

ATTACHMENT 2

Continuity of Care Process

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ADMISSIONS

I. General Admission Requirements

A. Admission criteria.

Individuals referred for admission at a State Hospital must:

1. Be 18 years of age or older.
2. Have previously received local community mental health treatment services.
3. Be presently receiving treatment in a community inpatient acute or extended acute setting.
4. Have a determination of need, made by the current treating psychiatrist, for long term intensive inpatient psychiatric services beyond the scope of the community inpatient acute unit.
5. Require treatment for a mental disorder of sufficient duration to meet diagnostic criteria established within the most current version of the Diagnostic and Statistical Manual of Mental Disorders (DSM).
6. Satisfy the criteria set forth in 55 Pa. Code §§ 5100.00 and 5100.89 for involuntary inpatient treatment under sections 304 and 305 of the MHPA, 50 P.S. §§ 7304 and 7305. Individuals with other extenuating circumstances may be considered for transfer to a SMH in exceptional circumstances, with prior review and approval by the County MH/ID Administrator and the SMH CEO.
7. 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 are identified. Factors which may have prevented the re-hospitalization, treatment issues requiring attention at re-admission, and changes in medication are also to be addressed.

Further information regarding the CSP process after admission to the SMH is found in the CSP Section of this document.

B. Admission Referral Exclusions.

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

1. An individual who has been determined to need Long Term Care nursing home services through the Preadmission Screening and Resident Review (PASRR) process.
2. An individual whose diagnosis does not meet the criteria for mental disorder as defined in the current version of the Diagnostic and Statistical Manual

- (DSM).
3. An individual subject to emergency involuntary examination and treatment under 55 Pa. Code § 5100.86 and Section 302 of the MHPA, relating to Involuntary emergency examination and treatment not to exceed 120 hours.
 4. Veterans of United States Military services who are eligible for and desire services from the Veterans' Administration, in keeping with OMHSAS Bulletin 99-85-07, "Admission and Discharge of Veterans from State Mental Hospitals."
 5. An individual with a co-occurring substance use disorder who needs detoxification services.
 6. An individual who is less than 18 years of age.
 7. Voluntary Admissions, except as provided under section II, below).
- C. Individuals who have been dually-diagnosed with intellectual disability, traumatic brain injury or autism spectrum disorder are provided additional screening to assure protection of individual rights and consideration of needed specialized services. See Section III, below.
- D. Individuals who are serving a criminal court sentence may be admitted in accordance with State Hospital Policy SMH-P-10-01.
- E. Admissions Referral process.
1. The community inpatient hospital must contact the County MH/ID Program when considering a referral to the SMH. A referral from a community inpatient provider calling directly to the SMH will be redirected to contact the County MH/ID Program to discuss the referral.
 2. The County MH/ID Program reviews the verbal clinical information supporting the referral with the community hospital staff to determine the most appropriate course of action, either diversion or screening for SMH admission.
 3. At the direction by the County MH/ID Program, the community hospital staff forwards a referral packet to the County MH/ID Program for further review.
 4. The County MH/ID Program reviews the referral packet to determine the appropriateness of the referral and either supports the referral or disapproves with a recommendation of alternative treatment for the individual.
 5. If there is support to make a SMH referral, the County MH/ID Program forwards the packet to the SMH Social Services Department Admission Coordinator for review. Referral packets must include all information needed to provide a clear, concise understanding of the individual's therapeutic needs, including any specialized services needed related to dual-diagnosis of mental illness and intellectual disability.
 6. The County MH/ID Program is responsible for initiating the referral to the SMH and assures that all admission referral information is forwarded to the SMH Social Services Department Admissions Coordinator.
 7. Admission services are provided by the SMH for designated counties in that

Service Area only. OMHSAS assigns counties to SMH Service Areas, as indicated in Attachment 1.

8. The SMH notifies the County MH/ID Program if additional clinical and medical information is needed to facilitate a decision on an application for admission.

F. Admissions Referral Packet Information.

1. The information required by the SMH from referral sources prior to admission approval must include the following:
 - a. Psychiatric Evaluation.
 - b. Symptoms and behavior precipitating current community hospitalization.
 - c. Risk assessment for violence and self-harm.
 - d. Summary of seclusion and restraint use.
 - e. Current psychiatric and medical medications and dosages.
 - f. Signed commitment order.
 - g. Strengths and skills in place.
 - h. Family and natural supports.
 - i. Community professional supports.
 - j. Resources such as housing, income, health insurance, etc.
 - k. Guardian or POA (durable or fiduciary), Living Will, Mental Health or Medical Advance Directive, Wellness Recovery Action Plan (WRAP) or Crisis Plan.
 - l. History of substance use including drugs, alcohol, tobacco and caffeine.
 - m. Criminal history.
 - n. Primary method of communication (American Sign Language (ASL), etc.) and primary language spoken.
 - o. Medical history and physical examination, including vital signs, weight and allergies.
 - p. 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.
 - q. Results of all other diagnostic and therapeutic test results including x-rays, ECG, EEG, MRI, QuantiFERON®-TB Gold test (QFT-G) or Tuberculin Skin Test (TST) and consultations completed within the last 30 days.
 - r. Functional assessment including activities of daily living (ADLs) and history of falls, and any access-related special needs or assistive technologies used or needed pertinent to mobility, vision, hearing or speech.
 - s. Nutritional screening and assessment including any diagnosis of dysphagia.
 - t. Pain screening and assessment.
 - u. Progress notes from the prior thirty days.
2. The following additional records should be included, if available:
 - a. Results of psychological testing, if available.
 - b. History of medication use.

- c. History of drug overdoses.
- d. History of physical and sexual abuse as a victim and/or perpetrator.
- e. Community Support Plan.
- f. Personal goals, wishes and hopes for a life in recovery.
- g. Educational history.
- h. Employment history.
- i. Absent without leave (AWOL) or elopement history.

G. Admission Referrals Screening: Approvals and Denials – General Process

1. If diversion efforts are exhausted, the County MH/ID Program Representative provides information outlining diversion efforts and giving county approval for admission to the SMH Admission Coordinator.
2. If the referral is declined by the SMH, the SMH first notifies the County MH/ID Program and then the community inpatient provider.
3. If the referral is approved for admission, a projected bed date is assigned based on the county's bed cap allocation. The SMH will collaborate with the County MH/ID Program to identify the bed date.
4. After an admission date is established and prior to admission, the mental health case manager coordinates the process to have the community inpatient provider forward the following information to the Admission Coordinator at the SMH:
 - a. Within the 24-hour period prior to admission, an updated list of the individual's current medications.
 - b. On the day of admission, a current order for involuntary inpatient treatment from the Court of Common Pleas. The SMH is named as the treating facility and the bed date is included, or the statement, "transfer to the SMH upon bed availability" is indicated on the order.
 - c. State identification, birth certificate and social security card, if available.
5. Please see sections II, III, and IV, below for additional specific information about admission referral screening for individuals who are in any one of the following categories:
 - a. Dually-diagnosed MH/ID.
 - i. For dually-diagnosed individuals (MH/ID), as agreed upon by the Office of Developmental Programs (ODP) and OMHSAS, a Higher-Level Review form and request for state facility must be completed prior to admission, as required under OMHSAS/ODP joint bulletin 00-02-16.
 - ii. To obtain the Higher-Level Review form, "Psychiatric Consultation Questionnaire for Persons with Developmental Disabilities" contact the office of Developmental Programs (ODP) at (717) 787-3700.
 - b. Seeking transfer to civil status from a forensic facility.

H. Admission Process.

1. All admissions are scheduled in accordance with the availability of beds.
2. Admissions are scheduled for arrival to the SMH Monday through Friday in

- the morning unless an exception has been authorized by the SMH.
3. It is the responsibility of the County MH/ID Program to verify arrangements for appropriate transportation for individuals accepted for admission to the SMH, and to communicate plans to the SMH Admission Coordinator.
 4. Individuals approved for admission to the SMH are enrolled in County MH/ID Program services and provided with mental health case management services delivered by the County MH/ID Program or the assigned private provider during treatment at the SMH. The case management function may be provided by Administrative Case Management, Targeted Case Management (TCM), Assertive Community Treatment Team (ACT) or Community Treatment Team (CTT) providers.

II. Voluntary Admissions

- A. Voluntary admissions are to be used on an exceptional basis, such as in the instance of an interstate compact transfer from a hospital, and only when all of the following conditions are met:
 1. The individual requests a voluntary admission.
 2. A physician's examination results in a recommendation for voluntary psychiatric admission as required under Section 201 of the MHPA, 50 P.S. § 7201.
 3. The county approves the clinical appropriateness of the voluntary admission in keeping with 55 Pa. Code § 5100.72(b)1, and all community treatment alternatives have been explored and discussed with the individual.
 4. The County Administrator and the OMHSAS Director of the Bureau of Community and Hospital Operations both concur that voluntary admission to the SMH is appropriate and communicate this to the SMH Chief Executive Officer. The concurrence may be conveyed verbally but must be followed up with written confirmation within 10 business days prior to admission.
 5. The SMH admitting physician finds the individual appropriate for treatment.
- B. The SMH retains the right to decline voluntary referrals if the SMH psychiatrist does not believe the individual is appropriate for voluntary treatment due to lack of capacity to give informed consent or due to clinical condition. The SMH notifies the OMHSAS Director the Bureau of Community and Hospital Operations and the responsible County Administrator when an individual is not accepted for voluntary admission.

III. Involuntary Commitments of Individuals With an MH/ID Dual-Diagnosis

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

- A. The community hospital must notify the County MH/ID Program or the mental

health case manager prior to filing a 304 petition for an individual with a diagnosis of intellectual disability. See 55 Pa. Code § 4210.101a, relating to Clarification of eligibility determinations - Statement of Policy, and Office of Developmental Programs Bulletin No. 4210-02-05, "Clarifying Eligibility for Determining Intellectual Disability Services and Supports," dated 5/31/02.

- B. The County MH/ID 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 an individual with a dual-diagnosis of intellectual disability and mental illness for possible diversion, prior to filing a 304 petition. Notification to OMHSAS occurs at the time of admission to the community hospital, and prior to filing a 304 petition for transfer to the SMH. The County MH/ID Program and the treating facility are responsible for completing the "Higher Level Review Form" and sending it to both the OMHSAS Field Office and the ODP Field Office coordinators and/or designees.
- C. Within two weeks of the receipt of the "Higher Level Review Referral Form" and all other supporting documentation, the Department of Human Services' (DHS) reviewers visit and assess the individual and interview the team members as appropriate. The following individuals are invited to participate: the individual, OMHSAS and ODP Field Office coordinators, SMH staff, County MH/ID staff, community provider staff and family members with the consent of the individual.
- D. Prior to the meeting, documentation of the following items must be compiled for participants to review:
 - 1. The individual's most recent Individual Support Plan (ISP) from ODP and a copy of any incident reports entered into the Home & Community Services Information System (HCSIS) within the previous 12 months.
 - 2. The individual's most recent community living plan.
 - 3. The individual's most recent Community Support Plan (CSP), if applicable.
 - 4. The individual's current community hospital treatment plan and discharge plan.
 - 5. Assessment and documentation of the individual's current psychiatric diagnosis and clinical symptoms necessitating continued inpatient psychiatric care.
 - 6. A written summary of efforts to develop a community-based alternative to SMH admission.
 - 7. 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 6 business days after the meeting, a separate report from both OMHSAS and ODP is written and submitted to the respective Bureau Directors, who review and forward to the SMH admissions office. A pre-admission packet for a dually-diagnosed individual is considered incomplete without this information, and no

further action is taken on the application for admission by the SMH until the reports are received.

- F. Upon receipt of all the information in section D, the designated SMH staff member assesses the clinical appropriateness of the admission for SMH level of care.
- G. The designated SMH representative discusses the case with the County MH/ID Administrator or designee to determine if the County MH/ID Program supports filing a petition for a 304 commitment.
- H. If the Higher Level Review process determines that the individual is deemed not clinically appropriate for SMH level of care, but care cannot be diverted, and all routine methods of resolution are unsuccessful, the SMH refers the request to OMHSAS so that both OMHSAS and ODP are involved in the final determination.

IV. Procedures for Transfer of Individuals from Forensic to Civil Commitment

- A. An individual in a Regional Forensic Psychiatric Center (RFPC) who converts to civil status is transferred to a civil unit of a SMH serving the county of residence not later than the first available open bed date at the designated civil hospital.
- B. Conditions for individual eligibility to convert from forensic status in the RFPC to civil status (no longer subject to criminal detention) include one of the following:
 - 1. The charges are dropped, nolle prossed, or the prosecution is withdrawn.
 - 2. There is an acquittal on charges.
 - 3. The individual is being released on bail.
 - 4. A finding that there is a substantial possibility that the individual is not expected to attain capacity to proceed in the foreseeable future as per section 403(d) of the MHPA, 50 P.S. § 7403(d).
- C. Requirements for transfer from RFPC to Civil Unit
 - 1. When the RFPC has received 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 verbally notifies 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 not later than the first available open bed date at the designated SMH.
 - 2. The RFPC is responsible to complete the following prior to the transfer:
 - a. Notify the Criminal Court and the Mental Health Review Officer (MHRO).
 - b. Notify the CEO of the receiving SMH, who notifies the respective Regional

Community Program Manager at OMHSAS.

- c. Notify the County Administrator and the Base Service Unit of the individual's county of residence, using form MH-537 dated 3/11 (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. The admission is not scheduled until a bed is made available and approved by the County MH/ID Program.
 4. Once the admission is scheduled, the civil commitment petition must be prepared and heard before the individual is moved to the civil unit. A confirmed commitment and certified court order must be received by the SMH before the admission can occur. Orders for inpatient care in a civil bed at a SMH under Section 304/305 of the Act must be signed by a civil or criminal judge and not the MHRO alone.

V. Recommitment Hearings

- A. As indicated by current commitment status and the clinical needs of the individual, the SMH treatment team files the petition for a recommitment hearing under Sections 304 or 305. A designated staff member from the SMH acts as the petitioner to recommend extensions for involuntary commitments.
- B. Recommitment hearings may be conducted by the MHRO at the discretion of the court.

COMMUNITY SUPPORT PLAN PROCESS

The Community Support Plan (CSP) process was originally developed as a collaborative process. Originally, it was to be used simultaneously with discharge planning from SMHs to facilitate a coordinated and supported discharge process for those in the SMH for two years or more. The CSP is intended to help an individual return to the community with the appropriate supports needed for recovery. Since then, the CSP process has been expanded to include all persons who are receiving treatment in a SMH setting, regardless of length of stay. The CSP is a person-centered plan which includes the services, supports and residential preference the individual has identified as vital to the recovery process to promote a successful transition from the SMH to the community. The CSP document is a living document that follows the individual and is intended to be updated as the recovery goals and needs of the individual change.

A referral to the SMH for an individual who was previously discharged from a SMH who had a prior CSP 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. These CSP meetings are scheduled and facilitated by the

assigned mental health case manager. SMH staff may be included with the individual's consent.

During the inpatient stay at the SMH, an individual is given the opportunity to participate in the development of a CSP or an update of an existing CSP to prepare for discharge back to the community. The CSP process is arranged by the SMH staff, and may be facilitated by SMH staff or by County MH/ID staff or the mental health case manager. Participants in the development or update of the CSP include the individual, preferred peer and family members with the individual's consent, staff from the individual's respective County MH/ID Program, community providers preferred by the individual, staff from the SMH, and anyone identified by the individual as a preferred support in a successful recovery journey. The individual is the most important member of the CSP process, and therefore is encouraged to participate. If the individual declines to participate, that decision is respected and honored by the treatment team. However, the SMH continues to encourage the individual to participate in the CSP process throughout the stay. These CSP meetings are scheduled and facilitated by the SMH staff or the mental health case manager.

SMH staff, in collaboration with the individual, the case manager, and any preferred supports begin to develop the CSP which is implemented during the admission to the SMH. A plan for close monitoring during the first month post-discharge is developed collaboratively as this is a crucial time for successful transition into the community. During the stay, SMH staff and the mental health case manager collaborate to offer the individual an opportunity to develop a WRAP or Crisis Plan and an Advance Directive. At the time of discharge, the SMH assures 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 mental health case manager, Assertive Community Treatment (ACT) team, or Community Treatment Team (CTT) working to support the individual's discharge from the SMH. After discharge, the County MH/ID Program representative or the mental health case manager, ACT, or CTT, assures that a copy of the final CSP document is provided to any additional supports subsequently authorized by the individual. The County MH/ID Program is responsible for monitoring the implementation of the CSP upon discharge.

Following discharge, it is the MH Case Manager's responsibility to provide regular updates to the County MH/ID Program on the status of the CSP implementation and changes that may occur after the individual returns to the community. If the person has ACT or CTT services, this is the ACT or CTT team's responsibility. It is the responsibility of the County MH/ID Program to develop a process with the mental health case manager, or the assigned ACT or CTT, to obtain regular updates on the status of the CSP implementation. The updates occur at a minimum of quarterly for the first year following the individual's SMH discharge. Updates are provided more frequently as needed based upon the individual's recovery needs. Updates include changes that were made in the CSP and the rationale for the changes.

DISCHARGE PROCESS

It is the joint responsibility of the County MH/ID Program and SMH to assure that appropriate 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 staff to notify the designated mental health case manager. The mental health case manager participates in pre-discharge planning conferences, and processes referrals for community services in accordance with the individualized CSP.

1. Discharge planning and arrangements for aftercare services are provided as mandated by the MH/ID Act of 1966. Discharge planning involves input from the individual, the family, natural and formal supports, the County MH/ID Program, the case management provider, and the SMH staff.
2. Aftercare services may be provided directly by the county, by county contracted service providers, or other private providers.

I. Planned Leave from the SMH

- A. A short-term leave may occur in preparation for the individual's discharge as clinically indicated and stated on the individual's treatment plan. Any short-term leave requires a physician's order that specifies the purpose and the duration of the leave.
- B. The mental health case manager is involved in discharge preparation and planning, including the arrangement of short-term leave plans that are included in the individual's SMH treatment plan.
- C. When an individual is approved for short-term leave, the SMH notifies the mental health case manager of the duration of the planned visit.
- D. Arrangements to pay for necessary expenses during the short-term leave are finalized prior to the scheduled leave. Clinical and financial abatements, if appropriate, are requested by the SMH Social Worker.
- E. The mental health case manager informs SMH staff if the individual requires emergency services, a critical event such as an arrest occurs, or the individual goes absent without leave (AWOL) during short term leave. If the incident occurs after 4:00 p.m. on a weekday, on a weekend or on a holiday, the mental health case manager immediately informs the SMH Nursing Office. During weekday business hours, the mental health case manager notifies the SMH Social Worker, or the SMH CEO if the SMH Social Worker is not available.
- F. The mental health case manager and the SMH staff discuss the individual's adjustment to the short term leave upon its completion in a meeting with the individual and the individual's treatment team.

- G. The individual's subsequent short-term leave, visitation schedule and discharge plan are developed by the SMH treatment team based on the individual's adjustment to community living as assessed by the mental health case manager.
- H. At the start of short-term leave, the individual is given a supply of medications consistent with the planned length of the leave, as ordered by the attending psychiatrist.
- I. Arrangements are made in advance to assure that the individual has access to auxiliary aids and interpreters as needed throughout the short-term leave period.
- J. The SMH staff is responsible to arrange transportation to the community residential setting for the short-term leave. Exceptions to this protocol are made through discussions at the CSP meetings.
- K. In accordance with civil commitment laws, an individual on short term leave may return to the SMH if needed.

II. ACTIONS NECESSARY FOR DISCHARGE INTO THE COMMUNITY

- A. The SMH works with the individual and the County MH/ID Program to develop specific individualized treatment goals with achievable progression toward 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. With appropriate consents, review and planning meetings are scheduled with the individual, SMH staff, county, community partners, and family to assist the individual with successful transitioning to community living.
- B. The SMH provides, at minimum, a 30-day supply of the individual's medications. The SMH staff and the mental health case manager collaborate to determine whether anticipated insurance or other benefits are available that cover medications prescribed at discharge. When prescribed medications are not formulary for the payment method available, an alternate payment method must be identified, or there must be a consultation with the treating psychiatrist to resolve the issue. The mental health case manager assists the individual to assure attendance at an outpatient medication check appointment so that continued medication orders can be provided.
- C. The SMH provides the County MH/ID Program with the SMH After Care Plan and Discharge Summary (form MH-537) at the time of discharge. The SMH also provides the County with a narrative Psychiatric and Medical Discharge Summary as soon as possible, but not later than 15 business days after discharge.

- D. Every county/joinder has filed a policy and procedure with OMHSAS stating that the county will not refer people ready for discharge from a SMH to a Personal Care Home (PCH) larger than 16 beds unless an exception has been granted. In this circumstance, the County MH/ID Program submits a Waiver Request and a copy of the CSP to the regional OMHSAS Community Program Manager for approval before the discharge occurs.
- E. When an individual receiving inpatient treatment in a SMH requires a nursing home level of care to address physical health needs, these needs must be considered in discharge planning. If these needs cannot be addressed in a non-institutional outpatient setting, and the individual's treatment team believes the individual needs nursing facility level of care, specific steps are taken in the order listed below to ensure this level of care is required, including the following:
1. A CSP meeting is held to discuss all possible community placement options. The individual and family members are encouraged to express their desires and opinions, and open communication between all involved parties is encouraged. If it is determined that a nursing facility placement should be considered, the SMH Medical Records Department and the assigned Social Worker 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; the list of current medications; and pertinent lab and testing information. The packet is forwarded to designated clinical staff in the Division of Clinical Review and Consultation at OMHSAS in Harrisburg.
 2. The designated OMHSAS staff reviews the information and writes a report with the recommendation either supporting or not supporting nursing facility admission. The report is then submitted to the Bureau Director of Community and Hospital Operations who approves or denies the recommendation of the OMHSAS staff review.
 3. If the nursing facility placement is deemed inappropriate 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. If the consideration of nursing facility placement is approved, the SMH contacts the local Area Agency on Aging (AAA) to refer the individual for an assessment and submits the following documents to the AAA:
 - a. Request for Assessment.
 - b. Medical Evaluation (MA 51).
 - c. Pre-Admission Screening Resident Review Identification Form (PA-PASRR-ID-MA 376).
 - d. DHS Authorization for Release of Information (PA 4).
 - e. AAA Release of Information Form.
 - f. Copies of Medical Records as required by the AAA.
 5. Following the completion of the Aging Well Network assessment, the AAA forwards the evaluation findings to the OMHSAS Division of Clinical Review

- and Consultation where the PASRR process will continue with a review to determine if the individual requires nursing facility services, whether the individual meets certain program office criteria and whether the individual may need specialized services related to the mental illness. A final decision is made regarding the appropriateness of nursing facility level of care, and the OMHSAS Division of Clinical Review and Consultation sends a letter of determination, as required.
6. If the PASRR process determines the individual is appropriate for nursing facility level of care according to the Omnibus Budget Reconciliation Act of 1987 (OBRA), the SMH is responsible to locate potential nursing facility placements, and the individual is encouraged to visit potential placement options.

III. FINANCIAL AND LOGISTICAL ASPECTS OF DISCHARGE PLANNING

It is the responsibility of the SMH staff and the mental health case manager to ensure appropriate financial resources and benefits are available to the individual being discharged. The SMH Social Worker and the mental health case manager are jointly responsible for developing a financial plan with the individual which addresses identified needs as discussed at the CSP discharge meeting. The financial plan addresses the following:

1. The SMH Social Worker determines whether the individual has health insurance or needs to apply for Medical Assistance benefits.
2. The SMH Social Worker completes the appropriate benefit applications and determines with the mental health case manager what actions are required for the individual to receive health and prescription benefits following discharge.
3. The mental health case manager projects the individual's monthly expenditures, identifies resources the individual has access to, and develops a realistic budget to cover the individual's anticipated expenses.
4. The mental health case manager determines whether the individual needs ongoing assistance with money management. The mental health case manager should work with the individual through the CSP process to identify potential resources for assistance with financial management.

IV. ABSENT WITHOUT LEAVE (AWOL)

If an individual leaves the SMH grounds without permission, the individual is considered absent without leave (AWOL). The SMH notifies the appropriate mental health case manager immediately upon elopement from the premises so attempts may be made to return the individual to the SMH for inpatient care, in keeping with the commitment order of record.

When an individual leaves the SMH AWOL, the following entities are notified by the appropriate SMH staff as indicated:

1. The Pennsylvania State Police and local or township police with a missing person's declaration.
2. The local judicial system if the individual is under judicial oversight.
3. The County MH/ID Administrator's Office during business hours, or other designated county contacts after business hours.
4. The Crisis Intervention Services after business hours.
5. The next of kin or other significant persons.
6. The intended victim of a specific and immediate threat of bodily injury from the individual when the threat is directed at a specifically identified or readily identifiable victim. See bulletin OMHSAS-99-09, "Emerich v. Philadelphia Center for Human Development, 720 A.2d 1032 (Pa.1998) Duty to Warn Third Parties – Tarasoff in Pennsylvania". available at: <http://www.dhs.pa.gov/publications/bulletinsearch/bulletinselected/index.htm?bn=OMHSAS-99-09&o=N&po=OMHSAS&id=10/01/1999>.

V. DISCHARGE AGAINST MEDICAL ADVICE (AMA)

A. Discharge against medical advice may occur when:

1. The individual on a voluntary commitment withdraws from treatment and there is no justification for a 302 commitment.
2. The court denies a petition to extend an involuntary commitment, and orders immediate discharge.
3. The individual is AWOL and the commitment expires.

B. If AMA discharge occurs, the SMH will immediately notify:

- a. The County MH/ID Program.
- b. The mental health case manager.
- c. The designated next of kin, in keeping with consent to release information.
- d. The intended victim of a specific and immediate threat of bodily injury from the individual when the threat is directed at a specifically identified or readily identifiable victim. See bulletin OMHSAS-99-09, "Emerich v. Philadelphia Center for Human Development, 720 A.2d 1032 (Pa.1998) Duty to Warn Third Parties – Tarasoff in Pennsylvania", available at: <http://www.dhs.pa.gov/publications/bulletinsearch/bulletinselected/index.htm?bn=OMHSAS-99-09&o=N&po=OMHSAS&id=10/01/1999>

VI. OUTPATIENT COMMITMENTS

A. At the time of discharge, the balance of an involuntary inpatient commitment may

be transferred to less restrictive treatment at outpatient or partial hospitalization services or under assisted outpatient treatment (AOT).

- B. At the time of discharge, involuntary transfer to a Long Term Structured Residential (LTSR) service must be ordered by the Court of Common Pleas during a re-commitment hearing or through amendment of an existing order.
- C. Transfer of remaining time on the involuntary inpatient order to outpatient or partial hospitalization is accomplished using the 306-transmittal letter (DHS form MH-788.2) which is mailed by the SMH to the County Administrator and to the indicated community treatment provider.
- D. Transfer from inpatient to AOT requires a petition under Section 304(c.1) of the MHPA, a hearing and an AOT treatment plan, as required in the MHPA.
- E. Transfer of remaining time on the involuntary inpatient order to LTSR is accomplished using the applicable order from the Court of Common Pleas, which is mailed by the SMH to the County Administrator and to the indicated community treatment provider.
- F. An individual subject to a voluntary commitment may not be transferred to involuntary outpatient, partial hospitalization, or LTSR services without due process under the MHPA.
- G. When the term of the order for involuntary inpatient treatment that has been transferred to outpatient treatment is close to expiration, it is the responsibility of the outpatient treatment team to determine the need to petition for additional involuntary treatment.

CONTINUITY OF CARE RESPONSIBILITIES

I. STATE MENTAL HOSPITAL AND COUNTY MH/ID PROGRAM AGREEMENT

The SMH and County MH/ID 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 petitions for involuntary mental health treatment in accordance with 55 Pa. Code Ch. 5100.
- C. To share information, comments, and recommendations in annual planning and budgeting processes.

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

II. THE ROLE AND FUNCTION OF SMH STAFF

- A. The SMH provides multi-disciplinary treatment designed to promote the individual's recovery from the effects of the mental illness and return to community living.
- B. The SMH social work staff and the treatment team maintain ongoing communication with the designated mental health case manager to share information regarding discharge preparation and planning, commitment status, treatment progress, and other relevant information.
- C. The SMH Social Work Department invites the mental health case manager to attend treatment team meetings, commitment hearings, CSP meetings, and other conferences related to discharge planning for the individual.
- D. The SMH Social Work Department assures that the County MH/ID Program and the mental health case manager are notified within one business day of the following critical incidents:
 - 1. Serious injury, illness or medical admissions.
 - 2. Assaults resulting in medical treatment or criminal charges.
 - 3. Death.
 - 4. AWOL incidents.
 - 5. Incidents involving criminal charges or police intervention.
 - 6. Attempted suicide or homicide.
 - 7. Allegations of abuse or neglect, whether the individual is the victim or alleged perpetrator.
 - 8. Serious or adverse effects of medication requiring medical intervention.
- E. For individuals who are currently receiving SMH treatment, the SMH coordinates the re-commitment process with the Court of Common Pleas and the assigned Mental Health Review Officer (MHRO), as needed.
- F. The SMH Social Work Department assists the individual with application for identification and for medical and other benefits in preparation for discharge.
- G. The SMH Social Work Department coordinates post-SMH discharge follow-up with the County MH/ID representative or the mental health case manager, on an as needed basis, to assist with problem solving using the CSP process to divert the individual from a readmission to inpatient level of care.

III. THE ROLE AND FUNCTION OF THE COUNTY MH/ID PROGRAM

- A. The County MH/ID Program screens all referrals for admission to the SMH and manages the bed cap for the county/joinder.
- B. The County MH/ID Program provides liaison services for all individuals from the county who are admitted to a SMH and assures that every individual admitted has access to case management services, such as administrative case management, Targeted Case Management (TCM), Assertive Community Treatment Team (ACT) or Community Treatment Team (CTT). Choice is offered where possible, particularly as the individual approaches discharge readiness.
- C. The County MH/ID Program takes a role in discharge planning, as appropriate.

IV. THE ROLE AND FUNCTION OF THE MENTAL HEALTH CASE MANAGER

- A. The mental health case manager is either an administrative case manager, a targeted case manager, a member of an ACT team or a member of a CTT. The mental health case manager may be employed by the county directly, or by a private provider agency in the local community. Assignment of the case management function is the domain of the County MH/ID Program.
- B. The case management provider agency assures the following:
 - 1. The mental health case manager participating in the SMH treatment team meetings, discharge planning or liaison services signs a confidentiality statement pertaining to information protected by the Mental Health Procedures Act and the Health Insurance Portability and Accountability Act (HIPAA).
 - 2. The mental health case manager complies with SMH policy regarding access to the SMH living units.
 - 3. The mental health case manager complies with the SMH sign-in and sign-out procedures.
 - 4. The mental health case manager understands that access to confidential health care information is governed by the requirements of the MHPA and the Health Insurance Portability and Accountability Act of 1996 (HIPAA), as stated under each SMH's medical records procedures.
- C. The mental health case manager maintains contact with individuals admitted to a SMH and participates in appropriate hospital treatment planning conferences and CSP meetings following admission and prior to discharge.
- D. The mental health case manager accepts referrals for aftercare support services recommended by the SMH staff, and ensures the individual is referred to the appropriate MH/ID provider for aftercare services in a timely manner.
- E. The mental health case manager and the SMH staff work cooperatively to ensure

continuity of care as follows:

1. Prior to an individual's discharge, the SMH staff provide the mental health case manager with the individual's discharge plan, social history, psychiatric and psychological evaluations, and other pertinent information required for referrals to community service programs.
2. Upon receipt of the information in sub-section one, the CSP team convenes to update the CSP.
3. The mental health case manager refers the individual to community services including treatment providers.
4. The mental health case manager ensures:
 - i. Completion of the County liability determination.
 - ii. Completion of referrals for aftercare support services.
 - iii. Scheduling of aftercare appointments.
 - iv. Follow-up on benefit applications initiated by the SMH social work staff.
5. In keeping with recovery-oriented services, the mental health case manager continues to involve the individual's family of choice in the aftercare process, in accordance with appropriate consents to share information.

V. THE ROLE AND FUNCTION OF OMHSAS STAFF

- A. OMHSAS Field Office staff assist with the exception process for requests to approve discharge to large (over 16 beds) Personal Care Homes.
- B. OMHSAS Clinical Review staff assist with the PASRR-ID process for nursing home placement requests.
- C. OMHSAS Hospital Operations staff and Bureau Directors assist with the review of admission requests for individuals with dual MH/ID diagnoses.
- D. OMHSAS Hospital Operations staff are available to troubleshoot issues regarding transfers of individuals from forensic to civil settings.
- E. OMHSAS Field Office staff assist with conflict resolution.
- F. OMHSAS Field Office staff participate in Continuity of Care meetings between the SMH and the counties within the SMH service area.

CONTINUITY OF CARE MEETINGS

- A. The appropriate OMHSAS Regional Field Office, Bureau of Community and Hospital Operations participates in quarterly Continuity of Care meetings with the County MH/ID Administrators and the SMH CEO or designees for each SMH Service Area.

- B. Each service area has the option to include consumer and family advocates in this meeting, as they are available to participate.
- C. The Continuity of Care meetings for a given service area may be convened separately for each individual county, or jointly for all counties in the service area.
- D. Continuity of Care meeting minutes are maintained by the SMH. The minutes address the following routine agenda items:
 - 1. OMHSAS updates.
 - 2. County reports.
 - 3. Community Support Program updates, if available.
 - 4. Trends and issues pertaining to system development from both the county and hospital perspective.
 - 5. State hospital updates.
 - 6. Admission referrals, diversions, admissions and discharges report.
 - 7. Issues impacting admissions and discharges.

CONFLICT RESOLUTION PROCESS

- A. The County MH/ID Program and the SMH agree to work toward resolution of disagreements 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 concerns to the attention of a supervisor. A disagreement that is not successfully resolved by the County Administrator and the SMH CEO is referred to the appropriate Field Office in the Bureau of Community and Hospital Operations of OMHSAS.
- B. Disagreements surrounding an individual's treatment are 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.
- C. Discharge planning issues may be addressed between the SMH Social Worker and the mental health case manager. If not resolved, the matter should be referred to the Chief Social Rehabilitation Executive at the SMH and the County MH/ID Program for resolution.