

ATTACHMENT 1

FRAMEWORK FOR PERSONS ADMITTED TO AND DISCHARGED FROM STATE MENTAL HEALTH TREATMENT FACILITIES

This attachment provides a summary of proposed recommendations for improving care coordination with individuals admitted to and discharged from state mental health treatment facilities (SMHTF). The primary goal is to ensure individuals receive care in the least restrictive setting and to reduce the time individuals spend waiting for admission to SMHTFs and discharge to their home community.

This framework provides guidance for three phases individuals go through in the SMHTF process:

- 1) Diversion and awaiting admission to a SMHTF;*
- 2) During the SMHTF stay; and*
- 3) Discharge planning.*

The next step is to incorporate select items that will likely have the greatest impact on improving care coordination into the Guidance Documents within the Managing Entity contracts. It is envisioned that the Managing Entities retain the flexibility to work with their system partners to implement these practices.

SECTION 1 – DIVERSION AND AWAITING ADMISSION TO A SMHTF:

1. Strengthen the Transfer Evaluation Process for Admission to SMHTFs from Receiving Facilities.

Chapter 65E-5.1301(2), F.A.C., requires a community mental health center or clinic to evaluate each person seeking voluntary admission to or for whom involuntary placement is sought in a SMHTF to determine and document:

- Whether the person meets the statutory criteria for admission to a SMHTF; and
- Whether there are appropriate more integrated and less restrictive mental health treatment resources available to meet the person's needs.

2. Increase Meaningful Consumer and Family Involvement Through Use of Advanced Directives, Personal Safety Plans, and Certified Recovery Peer Specialists.

One strategy is to offer individuals the opportunity to complete Advanced Directives and Personal Safety Plans while in the SMHTF, Receiving Facility (RF), or when assisted by the community behavioral health staff member, such as a Case Manager or Florida Assertive Community Treatment staff.

- Use uniform documents, such as the ones in the latest Baker Act Handbook.
- Include a copy of completed Advanced Directives and Personal Safety Plans in the SMHTF referral packet, or indicate that they were not completed.
- Add Advanced Directives and Personal Safety Plans to the SMHTF admission packet.

Additionally, Certified Recovery Peer Specialists (CRPS) can be utilized while an individual is in the receiving facility to assist with identifying less restrictive community alternatives.

3. Expand Use of Pre-Screening Committees to Centralize the SMHTF Admission Process.

A SMHTF pre-screening committee has been implemented in one county by the Managing Entity (ME). This approach could be tested in other areas to measure impact on admission rates to the SMHTFs. MEs should consider the option of processing all SMHTF packets for their respective areas. For some MEs, involvement by the local Substance Abuse and Mental Health Regional Office staff to encourage the participation of the designated private receiving facilities would help implement this process. It is important to recognize that all persons being petitioned for SMHTF admission, whether Department-funded or insured, are utilizing the ME's limited resources within the system of care, including SMHTF, and when reintegrating into the community.

Use of the centralized SMHTF Admission Process allows the MEs to:

- Track admissions;
- Facilitate diversions from the SMHTF;
- Ensure pre-admission screenings by FACT;
- Increase ease of referral to the SMHTF (complete packets submitted by one source); and
- Ensure accurate assignment of a community representative (case manager or FACT team) if one does not already exist.

4. Maintain Current Regional Inventory of Housing and Services.

Develop and provide to each local public and private receiving facility a Regional Inventory of Housing and Behavioral Health Services and Supports within the ME area. The MEs would provide current Regional Inventories to the Department and the Department for broader dissemination, including private receiving facilities. These Regional Inventories should be comprehensive and include community housing or living environments, services, and contact information. The addition of other natural supports, such as faith-based resources, or support groups by county within the ME area would further improve this resource.

5. Implement Use of a Diversion Resource Check List.

It is recommended that MEs develop a check list of existing community options to be considered by all system partners that may divert an individual from SMHTF admission. The listing should include services funded by the ME, as well as other services.

- The completed check list should be included in the individual's referral packet to the SMHTF.
- If the individual needs a nursing home then the Level of Care information should be present, along with a list of all the community nursing homes contacted for possible admission. If the individual was admitted to the receiving facility from a nursing home, that information should be clearly delineated on the State Mental Health Treatment Facility Admission Form.
- Consider use of Short-Term Residential Treatment Facilities (SRTs) as a diversion from SMHTF admission. In order to use the SRT, the individual's involuntary court order for placement must read SMHTF/SRT for diversion. The ME and providers should prioritize these referrals over other referrals that are Voluntary or not on the SMHTF wait list. SRT resources are currently limited to implement this option.
- Continue to evaluate the capacity for openings on existing FACT teams created through review of FACT team members for less intensive services. FACT could be used to divert more persons from SMHTF admission. MEs could also review system need for FACT services, and use existing funding to create additional FACT teams.

- If the individual cannot be diverted and is established with an existing Case Management or FACT team, that assessment information would be beneficial to add the individual's referral packet to the SMHTF.

SECTION 2 - DURING THE STATE MENTAL HEALTH TREATMENT FACILITY STAY:

1. Improve Communication Protocols around Discharge Planning Processes.

The SMHTFs can explore ways to better link with the individual's community providers in order to obtain and share relevant information that can assist to improve treatment outcomes and inform the discharge plan. Strategies include:

- Communicate with the individual's community provider throughout the resident's stay.
- Provide immediate notification to the community provider that the individual is ready for discharge and invite the community provider to be a participant in the individual's Discharge Planning Meeting.
- Develop and share the individual's Transition Plan, summarizing the individual's assessed needs for housing, behavioral health and other services upon their return to the community.

2. Increase Community Participation in Discharge Planning

It is imperative that the SMHTFs, MEs, and community providers work collaboratively to ensure an individual's successful transition back to the community. Below are alternative ways for the community provider to be an active participant in the individual's discharge planning process:

- Use of technology to share information about the individual's preference for potential living environments.
- Schedule additional times for community providers to participate in discharge planning meetings.
- Increase frequency of calls to discuss individuals on the "Seeking Placement List".
- Work directly with the community provider for assistance with securing community-based housing and services consistent with the individual's needs through the Managing Entity's Regional Inventory.
- Increase information about Supportive Housing and Florida Assertive Community Treatment through provider "in-reach" to the residents while at the facility.

3. Ensure the Individual has all the Needed Resources for a Successful Transition (i.e., benefits, identification documents, etc.)

The SMHTF must ensure that the individual returning to the community is equipped with all resources for which they are entitled, such as:

- Ensure that benefit planning starts within 30 days of the individual's admission to the facility and access services such as "Florida Licensing on Wheels", when available.
- Conduct self-audits of all individuals who are "pre-discharge ready" to ensure that all the facility requirements have been completed prior to the individual being added to the "Seeking Placement List" .

- Address any facility requirements identified as incomplete during the Department’s validation of the “Seeking Placement List”.

SECTION 3 - DISCHARGE PLANNING:

1. Use of a Peer Specialist Bridger Model

Utilizing CRPSs to provide care coordination at time of discharge from a SMHTF could increase opportunities for the individual to establish a rapport and facilitate their transition to the community. Suggested practices include:

- Introduction of a CRPS to the individual at least 30 days prior to their discharge, whenever possible.
- CRPSs to accompany individuals on site visits to the community prior to discharge.
- CRPS to follow the individual through their transition to community-based care, with emphasis on:
 - Developing a comprehensive recovery plan;
 - Teaching self-management skills; and
 - Assisting the individual with follow-through on appointments.

2. Use “Warm Hand Offs”

The term “warm hand off” implies that as the individual transitions between levels of care, staff from the SMHTF and the community provider work concurrently to ensure the individual is sufficiently supported. This will provide an opportunity for the individual and the community provider to establish rapport and develop discharge goals in partnership. Ideally, the community provider would be present (face to face) on the day of the individual’s discharge to the community. When this is not possible, at minimum a face-to-face visit within 24 hours of the individual’s discharge to the community should occur.

3. Increase Level of Support for the First 30 Days Post Discharge

Transitions are difficult, especially when an individual transitions from a highly structured environment to one that requires a higher degree of independence. To ensure that the individual is sufficiently supported during this critical time, it is recommended that the community provider representative maintains high level of services and supports by contacting the individual at least 3 times per week for the first 30 days after their return to the community.