WSH/RSN Working Agreement

All parties to this Agreement understand that it describes a framework for working collaboratively for the benefit of Regional Support Network (RSN) patients who are receiving treatment at Western State Hospital (WSH).

All parties acknowledge there will be good faith in the implementation of this agreement. Disagreements may occur and these will be resolved in a mutually agreeable manner by representatives appointed by each party using the Dispute Resolution Process. The Dispute Resolution and WSH Inter-RSN Transfer processes are attached to this Agreement. These attachments are considered to be integral parts of the WSH/RSN Agreement. Procedures developed from Agreement policies and processes are detailed in the RSN Liaison Manual.

PURPOSE

The purpose of this Agreement is to establish policies and define roles and responsibilities of the RSN, its provider agencies, and WSH for admission, treatment and discharge of RSN patients during WSH hospital stays. The overall goal is to provide care coordinated between the hospital and the community that is age, clinically, and culturally appropriate, making the client's safety, health and therapeutic benefit always the highest priority. Procedures developed from these policies can be found in the RSN Liaison Manual.

TERMS OF AGREEMENT

Admission

WSH will:

1. Attempt to determine the RSN of Responsibility when the pre-admission call is received and will update the call sheet.
2. Correct the assignment of a patient's RSN of Responsibility within one working day of written notification by a RSN Liaison.
3. Request a copy of the patient registration form (Face Sheet) from the transferring facility at the time an admission request is received.
4. Clearly communicate in writing, after discussion with the RSNs, general admission guidelines and protocols. Any anticipated change to admission guidelines shall also be communicated in writing. Exceptions to these general guidelines will be based on clinical judgment.

RSN will:

1. Validate the RSN of Responsibility within three working days of a patient admission and will notify the Patient Financial Services Admission's Office of needed corrections.
2. Monitor the WSH In-residence Census (IRC) and respond to WSH census alerts by making every effort to divert patients from admission to WSH or to extend their stay in local facilities, or to increase efforts to discharge patients from WSH when clinically appropriate.
3. Ensure efforts are taken to admit appropriate patients to VA hospitals.
4. Ensure to the extent necessary and whenever indicated, patients are medically cleared prior to their admission to WSH.

5. Ensure, whenever possible, that an admission packet is provided at the time of patient transfer from other hospitals, emergency rooms, evaluation and treatment centers, or nursing homes. If not coming from a facility, the admission packet is provided within three working days of admission.
6. Upon request from WSH, coordinate with other hospitals, emergency rooms, and mental health clinics etc. to provide a copy of the patient registration form (Face Sheet) within three working days of the request. The information should include patient demographics, third party benefits, resources and legal next of kin.
7. Contact WSH within three working days of the admission and complete the Notification Roster with the name of the responsible RSN Liaison in the Outside Data Section of the medical chart.

Treatment

WSH will:

1. Notify RSN Liaisons of all Master and Review Individual Treatment Plan meetings at least two weeks prior to the meeting. Provide at least two days notice to liaisons when meetings are cancelled whenever possible.
2. Will attempt to notify and/or consult with the RSN Liaison, in advance, regarding planned or anticipated changes in critical aspects of patient status. These would include: decision to allow a conversion to voluntary status, decision not to file a petition for further involuntary treatment, recommending an LRA (including recommended conditions), and the decision to release the patient from WSH care. The RSN Liaison will be notified through Cache as soon as practical regarding AL's, a patient's UL status, ward transfers, transfers to PALS, and discharge to community medical care.
3. Ensure the Social Worker informs the RSN of a patient's death the next working day after receiving notification.
4. Provide a special population consultation and assessment when requested by the treatment team for treatment and discharge planning purposes.
5. Whenever UR staff are notified of a request to evaluate for decertification or they determine a patient qualifies for decertification, the RSN Liaison and RSN Administrator will be notified.

RSN will:

1. Participate in treatment plan meetings as an integral member of the treatment team, whenever possible.
2. Collaborate with WSH to ensure that an adequate treatment plan and a comprehensive discharge plan are developed.
3. Monitor progress of the patient's treatment and document in the Community Notes in the Outside Data Section of the medical chart at least every 90 days. Documentation should include an assessment of the patient's readiness for discharge, barriers to placement and attempts to locate community placement options.
4. Respond to participation and documentation concerns expressed by WSH staff.
5. Provide clinical feedback, if needed, to the UR nurse or reviewing psychiatrist on decertification alerts.

Discharge

WSH will:

1. Whenever possible, participate with the RSN in a coordinated discharge process, which assures that patients are returned to the community as soon as the physician determines they are ready for discharge. Information, including information in the Community Notes, provided by the RSN and community providers will be reviewed and considered in the discharge planning process.
2. Jointly develop with the RSN a plan for appropriate community care.
3. Identify potential discharge barriers that may create a delay or prevent a patient from being placed in the service area of the responsible RSN. Staff of WSH and the RSN will work in close collaboration to seek creative methods of overcoming barriers to discharge.
4. Assess public safety risk issues.
5. Prepare a standard discharge packet, including conditions of the LRA, when a patient is discharged from WSH. This material will be available at the time of discharge.
6. Provide the RSN with a copy of the executed LRA within three working days of receipt.
7. Provide sufficient discharge medication (up to a two weeks supply when possible and clinically indicated) and refillable prescriptions (when possible and clinically indicated) to ensure an orderly transition to the community provider.
8. Complete the ECS Nursing Assessment for patients who have been at the hospital for more than 90 days.
9. Hold all planned discharges if notified by an RSN that it is invoking the discharge dispute protocol outlined in the August 8, 2002 memo from the Medical Director.

RSN will:

1. Coordinate and co-lead discharge planning efforts and attend treatment and discharge planning meetings with allied care systems that have direct responsibility for patient placement in the community. Allied care systems may include an RSN other than the RSN of responsibility, Aging and Disabilities Administration including Home and Community Services and Division of Developmental Disabilities, Eastern State Hospital, Veteran's Administration, Immigration Services, Department of Corrections, medical hospital, nursing homes or emergency rooms, or chemical dependency treatment services.
2. Participate in treatment/discharge planning meetings throughout the patient's stay to ensure timely and appropriate discharge for all patients regardless of diagnosis. Make best efforts to locate available and appropriate community placement/treatment options for all patients who are financially eligible and who meet statewide access to care standards.
3. Identify potential discharge barriers, may create a delay or prevent a patient from being placed in the service area of the responsible RSN. Staff of WSH and the RSN will work in close collaboration to seek creative methods of overcoming barriers to discharge.
4. Prior to discharge, and when appropriate, make an appointment with a community mental health care provider for patients preparing to leave WSH. Appointment information will be included with the discharge packet.

Legal/Forensics

WSH will:

1. Comply with requirements outlined in RCW 10.77 regarding timeliness and content of forensic reports, and assure that the appropriate CDMHP receives a copy of all forensic reports.
2. Notify the RSN Liaison in writing, using patient name and/or WSH medical identification number, when a petition for commitment pursuant to RCW 71.05 is filed for a forensic patient.
3. Notify the RSN Liaison, in writing, within three (3) working days, using the patient's name and or WSH medical identification number, when a petition for commitment pursuant to RCW 71.05 is granted.
4. Notify the RSN Liaison, in writing using the patient's name and/or WSH medical identification number, when a NGRI forensic patient is within 60 days of expiration of his/her sentence or is on a conditional release and ready for placement.
5. Ensure a staff contact person from CFS is available to problem-solve issues regarding the change in status of patients moving from CFS to civil wards or to PALS.
6. Provide RSN Liaisons with access to CFS, within security guidelines, to meet with patients and staff as necessary.

RSN will:

1. Participate in treatment recommendations/discharge planning for any forensic patient being evaluated for civil commitment when requested by CFS staff.
2. Identify staff to serve as contact point for providing relevant and/or requested clinical information related to forensic patients.
3. Participate in treatment planning meetings when requested and work with CFS to develop a plan of care for conditionally released patients who are financially eligible and who meet statewide access to care standards.
4. Respond to emergency requests for discharge planning for CFS patients who are subject to imminent release by criminal or civil courts.
5. Provide treatment to patients who are enrolled in RSN services and who are being restored to competency on an outpatient basis and convey relevant information to forensic evaluators for competency evaluation.

Cross-System Collaboration

WSH will:

1. Participate in a cross-system (MHD/WSH/RSN/HCS) Discharge Barriers Committee charged with addressing systemic issues that delay or prevent placement. The Committee will develop procedures for addressing discharge barriers.
2. Provide RSN Liaisons with a maintained working space including access to telephones and a computer. Liaisons will have access to copy and fax machines and will be issued keys for access to work space and treatment wards.
3. Provide RSN Liaisons with basic training in hospital policies and procedures regarding safety, patient interactions, documentation in patient charts, key use and return, and other mutually agreed upon topics to enhance the Liaison's ability to provide services at the hospital.

RSN will:

1. Participate in a cross-system Discharge Barriers Committee, Network Meetings and other groups charged with addressing systemic issues that delay or prevent placement. The committee will develop procedures for addressing discharge barriers.
2. Ensure the RSN Liaison attends training regarding WSH policies and procedures as needed to fulfill their function.
3. Provide the RSN Liaison with a long distance telephone access.

Data

WSH will:

1. Provide remote access and training on Cache for RSN Liaisons.
2. Make every effort to ensure the accuracy of data entered into the hospital's Cache system including treatment-planning dates, Models of Care and legal status.
3. Reconcile the prior day's midnight census by 12:00 PM of the following business day. Census will be made available when the reconciliation is completed.
4. Make available through Cache the RSN daily census and admission and release/discharge information within 24 hours Monday through Friday, or immediately following weekends or holidays.
5. Provide decertification information on Cache by RSN.

RSN will:

1. Provide WSH, at time of admission or as soon thereafter as is practical, with requested clinical data.
2. Participate in meetings convened to address issues related to data systems.
3. Support RSN Liaison training in proper techniques for accessing Cache and other data.

DEFINITION OF TERMS

Admission Packet: The admission packet is provided with the patient at the time of admission to WSH. The standard admission packet includes: the registration form (Face Sheet) from the patient's previous facility containing information on third party payers, home address, the current treatment plan, 90-day review, recent progress notes, drug and alcohol information and pertinent medical information. Any critical unique information regarding treatment of the client, e.g., on-call sheet, crisis plan, risk plan, individual service plan, language proficiency, name and phone number of the attending community physician. Information to complete the packet is mailed or faxed as it becomes available. As much information as available to the CDMHP, or other RSN designee, is sent with 72-hour holds.

Clinically Ready for Discharge: A patient who no longer requires or benefits from inpatient hospital treatment as determined by WSH clinical staff. A decertification notification/alert may be issued. It is recognized that this is a clinical status, which may change over time.

Community Notes: Ongoing community entries into WSH patient charts relating to treatment, court, discharge decisions, etc. The Outside Data Section of the patient's chart contains the Notification Roster and the Community Notes.

Decertification: An internal WSH clinical utilization review process, which determines that a patient no longer meets criteria, which supports billing for medical care. At decertification, the patient or guardian becomes responsible for the cost of care at WSH.

Discharge Packet: A standard packet of information prepared by WSH, which includes conditions of the LRA, and other information sufficient to facilitate appropriate treatment by a community mental health provider. The packet is sent prior to the patient's release from WSH and includes: income and payment information, current treatment plan, psychiatric evaluation, psychosocial assessment, physical examination, drug and alcohol information, community notes, diagnosis, and information about medication history including current prescribed medications. Documents such as court orders and discharge summaries that are not available at the time of release will be mailed as soon as possible. Clozaril discharges will be accompanied by lab test and other documents, as necessary.

Discharge Planning: Planning meeting to identify and plan for the comprehensive housing, treatment, and community support needs of patients discharged from WSH.

Dispute Resolution: A process for resolving disputes between any party to this agreement. Disputes may arise regarding any part of this agreement or regarding any practice of WSH or of WSH Liaisons. Disagreements shall be resolved in an agreeable manner as close to the problem as possible with participation of all parties involved. Unresolved disagreements shall rise through the appropriate administrative and/or clinical levels as described in the Dispute Resolution Process attachment of this agreement.

Inter-RSN transfer: A procedure for supporting a patient or RSN request to move into the geographic area of an RSN other than the one currently designated as the RSN of Responsibility. The procedure is attached to this agreement.

In-Resident Census: (IRC) the daily count of all voluntary and involuntary civilly committed patients (RCW 71.05), regardless of where in the hospital they are housed, who are in care at WSH at midnight. Patients committed under the criminal insanity statute (RCW 10.77) are not included in the IRC. Patients committed by municipal or district court judges after failed competency restoration are under RCW 10.77. These patients will not be included in the IRC until a petition for 90 days has been granted in court.

Network Meeting: A monthly meeting for the RSN Liaisons and WSH staff to identify issues, problem-solve and share information.

Ready for Placement: A patient who meets all of the following criteria: a) is clinically ready for discharge; b) is screened and approved for financial entitlement/medical assistance; c) is assessed for community "level of care."

RSN Liaison: The individual/individuals designated by RSN or, if delegated, their provider agencies as their official representatives to WSH. Liaison services include receiving and distributing admission/discharge packets, level of care screening and other assessments, enrollment/registration determinations, treatment and discharge planning meetings for patients at WSH. Terminology, roles, and responsibilities depend on RSN assignments.

RSN Liaison Manual: Manual containing written procedures for detailing the policies contained in the RSN/WSH working agreement. The manual is available to RSN Liaisons, RSN Administrators, WSH Social Work staff and others.

RSN of Responsibility Roster: The patient list, including PALS, which is updated daily, to reflect the IRC. The roster includes patient demographics, medical identification number, Models of Care (MOC), due date of next treatment plan review, legal status and decertification information. The roster is accessed by individual RSNs through Cache.

Treatment Teams: Multidisciplinary teams directly involved in patient care at WSH. RSN Liaisons are an integral member of the WSH treatment team.

Amendments to the Agreement

Either WSH or the RSN may initiate amendments to this Agreement. An amendment shall be accepted as part of this agreement when both parties sign the document.

WSH and RSN representatives shall meet to review compliance with the terms of this Agreement. When plans for correction and changes to the Agreement are identified and implemented, they will be evaluated at the following annual meeting. Annual meetings may be held in conjunction with other RSN reviews.

Duration of Agreement

This Agreement shall remain in force until either party expresses in writing that they wish to terminate the Agreement. The parties agree to the above and affix their signatures.

FOR THE REGIONAL SUPPORT NETWORK	FOR WESTERN STATE HOSPITAL
_____	_____
Signature	Signature
_____	_____
Typed Name	Typed Name
_____	_____
Title	Title
_____	_____
Date	Date