State Mental Health Treatment Facility Admission and Discharge Processes

Authority: Chapter 394, F.S.
Chapter 916, F.S.
Rule 65E-4.014, F.A.C.
Chapter 65E-5, F.A.C.
Children and Families Operating Procedures (CFOP) 155-13, 17, 18, 19, 22, 38, 48

To comply with F.S. 394.4573., Network Service Providers shall provide case management services for each civil resident of a State Mental Health Treatment Facility (SMHTF) whose home county is within the Managing Entity's geographic service area. These services may be provided by a community case manager, a Florida Assertive Community Treatment (FACT) team member, or other designated community Network Service Provider staff. The Managing Entity shall monitor Network Service Providers to ensure the following activities are performed for individuals transferring into or out of state mental health treatment facilities member.

(1) Network Service Providers adhere to the requirements described in this Incorporated Document, including:

- **a.** Maintain an open case for the individual during the time he/she resides in a SMHTF;
- **b.** Participate in the development of a SMHTF recovery plan;
- **c.** Participate in monthly reviews of the recovery plan;
- **d.** Maintain at least monthly contact with state treatment facility staff concerning the status of the individual;
- **e.** Maintain contact with the individual's family consistent with Chapter 3943.9082(5)(r), F.S.;
- **f.** Share relevant information with the SMHTF staff;
- **g.** Participate in 100% of the discharge planning meetings for each individual in a SMHTF;
- **h.** Locate housing and services in the community in collaboration with the SMHTF;
- **i.** Have a face-to-face contact with the individual in the community within 2 business days of discharge from the SMHTF; and
- **j.** Maintain progress notes in the SMHTF medical reflecting all meetings and communications with SMHTF staff, the resident, the family, or significant others.

(2) The community service provider will ensure the individual who has been discharged from a SMHTF is transported to the Social Security office within 5 business days of being transitioned back to the community.

(3) The Network Service Provider shall ensure that the following priority individuals are eligible to receive, Case Management services or Intensive Care Management services, as clinically indicated and as described in *Rule 65E-4.014, F.A.C.*:

- **a.** Individuals who are awaiting admission to a SMHTF;
- **b.** Persons who are in a SMHTF regardless of admission date;

c. Individuals who transfer from one Region to another Region where they had been receiving case management and other services;

d. Individuals who are at risk of institutionalization or incarceration for mental health reasons;

e. Individuals discharged from a SMHTF;

f. Individuals who have had one or more admission to a crisis stabilization unit (CSU), short-term residential facility (SRT), inpatient psychiatric unit; or a mental health residential treatment facility (RTF);

g. Persons who have resided in a SMHTF for at least 6 months in the last 36 months; and

h. Persons who reside in the community and have had two or more admissions to a SMHTF in the last 36 months.

CONTINUITY OF CARE

Admission to a Civil SMHTF

The Network Service Provider shall comply with *Rule 65E-5.1301, F.A.C.* and shall:

a. Ensure the case manager, or other assigned community behavioral health staff members are assigned to each resident within 3 business days of admission to the SMHTF and that the contact information is provided to the identified staff at the SMHTF;

b. Participate in the development of the recovery plan for each individual at the SMTHF within 30 days of admission;

c. Ensure all information required to assist with the individual's treatment is provided by the community case manager to the SMHTF.

d. Have pre-admission calls with the Civil SMHTF for individuals on the waiting list for the purpose of information sharing.

e. Have calls with the Receiving facilities for anyone on the SMHTF waitlist over 60 days to discuss current need for treatment in a SMHTF and possible diversion to a placement in the community.

Discharge Planning Process while at SMHTF

Civil

The Network Service Providers shall:

a. Comply with the standards established in CFOP 155-17, Guidelines for Discharge of Residents from a State Civil Mental Health Facility to the Community;

b. Work in collaboration with the SMHTF social services staff or discharge planner to identify independent living or supportive housing resources or to the identified level of care that best meets the treatment needs of the individual;

c. Maintain at least monthly contact with the SMHTF social services staff;

d. Visit individuals at the SMHTF at least quarterly; and

e. Ensure services recommended services by the Community Case Manager and SMHTF Recovery Team are available and accessible after the individual's discharge from a SMHTF.

f. Participate in 100% of the discharge planning calls for each assigned individual served by the Network Service Provider; Discharge individuals determined to be discharge ready by the SMHTF within 30 days (civil) of the discharge planning meeting;

g. If individuals are not discharged within 30 days, the network service provider must provide at least weekly updates on progress towards locating placement to the LSFHS Care Coordinator and discharge planner at the SMHTF.

Forensic

The Network Service Providers shall:

a. Comply with the standards established in 155-22, Leave of Absence and Discharge of Residents Committed to a State Mental Health Treatment Facility Pursuant to Chapter 916, F.S.;

b. Collaborate with the Forensic SMHTF facility staff to develop a recovery plan and ensure the Forensic Community Case Manager locates housing and services for forensic residents who are actively seeking return to the community on conditional release or with aftercare conditions;

c. Ensure a sufficient number of Network Service Providers are designated as Forensic Specialists;

d. Ensure the Forensic Community Case Manager will participate in all reviews of the recovery plan and visit individuals at the SMHTF at least quarterly; shall be actively involved in the discharge process; and shall collaborate with the SMHTF recovery teams in finding a living environment and identifying community services that will support the level of need;

e. Participate in 100% of the discharge planning calls with the SMHTF;

f. Discharge individuals who are determined to be appropriate for community placement in 90 days;

g. Assist the SMHTF and appropriate court personnel in the development of conditional release plans;

h. Provide information to the Courts and the attorneys pertaining to the individual's treatment in the SMHTF, as requested; and

i. Ensure services recommended by the Forensic Case Manager and SMHTF Recovery Team are available and accessible when resident is returned to the community by way of direct discharge from the SMHTF or release from Jail.

j. The Network Service Provider shall follow F.A.C. 65E-14.021(4)(k)4.b.(V) when billing for incidental expenses.

The State Mental Health Treatment Facility Admission and Discharge Processes will be administered according to DCF Guidance 7, which can be found at following link using the applicable fiscal year: http://www.myflfamilies.com/service-programs/samh/managing-entities.