



# Data for Olmstead Planning

**May 2003**

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System Planning**

**Office of Mental Health & Addiction Services  
Health Services – Department of Human Services**



## Step / Action

- 1) At admission, the admitting physician completes a written admission note which contains reasons for admission, including:
  - a) A provisional diagnosis
  - b) A behavioral description of the patient's problems, which brought the patient to the hospital for admission.
  - c) Hospital Social worker contacts county of responsibility and county of commitment to augment information regarding admission.
  - d) County will forward pertinent information, especially medication history.

## Responsible

- Interdisciplinary Treatment Team (IDT)



## Step / Action

- 2) Within 72 hours of admission, a working Problem List and Treatment Plan must be developed and entered into the patient's written medical record. The Treatment Plan must include written criteria for progress to discharge
- 3) By 10 days after admission, a formal Problem List (PL) is developed and entered into the patient's written medical record. It includes behavioral specifics about problems to be resolved for the patient to be discharged. Copy of Treatment Plan and Problem List made available to County upon request within laws related to confidentiality.
- 4) At 10 days, a formal Treatment and Care Plan (TCP) is developed and entered into the patient's written medical record. It specifies intervention targeted to problems on the PL and it identifies the clinician responsible for those interventions, with target dates for completion.

## Responsible

- Interdisciplinary Treatment Team (IDT)



## Step / Action

- 5) The TCP includes a brief Discharge Plan (DP), which specifies the type of placement at which the patient will be successful and the general location by city or county where the patient desires to live upon discharge.

## Responsible

- Interdisciplinary Treatment Team (IDT)

## Step / Action

- 6) The PL and TCP are reviewed for progress by the patient's Interdisciplinary Treatment Team (IDT) at intervals prescribed by State Hospital policy and JCAHO. County of responsibility advised of review date and invited to attend in person or via conference call. That review is documented in the patient's medical record by the IDT and made available to county case manager upon request and within the confines of patient confidentiality.

## Responsible

- Interdisciplinary Treatment Team (IDT)
- County Case Manager



## Step / Action

- 7) The DP is reviewed and documented in the patient's medical record by the patient's social worker monthly. The hospital social worker will keep the county case manager updated on discharge plan development.

## Responsible

- Social Worker

## Step / Action

- 8) Social worker discusses with patient community-based options and the patient's preferences, including geographical areas, desire for employment, and types of recommended housing. County case manager may participate either in person or via conference call once RTP decision has been made.

## Responsible

- Social Worker
- County Case Manager



## Step / Action

- 9) As soon as a patient is ready for discharge, the IDT documents Ready to Place (RTP) in the patient's medical record, using a standardized progress note format. This means that the patient has met those criteria for discharge established in the patient's PL and TCP. Date of readiness to place entered in OPRCS by staff designated by the IDT.

## Responsible

- Interdisciplinary Treatment Team (IDT)

## Step / Action

- 10) The social worker makes a formal referral to the appropriate CMHP and likely provider(s). If patient is referred to the ECMU, ECMU liaison will forward information packet to County. Documented in patient's medical record.

## Responsible

- Social Worker



## Step / Action

- 11) The CMHP and provider accept the patient. This is documented in the patient's medical record by hospital social worker.

## Responsible

- Community Provider

## Step / Action

- 12) The patient agrees with a discharge to the CMHP and provider. This is documented in the patient's medical record.

## Responsible

- Patient or Guardian



## Step / Action

13) The patient is discharged. Date of discharge entered in OPRCS.

## Responsible

- Physician

## Step / Action

14) If the DP requires a level of structure provided by the Extended Care Management Unit (ECMU) facility, or, if the patient has remained on OPRCS, past the Interdisciplinary Treatment Team (IDT)'s determination of readiness for discharge in excess of 90 days, the patient would be referred to ECMU as soon as possible after admission or soon as 90 days post RTP determination is entered into OPRCS. The ECMU then will follow the discharge process for Community-Based Settings Managed by ECMU for Adult Civilly Committed Patients. Initial data will be provided from OPRCS and will be augmented by ECMU staff as patient information is entered into the Ready to Place (RTP) database. ECMU staff will interview patient as soon after receiving referral as possible.

## Responsible

- Patient or Guardian



## Step / Action

15) Referral packet reviewed by Extended Care Management Unit state hospital liaison.

## Responsible

- ECMU

## Step / Action

16) Determination of patient's needs and supports by Interdisciplinary Treatment Team (IDT), patient, ECMU and others as appropriate. ECMU liaison contacts the county for additional information and to keep county case manager current with status of patient.

## Responsible

- Interdisciplinary Treatment Team (IDT)
- ECMU
- Patient
- Other support system members as appropriate



## Step / Action

- 17) Decision by ECMU in consultation with the IDT concerning which CMHPs and providers to consider for placement of the patient.
- 18) Referral packet sent to CMHP(s) and provider(s).

## Responsible

- ECMU

## Step / Action

- 19) Review of the referral packet by CMHP(s) and provider(s).
- 20) Interview(s) with patient.

## Responsible

- CMHP Case Manager(s) and Provider(s)



## **Step / Action**

- 21) Within one week of interviewing the patient, a decision must be made to accept the patient or not and this decision will be documented and sent to the hospital social worker. If a decision has not been made, ECMU liaison will follow up with provider.

## **Responsible**

- Provider's and ECMU

## **Step / Action**

- 22) Decision to accept placement.

## **Responsible**

- Patient or Guardian



## **Step / Action**

23) Projected discharge date, placed on the waiting list, or continue referrals.

## **Responsible**

- ECMU and Social Worker

## **Step / Action**

24) On-going review of placement status and patient's clinical condition. Current information entered into ECMU RTP database.

## **Responsible**

- ECMU



## **Step / Action**

- 25) Bi-weekly review of placement alternatives, possible wrap around service needs, provider recruitment, or program development.

## **Responsible**

- ECMU, Social Worker and CMHP's

## **Step / Action**

- 26) When placement is accepted, coordination of community-based supports, finances, and other like needs.

## **Responsible**

- Social Worker, Provider, CMHP, ECMU as needed



## Step / Action

27) Discharge from state hospital.

## Responsible

- Interdisciplinary Treatment Team (IDT)

## Step / Action

28) The following may be reasons why a planned discharge does not take place or is very difficult to develop:

- a) Repeated placement failures.
- b) The patient de-compensates prior to discharge.
- c) An appropriate provider is not available to accept the patient.
- d) A patient may require specialized services, such as, treatment for medical problems, high levels of structure, or interventions for high-risk behaviors which impact public safety.
- e) Interdisciplinary Treatment Team (IDT) changes need with respect to level of care.
- f) Other unforeseen circumstances.

## Responsible

- Social Worker, Provider, CMHP, ECMU as needed



## Step / Action

- 29) No discharge or placement 90 days post entry on RTP list, the case will be identified and reviewed by an administrative review team to determine what barriers preclude placement and what resources might be needed to successfully place the individual in the community.

## Responsible

- ECMU Manager, State Hospital Social Work Director, System Planning Manager, IDT Representative

## Current Ready To Place (Monthly Report) as of:

May 22, 2003

(including individuals not ready to discharge)

Date Referred	ID #	Not Ready		Location	Level of Care
			for Discharge		
	122			OSH 50D	Adult Foster Home
	743			OSH 48C	Enhanced Care Facility
	124			OSH TLC	Adult Foster Home
	913			OSHP 5A	Residential Treatment Facility
	47	x		OSH 50C	Unknown
1/1/1997	107			EOPC T1W	Adult Foster Home
2/17/2000	31	x		OSH 35C	Secure Residential Treatment Facility
5/1/2000	26			OSH 35A	Residential Treatment Facility/Home
5/18/2000	33			OSH 35C	Residential Treatment Facility/Home
8/1/2000	15	x		OSH 34D	Secure Residential Treatment Facility
8/10/2000	20	x		OSH 35A	Secure Residential Treatment Facility
8/10/2000	40			OSH 35A	Secure Res Txt Facility or ECF
8/21/2000	266	x		OSH 50I	Secure Residential Treatment Facility
9/11/2000	64			OSH 35C	Residential Treatment Facility/Home
10/30/2000	9			OSH 34A	Residential Treatment Home
11/1/2000	8			OSH 34A	Enhanced Care Facility
11/3/2000	112			EOPC T1E	Secure Residential Treatment Facility
11/14/2000	298			OSH 50C	Secure Residential Treatment Facility
11/15/2000	43			OSHP 1A	Secure Residential Treatment Facility
12/8/2000	117			OSH 34C	Residential Treatment Facility/Home
2/1/2001	118			EOPC T1E	Residential Treatment Facility/Home
2/1/2001	34			OSH 35C	Secure Residential Treatment Facility

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## Exceptional Barriers List

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**Location**

Last/ First Name:

DB ID #:

Not ready for D/C:

Date Referred:

Traumatic Brain Injury

Low Intellectual Functioning

Sex Offender

Parole / Probation

Medical

Trauma Survivor

Discharge Refusal

Special Placement Needs:

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### General Notes:

First Name  Last Name  M/ F  County of Resp.

RTP ID #  Case #  Birth Date   ATS / GTS / FTS  Age

**Full Name**

CONDITIONS ASSESSMENT DETAIL

Referred Date  Location  Original date of admission

ID #:  Commitment:  Residential:

- |   |   |
|---|---|
| <input type="checkbox"/> ECMU Assessed            | <input type="checkbox"/> Medical                                      |
| <input type="checkbox"/> Traumatic Brain Injury   | <input type="checkbox"/> PSRB   |
| <input type="checkbox"/> Developmental Disability | <input type="checkbox"/> Aggressive Behavior <input type="text"/>     |
| <input type="checkbox"/> Sex Offender             | <input type="checkbox"/> Self-Injurious Behavior <input type="text"/> |
| <input type="checkbox"/> Parole / Probation       | <input type="checkbox"/> Substance Abuse <input type="text"/>         |
| <input type="checkbox"/> Trauma Survivor          | <input type="checkbox"/> Vocational / Employment Interests            |
| <input type="checkbox"/> Passages                 | <input type="checkbox"/> Discharge Refusal                            |

Clients Level of Involvement in Txt.   
Ability to Perform ADL's   
Ability to Manage Own Finances

Date PAS Screened:  Clients Preference:

Referred By:   
Date Entered:

## Exceptional Barriers

### *Caseload Growth*

Trauma Survivors	County	Treatment Services	Low Intel. Functioning	Medical	Traumatic Brain Injury	Parole / Probation	Discharge Refusal	Trauma Survivor	Date of Referral
	Lane	ATS		x			x		2/01/01
	Lane	ATS		x					2/17/00
	Lane	GTS		x					4/01/02
	Clatsop	ATS	x						5/18/00
	Jackson	GTS			x				11/01/00
	Mult.	ATS	x						5/03/02

Sex Offender	County	Treatment Services	Low Intel. Functioning	Medical	Traumatic Brain Injury	Parole / Probation	Discharge Refusal	Trauma Survivor	Date of Referral
	Umatilla	ATS	x						2/01/01
	Polk	ATS	x	x					8/01/00
	Linn	ATS	x	x					4/26/01
	Lane	ATS	x			x			4/24/01
	Lane	ATS		x	x				8/10/00
	Mult.	ATS	x	x					8/31/01
	Marion	ATS	x	x		x			8/31/01