

CENTRAL STATE HOSPITAL
POLICY AND PROCEDURE

SUBJECT: CONTINUITY OF CARE, TRANSITION PLANNING AND MEDICAL
ALERT

ANNUAL REVIEW: April

RESPONSIBLE FOR REVIEW: PTFS Service Chief

LAST REVISION DATE: April 2008

PURPOSE

The purpose of this policy and procedure is to ensure continuity of care and services for persons' transition from Central State Hospital (CSH), into appropriate settings.

APPLICABILITY

This policy is applicable to all persons who are admitted to CSH and who will be in need of services following discharge.

Individuals who are not normally referred to outpatient treatment programs at the time of transition from PTFS include:

1. Those persons who are admitted from prisons, youth development centers and other institutions and who will be returning to those institutions following transition; and
2. Those persons who are admitted for court-ordered forensic evaluations.

POLICY STATEMENTS

1. Transition planning by the treatment team will begin at the time of admission. Such transition planning will include the arrangement for the provision of needed services in the community setting.
2. For those individuals who will need outpatient services after transition, service staff will:
 - A. Notify the community provider of each individual admitted within one working day of their admission.
 - B. Work with the individual and the community provider to develop transition plans.

- C. Include the person’s family or significant others (as determined by the individual) in the development of transition plans whenever possible and appropriate.
3. The individual and the community provider will be notified of the need for medical follow-up should any pertinent medical test results, particularly those indicating an infectious or communicable disease, become available following discharge of the individual from the facility. HIPAA and state law regulations/confidentiality must be observed in this communication process.

PROCEDURE

<u>RESPONSIBLE PERSON(S)</u>	<u>ACTION</u>
SERVICE CHIEF	I. Ensure that a mechanism to accomplish these required tasks is in place.
TREATMENT TEAM	<p>I. For those individuals who will need outpatient services after being transitioned from CSH:</p> <ul style="list-style-type: none"> A. Obtain appropriate release of information authorization. B. Notify the community provider of the admission within one working day of the admission. C. If the hospital stay is ten (10) days or less, conduct and document transition planning with input from the community provider, including documentation of at least one telephone contact. D. If the hospital stay is more than ten (10) days, conduct and document transition planning with input from the community provider, including documentation of at least one face-to-face meeting with the community provider, if possible. E. With the individual, his/her family or significant others, if appropriate and possible, and the community provider, develop and document a transition plan. <p>II. For each individual who is in need of services following transition from CSH, but who refuses to participate in the planning for such services:</p> <ul style="list-style-type: none"> A. Consider the need for involuntary community services if appropriate. B. Recommend mandated outpatient services to the

	community provider.
HIM Director/Designee	<p>I. Submit the transition plan (form CSH-527, Final Summary) to the community provider within 30 days after discharge.</p> <p>II. At the time of transitioning to the community, provide a hard copy of the completed form CSH-475 (Release Notification) to the community provider staff.</p>
ATTENDING MEDICAL STAFF AND/OR CLINICAL DIRECTOR	<p>I. If medical tests indicating the need for medical follow-up, particularly those indicating an infectious or communicable disease, are returned to the living unit following discharge of the individual:</p> <p>A. Contact the individual or that person’s guardian by telephone to explain the test results and the need for medical follow-up. If the individual is not capable of understanding the information and does not have a guardian, inform that persons representative of the need to follow-up with that individual’s healthcare provider as soon as possible.</p> <p>B. Document this communication in the medical record.</p> <p>C. Prepare the “Medical Alert Letter” (attachment I) and send it to the individual or guardian by registered mail, signature required. Place a copy of this letter in the medical record.</p> <p>D. Send a copy of the Medical Alert Letter to the community provider that is providing services to the individual.</p> <p>E. Maintain confidentiality of information per HIPAA regulations and state law in all of these communications.</p> <p>F. Notify the Office of the Chief Medical Officer that these actions have been taken.</p>

Approved:

This policy has been approved by the CEO and CMO on 4/20/09.

Attachment I: Medical Alert Letter

DATE:

MEMORANDUM

TO:

FROM:

RE: MEDICAL ALERT LETTER

At the time of discharge from our facility some of your test results were not available. These results are now available and they indicate the need for additional follow-up or treatment. Please contact your healthcare provider for further evaluation or treatment. Your healthcare provider can obtain these test results only after you provide authorization for the release of your confidential medical information.

DATE OF REPORT:

cc: Medical Record