Policy and Procedure Milwaukee County Behavioral Health Division Community Services Branch	Date Issued 8/16/2011	Section	Policy Number	Page 1
	Date Revised	Subject: Inpatient and Community Case Management Collaboration Standard of Practice		

1. POLICY:

It is the policy of the Behavioral Health Division (BHD) that the **Inpatient Social Work Staff** (Psychiatric Social Worker-PSW) responsibilities include, but are not limited to, participating in discharge planning, arranging for follow-up care, and developing mechanisms for timely exchange of appropriate information with sources outside of the hospital. Additionally, PSW's will actively collaborate with case managers, significant others, and collateral contacts in regard to each client's treatment and discharge planning. This collaboration will allow all available information and expertise to guide the discharge process. Timely identification of individual needs and appropriate treatment planning/interventions will help identify strategies that will work best for each individual patient and continuity of care.

Community Case Managers are responsible for maintaining a therapeutic treatment relationship with their client on a continuing basis, whether the client is in the hospital, in the community, or involved with other agencies. Case managers provide valuable information about what has occurred prior to a client's hospitalization and assist with transitioning the client safely back into the community. The case manager is also responsible for advocating for the client, coordinating and sharing information relevant to treatment and individual need, collaborating regarding the discharge plan, and coordinating housing for the client.

2. PROCEDURE:

A. When a client is admitted to a psychiatric inpatient unit, the community provider/case manager must contact the appropriate inpatient treatment team within 24 hours of notification of the hospital admission in order to develop a plan of discharge. If there has been no contact from the community agency, the PSW will contact the case management agency. Case managers are to meet with hospital unit staff and the patient at a minimum of **once per week,** and more often when clinically indicated. The inpatient social worker will continue to collaborate with the case manager throughout the client's hospitalization in an effort to create a well-developed discharge plan and transition to the community. If the case manager is not available for communication and/or planning, the case management supervisor will be contacted.

B. The case manager and inpatient social worker will collaborate immediately to share information and identify interventions relevant to the course of treatment for the client. It is good practice and highly recommended to have a discharge planning conference with the treatment team (MD, treatment director, PSW, RN, and other treating professionals) prior to the client's discharge, especially in high-risk situations (i.e. history of suicide attempts, poor impulse control, compromised "Activities of Daily Living", history of homelessness, etc.).

C. When meeting with the recovery treatment team and/or client on the unit, the case manager will complete the **Community Services Consultation Note**. Forms can be obtained in the nurses' stations file cabinets on each inpatient unit. A supply of forms can also be obtained via Community Services Branch/ SAIL if case managers prefer to bring the forms to the hospital. Instructions are as follows:

   a. Indicate date/time your agency was notified of client's hospitalization.

   b. Indicate your date of contact, length and T-19 procedure code.

c. Indicate your agency name and level of service designation (CSP, TCM).

d. Indicate your name and the phone number where you can be reached.

e. Note Section: Indicate the precipitating events/issues that have occurred with your client prior to this hospitalization. List what factors have occurred that are pertinent to share with the treating team. Some areas that may be covered, but are not limited to, include medication compliance, present stressors/crisis, housing issues, medical concerns, and previous treatment courses and interventions. Also list what treatment goals you and the client are working on and what strategies may work best for the client.

f. Plan/Recommendations: Identify what is your plan and recommendations on behalf of your client during this hospitalization. Some ideas include suggestions of "what works best" for your client and what is needed in the area of new referrals and supports. List what would help the client to return to the community and remain well, what will be the housing plan and follow-up psychiatric care plan upon discharge, are there any obstacles that need attention, etc. **Identify with the unit social worker a target date for discharge and the specific plan for housing and follow-up care.**

g. Sign your name and date the form.

h. Ask unit staff to stamp/addressograph the form.

i. **Hand original copy of form to the assigned unit social worker. If unavailable, put form in the designated unit social worker's mailbox. Maintain yellow copy of form for your records.**

j. The unit social workers are to ensure this information is relayed to the treating team including the Treatment Director.

k. All consultation forms are to be filed by the unit staff in the patient file under the heading "Consultations."

D. Housing:

a. If the client is homeless (prior to hospitalization -street or shelter), the PSW will contact the CM to coordinate appropriate housing following discharge. This may include, but not limited to, referrals to Safe Haven, My Home, supportive housing, contacting the Housing Division for housing options, Crisis Respite, and/or contacting collaterals for support. (NOTE: If transitioning to Safe Haven, the patient must remain in a homeless status to be eligible.)

b. If the patient has had previous housing arrangements, the PSW will contact the CM to confirm that the patient can return or if an increase in level of care is to be pursued.

E. Psychiatric Appointments:

a. If the patient has services with a CSP, the PSW will contact the CM for a confirmed appointment (date and time) with the CSP psychiatrist.

b. If the patient has services with a TCM, the PSW will make the psychiatric appointment with the appropriate provider.

F. Upon discharge from the hospital, it is policy of the Community Service Branch that the Case Manager, or an agency team representative, has face-to-face contact with the client within 24 business hours of discharge (this may include picking up the client from the hospital at the time of discharge).

   a. The face-to-face contact should include activities such as: transporting the individual to their home from the hospital, reviewing pertinent discharge instructions, ensuring acquisition and set up of medications, arranging for a clinically appropriate level of medication monitoring, assisting the individual with grocery shopping, and/or meeting other basic needs to live comfortably and safely in the community. It is preferred that this contact takes places at the client's home. A minimum of phone contact would be adequate only in instances where face-to-face is not possible, contraindicated, and/or unwelcome by the client.

   b. This contact will be documented with a progress note in accordance with the agency's existing policy and procedure. For purposes of utilization review, a copy of this progress note is to be faxed to SAIL at 414-454-4242 to the attention of Susan Tarver-Harris.

G. Discharge Medication:

   a. If the patient has services with a CSP, the CM, or agency representative, will make arrangements to pick-up the discharge medication from the unit or the BHD pharmacy.

   b. If the patient is discharged on Friday or on the weekend, the patient will be given no more than a 2 day supply of their prescription medications if they are not being seen on the weekend. If the client is normally seen on the weekend, the CSP agency will resume weekend delivery.

Reviewed & Approved by:

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