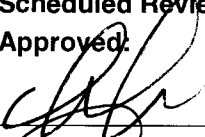
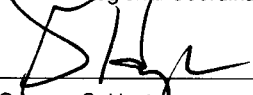
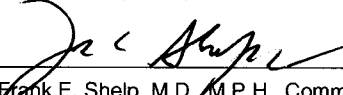
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Chapter: Hospital Operations Subject: Follow-up for Individuals Discharged from the State Hospital Who Were on the Mental Health Olmstead List		
Applicability: State Hospitals and Community Providers of Behavioral Health Services	Original Effective Date: September 15, 2010 Scheduled Review Date: September 2011	
References: none	Approved:  9/1/10	
Attachments:	Charles Ringling, Date DBHDD Regional Coordinator Team Leader	
none	 9-2-10	
	Gregory C. Hoyt Date Director, Hospital Operations	
	 9-3-10	
	Frank E. Shelp, M.D., M.P.H., Commissioner Date	

FOLLOW-UP FOR INDIVIDUALS DISCHARGED FROM THE STATE HOSPITAL WHO WERE ON THE MENTAL HEALTH OLMSTEAD LIST

POLICY

DBHDD conducts follow-up activities and collects information on outcomes for individuals who have been discharged after having been on the Mental Health (MH) Olmstead List. The purposes of this follow-up are to:

- Evaluate the extent to which individuals have received, after discharge, the services and supports defined during transition planning;
- Identify any additional service(s) or support (s) needed during the follow-up period and collaborate with community provider(s) to make the needed services and supports available.
- Act to reduce undesirable outcomes after discharge from the hospital including incarceration, re-hospitalization, or inappropriate nursing home admission.

The purpose of the data collection:

- Evaluate the efficacy of transition planning processes performed by hospital staff, Case Expeditors, and others; and
- Identify improvements needed in transition planning processes

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PROCEDURES

1. The hospital treatment team, with the involvement of key stakeholders including the person served, is responsible for identifying the treatment needs and supports indicated for the person to continue the recovery process in the community. The community provider(s) selected to serve the person is responsible to deliver and arrange for the provision of services and supports outlined in the PCTP.
2. Case Expeditors, with the participation and support of hospital and community provider staff, engage with individuals on the Mental Health Olmstead list prior to discharge, in order to facilitate following-up with them after they have transitioned to the community. The Social Work Chief will insure that the Transition Action Plan (TAP) section of the Person Centered Transition Plan (PCTP) is complete and provided to the Case Expediter and Community Provider prior to discharge, in order for the Case Expediter to complete required follow up.
3. Case Expeditors maintain continuity between hospital transition planning and subsequent monitoring/follow-up activities.
4. Prior to discharge, the Case Expediter and the Hospital Treatment Team explain the Transition Monitoring procedures to the person (and as appropriate, family, service providers, and others).
5. Monitoring requirements and expectations are as follows:
 - a. Types of contacts: Case Expeditors make face-to-face or telephone contacts with the individual and Service Provider(s) identified in the PCTP. Additional service/support providers may be contacted face-to-face, via telephone, or by email.
 - b. Frequency of contacts: At a minimum, follow-up is provided within each of the following timeframes after discharge:
 - i. Within the first 14 days, unless earlier follow-up is specified in the PCTP.
 - ii. Between the 15th and 30th day.
 - iii. Between the 31st and 60th day.
 - iv. Between the 61st and 90th day
 - v. If, during the 4th Transition Monitoring, it is determined that additional transition monitoring is needed, the Expediter consults with their Regional Coordinator to determine whether to extend monitoring beyond the 90 day post-discharge period.

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6. The Case Expediter:

- a. Communicates with the consumer and other person(s) who are knowledgeable about the status of each service/support that was included in the PCTP at the time of discharge;
 - b. Asks them to evaluate and rate how well things are going and whether any changes need to be made in the services/supports that the individual is receiving; and
 - c. Identifies when a service/support is not in place by the target date identified in the PCTP; the Expediter then documents the reasons for the delay and estimates the degree (percentage) of completion of activities intended to make that service/support available.
 - d. When changes are appropriate, the Expediter works with the service provider(s) to facilitate modifications in their treatment plan.
 - e. Documents the actions taken and any changes in the treatment plan and the ratings for the follow-up question, "how well things are going" for each service/support, according to the respective informants: consumer, informant, service provider, or Case Expediter. *(For example, the adequacy of a plan for employment supports may be evaluated by the consumer, the job coach, and the Expediter.)*
 - f. Is alert to "early warning signs" that might lead to the readmission to hospitals and works with providers to increase intensity of service or changes in services in response to these "early warning signs".
 - g. Enters follow-up data into the state wide database designed for this purpose.
7. DBHDD maintains a database, called Expediter Information System (EXIS), designed to capture data related to Mental Health Olmstead consumers and to evaluate the efficacy of the PCTP. The case expediter transfers the service needs and community supports identified in the PCTP to EXIS prior to the individuals discharge. EXIS is used to capture post-discharge data on each of the identified service needs and community supports, as well as any newly identified needs.
8. Data are maintained, analyzed and distributed, by the Olmstead Data Manager, to the Hospital's quality manager. It is the responsibility of the Quality Manager to further distribute, as appropriate, information to Hospital treatment teams, the Hospital's Quality Council, and others, as appropriate, for the purpose of improving the Person Centered Transition Planning and follow-up processes.

Additional Information Relevant to Follow-up

The DBHDD contract identifies individuals who are transitioning to the community as a priority population, and requires that the provider agrees to schedule an appointment for the consumer with a licensed professional, associate licensed professional or certified addiction specialist, to occur within three (3) business days of discharge (or sooner if clinically indicated), and with a licensed

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physician/psychiatrist to occur within thirty (30) calendar days of discharge (or sooner if clinically indicated).

On those occasions when individuals choose professionals that are not DBHDD-contracted providers, Case Expeditors follow-up with the professional chosen by the person.