pennsylvania
DEPARTMENT OF HUMAN SERVICES

OFFICE OF MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES BULLETIN

ISSUE DATE:	EFFECTIVE DATE:	NUMBER:
	Immediately	**OMHSAS-18-**

SUBJECT:	BY:
Admissions, Discharges and Continuity of Care for State Mental Hospitals	**Deputy Secretary** **Office of Mental Health and Substance Abuse Services**

SCOPE:

This bulletin applies to State Mental Hospitals, South Mountain Restoration Center Chief Executive Officers and staff, County Mental Health/Intellectual Disability Administrators, Base Service Unit Directors, and Office of Mental Health and Substance Abuse Services Field Offices.

PURPOSE:

The purpose of this bulletin is to update the policy previously published in Mental Health Bulletin 99-84-24 entitled “Continuity of Care.” This bulletin is not applicable to the Regional Forensic Psychiatric Centers (RFPCs). RFPCs should follow the Office of Mental Health and Substance Abuse Services (OMHSAS) bulletin OMHSAS-16-10.

BACKGROUND:

OMHSAS continues to review and improve its practices in order to best meet the needs of individuals who require the services of State Mental Hospitals (SMHs). Updates to Continuity of Care practices are part of the effort to support recovery in the least restrictive setting possible for the individual being served. Continuity of Care is addressed in Section 116 of the Act of July 9, 1976, (P.L. 817, No. 143, the Mental Health Procedures Act) as amended on November 26, 1978 by (P.L. 1326, Act 1978-324). Continuity of Care is also codified in 55 Pa. Code § 5100.61 regarding Mental Health Procedures.

DISCUSSION:

Continuity of care is a shared responsibility between the SMH, South Mountain Restoration Center (SMRC) and the county mental health/intellectual disability (MH/ID) program. Appropriate continuity of care requires sound planning for the individual’s needs, including

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evaluation and treatment in the least restrictive setting. Proper continuity of care requires cooperation and collaboration between the individual, the individual's family, clinical supports, administrative staff of the state facility and community, and those in the individual's support system. Treatment and supportive rehabilitation services must be planned and integrated as early as possible to determine each individual's treatment needs, the most effective methods to address the treatment needs and to establish the responsibility for the provision of services.

Treatment planning and implementation in the least restrictive setting is the underlying foundation and goal of Pennsylvania's mental health program, and is clearly mandated in the 1966 MH/MR Act and Act 143. As required by the Centers for Medicare and Medicaid Services (CMS), planning and provision of treatment must be developed with the inclusion of the individual in order to promote recovery, self-sufficiency and independence.

The Olmstead Plan for Pennsylvania's State Mental Health System, first issued in 2011 and revised in 2014 and 2016, contains core principles and specific steps for the Commonwealth to take in order to achieve the goal of reducing unnecessary institutionalization of adults who have serious and persistent mental illness. Individual needs are best assessed through a Community Support Plan (CSP) or similar planning process in which individuals, family members, and other persons involved in the recovery process are able to participate in decision making. The planning process ensures the individual has a voice in the development of the plan including the choice in defining the services and supports required to live in the least restrictive integrated setting. The CSP will be used to assess the needs of the individual who is preparing to be discharged from the state hospital system. The services and supports an individual is provided upon discharge will be consistent with their CSP, and adequate to support their recovery and reintegration into the community.

ATTACHMENTS:

Attachment 1: County Service Area Designations
Attachment 2: Admissions: General Admission Requirements; Voluntary Commitment; Involuntary Commitments of MH/ID Dually Diagnosed Individuals; Forensic Commitment; Recommitment Hearings
Attachment 3: Community Support Plan Process
Attachment 4: Discharge Process
Attachment 5: Continuity of Care: SMH Staff; County Staff; OMHSAS Staff
Attachment 6: Continuity of Care Meetings
Attachment 7: Conflict Resolution Process

RELATED BULLETINS:

99-85-07	Admission and Discharge of Veterans to/from SMHs
99-85-21	Readmission from Community Placement within 30 days of Discharge
99-86-14	Involuntary Outpatient Commitment
99-86-30	Discharge from Unauthorized Absence
OMH-91-05	Medical Assistance Patients under Age 21 Certification of Necessity
SMH-05-04	Administrative Transfers between SMHs Civil Sections
SMH-P-10-01	Referrals for Potential Civil Admission from Department of Corrections and County Jails
SMH-P-12-01	Unsupervised Leave of Patients Found Not Guilty by Reason of Insanity
SMH-P-12-03	Proper Implementation of Discharge or Transfer Procedures for Certain Persons in the Category “Acquitted Because of Lack of Criminal Responsibility.” (Not Guilty by Reason of Insanity)
OMHSAS-16-10	Admissions, Transfers, Level of Care and Service Area Designation for the Regional Forensic Psychiatric Centers

OBSOLETE BULLETINS:

This bulletin obsoletes the following OMHSAS bulletins:

99-84-24	Continuity of Care
SMH-91-04	SMH Admission of Involuntarily Committed Individuals

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COUNTY SERVICE AREA DESIGNATIONS

Clarks Summit State Hospital

Bradford
Carbon
Lackawanna
Luzerne
Monroe
Pike
Sullivan
Susquehanna
Tioga
Wayne
Wyoming

Danville State Hospital

Centre
Clinton
Columbia
Cumberland
Dauphin
Franklin
Fulton
Huntington
Juniata
Lycoming
Mifflin
Montour
Northumberland
Perry
Schuylkill
Snyder
Union

Norristown State Hospital

Bucks
Chester
Delaware
Montgomery
Philadelphia

Torrance State Hospital

Allegheny
Armstrong
Beaver
Bedford
Blair
Butler
Cambria
Fayette
Greene
Indiana
Lawrence
Somerset
Washington
Westmoreland

Warren State Hospital

Cameron
Clarion
Clearfield
Crawford
Elk
Erie
Forest
Jefferson
McKean
Mercer
Potter
Venango
Warren

Wernersville State Hospital

Adams
Berks
Lancaster
Lebanon
Lehigh
Northampton
York

ADMISSION

I. GENERAL ADMISSION REQUIREMENTS

A. Admission Referral Criteria

Individuals referred for admission must:

1. Be 18 years of age or older;
2. Have previously received local community mental health treatment services;
3. Have been determined by an inpatient psychiatric provider to be in need of longer term inpatient psychiatric services;
4. Require treatment for a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria established with the Diagnostic and Statistical Manual of Mental Disorders (DSM), and satisfy the criteria set forth in 55 Pa. Code § 5100 pertaining to mental health procedures for involuntary treatment.

B. Admission Referral Exclusions

To assure the protection of individual rights and the necessary level of treatment, the following individuals are excluded from SMH admission referral:

1. An individual deemed to be in need of Long Term Care supports through an Options Assessment;
2. An individual not diagnosed with a persistent serious mental illness (SMI) per OMHSAS;
3. An individual subject to emergency examination under 55 Pa. Code § 5100.86 pertaining to involuntary emergency examination and treatment not to exceed 120 hours;
4. An individual who is expected to be incarcerated;
5. Veterans of United States Military services who are eligible for and desire services from the Veterans' Administration;
6. An individual with a substance use disorder who is in need of detoxification services;
7. An individual less than 18 years of age;
8. Voluntary Admissions.

C. Individuals dually diagnosed with intellectual disability, traumatic brain injury or autism spectrum disorder will be provided additional screening to assure protection of individual rights and consideration of needed specialized services.

D. Community Support Plan (CSP)

Individuals referred to the SMH or SMRC must have a CSP meeting to assess their needs and develop strategies to prevent re-hospitalization. The individual, referring hospital, county representative, involved family, and representatives from the SMH shall be included in CSP meetings which shall be coordinated by the individual's county of residence. If the individual is referred for readmission and had a CSP in the past, the county of residence is responsible to schedule a CSP update meeting. Readmissions require a review of the previous CSP and its implementation. Additionally, issues resulting in the individual's re-hospitalization and re-referral to a SMH shall be identified. Factors which may have prevented the re-hospitalization, treatment issues requiring attention at re-admission, and changes in medication shall also be addressed. Further information regarding the CSP process is found in **Attachment 3**.

E. Admissions Referral process

1. A referral to the SMH or SMRC may be initiated through the treating community facility or the county MH/ID program serving the individual's county of residence.
2. All referral sources must contact the County Program Representative when considering a referral to the SMH. A referral source shall be advised to contact the County Program Representative if the SMH or SMRC is contacted first.
3. The County Program will review all referrals made to the SMH and SMRC to determine the appropriateness of the referral and either approve the admission, or disapprove with a recommendation of alternative treatment for the individual.
4. The County Program is responsible for authorizing the referral to the SMH or SMRC and shall assure all the admission referral information is forwarded to the SMH Social Services Department Admissions Coordinator.
5. Admission services are provided by each SMH for designated counties as determined by OMHSAS as indicated in **Attachment 1**.
6. The County Program Representative will review the clinical information supporting the referral with the appropriate hospital staff to determine the most appropriate course of action.
7. The community referral source will forward a referral packet to the SMH Social Services Department Admission Coordinator for review. Referral packets shall include all information needed to provide a clear, concise understanding of the individual's therapeutic needs.
8. The SMH will notify the County Program Representative if additional clinical and medical information is needed to facilitate a decision on an admission acceptance. The reasons the admission referral is not acceptable shall be promptly communicated.

F. Admissions Referral Packet Information

The information required from referral sources prior to admission approval shall include the following:

1. Psychiatric Information

    a. Symptoms and behavior precipitating current community hospitalization;
    b. Current mental, emotional, and behavioral functioning;
    c. Risk assessment for violence and self-harm;
    d. History of physical and sexual abuse (as a victim, perpetrator, or both);
    e. Assessment of seclusion and restraint use;
    f. Results of psychological testing if available;
    g. Current psychiatric and medical medications and dosages;
    h. History of medication use if available; and
    i. History of drug overdoses.

2. Psychosocial Information

    a. History of substance use including drugs, alcohol and caffeine;
    b. Family and community supports;
    c. Educational history;
    d. Employment history;
    e. Criminal history; and
    f. Absent without leave (AWOL) or elopement history.

3. Medical Information

    a. Medical history and physical examination, including vital signs, weight and allergies;
    b. Laboratory tests completed within the last 30 days, including a minimum of CBC, Electrolytes, glucose, liver function tests (ALT, AST), serum calcium, BUN, TSH, creatinine, and urinalysis;
    c. Results of all other diagnostic and therapeutic test results including x-rays, ECG, EEG, MRI, TST and consultations;
    d. Functional assessment including activities of daily living (ADLs) and history of falls;
    e. Nutritional screening and assessment including any diagnosis of dysphagia;
    f. Pain and screening assessment;
    g. Advance directives (medical and psychiatric); and
    h. Organ donation requests.

4. Acceptable Formats for Admissions Packet Information

    a. Psychiatric evaluation report;

b. Medical history and physical examination report;
c. Other screening and assessment forms;
d. Progress notes from the prior two weeks;
e. Medication administration records;
f. Seclusion and restraint documentation.

G. Admission Approvals and Denials

1. If diversion efforts are exhausted, the County Program Representative will forward a written statement of county approval to the SMH or SMRC Admission Coordinator.

2. If the referral is denied, the County MH/ID Program and the Community MH Unit will be notified in that order.

3. If the referral is approved for admission, a projected bed date will be assigned following the SMH or SMRC clinical team approval of the referral packet and when a bed date becomes available based on the county's bed cap allocation. Bed dates may change based upon bed availability, the county bed cap allocation or both.

4. After an admission date is established and prior to admission (unless otherwise noted), the following information will be provided to the Admission Coordinator at the SMH or SMRC:

   a. Within 24 hours prior to admission, a list of the individual's current medications;
   b. On the day of admission, a current MH civil court order. The SMH or SMRC shall be named as the treating facility and the bed date indicated, or the statement, "upon all approvals" shall be on the order;
   c. A completed copy of the SMH Admission Data Form;
   d. For dually diagnosed individuals (MH/ID), and as required by joint OMHSAS/OMR Bulletin # 00-02-16, the "Psychiatric Consultation Questionnaire for Persons with Developmental Disabilities"; and
   e. State identification, birth certificate and social security card.

H. Admission Process

1. All admissions will be scheduled on days and times in accordance with the availability of beds.
2. Admissions are scheduled for arrival to the SMH or SMRC Monday through Friday in the morning unless an exception has been authorized by the SMH or SMRC.
3. It is the responsibility of the County MH/ID Program to arrange for appropriate transportation for individuals accepted for admission to the SMH through communication with the SMH Admission Coordinator.
4. Individuals approved for admission to the SMH will be enrolled in

County MH/ID program services, and will be provided with County Case Management services during the course of their treatment at the SMH. Additionally, discharge planning and aftercare services will be provided as mandated by the MH/MR Act of 1996. These services may be provided directly by the county or via county contracted services.

II. VOLUNTARY ADMISSIONS

A. Voluntary admissions are to be used on an exceptional basis such as in the instance of an interstate compact transfer, and only under the following conditions:

1. The individual requests a voluntary admission.
2. The county approves the clinical appropriateness of the voluntary admission, and all community treatment alternatives have been explored and discussed with the individual.
3. The County Administrator (or designee) and the OMHSAS Director of the Bureau of Community and Hospital Operations shall provide authorization for the voluntary admission to the SMH Chief Executive Officer (or designee). The authorization may be conveyed verbally but must be followed up with written confirmation within 10 business days prior to admission.
4. The SMH admitting physician finds the individual appropriate for treatment.

B. The SMH retains the right not to admit voluntary referrals if the psychiatrist does not believe the individual is appropriate for voluntary treatment due to competency or clinical condition. The hospital must notify the OMHSAS Director the Bureau of Community and Hospital Operations and the responsible County Administrator (or designee) when the individual is not accepted for voluntary admission.

III. INVOLUNTARY COMMITMENTS OF MH/ID DUALLY DIAGNOSED INDIVIDUALS

The Procedure for 304 Involuntary Commitments of MH/ID Dually Diagnosed Individuals is as follows:

A. The community hospital must notify the County Program or its Case Management Representative prior to filing a 304 petition for an individual with a diagnosis of intellectual disability (i.e., a full scale I.Q. of 70 with significant adaptive deficiencies in at least two functional skill areas diagnosed prior to age 22. See 55 PA Code Section 4210.101a. and Office of Developmental Programs Bulletin No. 4210-02-05,“Clarifying Eligibility for Determining Intellectual Disability Services and Supports”, 5/31/02)

B. The County Program or Case Management Representative must notify both OMHSAS and the Office of Developmental Programs (ODP) regional Field Office staff to request a review of the dually diagnosed individual for possible

diversion prior to filing a 304 petition. Notification to OMHSAS will occur at the time of admission to the community hospital or prior to filing a 304 petition. The county and treating facility are responsible for completing the "Higher Level Referral Form" and sending it to both the Field Offices and the MH/ID coordinators.

C. Within two weeks of the receipt of the "Higher Level Referral Form" and all other supporting documentation, the Department of Human Services' (DHS) reviewers will visit and assess the individual and interview the team members as appropriate. The following individuals will be invited to participate: OMHSAS and ODP coordinators, OMHSAS and ODP Field Office representatives, SMH or SMRC staff, MH/ID county staff, provider and treatment team members, family members and the individual.

D. Prior to the meeting, documentation of the following activities must be compiled for participants to review:

1. The individual's most current community living plan with their updated Community Support Plan (CSP), if the individual has previously been hospitalized in a SMH and has had a CSP;
2. The individual's hospital treatment plan and discharge plan;
3. Documentation and assessment of the individual's current psychiatric diagnosis and clinical symptoms necessitating continued inpatient psychiatric care;
4. A written summary of efforts, to date, to develop a community based alternative to SMH admission;
5. Prioritization for Urgency of Need for Service (PUNS) registry information and any available school records supporting the individual's ID or developmental disability determination.

E. Within one week after the meeting, a separate report from both OMHSAS and ODP will be written and submitted to their perspective Bureau Directors. A pre-admission packet for a dually diagnosed individual will be considered incomplete without this information, and no further action will be taken on the case by the SMH until the reports are received.

F. Upon receipt of all the information in D, designated SMH staff will assess the clinical appropriateness of the admission for SMH level of care.

G. The designated SMH representative will discuss the case with the MH/ID Administrator or their designee to determine if they support filing a petition for a 304 commitment.

H. If the case is not clinically appropriate for SMH or SMRC level of care and cannot be diverted, and all routine methods of resolution are unsuccessful, the SMH will refer the request to OMHSAS so that both OMHSAS and ODP are involved in the final determination.

IV. PROCEDURES FOR TRANSFER OF INDIVIDUALS TO CIVIL STATUS FROM FORENSIC FACILITIES TO CIVIL UNITS OF SMHs

A. Individuals in a Regional Forensic Psychiatric Center (RFPC) who convert to civil status must be transferred to a civil unit of a SMH serving their county of residence as soon as feasible, but no later than the first available open bed date at the appropriate civil hospital catchment area.

B. Conditions in which a forensic individual converts to civil status (no longer subject to criminal detention):

1. The charges have been dropped, nolle prossed, or the prosecution has been withdrawn; or,
2. There has been an acquittal on charges; or,
3. The individual has been placed on probation or parole; or,
4. The individual has been released on bail; or,
5. The individual has served the maximum sentence; or,
6. The individual has received credit for time served, causing the sentence to expire; or,
7. The committing court has ordered the individual to transfer to a civil unit; or,
8. The individual from a county jail or State Correctional Institution (SCI) who has been served within the RFPC is no longer in need of a secure stetting.
9. A finding that there is a sustainable possibility that the individual will not become competent in the foreseeable future as per section 403(d) of the Mental Health Procedures Act.

C. Requirement for transfer

1. When the RFPC has verbal notification that an individual is no longer subject to criminal detention and an appropriate commitment exists to permit transfer to a civil hospital, the RFPC will verbally notify the admissions office of the receiving hospital to begin planning and establish a tentative date for transfer. The court must be in agreement and provide written notification regarding the status of the criminal charges prior to a transfer occurring. The goal of DHS is for the transfer to occur as soon as feasible, but no later than the first available open bed date at the appropriate SMH catchment area.

2. The RFPC is responsible to complete the following pending the transfer:

a. Notify the Criminal Court and the Mental Health Review Officer (MHRO);
b. Notify the CEO of the receiving SMH, who shall notify the

respective Regional Manager;

c. Notify the County Administrator and the Base Service Unit of the individual's county of residence, using MH form 537-6138 (Aftercare Plan and Discharge Summary);

d. Notify the individual's next of kin, significant other or legal guardian;

e. Arrange for transportation for the individual to the civil hospital on the date of transfer.

3. Within five business days of the initial forensic admission or the forensic recommitment of an individual whose sentence will expire during the term of the current commitment to a RFPC, the forensic unit shall verbally and in writing notify the SMH Admission Coordinator of the civil hospital serving the individual's county of residence that a forensic-to-civil transfer may be forthcoming.

4. The admission shall not be scheduled until a bed is made available and cleared by the county program. The SMH system must comply with admissions from the Pennsylvania SCIs, if appropriate, when a bed is available based upon the expiration of the criminal sentence. SMH or SMRC admissions will be scheduled Monday through Friday during business hours unless approved by the SMH or SMRC.

5. Once the admission is scheduled, the civil commitment petition must be prepared and heard in order for the individual to be moved. A confirmed commitment and certified court order must be received by the SMH before the admission can occur. 304/305 orders must be signed by a civil or criminal judge and not the MHRO alone.

V. RECOMMITMENT HEARINGS

As indicated by the clinical needs of each individual, the SMH treatment team will petition for recommitment hearings under Sections 303, 304, and 305. The SMH shall act as the petitioner to recommend extensions for involuntary commitments.

COMMUNITY SUPPORT PLAN PROCESS

The Community Support Plan (CSP) process was developed to be used simultaneously with discharge planning from SMHs to facilitate a coordinated and supported discharge process to return an individual to the community with appropriate support. The CSP is a person-centered plan which includes the services, supports and residential preference the individual has identified as vital to their recovery process to promote a successful transition from the SMH to the community. The CSP document follows the individual and will be updated as the recovery goals and needs of the individual change.

During admission to a SMH, an individual will have the opportunity to participate in the development of their CSP to prepare for discharge back to the community. Additionally, all individuals who have been in a SMH for two years or more will have a completed CSP. Participation in the development of the CSP will include staff from the individual's respective county, community and hospital, the individual's family, and anyone identified by the individual as supporting their successful recovery. The individual is the most important member of the CSP process, and therefore will be encouraged to participate. If the individual declines to participate, their decision will be respected and honored by the treatment team. However, in this circumstance, the SMH will continue to encourage the individual to participate in the CSP process throughout their stay.

A referral to the SMH for an individual who was previously discharged from a SMH, requires that a CSP review meeting be held to attempt to divert the individual from readmission. The purpose of this meeting is to review community based options to divert admission.

SMH staff will begin to initiate portions of the CSP which will be implemented during the admission to the SMH. At the same time, community staff will prepare the remainder of the plan to be implemented upon discharge. A plan for close monitoring during the first month post discharge is to be developed collaboratively as this is a crucial time for successful transition into the community.

At the time of discharge, the SMH will assure that a copy of the final CSP document is provided to the individual, the individual's family as permitted by the individual, the representative from the admitting county, and the County Case Manager, Assertive Community Treatment (ACT) team, or Community Treatment Team (CTT) working to support the individual's discharge from the SMH. The county Behavioral Health representative or the County Case Manager, ACT, or CTT, based on county procedures, will assure that a copy of the final CSP document is provided to any additional supports authorized by the individual. The county behavioral health program is responsible for monitoring the implementation of the CSP upon discharge.

Following discharge, it will be the County Case Manager's responsibility to provide regular updates to the county Behavioral Health Representative on the status of the CSP implementation and changes that may occur after the person returns to the community. If the person has ACT or CTT services this will be the team's responsibility. It will be the responsibility of the county Behavioral Health program to develop a process with the County

Case Manager, or if applicable the ACT or CTT entities, to obtain regular updates on the status of the CSP implementation. The updates shall occur no less than quarterly for the first year following the individual's SMH discharge. Updates may be provided more frequently as needed based upon the client's recovery needs. This information will include changes that were made and why the changes were necessary.

DISCHARGE PROCESS

It is the joint responsibility of the County MH/ID Program and SMH or SMRC to assure that appropriate and expeditious arrangements are made for individuals who are clinically ready to be discharged from the SMH.

After the SMH treatment team has recommended an individual be discharged, it is the responsibility of the SMH or SMRC staff to notify the designated County Case Manager. The County Case Manager shall participate in pre-discharge planning conferences, and process referrals for community services in accordance with the individualized CSP.

I. PLANNED LEAVE FROM THE SMH

A. A trial visit or leave shall occur in preparation for the individual's discharge as clinically indicated, and will be stated on the individual's treatment plan.

B. The County Case Manager will be involved in discharge preparation and planning including the arrangement of trial visits and leave which shall be included in the individual's treatment plan.

C. When an individual is released on a trial visit, the SMH will notify the County Case Manager of the duration.

D. Arrangements to pay for necessary expenses during the trial visit or leave will be finalized prior to the scheduled leave. Clinical and financial abatements, if appropriate, will be requested by the SMH Social Worker.

E. The County Case Manager shall inform SMH staff if the individual requires emergency services, a critical event such as an arrest occurs, or the individual goes AWOL during a trial visit or leave. If the incident occurs after 4:00 p.m. on a weekday, on a weekend or on a holiday, the County Case Manager or their designee will immediately inform the SMH Nursing Office. During weekday business hours, the County Case Manager will notify the SMH or SMRC Social Worker, or the SMH CEO if the SMH or SMRC Social Worker is not available.

F. The County Case Manager and the SMH staff will discuss the individual's adjustment to the trial visit or leave upon its completion in a meeting with the treatment team.

G. The individual's subsequent leave, visitation schedule and discharge plan will be developed by the SMH Treatment Team based on the individual's adjustment to community living as conveyed by the County Case Manager.

H. The SMH staff will be responsible for transportation to the community residential setting for the trial visit or leave. Exceptions to this protocol will be

made through discussions at the CSP meetings.

I. In accordance with civil commitment laws, an individual on a trial visit may return to the SMH if insufficient adjustment to the community occurs.

J. An individual on a trial visit or leave will be given an adequate supply of medications upon departing the SMH.

II. ACTIONS NECESSARY FOR DISCHARGE INTO THE COMMUNITY

A. The SMH or SMRC shall work with the County MH/ID Program to develop specific individualized treatment goals with achievable progression toward re-entry into community living. The CSP process begins at admission and identifies the necessary support services to be in place when the individual is discharged from the SMH. Review and planning meetings will be scheduled with the SMH staff, county, community partners, and family to assist the individual with successful transitioning to community living.

B. The SMH or SMRC will provide, at minimum, a 15-day supply of the individual's medications. Up to a 30-day supply of medication may be provided based upon the treatment circumstances of the individual, and as determined by the SMH CEO and Chief Medical Officer (CMO) or the SMRC CMO. Individuals having a Medicare Part D plan will receive one week of medication and a prescription for an additional 21 days of medication. The County Case Manager will assist the individual to assure attendance at an outpatient appointment so their medication regime continues.

C. The SMH or SMRC shall provide the County MH/ID Program with the SMH After Care Plan and Discharge Summary (MH 537). The SMH shall also provide the County with a Psychiatric and Medical Discharge Summary.

D. The OMHSAS guidance document dated August 18, 2009 states that SMHs will not refer people ready for discharge to a Personal Care Home (PCH) larger than 16 beds unless an exception has been granted. In this circumstance, the SMH or SMRC will submit a Waiver Request to the OMHSAS Community Program Manager for approval before the discharge occurs.

E. Within the SMH system, there are situations where an individual may require intensive skilled nursing or rehabilitative services to address their needs. If the individual's treatment team decides the individual may benefit from nursing facility level of care, specific steps shall be taken to ensure this level of care is required. Steps to be taken include the following:

1. A CSP meeting is held to discuss all possible community placement options. If it is determined that a nursing facility placement should be considered, Medical Records and the assigned Social Worker shall develop a packet containing documentation from the last three months

which includes the following: medical, psychiatric, psychological, nursing, and social work assessments; the last 30 days of progress notes; and pertinent lab and testing information. The packet is forwarded to designated clinical staff at OMHSAS in Harrisburg.

2. The designated OMHSAS staff reviews the information and writes a report with their recommendation for nursing facility admission. The report is then submitted to the Bureau Director of Community and Hospital Operations who provides the final recommendation for approval or denial of a nursing facility admission.
3. In the event that the nursing facility placement is denied by either the OMHSAS clinical staff or the Bureau Director of Community and Hospital Operations, the review process terminates, and alternative placement options must be considered.
4. In the event that the nursing facility placement is approved, the SMH shall contact the County Area Agency on Aging (AAA) to refer the individual for an assessment. Following the completion of the AAA assessment, the AAA shall forward their findings to the Omnibus Budget Reconciliation Act (OBRA) where a final decision is made regarding the appropriateness of nursing facility level of care.
5. During this process, the individual and family members are encouraged to express their desires and opinions, and open communication between all involved parties is encouraged.
6. If OBRA determines the individual is appropriate for nursing facility care, the SMH is responsible to locate potential nursing facility placements, and the individual is encouraged to visit potential placement options.

III. EXPECTATIONS FOR FINANCIAL AND LOGISTICAL ASPECTS OF DESCHARGE AND RE-ENTRY INTO THE COMMUNITY

It is the responsibility of the SMH or SMRC staff and the County Case Manager to ensure appropriate financial resources and benefits are available to the individual being discharged. The SMH or SMRC Social Worker and the County Case Manager will be jointly responsible for developing a financial plan with the individual which addresses their needs as discussed at the CSP discharge meeting. The financial plan shall address the following:

A. The SMH or SMRC Social Worker shall determine the individual's health insurance and the need to apply for Medical assistance benefits on behalf of the individual.

B. The SMH or SMRC Social Worker will complete the appropriate benefit applications and will determine with the County Case Manager what actions are required for the individual to receive benefits following discharge.

C. The County Case Manager will project the individual's monthly expenditures and ensure the individual has adequate income to cover expenses.

D. The County Case Manager will determine the individual's need for ongoing assistance with money management.

IV. AGAINST MEDICAL ADVICE (AMA) AND AWOL DISCHARGES

The SMH or SMRC shall notify the appropriate County Case Manager of an individual leaving the SMH grounds AWOL or AMA immediately upon elopement from the premises so attempts may be made to re-involve the individual in treatment services.

When an individual leaves the SMH or SMRC, AWOL or AMA, the following entities shall be notified by the appropriate SMH or SMRC staff as indicated:

A. The Pennsylvania State Police with a missing person's declaration;
B. The local township police if the individual has been placed in the judicial system;
C. The local judicial system if the individual is on an involuntary forensic commitment or under judicial oversight;
D. The MH/ID Administrator's Office during business hours, or the CEO/Administrator on Call will notify the county contacts after business hours;
E. The Crisis Intervention Services after business hours;
F. The next of kin or other significant persons;
G. Any person believed to be "at risk" of harm from the individual.

V. OUTPATIENT COMMITMENTS

The balance of an inpatient commitment will be transferred to outpatient, partial hospitalization services or Long Term Structured Residential (LTSR) services as clinically determined by the SMH and community staff. Effective the date of discharge, the individual's balance for inpatient commitment shall be transferred to the appropriate service as recommended by the SMH or SMRC Treatment Team.

CONTINUITY OF CARE

I. THE STATE HOSPITAL AND COUNTY PROGRAM AGREEMENT

The SMH and County Program agree:

A. To share and protect an individual's information and provide access to an individual's records in accordance with State and Federal regulations governing confidentiality and the protection of individual rights;

B. To cooperate in the preparation of mental health petitions in accordance with 55 Pennsylvania Code § 5100;

C. To share information, comments, and recommendations in annual planning and budgeting processes; and

D. To share in any statistical reporting or other related communications.

II. THE ROLE AND FUNCTION OF SMH STAFF

A. The SMH or SMRC social work staff and the treatment team will maintain ongoing communication with designated County Case Managers to share information regarding discharge preparation and planning, commitment status, treatment progress, and other relevant information. County Case Managers will be invited to attend team meetings, commitment hearings, CSP meetings, and other conferences related to discharge planning for the individuals.

B. The SMH Social Work Department will assure the County liaison is notified within one working day of the following critical incidents:

1. Medical admissions;
2. Assaults resulting in medical treatment or criminal charges;
3. Death;
4. AWOL incidents;
5. Incidents involving criminal charges;
6. Incidents involving serious injury.

III. ROLE AND FUNCTION OF THE COUNTY CASE MANAGERS

A. The County MH/ID Program will provide liaison services for all individuals from its county admitted to a SMH. County Case Managers shall maintain contact with individuals admitted to a SMH and will participate in appropriate hospital treatment planning conferences following admission and prior to discharge. The county liaison

shall accept referrals for aftercare support services recommended by the SMH or SMRC staff, and ensure the individual is referred to the appropriate MH/ID provider for aftercare services in a timely manner.

B. The case management entity will assure the following:

1. The County Case Manager participating in the SMH or SMRC treatment team meetings, discharge planning or liaison services will sign a confidentiality statement pertaining to information protected by the Health Insurance Portability and Accountability Act (HIPAA).
2. Access to each SMH's or SMRC's living units will be governed by each facility's policy.
3. Upon a County Case Manager's arrival and departure, the SMH or SMRC's sign-in and sign-out procedures shall be adhered to.
4. Access to confidential health care information will be governed by each SMH's or SMRC's medical record's procedures.
5. Participation in training as per SMH or SMRC requirements which may include safety procedures and crisis intervention.

D. The County Case Manager and the SMH or SMRC staff will work cooperatively to ensure continuity of care. Prior to an individual's discharge, the SMH or SMRC staff will provide the County Case Manager with the individual's discharge summary, social history, psychiatric and psychological evaluations, and other pertinent information required for referrals to community service programs. Upon receipt of this information, the County Case Manager shall develop a CSP and refer the individual to community services including treatment providers. Information released to the County Program will be used in securing aftercare support services from service providers with whom the County Program has a contractual agreement. The County Case Manager shall ensure the completion of the County liability determination, applications and referrals for aftercare support services, scheduling of aftercare appointments, and follow-up on benefit applications.

CONTINUITY OF CARE MEETINGS

The appropriate Field Office, Bureau of Community and Hospital Operations, and OMHSAS will hold quarterly Continuity of Care meetings with the County MH/ID Administrator and the SMH CEO or their designees. Continuity of Care Meetings will involve planning for the individual's evaluation and treatment in the least restrictive setting. Cooperation and collaboration shall be encouraged among the individual, the individual's family, clinical supports, administrative staff of the state facility and community, and those in the individual's support system. Additional county specific meetings may be convened as needed.

Continuity of Care meeting minutes will be maintained by the SMH and shall address the following routine agenda items:

1. OMHSAS updates;
2. County reports (each SMH has designated counties in their catchment area as indicated **Attachment 1**);
3. CSP updates, trends and issues pertaining to system development from both the county and hospital perspective;
4. State hospital updates;
5. Admission referral, admissions, and discharges report;
6. Issues impacting admissions and discharges.

CONFLICT RESOLUTION

It is the policy of the County MH/ID Program and the SMH or SMRC that disagreements be resolved at the lowest level possible. Staff of either agency, if dissatisfied with action taken by a staff member of the other agency, have the right to bring their concerns to the attention of their supervisor. A disagreement that is not successfully resolved by the County Administrator and the SMH CEO will be referred to the appropriate Field Office in the Bureau of Community and Hospital Operations of OMHSAS.

Disagreements surrounding an individual's treatment shall be addressed first with the attending psychiatrist, and subsequently with the Chief Medical Executive. Issues pertaining to an individual's rights should be reported through the SMH grievance process or to the External Advocate at the SMH or SMRC.

Discharge planning issues may be addressed between the SMH Social Worker and the County Case Manager. If not resolved, the matter should be referred to the Chief Social Rehabilitation Executive.