

DDD AND MH COLLABORATIVE SERVICES & DECISION-MAKING FLOW CHART

A. Essential Components

1. Baseline

- a. Challenging behaviors and/or emotional distress occurs at a minimal risk level.
- b. Various levels of services provided by DDD and MHD based on wishes of person served, level of need, and resources available.
- c. Focus is on quality of life as exemplified by Community Guidelines, i.e., improving competencies, establishing and maintaining relationships, maximizing integration, increasing status, increasing opportunities for power and choice, maximize health and safety.
- d. Where currently available, a Positive Behavior Support Plan (PBSP) is implemented.

2. Crisis prevention and intervention

- a. Challenging behaviors and/or emotional distress increase risk of danger to self or others or becoming gravely disabled.
- b. Focus is on return to baseline functioning
- c. DDD continues to deliver baseline services.
- d. MHD increases services and may include crisis services.
- e. Where currently available, a Cross Systems Crisis Plan (CSCP) is implemented.

3. State hospital admission

- a. Challenging behaviors and/or emotional distress presents an unacceptable risk of danger to self or others or being gravely disabled.
- b. Person not currently able to live in community.

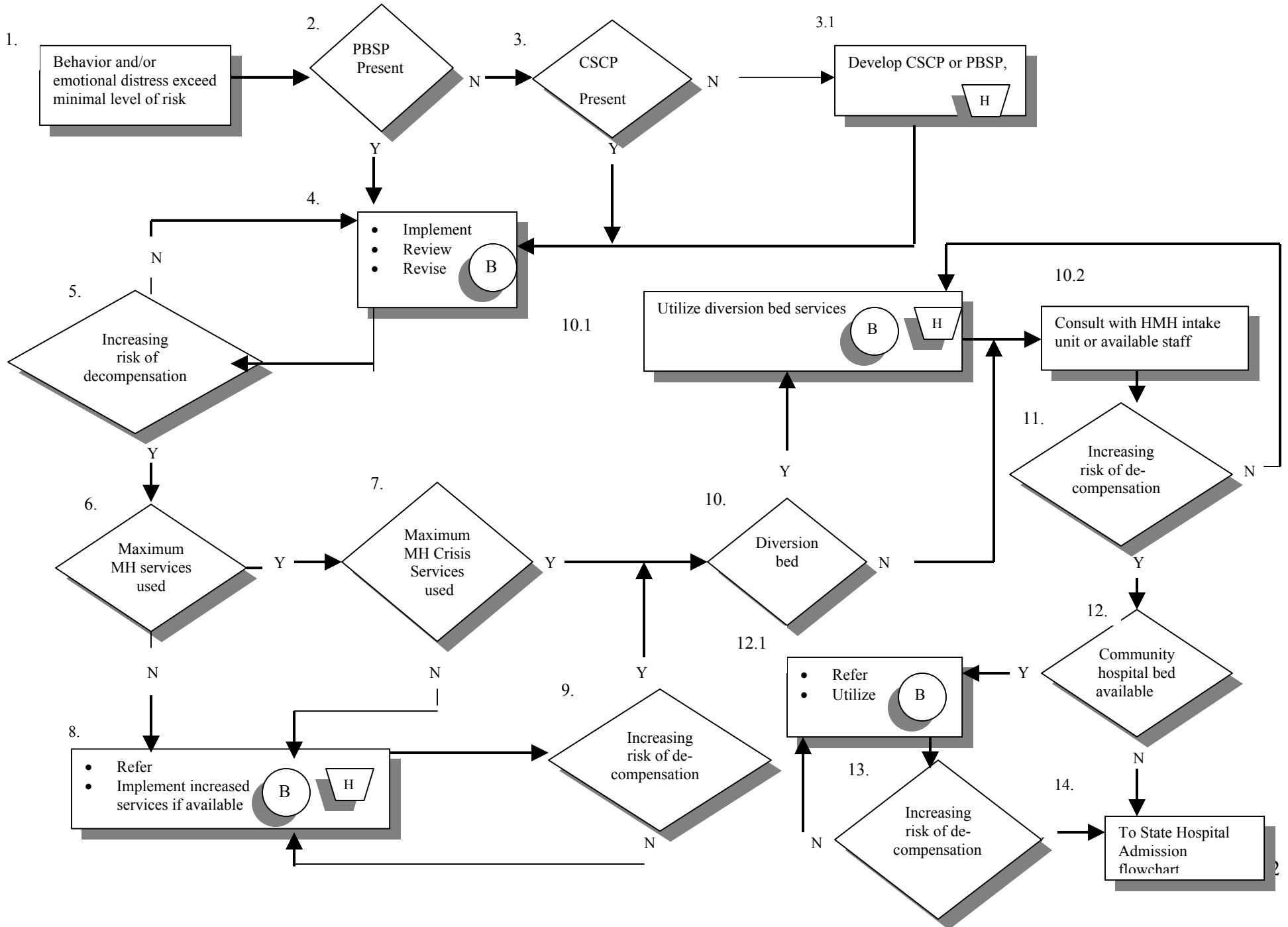
4. State hospital discharge

- a. Hospital treatment and discharge planning is focused on returning the individual to baseline functioning and returning to the community.


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
B. Flowcharts for Essential Components

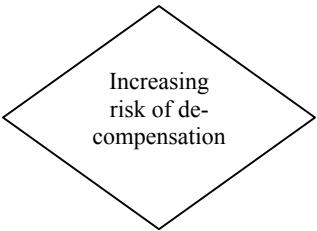
2. Flowchart for crisis prevention and intervention



2.1 Explanation of crisis prevention and intervention flowchart

 This icon should be read as a decision whether or not the person’s behavior or emotional state has returned to baseline functioning. If it has, then the baseline component should be implemented and maintained. The person need not be returned directly to baseline conditions. For example, from Step 12.1 (community hospital use) the person could go to Step 10.1 (diversion bed use). For example, additional funds for residential services may be available upon return, or the staff may have been trained in alternative response techniques, which can alleviate the crisis.

 This icon should be read as an action to contact the DDD specialized units for patients with a dual diagnosis at Western and Eastern State Hospitals for the purpose of getting consultation and/ or informing the administration of the HMH Unit of the emerging crisis. Such an action is especially important if the person with a developmental disability was a patient on the HMH unit in the past.



(Items 5., 9., 11., 13.) The decision here is whether or not the risk of danger to self, others and/or of being gravely disabled increased substantially after or during the implementation of the previous intervention. If the risk has increased, go to the next operation. If the risk did not increase (that is, it stabilized), then the previous operation is continued. Note that stabilizing the risk is not the same as returning to baseline; the risk should return to the minimal level in order for the individual and services to return to baseline. The assessment of risk is relative to the individual, and is best represented by a continuum from low to high levels. Generally, it is based on the frequency, and severity of the behavior as well as its socio- cultural implications.

1. **Behavior and/or emotional distress exceed minimal level of risk.** This is the boundary condition for entering the crisis prevention and intervention decision-making flowchart. Up to this point the person is maintained where the risk of danger to self, others and/or of being gravely disabled was at a minimal level. When the risk substantially increases so that it is no longer at a minimal level, then the crisis prevention and intervention decision-making flowchart is implemented.
2. **PBSP Present?** The decision here is whether or not a Positive Behavior Support Plan (PBSP) is in operation. It is possible that an individual does not have a PBSP.
3. **CSCP Present?** The decision here is whether or not a Cross Systems Crisis Plan (CSCP) is in operation. It is possible that an individual does not have a CSCP.

3.1 Develop CSCP or PBSP. This action here is undertaken when neither a PBSP nor a CSCP exists. The Service Team (Residential and Vocational Providers, Case Managers, Guardian, Psychologist, etc.) should decide whether either or both plans are indicated and develop it. Staff of the HMH units at the state hospitals can provide helpful information on former patients.

- 4. Implement, Review, Revise.** If either a PBSP or CSCP or both are in operation, then those serving the individual should implement them. The Service Team should review and revise the documents and their implementation of these plans in light of their effectiveness.
- 5. Increasing risk of decompensation?** Go to number 4 above.
- 6. MH services fully implemented?** The decision to be made here is whether or not the mental health services in the community have been fully implemented to support the client. Just as is the case with developmental disabilities services at baseline, mental health services are likely to be a function of expressed wishes of the person, assessed need, and the resources available. Mental health services at this step usually include on-site mental health services such as problem-solving and staff consultation and are distinct from mental health “crisis” services in number 7 below.
- 7. MH crisis services fully implemented?** If the person is receiving all the available mental health services and the risk has increased (Item 5), then additional crisis stabilization services may be needed. The decision as this step is whether or not maximum MH crisis services have been provided. Crisis services may include on-site intervention and de-escalation, staff consultation, crisis center visits, etc.
- 8. Refer, Implement increased services if available.** If either regular or crisis MH services are not at maximum utilization, then the Service Team needs to refer the person to a higher level of care in order to increase services in light of the increase in risk (Item 5). This operation includes the implementation of additional available services. Staff on the HMM units at the state hospitals can provide helpful information on former patients.
- 9. Increasing risk of decompensation?** See # 8 above.
- 10. Diversion bed?** Once mental health regular and crisis services are provided at a maximum level, then the decision needs to be made whether or not admission to a diversion bed is appropriate.
- 10.1 Utilize diversion bed services:** If use of diversion bed is appropriate, then such services are implemented. Note that diversion bed services may include alternatives to actual bed use such as mobile diversion services (diversion sites and activities can be provided by diversion bed staff in addition to or in place of actual diversion bed use). Staff on the HMM unit can provide helpful information, but need to be alerted to the fact that the crisis has reached this stage, where a referral for state hospital admission is pending.
- 10.2 Consult with HMM intake.** Given the increased level of risk (Items 5 and/or 9) and the necessity for diversion bed use, the HMM intake staff needs to be alerted to the situation. The early intervention role of HMM is to provide consultation and assessment of need for and appropriateness of State Hospital treatment if risk continues to increase.
- 11. Increasing risk of decompensation?** See # 10 above.

1-16-04

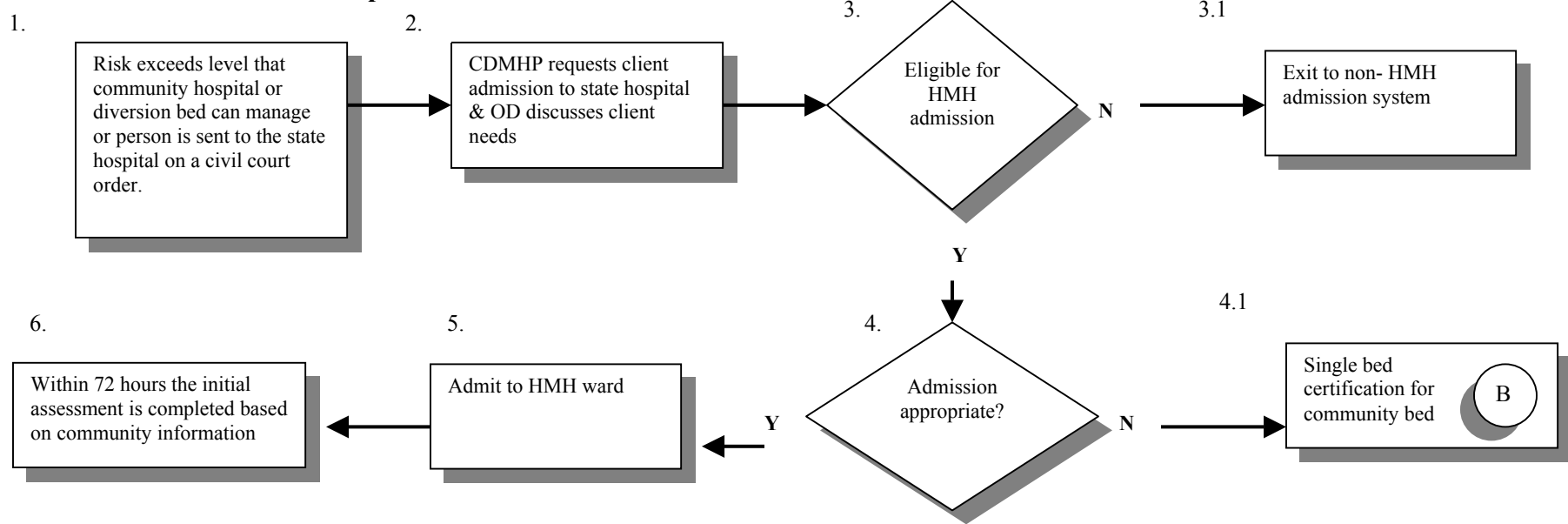
12. Community hospital bed available/appropriate? The decision at this point is whether or not admission to the psychiatric services of a community hospital is available, necessary, and appropriate.

12.1 Refer, utilize. If the psychiatric services of a community hospital are available, necessary, and appropriate, then the Service Team or CDMHP refers the person to the hospital intake. This could involve either voluntary admission or civil commitment.

13. Increasing risk of decompensation? If the risk for decompensation is present, or there is no available and appropriate community hospital bed, see 14 below.

14. Exit to Flowchart for State Hospital Admission. At this point the person moves from the Crisis prevention and intervention flowchart to the flowchart for State Hospitalization Admission. See the flowchart for this system on the next page.

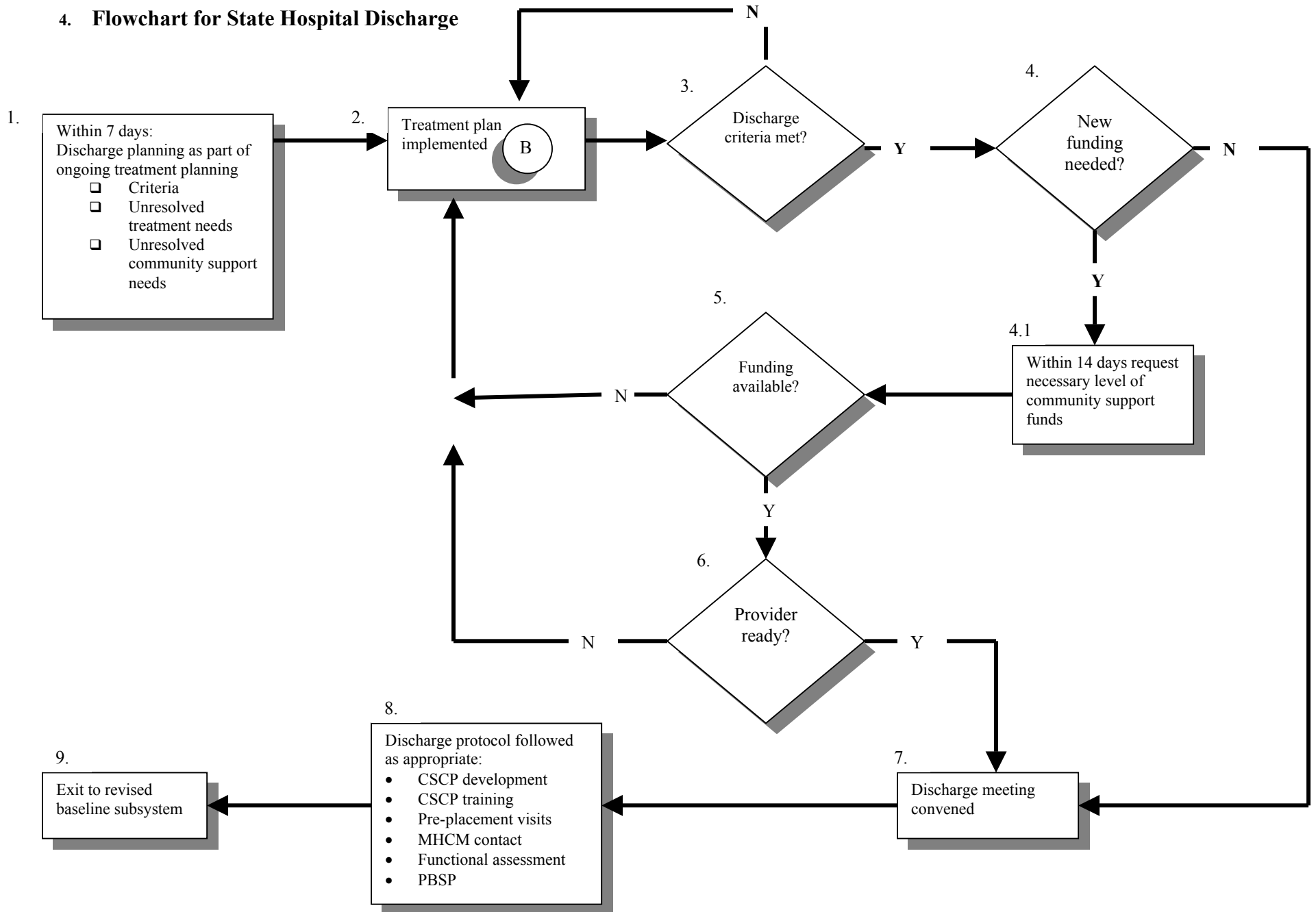
3. Flowchart for State Hospitalization Admission



3.1 Explanation of Flowchart for State Hospital Admission

1. **Risk exceeds level that community hospital or diversion bed can manage.** This is the condition that results in entry into the flowchart for state hospital admission. The assessment of risk is relative to the individual, and is best represented by a continuum from low to high levels. Generally, it is based on the topography, frequency, and severity of the behavior as well as its socio-cultural implications. The CDMHP and the legal system are the gatekeepers for this step.
2. **CDMHP requests client admission to state hospital & OD discusses client needs.** The CDMHP contacts the Officer of the Day at the state hospital to arrange admission. These two components share information regarding the needs of the client. The OD will discuss the client needs with the CD-MHP; including what community alternatives have been tried.
3. **Eligible for HMH Services?** The decision to be made is whether or not the person is eligible for admission into the Habilitation Mental Health (HMH) ward. The key criterion to be considered is whether or not the person is enrolled in the Division of Developmental Disabilities. State hospital nursing staff will ensure the client meets eligibility criteria and will arrange for the individual to be directly admitted to the HMH ward.
 - 3.1 **Exit to non-HMH admission system.** If the person is not HMH eligible, then he/she exits this flowchart and enters another hospital admission unit that can accommodate him/her.
4. **Admission is Appropriate?** The decision to be made is whether or not a bed is available and if the admission meets hospital requirements.
 - 4.1 **Single bed certification for community bed:** If the individual's need meets the hospital requirements, but no space is available, the state hospital has the authority to certify a bed for the person in a community hospital.
5. **Admit to HMH ward.** If a bed is available, and the individual's admission meets the hospital requirements, the state hospital will admit the client to an HMH ward.
6. **Within 72 hours assessments completed based on community information.** Within 72 hours, information from the community providers (DD and MH) will be provided to the hospital in order for professional assessments to be completed regarding the best placement and treatment plan for the client.

4. Flowchart for State Hospital Discharge



4. Flowchart of State Hospital Discharge

1. Admission to a State Hospital/ Discharge Planning as part of Treatment Planning:

When a DDD client is admitted to a state psychiatric facility, the DDD Placement Team will notify the HMH Unit Treatment team if the patient has a current community provider and existing funding. Within seven days of admission, the initial treatment/discharge conference will occur. The initial treatment plan will be developed by the HMH Unit Treatment Team, in consultation with the DDD Placement Team. Upon admission, the DDD Placement Team will notify the HMH Unit Treatment Team of the existence of a community provider. If the patient was admitted from a community placement or has existing funding, the HMH Unit Treatment Team will consult with a representative of the community provider about conditions that may have precipitated the admission. Initial treatment plans shall include individualized behavioral strategies, treatment goals targeted to address the reasons for the patient's hospitalization, including the factors that cause the patient to be a danger to self or others or be gravely disabled, and initial discharge criteria. The HMH Unit Treatment Team and the DDD Placement Team shall also identify factors that may present an obstacle to the patient's return to the community, including unresolved treatment needs and community support needs, and shall begin identifying potential providers and funding needs. The discharge criteria will be objective, measurable, individualized, and clinically based, and will be developed jointly by the HMH Unit Treatment Team and the DDD Placement Team.

The HMH Unit Treatment Team and the DDD Placement Team will consult with the patient and his or her guardian (if any), or appropriate family members (with consent of the patient) and any existing community providers when formulating discharge criteria and treatment plans. This consultation will be documented in the patient's chart. The patient or the patient's guardian (if any) and the DDD Placement Team will be provided with a copy of the treatment plan including the discharge criteria. The patient's family members will be provided with a copy of the treatment plan, upon request, and with consent of the patient or guardian. The patient's chart shall contain documentation that copies were provided. The DDD Mental Health Case Resource Manager will be the designated contact person for guardians, or authorized family members who have questions about the discharge process.

Treatment plans and discharge criteria will, to the extent possible, be written in a manner that is understandable to the patient. Patients or their representatives will be offered an opportunity to receive summaries of treatment plans and discharge criteria in a simplified form that reasonably facilitates patient understanding, taking into account the patient's level of cognitive functioning. For patients incapable of understanding such documents, treatment plans and discharge criteria will be explained verbally to them in a manner reasonably tailored to their ability to comprehend and this will be documented in their charts.

2. Treatment plan implementation:

The patient will participate in active individualized habilitative mental health treatment throughout the hospitalization. Progress in treatment and toward meeting discharge criteria will be documented on a regular basis and in compliance with hospital policy. The treatment plan,

1-16-04

including discharge criteria, shall be reviewed on an on-going basis by the HMH Unit Treatment Team and the DDD Placement Team as well as other relevant parties such as the RSN liaison, community care givers, and family/guardians, as appropriate. Such reviews shall take place no less than every 90 days and shall be documented in the patient's chart at the state hospital. If patients are not making reasonable progress toward treatment goals, modifications to the treatment plan will be considered. It is at this stage that efforts begin towards securing an appropriate level of residential services and supports.

3. Discharge Criteria Met:

On an ongoing basis, the DDD Placement Team, the HMH Unit Treatment Team, and the RSN to which it is anticipated the client will return upon discharge, will work with community providers to identify client needs and determine appropriate residential support needs and other appropriate community support and funding needs, including mental health services. Identified providers will be informed of treatment goals and asked to participate in on-going treatment and discharge planning efforts.

The HMH Unit Treatment Team and DDD Placement Team will make decisions regarding the patient's progress in meeting discharge criteria hospital jointly. The HMH Unit Treatment Team, after consultation with the DDD Placement Team, will consider modifications to the treatment plan, including modifications to discharge criteria, on a clinical basis. A copy of any revised treatment plan will be provided to the DDD Placement Team.

The patient, the patient's guardian (if any) or appropriate family members (with the patient's consent) will be notified about the reassessment of the treatment plan, amendment process and notified of any changes. The patient or guardian will be provided with copies of the new or amended treatment plan with the specific changes noted. With the patient's consent, appropriate family members will receive a copy of the amended treatment plan upon request. The patient's chart will document that such copies were provided.

A pre-discharge meeting shall be convened by the HMH Unit Treatment Team, allowing sufficient time to arrange for appropriate community services, funding, or transitioning services to the community (as determined by the treatment team). At that meeting, the HMH Unit Treatment Team and the DDD Placement Team shall review the treatment plan, the patient's current community service needs, including residential service needs, whether providers have been identified to meet those needs, and whether funds currently exist to meet the identified needs.

4. New Funding Needed:

Where there exists funding to meet identified needs, and a placement is available, the placement will occur according to the provisions of the discharge plan.

4.1.a. If new funding is required to meet identified needs, relevant information about the patient, along with a request for funding for any necessary services, shall be submitted within 14 days of the pre-discharge meeting by a designee from the DDD Placement Team to the DDD Mental Health Program Manager and the MHD Program Administrator.

5. Funding Available:

When new or additional funding is needed for a discharge to the community, the DDD Mental Health Program Manager and the MHD Program Administrator will notify the HMH Unit Treatment Team and the DDD Placement Team, in writing, when the requisite new funding is authorized. Patients will be informed about such funding if receipt of this information is considered clinically appropriate by the HMH Unit Treatment Team. When new or additional funding necessary for discharge of a particular patient is determined to be unavailable, disapproved, or otherwise not authorized, the DDD MH Program Manager and or the MHD Program Administrator will notify WPAS within seven working days of such determination. While awaiting approval for new funding, the client will continue to receive active treatment on the unit.

When funding is approved, and discharge criteria are met, move to step 6.

6. Provider ready:

See number 8.

7. Final Discharge Meeting:

When the community placement is in place, the HMH Unit Treatment Team and the DDD Placement Team will meet in a timely manner, consistent with the individual patient's needs, to finalize discharge preparation. The final discharge meeting shall be held sufficiently in advance of discharge to reasonably ensure that all appropriate preparations for discharge are in place.

8. Discharge protocol:

No patient will be discharged without a cross-system crisis plan. The cross-system crisis plan will be developed/revised by the HMH Unit Treatment Team, the DDD Placement Team, DDD and MH community providers, the patient, the patient's guardian (if any), and appropriate family members (with consent from the patient) prior to the patient's discharge. The meetings to develop the cross-system crisis plan should be done in a location that is convenient to most participants, most often the client's home community. Teleconferencing will be available for participants as needed. A member of the crisis team in the region to which the patient will be discharged will be notified of the meeting and should attend or participate by teleconference. This shall occur at least 14 days prior to discharge unless a placement will be available within a short timeframe, in which case the meeting will be held at the earliest possible date.

Prior to discharge the RSN liaison will ensure that a copy of the cross system crisis plan has been provided to the crisis team. DDD staff, and others as appropriate, will provide training to community facility staff prior to discharge. Pre-placement visits by the patient to the community facility or other opportunities for facility staff to meet with the patient will be provided if needed for a successful and timely discharge. The patient will have an appointment with the mental health provider scheduled prior to discharge. The HMH Treatment Unit

1-16-04

Team will ensure that adequate client information be provided to the community support network including mental health follow up, and current medications. The HMH Unit Treatment Team and the DDD Placement Team will ensure that the receiving residential provider/caregiver has the current PBSP, Functional Assessment, Cross System Crisis Plan and other relevant information.

9. Exit to the community:

On the day of discharge, the patient will move to his/her community residence, which may be a new residence, or a former residence that has undergone any appropriate revision to support the individual. HMH Unit treatment staff will be available for consultation as needed.

Appendix to Flowchart for State Hospital Discharge:

Definitions:

- a. **“Initial Treatment Plan” or “Treatment Plan”** means an individualized plan established within seven days of admission that provides individualized behavioral strategies and treatment goals targeted to address the reasons for the client’s hospitalization. The plan is done in consultation with the patient, guardian (if any), or appropriate family members (with consent of the patient) and provider.
- b. **“Initial Discharge Criteria: or “Discharge Criteria”** means criteria developed and clearly linked to the treatment plan. These criteria will be objective, and measurable, and will be agreed upon by the HMH Unit Treatment Team and the Division of Developmental Disabilities Placement Team. In establishing these criteria the teams will identify factors that may present an obstacle to the patient’s return to the community, including unresolved treatment needs and unresolved community support needs.
- c. **“HMH Unit Treatment Team”** means staff of Western State and Eastern State HMH Units who are responsible for development and implementation of all treatment plans, and development and implementation of discharge criteria.
- d. **“DDD Placement Team”** means those employees of the Division of Developmental Disabilities (DDD) who are responsible for facilitating the development of community resources, including residential services and other appropriate supports, for DDD enrolled individuals who are at Western State or Eastern State Hospital. This typically involves the appropriate DDD Regional Field Services Psychologist and the DDD Regional Mental Health Case/Resource Manager, but in some cases may involve other DDD staff.

- e. **“DDD Mental Health Case Resource Manager”** means the DDD regional employee responsible for facilitating the development of community resources for DDD enrolled individuals being discharged from Western State and Eastern State Hospitals.
- f. **“DDD Mental Health Program Manager”** means the DDD headquarters employee assigned to manage DDD’s mental health program.
- g. **“MHD Program Administrator”** means a headquarters employee of the State Mental Health Division who is responsible for administering the Mental Health Division’s collaboration with the Division of Developmental Disabilities.

Dispute Resolution:

Any dispute regarding implementation of this discharge policy between the HMH Unit Treatment Team and the DDD Placement Team will be resolved by submitting the issue to the MHD Program Administrator and the DDD Mental Health Program Manager, or their designees. In the event that they cannot resolve the dispute within 10 working days of its submission to them, the issue will be submitted 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. The Director of the Mental Health Division will make the final resolution to any disputes within 10 working days of their submission to the Directors.

Discharge Prioritization:

The MHD Program Administrator and the DDD Mental Health Program Manager will review new funding requests when the patient has been determined to be ready for discharge. When more than one HMH Unit patient is currently ready for discharge, the following criteria may be considered as appropriate in evaluating who will access available funds, together with other criteria appropriate to the patients’ needs and circumstances:

- The current availability of identified residential providers and needed community resources.
- The relative potential risk for patients at the state hospital who are ready for discharge, as assessed by the HMH Unit Treatment Team.
- The willingness of the patient to cooperate with his/her treatment plan.

These criteria are not exclusive and are not listed in any order of priority. Each determination must be based on the respective needs of the individual patient and other patients at the state hospital.

1-16-04