Genesee HEALTH SYSTEM

SUBJECT: State Facility Discharge – Clinical Monitoring Guidelines		Page **1** of **3**
WRITTEN BY: L. Tompkins, VP of Clinical Services	**AUTHORIZED BY:** L. Tompkins, VP of Clinical Services	
Relates To Policy:	06-207-03	

I. AFFECTED DEPARTMENTS

Consultative & Coordinating Services; DD Services – Adults; Medication Clinic; MI Services - Adults

II. PURPOSE

The purpose of this procedure is to facilitate the successful re-integration of clients from a state hospital to community placement. The first 90 days of community placement for these individuals are critical to a successful community placement and require frequent multi-disciplinary clinical contact. This procedure outlines "clinical minimums," and any practitioner may and should exceed the minimums as clinically necessary.

III. PROCEDURE

A. The State Hospital clinical treatment team identifies an individual as stable/baseline and ready for discharge and notifies the State Hospital Liaison.

B. The State Hospital Liaison requests a referral packet from the State Hospital:
   1. Assessments: Psychiatric; Social Work; Physical Health; Nursing
   2. List of current medications
   3. Medical consultation reports
   4. Other documentation as provided

C. When received, the State Hospital Liaison will scan and upload the referral packet into CHIP.

D. The State Hospital Liaison will complete a Biopsychosocial Assessment and determine if an LLP assessment should be performed prior to discharge.

E. If specialized residential is recommended, the State Hospital Liaison will submit a request to the GHS residential committee, which will review and identify residential placement(s) and distribute the referral packet to residential provider(s), once the State Hospital Liaisons obtain a signed Consent to Exchange Health Information. Once a provider is chosen, the following will occur:

   1. The State Hospital Liaison will contact the Program Manager or designee for the name of the assigned case manager.
   2. The State Hospital Liaison will meet with the pre-discharge clinical team to determine a ***Clinical Support Category*** (see section IV) for the individual to be discharged.
   3. The State Hospital Liaison will determine a discharge date and make aftercare appointments and communicate this with the clinical team.
   4. The State Hospital Liaison will open a program assignment, update the new address and telephone number and enter an initial auth for service into CHIP.

F. Liaison will complete an initial Plan of Service.

IV. CLINICAL SUPPORT CATEGORIES

A. The frequency of face-to-face case management contact for these placements, including **Not Guilty by Reason of Insanity (NGRI)/Authorized Leave Status (ALS),** should minimally proceed as follows:

1. *Intensive* Clinical Support Category:
   a. **First 30 days:** Two contacts per week across multiple settings where the individual is engaged.
   b. **Remaining 60 days of the first quarter:** One contact per week, assuming increasing stability.
   c. **Remaining 9 months of the first year in community placement:** Two contacts per month, assuming increasing stability.
   d. **After one full year of continuous community placement and no hospitalizations**, frequency of face-to-face contact may decrease to less than two contacts per month, as medically necessary.
2. *High* Clinical Support Category:
   a. **First 30 days:** One contact per week across multiple settings where the individual is engaged
   b. **Remaining 60 days of the first quarter:** Two contacts per month, assuming increasing stability.
   c. **Remaining 9 months of the year:** At least (2) monthly contact assuming stability.
   d. **After one full year of continuous community placement and no hospitalizations**, contacts may adjust downward to the amount medically necessary..
3. *Moderate* Clinical Support Category:
   a. **First 30 days:** One contact per week across multiple settings where the individual is engaged.
   b. **Remaining 60 days of the first quarter:** Two contacts per month, assuming increasing stability.
   c. **Remaining 9 months of the year:** At least monthly contact assuming stability.
   d. **After one full year of continuous community placement and no hospitalizations**, contacts may adjust downward to the amount medically necessary.

B. Behavioral Services-Psychology
1. Direct staff support and intensive monitoring, as well as support for the discharged individual, is critical in the first 90 days of community placement. The behavioral psychologist is a key consultative support for placement success.
2. Direct contact minimums should mirror those for case management/supports coordination according to the Clinical Support Category.

C. Nursing and Other Professionals
   If and when the service is engaged, clinical monitoring minimums can be determined by the identified professional with consultation with other members of the clinical support team.