of the MHD Program Administrator and the DDD Mental Health Program Manager when the DDD mental health resource team and the hospital treatment team agree that approval of the requested exception is clinically appropriate, and would facilitate an appropriate discharge for the patient.

11. Dispute Resolution:

Dispute Resolution is a process that is designed to help resolve differences between DDD and MHD related to issues that may arise through the implementation of this discharge protocol. DDD and MHD 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:

- Establishing patient discharge criteria

- Patients achievement of discharge criteria
 - The clinical relevance of a patient related incident subsequent to their having met discharge criteria, but not yet discharged from the hospital
 - Resolution of discharge barriers not related to any of the above.
- a. Any dispute regarding implementation of this discharge policy will be resolved by submission of the issue by the state hospital HMH Program Manager, or designee, or the DDD Mental Health Resource Manager, or designee, to the MHD Program Administrator and the DDD Mental Health Program Manager, or their designees.
 - b. In the event that they cannot resolve the dispute within 10 business days of its submission to them, the issue will be submitted by the MHD Program Administrator and the DDD Mental Health Program Manager to the Director of the Mental Health Division and the Director of the Division for Developmental Disabilities for their consideration. The Directors will review all relevant issues.
 - c. In the event that the Directors cannot resolve the issue within 10 business days, the issue will go to the Assistant Secretaries of HRSA and ADSA.
 - d. In the event that the Assistant Secretaries cannot resolve the issue within 10 business days, the issue will go to the DSHS Secretary, or designee.
 - e. The final resolution to any dispute will be made by the DSHS Secretary within 30 business days of referral by the Assistant Secretaries.
 - f. The recommended resolution of the dispute at any level will be sent in writing to the appropriate individuals.