Department of Mental Health

TRANSMITTAL LETTER

SUBJECT **Continuity of Care Practice Guidelines for Adult Mental Health Providers**		
POLICY NUMBER **DMH Policy 200.2B**	DATE AUG 1 5 2012	TL# 178

Purpose. To establish specific guidelines to ensure continuity of care between providers of mental health services and supports to Department of Mental Health (DMH) adult consumers who seek or receive urgent or emergency mental health treatment and supports and/or transfer, or who are discharged to different levels of care within the mental health system.

Applicability. Applies to Core Services Agencies (CSAs), Assertive Community Treatment (ACT) providers, Saint Elizabeths Hospital, community hospitals, Crisis Emergency Providers, the Mental Health Authority; and all other providers who have an agreement or contract with DMH or certified providers regarding provision of services for DMH adult consumers.

Policy Clearance. This policy has been reviewed by affected responsible staff and cleared through appropriate MHA offices.

Implementation Plans. A plan of action to implement or adhere to a policy must be developed by designated responsible staff. If materials and/or training are required to implement the policy, these requirements must be part of the action plan. Specific staff should be designated to carry out the implementation and program managers are responsible to follow through to ensure compliance. Action plans and completion dates should be sent to the appropriate authority. Contracting Officer Technical Representatives (COTRs) must also ensure that contractors are informed of this policy if it is applicable or pertinent to their scope of work. Implementation of all DMH policies shall begin as soon as possible. Full implementation of this policy shall be completed within sixty (60) days after the date of this policy.

Policy Dissemination and Filing Instructions. Managers/supervisors of DMH and DMH contractors must ensure that staff are informed of this policy. Each staff person who maintains policy manuals must file this policy in the DMH Policy and Procedures Manual, and contractors must ensure that this policy is maintained in accordance with their internal procedures.

ACTION

REMOVE AND DESTROY	INSERT
DMH Policy 200.2A	**DMH Policy 200.2B**

Stephen T. Baron
Director, DMH

GOVERNMENT OF THE DISTRICT OF COLUMBIA DEPARTMENT OF MENTAL HEALTH	Policy No. 200.2B	Date AUG 15 2012	Page 1
	Supersedes: DMH Policy 200.2A Continuity of Care, dated January 27, 2012		

Subject: Continuity of Care Practice Guidelines for Adult Mental Health Providers

1. **Purpose**. To establish specific guidelines to ensure continuity of care between providers of mental health services and supports to Department of Mental Health (DMH) adult consumers who seek or receive urgent or emergency mental health treatment and supports and/or transfer, or who are discharged to different levels of care within the mental health system.

2. **Applicability**. Applies to Core Services Agencies (CSAs), Assertive Community Treatment (ACT) providers, Saint Elizabeths Hospital, community hospitals, Crisis Emergency Providers, the Mental Health Authority; and all other providers who have an agreement or contract with DMH or certified providers regarding provision of services for DMH adult consumers.

3. **Authority**. Department of Mental Health Establishment Amendment Act of 2001.

4. **Definitions/Abbreviations**. For purposes of this policy:

4a. DMH Continuity of Care Practice Guidelines for Adult Providers in the Mental Health System of Care - guidelines that describe the responsibilities and actions of providers and DMH in response to adult consumers who seek or receive urgent or emergency mental health treatment and supports and/or transfer, or who are discharged to different levels of care within the mental health system.

4b. Mental Health Provider- referred to in this policy as provider, is: (a) any individual or entity, public or private, that is licensed or certified by the District of Columbia to provide mental health services or mental health supports; (b) any individual or entity, public or private, that has entered into an agreement with DMH to provide mental health services or mental health supports; or (c) Saint Elizabeths Hospital.

4c. Community Hospitals - private hospitals in the District of Columbia that have arrangements with the DMH for provision of services to DMH consumers.

4d. Crisis Emergency Provider – A provider certified by DMH to provide crisis emergency services or who has contracted with DMH to provide same. This provider may be part of a CSA or may be a separate entity. The provider is accessible twenty-four hours per day, seven days per week (24/7) to offer crisis intervention to callers who are in crisis to dispatch mobile crisis services, and to assist all persons in the District who may need emergency mental health care.

4e. Nursing facility (NF). A facility licensed to provide nursing home or skilled nursing services.

5. **Policy**. To ensure continuity of care, all providers will follow the DMH adult continuity of care practice guidelines in the provision of services to adult consumers of mental health treatment in the District of Columbia.

6. **Responsibilities for DMH**. DMH shall:

6a. **Issue** the continuity of care practice guidelines to all newly certified providers who provide services and supports to adults;

6b. **Notify** providers of all changes to the continuity of care practice guidelines as soon as the changes become effective; and

6c. **Monitor** treatment and care in compliance with the adult continuity of care practice guidelines, and take appropriate action where necessary.

7. **Specific Guidance for All Adult Mental Health Providers**.

7a. Utilize the DMH Continuity of Care Practice Guidelines for Adult Providers in the Mental Health System of Care (Exhibit 1) for urgent, emergency, transfer, and admission and discharge situations when an adult consumer:

(1) is assigned to the provider via the Access Helpline;
(2) presents for treatment at a crisis emergency provider;
(3) presents for treatment at a CSA or ACT Provider;
(4) is referred to a crisis bed;
(5) is admitted to or discharged from a community hospital;
(6) is admitted to or discharged from a nursing facility and reintegrated in the community;
(7) is admitted to or discharged from Saint Elizabeths Hospital;
(8) transfers to another CSA; and
(9) is incarcerated in the D.C. Jail.

7b. Link the adult consumer to resources that are most relevant to the consumer's identified needs. The provider shall link the consumer to these services, rather than having the consumer locate their own services; and

7c. Be Familiar with the adult continuity of care practice guidelines to ensure continuity of care.

8. **Exhibit.**

Continuity of Care Practice Guidelines for Adult Providers in the Mental Health System of Care

Approved By:

Stephen T. Baron
Director, DMH

Stephen T Baron AUG 15 2012

(Signature) **(Date)**

District of Columbia Department of Mental Health
Continuity of Care Practice Guidelines for
ADULT Providers in the Mental Health System of Care

These guidelines outline the responsibilities of the District of Columbia Department of Mental Health (hereafter called DMH) system of care providers for adult consumers.

The following sections describe the responsibilities and actions of providers and the DMH Division of Care Coordination Access Helpline in response to adult consumers who seek or receive urgent or emergency mental health treatment and supports and/or transfer to different levels of care within the mental health system of care. The outline below describes the structure of these guidelines:

1. Crisis Response, Urgent and Emergency Care
   - 1A. Contacting the DMH Access Helpline (AHL)
   - 1B. Presentation to Providers who are a CEP
   - 1C. Presentation at Providers who are a CSA or ACT Provider

2. Continuity of Care Upon Involuntary Admission to a Community Acute Care Facility
   - 2A. If the Consumer has a CSA/ACT Provider
   - 2B. If the Consumer has no CSA and is Eligible for CSA Enrollment
   - 2C. Responsibilities of the Community Acute Care Facility
   - 2D. Transfer from a Community Acute Care Facility to Saint Elizabeths Hospital

3. Continuity of Care for Forensic and Criminal Justice involved Consumers (including those who are pre-trial, serving a sentence either in a correctional institution or psychiatric facility).
   - 3A. Inmates who are Enrolled in a CSA/ACT Provider
   - 3B. Inmates who are not Enrolled in a CSA

4. Continuity of Care Upon Admission to Saint Elizabeths Hospital
   - 4A. If the Consumer is not Enrolled in a CSA
   - 4B. If the Consumer has a CSA/ACT Provider
   - 4C. Responsibilities of Saint Elizabeths Hospital

5. Continuity of Care Upon Admission to a Crisis Bed
   - 5A. Referral to a Crisis Bed
   - 5B. If the Crisis is not Resolved within 48 Hours
   - 5C. If Medical Necessity is Met
   - 5D. If Medical Necessity is not Met or Resolved
   - 5E. Notice of Unplanned Discharge

6. Continuity of Care for any CSA Transfer/Change
   - 6A. Right to Change a CSA
   - 6B. Responsibilities upon Knowledge of Consumer's Intent to Transfer or Change CSA.

7. Continuity of Care for Referral, Admission to a Nursing Facility (NF), Transfer and Reintegration in the Community
   - 7A. Referral to a Nursing Facility (NF)
   - 7B. NF Resident Review

7C. Transfer and Reintegration in the Community

8. Monitoring

9. Definitions

The provider shall adhere to DMH clinical policies, including DMH Policy 311.1, D.C. Medication Access Project (DCMAP); DMH Policy 300.1C, Level of Care Utilization System (LOCUS/CALOCUS) Evaluations; DMH Policy 511.3A DMH Guidelines on Nursing Facility Referrals and Required Reviews, and DMH Policy 645.1, DMH Privacy Policies and Procedures. All consumer information is subject to the Health Insurance Portability and Accountability Act (HIPAA) and the Mental Health Information Act (MHIA) protections.

1. Crisis Response, Urgent and Emergency Care.

Consumers in crisis may seek or be presented for treatment at several different locations. The provider's crisis response shall be consistent with the provider's role for that consumer, based on that consumer's need at that time, as described below:

1A. Contacting the DMH Access HelpLine (AHL):

When a consumer, family member, or other individual or entity contacts the AHL for a person in crisis, the AHL staff will complete a telephonic risk assessment.

1. When the consumer's needs are identified as urgent or emergency, AHL will respond as follows:

   a. If consumer has a CSA/ACT Provider, AHL staff will contact the CSA/ACT Provider, unless immediately calling 911 or crisis emergency provider is indicated upon determination that the consumer is likely to injure self or others due to his/her mental illness.

      i. If no response from CSA/ACT Provider within thirty (30) minutes, contact CSA/ACT Provider again.

      ii. If no response from CSA/ACT Provider within two (2) hours from first contact (or sooner based on assessed need), contact the CSA/ACT Provider senior administrator or designee or on call staff.

      iii. In the absence of a CSA/ACT Provider response, AHL staff may deploy a Crisis Emergency Provider.

   b. If consumer does not have a CSA/ACT Provider, AHL will contact a Crisis Emergency Provider, unless immediately calling 911 is indicated upon determination that the consumer is likely to injure self or others.

2. AHL staff will document the planned action in the electronic management system.

1B. Presentation to Providers who are a Crisis Emergency Provider:
(See Section 8 for definition of Crisis Emergency Provider)

A consumer may present directly to a Crisis Emergency Provider or may be linked by Access Helpline (AHL). If the consumer presents directly to a Crisis Emergency Provider, the Crisis Emergency Provider **MUST** contact AHL.

1. Whenever a consumer is treated at any Crisis Emergency Provider, the consumer will receive the following services before any disposition or outcome:

a. If consumer has a CSA/ACT Provider, the Crisis Emergency Provider will contact the CSA/ACT Provider to notify them that one of their consumers is presenting for services, obtain previous treatment history, and notify AHL. The AHL or Crisis Emergency Provider will request CSA/ACT Provider face to face response, unless immediately calling 911 is indicated upon determination that the consumer is likely to injure self or others.

i. If no response within thirty (30) minutes, contact the CSA/ACT Provider again.

ii. If no response within two (2) hours (or sooner based on assessed need), the Crisis Emergency Provider should notify the AHL for follow-up with CSA/ACT Provider.

iii. Crisis Emergency Provider should provide services in accordance with subsections 2 and 3 below, as applicable.

b. If consumer has no CSA/ACT Provider:

- Crisis Emergency Provider should provide services in accordance with subsections 2 and 3 below, as applicable.
- The Crisis Emergency Provider will also offer the consumer linkage to a CSA through the consumer choice process and if agreeable, assist the eligible consumer with calling AHL to enroll in a CSA. The Crisis Emergency Provider will also assist with arranging a CSA emergency or urgent need intake appointment as part of the Crisis Emergency Provider treatment discharge planning.

2. Consumers who meet criteria for emergency need or who have an FD-12, Application for Emergency Hospitalization, for involuntary treatment assessment must be seen by the Crisis Emergency Provider within one (1) hour. An assessment must be conducted and include a mental status examination, screening for suicide or homicidal ideations, and assessment of inpatient treatment need. This contact will be required for admission to a facility. Admission to an acute care facility may proceed if a Crisis Emergency Provider physician or qualified psychologist recommends admission based on medical necessity.

3. Consumers who meet criteria for urgent need for mental health services will have an assessment including mental status examination, and screening for suicide or homicidal ideation. The Crisis Emergency Provider will complete a crisis plan to address the current situation and provide it to the consumer and assigned CSA/ACT provider. If the consumer is not linked to a CSA/ACT Provider and is eligible for MHRS, the Crisis Emergency Provider will contact AHL to assist the consumer with enrollment to a CSA for ongoing services and supports.

If the consumer is a resident of the District of Columbia, the consumer shall be referred to a private mental health provider or enrolled in a CSA of their choice, as applicable. If the consumer is not a resident of the District of Columbia, contact must be made (or attempted) with the mental health authority representatives in the consumer's home jurisdiction and/or the consumer's designated family/friend.

1C. Presentation at Providers who are Core Services Agency (CSA)/Assertive Community Treatment (ACT) Provider:

When a consumer presents in crisis at a CSA/ACT Provider, that provider will:

1. Provide any needed emergency care to stabilize immediate life threatening situations, which may include but is not limited to calling 911, and then refer consumer for further treatment based on their knowledge of that consumer's status.

2. Use these practice guidelines and/or LOCUS screening to indicate level of acuity and service needs.

3. If the consumer is enrolled with the CSA/ACT Provider and the consumer meets the guidelines for urgent or emergency need, initiate appropriate clinical intervention based on the assessed needs of the consumer.

4. If the consumer is not in active treatment with that CSA/ACT Provider, the CSA/ACT Provider may call AHL to request crisis emergency services.

2. Continuity of Care Upon Involuntary Admission to a Community Acute Care Facility.

AHL will authorize involuntary admission, inform the acute care facility of the consumer's assigned CSA/ACT Provider, and immediately notify the assigned CSA/ACT Provider of the admission. Upon admission to an acute care facility (referred to as facility) the protocol below will be followed.

A DMH Care Manager will be assigned to coordinate the continuity of care between the CSA/ACT Provider and the acute care facility.

2A. If the Consumer has a Core Services Agency (CSA)/Assertive Community Treatment (ACT) Provider:

1. The acute care facility will communicate with the consumer's CSA/ACT Provider within one (1) day of admission. Communication will include discussion of the consumer's psychosocial history, IRP, treatment course history, and medication history.

2. The CSA/ACT Provider will have face to face contact with the consumer and designated acute care facility staff within two (2) days of notification of admission. That contact will include the initial treatment team meeting to establish discharge planning with the consumer and the facility treatment team.

3. During the time of treatment in the acute care facility, the CSA/ACT Provider shall:

   a. Ensure LOCUS screenings are performed at appropriate intervals to indicate level of acuity and appropriate service needs;

   b. Have face to face contact with consumer and facility treatment team at least once a week during the entire length of stay at the facility; and

   c. Notify significant others as noted on the IRP and in the advanced instructions the same day of notification of admission if possible, but no later than the following day or as directed in the consumer's IRP/advanced instructions.

4. CSA/ACT Provider will maintain progress notes in the consumer's clinical record, reflecting all meetings and communications with facility staff, the consumer, and all significant others. If appropriate the CSA/ACT Provider treating psychiatrist will consult telephonically or in person with the acute care facility treating psychiatrist.

5. The CSA/ACT Provider will participate in the development of an appropriate discharge plan with the consumer and acute care facility staff. Discharge planning must be documented in the consumer's clinical record and include:

   a. A face to face appointment between the CSA/ACT Provider and the consumer, within seven (7) days of the consumer's discharge from facility to the community;

   b. A scheduled medication somatic appointment for all consumers on psychotropic medications with the CSA/ACT Provider within ten (10) days of discharge; and

   c. Evidence of an attempt to address the consumer's individual needs including benefits acquisition, and housing, as applicable.

2B. If Consumer has no Core Services Agency (CSA) and is Eligible for CSA Enrollment:

1. If the consumer is not a resident of the District of Columbia, contact must be made (or attempted) with the mental health authority representatives in the consumer's home jurisdiction and/or the consumer's designated family/friend to gain collateral information including psychosocial history, treatment course history, and medication history.

2. If eligible for CSA enrollment, the AHL staff will enroll the consumer with a CSA if the consumer is able and willing to have a telephone conversation. This will be done through the consumer choice process. If the consumer is unable or unwilling to have this telephone contact, a CSA will be randomly assigned.

- If random CSA assignment occurs, the CSA will be responsible for ensuring that the choice menu form is completed when the consumer is more stable, and filed in the consumer's clinical record.

3. The AHL will notify the assigned CSA of admission of the consumer and their enrollment to the CSA.

4. The CSA will have face-to-face contact at the acute care facility with the consumer within two (2) days of the consumer being assigned to that CSA to work with the acute care facility to develop an appropriate discharge plan.

5. Discharge planning/documentation must include:

a. A face to face appointment between the CSA and the consumer, within seven (7) days of the consumer's discharge from facility to the community;

b. A scheduled medication somatic appointment for all consumers on psychotropic medications with the CSA within ten (10) days of discharge;

c. LOCUS screening to indicate level of acuity and appropriate service needs; and

d. Evidence of an attempt to address the consumer's individual needs including benefits acquisition, and housing, as applicable.

2C. Responsibilities of the Community Acute Care Facility:

Upon admission, the acute care facility will communicate with the consumer's CSA/ACT Provider within one (1) day of admission and will perform the following responsibilities for the consumer's continuity of care. Acute care facilities have additional responsibilities, such as those imposed by District and federal laws including the Ervin Act, to include coordination with the Office of the Attorney General (OAG) Mental Health Section, and

completion of necessary legal forms (such as Form 522, 541, and 5-day letter for the return of committed patients).

1. The acute care facility will schedule an initial treatment team meeting to be held within two (2) days of admission to the facility, and document invitation of a CSA/ACT Provider representative.

2. The acute care facility staff will ensure the consumer is invited to all treatment team meetings, and every discharge planning meeting. The acute care facility staff must document in the consumer's clinical record each time an attempt was made to include the consumer for every date where a consumer did not attend.

3. The acute care facility shall notify the CSA/ACT Provider, the assigned DMH Care Manager, and the OAG Mental Health Section immediately of any transfer, request for discharge against medical advice, or unplanned discharge.

4. Prior to converting an involuntary consumer to a voluntary status, the acute care facility must ensure they are in compliance with DMH Policy 303.3, Converting Civilly Committed Consumers to Voluntary.

5. At discharge, the acute care facility will provide a prescription or enough medication for the consumer until the next scheduled medication somatic appointment scheduled at their CSA/ACT Provider, or as determined in the discharge planning process.

6. The acute care facility will provide the CSA/ACT provider a discharge summary upon discharge.

2D. Transfer from a Community Acute Care Facility to Saint Elizabeths Hospital:

1. If an involuntary adult consumer needs to be transferred to Saint Elizabeths Hospital, the assigned DMH Care Manager will authorize the transfer.

2. If the consumer is authorized to be transferred from a community acute care facility to Saint Elizabeths Hospital, the CSA/ACT Provider will communicate with the Saint Elizabeths Hospital staff within one (1) day after transfer.

3. Once transferred, the CSA/ACT Provider will have face to face contact with the consumer and the Saint Elizabeths Hospital staff within two (2) days after transfer.

- Communication with the Saint Elizabeths Hospital staff will include discussion of the consumer's psychosocial history, IRP, treatment course history, medication history, and scheduling of initial treatment team meeting with staff to include appropriate discharge planning.

3. Continuity of Care for Forensic and Criminal Justice Involved Consumers.

Consumers on Pre-Trial Status. CSA/ACT Providers with consumers on pre-trial status will be expected to communicate with the DMH Court Liaison or the appropriate supervision agency.

CSA/ACT Providers with Consumers Ordered to Competency Restoration (on an in or outpatient basis) will be required to provide information and coordinate care with the competency restoration staff either at the DMH Mental Health Services Division (MHSD) or at Saint Elizabeths Hospital.

Consumers who are not linked to CSA/ACT Providers may request to be enrolled with a CSA through AHL with support from a variety of court personnel or supervision staff.

Consumers Incarcerated in Jail or Prison. The DMH Jail Liaison shall be responsible for linking all referred mental health or mentally ill adult jail inmates to a CSA. There are no restrictions for referrals to the DMH Jail Liaison. The DMH Jail Liaison shall be responsible for facilitating the continuity of care process with the CSA.

3A. Inmates who are Enrolled in a Core Services Agency (CSA)/ACT Provider:

1. The DMH Forensic Services staff shall notify the CSA/ACT Provider of the consumer's incarceration.

2. The CSA/ACT Provider shall schedule a tentative appointment with the DMH Jail Liaison to see the consumer and shall provide information to the mental health staff of the Department of Corrections (DOC) related to the inmate's diagnosis, medication and treatment.

3. The DMH Jail Liaison prepares a list on a regular basis of staff from DMH CSAs and ACT teams for the DOC who are approved to enter the D.C. Jail. For those CSA/ACT Provider staff not already on the list, the DMH Jail Liaison shall prepare a written request to the Jail Deputy Warden for Programs for the CSA/ACT Provider staff to visit the inmate.

   a. The CSA/ACT Provider staff shall report to the D.C. Jail main entrance for an escort.

   b. All visitors shall be required to go through the D.C. Jail security check.

4. The CSA/ACT Provider, with input from the D.C. Jail mental health staff, shall complete a LOCUS evaluation upon initial assessment of the inmate and prior to release if notified. The CSA/ACT Provider shall conduct an assessment of the inmate's needs to determine the status of support and services required or in place for the consumer when they are released from jail.

5. The CSA/ACT Provider shall develop a discharge plan to meet the psychosocial needs upon release to the community that will address housing, benefits, and other follow-up requirements, and as necessary, complete applications for benefits and housing.

- The discharge plan shall include criminal justice staff and family members (as applicable and available) involved in the consumer's care, treatment, and services.

6. The DMH Jail Liaison shall notify the CSA/ACT Provider of the court hearing date as soon as possible. The CSA/ACT Provider shall participate in the court hearing process.

7. The DMH Jail Liaison shall notify the CSA/ACT Provider of the consumer's release date and obtain an appointment date for the inmate to see the CSA/ACT Provider within seven (7) days of release from jail.

8. The Department of Corrections shall at the time of release provide written discharge instructions in a form that the consumer can understand. Information shall include the name of the CSA/ACT contact, telephone number, address of the CSA/ACT Provider, and appointment date.

3B. Inmates who are not Enrolled in a Core Services Agency (CSA):

The DMH Jail Liaison shall facilitate the referral of mentally ill inmates who are not enrolled in a CSA who are in need of and/or request services.

1. The DMH Jail Liaison shall screen and provide information regarding the various CSAs.

a. The DMH Jail Liaison shall contact the DMH Access Helpline (AHL) and the CSA to enroll the inmate in a CSA. For situations where the inmate has had multiple jail admissions without connection to a CSA, the DMH Jail Liaison may refer to the D.C. Linkage program.

b. In all situations, a CSA contact person shall be assigned to the inmate.

c. The CSA contact person shall schedule a tentative appointment with the DMH Jail Liaison to see the consumer at the D.C. Jail.

2. The DMH Jail Liaison shall prepare a written request to the Jail Deputy Warden for Programs for the CSA contact person to visit the inmate.

3. After the tentative appointment has been scheduled, the DMH Jail liaison and CSA contact person should follow the same procedures outlined in Section 3A2 – 3A7.

4. Continuity of Care Upon Admission to Saint Elizabeths Hospital.

All individuals admitted to Saint Elizabeths Hospital under a civil admission will be assigned to a CSA if not already enrolled. Saint Elizabeths Hospital will be responsible for finding out if the individual is currently assigned to a CSA/ACT Provider.

4A. **If the consumer is not already enrolled**, the AHL staff will enroll a consumer with a CSA.

- If the consumer is able and willing to have a telephone conversation, this will be done through the consumer choice process.
- If the consumer is unable or unwilling to have this telephone contact, a CSA will be assigned randomly to the consumer, first by home location, then by location of consumer at time of crisis (e.g., shelter, street).
- If random CSA assignment occurs, the CSA will be responsible for ensuring that the choice menu form is completed when consumer is more stable, and filed in the consumer's clinical record.
- The AHL will notify the assigned CSA of admission of consumer and their enrollment to CSA.

4B. **If the Consumer has a CSA/ACT Provider**:

1. Saint Elizabeths Hospital shall be responsible for communicating with the consumer's CSA/ACT Provider within one (1) day of admission.

2. The CSA/ACT Provider shall arrange for a face to face contact with the consumer and designated Saint Elizabeths Hospital staff. Face to face contact should occur within two (2) days of admission.

- Communication with designated Saint Elizabeths Hospital staff will include discussion of the consumer's psychosocial history and IRP, treatment course history, medication history, and scheduling of initial treatment team meeting with Saint Elizabeths Hospital staff, to be held within five (5) days of admission.

3. During the time of treatment in Saint Elizabeths Hospital, the CSA/ACT Provider shall:

a. Have face to face contact with consumer and staff at a minimum of once a week for the first thirty (30) days of stay at Saint Elizabeths Hospital.

b. Have face to face contact with the consumer and staff at least once a month for subsequent lengths of stay at Saint Elizabeths Hospital and attend all treatment team meetings.

c. Make contact with significant others as noted on the IRP and in the advanced instructions to notify of admission the same day of admission, if possible, and no later than the following day or as directed in the consumer's IRP advanced instructions.

d. The CSA/ACT Provider, in conjunction with the Saint Elizabeths Hospital treatment team, shall also complete LOCUS evaluations at appropriate intervals.

4. The CSA/ACT Provider will develop discharge planning with consumer and staff.

5. CSA/ACT Provider will maintain progress notes in the Saint Elizabeths Hospital clinical records and at the CSA/ACT Provider, reflecting all meetings and communications with staff, the consumer, and all significant others. If necessary the CSA/ACT provider treating psychiatrist will consult telephonically or in person with the Saint Elizabeths Hospital treating psychiatrist.

6. CSA/ACT Provider will participate in the Saint Elizabeths Hospital discharge planning process in order to affect a discharge that encourages successful community tenure. In addition, discharge planning and documentation must include:

a. A scheduled medication somatic appointment for all consumers on psychotropic medications with the CSA/ACT Provider within ten (10) days of discharge.

b. A face to face meeting between the CSA/ACT Provider, and the consumer, within seven (7) days of the consumer's discharge from Saint Elizabeths Hospital to the community.

c. Evidence of plans to address the consumer's individual needs including benefits acquisition and housing, and if applicable, discussion of legal status and hearing schedule to determine contingency plans based on possible court decisions and plans on coordinating care with the forensic outpatient division during community tenure, as applicable.

d. For consumers who have a forensic legal status, the court date must be treated as a discharge date from the hospital, and the CSA/ACT Provider is expected to attend each scheduled court date.

e. For consumers who are Not Guilty by Reason of Insanity (NGRI), linkage to appropriate providers will be in accordance with their court order.

4C. Responsibilities of Saint Elizabeths Hospital:

1. Saint Elizabeths Hospital will schedule the initial treatment planning meeting to be held within five (5) days of admission, and document invitation of CSA/ACT Provider representative. The initial treatment planning meeting will also include discharge planning as reflected in the Saint Elizabeths Hospital discharge planning process.

2. Saint Elizabeths Hospital will request the consumer's and CSA/ACT Provider's attendance at all treatment planning meetings, and discharge-planning meeting, if applicable.

- Saint Elizabeths Hospital must document in the consumer's clinical record each time an attempt was made to include the consumer, for every date where a consumer did not attend.

3. Saint Elizabeths Hospital shall notify the CSA/ACT Provider immediately of any transfer or unplanned discharge.

4. Upon conditional release of a forensic consumer or discharge of civil consumer, Saint Elizabeths Hospital will provide a prescription for medication for the consumer until the next scheduled medication somatic appointment scheduled at their CSA/ACT Provider, or as determined in the discharge planning process. In addition, the consumer will be provided with instructions regarding follow-up monitoring procedures in the community.

5. Continuity of Care Upon Admission to a Crisis Bed.

5A. Referral to a Crisis Bed. A consumer, natural support, CSA/ACT Provider, community acute care facility, or a crisis emergency provider may refer a consumer to a crisis bed.

1. The Crisis Bed Provider will:

- Gather information from the referring party, and admit if appropriate based on the clinical presentation (consumer has an Axis I diagnosis that is not primary substance abuse only or Axis II serious mental illness and a demonstrated need for 24-hour supervision and assistance while stabilization of symptoms in the community occurs).

- If admitted, notify AHL of the admission, and obtain collateral information as needed.

- The Crisis Bed Provider will notify the CSA/ACT Provider immediately, but no later than within 24 hours of admission. A treatment plan meeting will be held within 72 hours of admission if the consumer remains in the crisis bed.

2. If the consumer does not have a CSA/ACT Provider and is eligible for CSA enrollment, AHL will enroll the consumer with a CSA upon admission to the crisis bed.

- The AHL will document the admission to a crisis bed in the electronic management system.

5B. If the crisis is not resolved within 48 hours,

1. The crisis bed provider staff will provide AHL a written clinical presentation for a continued stay, LOCUS worksheet, and psychiatric evaluation.

2. AHL will review the documentation provided by the crisis bed provider and determine medical necessity.

5C. If medical necessity is met,

1. AHL will provide continued stay authorization at the crisis bed (not to exceed 14 calendar days).

2. If the crisis has not been resolved by Day 14, the consumer will be assessed for a more appropriate level of care.

5D. If medical necessity is not met or resolved, the CSA/ACT Provider will ensure the following crisis bed discharge planning is addressed/arranged:

1. face to face appointment between the clinical manager, or clinician designated in the consumer's IRP and the consumer, within seven (7) days of the consumer's discharge from the crisis bed to the community;

2. medication somatic appointment if the consumer is on psychotropic medications with the CSA/ACT Provider within ten (10) days of discharge; and

3. attempt to address the consumer's individual's needs including benefits acquisition, and housing, as applicable.

5E. Notice of Unplanned Discharge. The crisis bed provider is responsible for notifying AHL and the CSA/ACT Provider of any unplanned discharge (e.g., elopement or request for discharge against medical advice (AMA).

6. Continuity of Care For any CSA Transfer/Change.

6A. Right to Change a CSA. Consumers have the right to change their CSA at any time for any reason. This change can be made by telephone call only to the DMH Access HelpLine (AHL). Three (3) changes of CSA by a consumer within a benefit year may trigger a Care Coordination utilization review.

6B. Responsibilities upon Knowledge of Consumer's Intent to Transfer or Change CSA:

1. When a consumer notifies the AHL of their intent to transfer, the AHL staff will:

   a. Educate the consumer as to all available CSAs and their services, but may neither recommend nor suggest a CSA.

   b. If the consumer makes a choice of a new CSA he/she wants to receive services from, AHL will:
   - close the consumer's enrollment with the current CSA,
   - enroll the consumer with the new CSA,
   - assist the consumer with arranging an intake appointment at the new CSA, and
   - send an email notification to the old and new CSA.

2. If the consumer completed and signed a DMH-HIPAA Form 2 Consent for the Use and Disclosure of Protected Health Information Among Participating Network Providers, the old CSA will send the following documentation to the new CSA within one (1) week of the transfer and communicate to the new CSA any additional collateral information as needed:

   a. Diagnostic assessment;

   b. IRP;

   c. Clinical manager/approving practitioner's progress notes for past six (6) months;

   d. Psychiatrist's progress notes for past six (6) months; and

   e. Current medication records including lab reports, and physical.

3. If the consumer refuses to sign a DMH-HIPAA Form 2, Consent for the Use and Disclosure of Protected Health Information Among Participating Network Providers, for sharing records, the new CSA clinical manager/approving practitioner will discuss with the consumer the importance of the sharing of information and present options to the consumer to sign a limited authorization of disclosure (DMH-HIPAA Form 3, Authorization to Use or Disclose Protected Health Information). This may mean educating the consumer as to what portions of the record would be acceptable to transfer to the new CSA.

4. If the consumer transfers to a new CSA without first notifying the previous CSA, both agencies will learn of this via the DMH electronic management system. When this occurs, the previous CSA will:

- Ensure the consumer signed an authorization for disclosure form and then follow the same procedures in 6B2above. If the consumer refuses to sign an authorization for disclosure, the new CSA will follow 6B3 above.

7. Continuity of Care for Referral, Admission to a Nursing Facility (NF), Transfer and Reintegration in the Community (Specific procedures for this section are found in DMH Policy 511.3A DMH Guidelines on Nursing Facility Referrals and Required Reviews).

7A. Referral to a Nursing Facility (NF)

The main criteria for placement in a nursing facility is the need for the individual to have a 24-hour nursing care and supervision due to chronic and/or acute somatic illness and impaired self-care ability.

7B. NF Resident Review

1. DMH shall conduct the Preadmission Screening and Resident Review (PASRR) for District citizens who are seeking placement in a nursing facility and have a mental illness or a history of mental illness.

2. The PASSR Coordinator shall facilitate reviews for those already in nursing facilities. LOCUS will be conducted every one hundred eighty (180) days to review continued appropriateness of level of care (LOC). When nursing facility is no longer indicated in the individual's LOC, and community-based services are more appropriate, he/she will be referred for transfer and reintegration in the community.

7C. Transfer and Reintegration in the Community

1. Reintegration in the community will be handled by the DMH Chief of Continuity of Care.

2. The DMH Chief of Continuity of Care will facilitate the assistance for the consumer. He/she will assist the consumer/guardian to enroll with the DMH network provider when the consumer is assessed to be appropriate for community re-integration and eligible for public mental health services.

8. Monitoring.

DMH will monitor provider responsiveness regarding a crisis/emergency situation and will monitor compliance with the Continuity of Care Practice Guidelines including continuity of care responsibilities regarding consumers change in level of care. Appropriate actions will be taken as necessary.

8. Definitions. For purposes of these adult continuity of care guidelines:

ACT – Assertive Community Treatment (ACT) is an intensive, integrated, rehabilitative, crisis, treatment, and mental health rehabilitative community support service provided by an interdisciplinary team to adults with serious and persistent mental illness with dedicated staff time and specific staff to consumer ratios.

ACT Provider – Assertive Community Treatment (ACT) Provider is an agency certified by DMH to provide ACT services, consistent with the MHRS Standards and the Department of Mental Health Establishment Amendment Act of 2001, and the Mental Health Consumers' Rights Protection Act.

Acute Care Facility – Private community hospitals and Saint Elizabeths Hospital at which acute or crisis mental health services are provided, also referred to as "facility" in this document.

Advanced Instructions – A written document prepared in accordance with D.C. Official Code § 7-1231.06 and Chapter 1 of Title 22A, DCMR, that details a consumer's mental health treatment preferences including his/her informed choice to accept or forego particular mental health services and mental health supports. Advance instructions become effective when the consumer is certified as incapacitated.

Approving Qualified Practitioner – The qualified practitioner responsible for overseeing the development and approval of the IRP. The approving qualified practitioner serves on the diagnostic/assessment team and may also serve as the clinical manager. Only a psychiatrist, psychologist, LICSW, APRN, or LPC may act as an AQP.

Authorization Plan – Items from the IRP that are entered into the DMH electronic management system and result in authorization plan numbers.

Clinical Manager – The qualified practitioner who coordinates service delivery. The clinical manager shall participate in the development and review of the consumer's IRP, along with the approving practitioner. The clinical manager may also serve as the approving practitioner. The clinical manager shall be employed by the CSA/ACT Provider, except that a psychiatrist serving as a clinical manager may be under contract to the CSA/ACT Provider.

Conditional Release – A person who is confined to a hospital under D.C. Official Code 24-501(d), who is granted release to the community under conditions of the court.

Consumer – A person who seeks or receives mental health services or mental health supports funded or regulated by DMH.

Continuity of Care (COC) - Coordination of services towards the stability of consumer-provider relationships over time. The relationship is typically established with a team rather than a single provider. Care provided by different professionals is coordinated through a common goal. A unique feature is continuity of contact, where the providers maintain contact with consumers, monitor their progress, and facilitate access to needed services.

Court Personnel - Attorneys for the prosecution or defense and staff of the Court.

Core Services Agency (CSA) – A DMH-certified community-based MHRS provider that has entered into a Human Care Agreement with DMH to provide specified MHRS. A CSA shall provide at least one core service directly and may provide up to three core services via contract with a sub-provider or subcontractor. A CSA may provide specialty services directly if certified by DMH as a specialty provider. However, a CSA shall also offer specialty services via an affiliation agreement with all specialty providers.

Crisis Emergency Provider (CEP) - A provider certified by DMH to provide crisis emergency services or who has contracted with DMH to provide same. This provider may be part of a CSA or may be a separate entity. The provider is accessible twenty-four hours per day, seven days per week (24/7) to offer crisis intervention to callers who are in crisis, to dispatch mobile crisis services, and to assist all persons in the District who may need emergency mental health care.

D.C. Jail – Provides Central Detention Facility and Central Treatment Facility.

Department of Corrections (DOC) – Provides incarceration services at the D.C. Jail and the halfway houses in the District.

DMH Access Helpline (AHL) – A telephone-based service center operated by DMH twenty-four hours per day, seven days per week (24/7). The DMH Access Helpline, 888-7WE-HELP (888-793-4357), provides crisis intervention, information and referral, service authorization and eligibility, and enrollment in the DMH system of care.

DMH Care Manager – A clinically licensed staff member that reports to the DMH Division of Integrated Care to provide care management and discharge support to eligible consumers.

DMH Chief of Continuity of Care – The position responsible for coordination of services towards the stability of consumer-provider relationships over time. In transitioning consumers towards re-integration in the community from nursing homes, this position is specified in facilitating the needed assistance for those eligible for mental health services.

Eligibility – Eligibility for MHRS services requires that a person have an Axis I diagnosis that is not primary substance abuse only, or a primary diagnosis on Axis II; and is certified as requiring

MHRS by an approving qualified practitioner; and is a resident of the District, except for emergency psychiatric care.

Emergency Need – For consumers who are involved in active crisis where the safety of the consumer or others is at risk within the next twenty-four (24) hours. Safety may be at risk due to suicide, homicide, and/or severe decompensation of functioning. Face to face services must be provided within one (1) hour of presentation at a CSA/ACT Provider. Crisis emergency services by a CEP must be provided within one (1) hour of the request or referral.

Individualized Recovery Plan (IRP) - The individualized recovery plan for adult consumers, which is the result of the diagnostic/assessment. The IRP is maintained by the consumer's CSA/ACT Provider. The IRP includes the consumer's treatment goals, strengths, challenges, objectives, and interventions. The IRP is the authorization of treatment, based upon certification that MHRS are medically necessary by an approving practitioner.

LOCUS – Level of Care Utilization System for psychiatric and addiction services, adult version assessment tool.

Mental Health Provider – (a) Any individual or entity, public or private, that is licensed or certified by the District of Columbia to provide mental health services or mental health supports; (b) any individual or entity, public or private, that has entered into an agreement with DMH to provide mental health services or mental health supports; or (c) Saint Elizabeths Hospital, also referred to in these guidelines as "provider."

Mental Health Rehabilitation Services (MHRS) – Those mental health services performed by DMH certified providers, according to the Mental Health Rehabilitation Services Provider Certification Standards; Chapter 34 of Title 22A District of Columbia Municipal Regulations.

Natural Settings – The consumer's residence, workplace, or other locations in the community the consumer frequents, such as the consumer's home, school, workplace, community centers, homeless shelters, street locations, or other public facilities. Natural settings do not include inpatient hospitals or community residential facilities.

Natural Supports – People who are informal supports and are acquainted or are related to the consumer, but do not provide a paid service. Natural supports can also be found in the consumer's community, such as the faith community, school, or community organizations, or workplace.

Nursing facility (NF) - A facility licensed to provide nursing home or skilled nursing services.

Pre-admission Screening and Resident Review (PASRR) Level 1 Screening - The initial screening required for all individuals prior to admission to a Medicaid certified nursing facility, regardless of payer source. The screening is conducted by hospitals, nursing facilities or DMH providers for preadmission screenings.

District of Columbia Department of Mental Health
Continuity of Care Practice Guidelines for
ADULT Providers in the Mental Health System of Care

Resident of the District – A person who voluntarily lives in the District of Columbia and has no intention of presently removing them self from the District. The term "resident of the District" shall not include a person who lives in the District solely for a temporary purpose.

Routine Need – CSAs response time of seven (7) business days for individuals seeking services who are not in urgent or emergency need.

Supervision Agency - In the District of Columbia the agencies supervising defendants or offenders is Pre-Trial Services or Court Supervision Offender Services Agency, or U.S. Parole Commission.

System of Care for Adults – A community support system for persons with mental illness that is developed through collaboration in the administration, financing, resource allocation, training, and delivery of services across all appropriate public systems. Each person's mental health services and mental health supports are based on an individual recovery plan (IRP), designed to promote recovery and develop social, community and personal living skills, and to meet essential human needs. It includes the appropriate integrated, community-based outpatient services and inpatient care, outreach, emergency services, crisis intervention and stabilization, age-appropriate educational and vocational readiness and support, housing and residential treatment and support services, family and caregiver supports and education, and services to meet special needs, which may be delivered by both public and private entities.

Urgent Need - Consumers experiencing distress that will develop into a crisis state without intervention, but where there is not yet a likely risk of injury to the consumer or others. Distress may be defined as at risk behavior such as suicide, homicide, a recent major loss, or a severe decompensation of functioning. Services must be provided within the same day of consumer presentation.

Approved By:

Stephen T. Baron
Director, DMH

Stephen T Baron 8-15-12
(Signature) **(Date)**