DMH INTERNAL PROTOCOLS REGARDING DISCHARGE OF CLIENTS COVERED BY THE FY 15 COMMUNITY EXPANSION PLAN

The Massachusetts Department of Mental Health, in the interest of promoting and maintaining optimal clinical care and treatment for DMH clients, plans to implement the following practices and protocols concerning patients who are to be discharged from DMH continuing care hospitals under the FY 15 Community Expansion Plan.

- If any of the 100-160 patients discharged from DMH Continuing Care Facilities as part of the FY15 Community Expansion Initiative is determined to need inpatient level of care by an Emergency Services Program (ESP) in conjunction with her/his DMH or CBFS care team within 30 days of discharge, the appropriate Area Medical Director will be notified by that ESP or involved DMH or provider staff. The following steps will then be taken:

    1. The Area Medical Director, in collaboration with the State Medical Director, will authorize and facilitate admission to the continuing care facility from which the patient was discharged. It is understood that prior to authorizing such an admission, all involved parties will consider other dispositions (e.g. respite, community crisis beds, etc) as well as the appropriateness of a brief acute admission. Admission decisions must be clinically driven.

    2. Within 24 hours of the patient's readmission to the Continuing Care Facility, a case conference will be convened to review the circumstances of the "unsuccessful discharge" and a revised disposition plan will be developed.

- DMH is interested in ensuring that all DMH clients discharged from acute inpatient and continuing care facilities have a "Crisis Plan" in hand when they leave. This "Crisis Plan" will be developed in conjunction with Inpatient Staff, the DMH Site Office Staff, the CBFS or PACT worker or the DMH Case Manager and most significantly, the client.

    The "Crisis Plan" may include the following:

    1. Name, telephone number and email addresses of all outpatient and community based care givers. Such a list might also include family members, peer supporters, community and social supporters, et al. Staff and clients will work collaboratively to identify individuals who can be called upon to avert or ameliorate a crisis.

    2. DMH will coordinate the action steps to be taken if disposition plans and recommendations are not followed. These action steps may include: identification of the emergency services program/staff to call when an emergency is imminent; the names and numbers of peer supports and navigators; the names and numbers of therapists and counselors; the names and numbers of respite and community crisis bed providers. Ideally, the client will connect with all or any of the above responders if he or she is in crisis or at risk of such. If any individual identified in the "Crisis Plan" has a concern

about the client, that individual may reach out to whomever he or she thinks might be helpful in managing a crisis that could lead to a hospital admission.

3. The "Crisis Plan" may also state a preference for a particular facility should acute hospitalization be required.

4. If the client is able to fully understand and accept the need for and benefit of treatment at the point of discharge from an acute hospital, a signed voluntary "treatment contract" that allows for the administration of medications and other appropriate interventions in a non hospital setting and in a non coercive manner might be completed. ESPs, urgent care/walk in centers, etc. should be identified so that a client experiencing a decline in functioning or a change in mental status can receive help in an environment that he or she plays a role in choosing.

At discharge, a designated DMH staff person (possibly the DMH Liaison) will forward these "Crisis Plans" to all DMH and provider staff and programs identified in the "Crisis Plan" and to the appropriate emergency services programs and all others named in the Plan. It is expected that these plans will become a part of the client's community based medical or program record. "Crisis Plans" should be updated every time they are used.

- If a DMH client is acutely hospitalized more than three times in a calendar year, the appropriate DMH Site Office and possibly the DMH Liaison will convene a clinical case review during the third hospitalization that will examine the following:

  1. The reasons for and courses of the previous hospitalizations.
  2. Compliance with prior treatment recommendations
  3. The patient's understanding of why multiple hospitalizations occurred; the patient's thoughts about what he or she needs to do (e.g. identify service gaps or problems) to avoid repeated hospitalizations.
  4. Community programs' input regarding the "unsuccessful discharges".

  It is expected that the clinical review generated after the third hospitalization in a calendar year will yield a new treatment/disposition plan that addresses whatever deficiencies, gaps in services, etc. are identified. These revised treatment/disposition plans should be appended to the above described 'Crisis Plans" and disseminated to all involved DMH and provider staff and programs.

  If appropriate, a referral to a continuing care facility will be generated after this clinical case review and given priority status for transfer.

- DMH liaisons should be contacted by acute hospital or ESP staff if there are questions as to whether or not a patient is covered by the FY 15 Community Expansion Initiative

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