##### **REFERRALS / TRANSFERS / DISCHARGE**

Referrals and transfers into and out of Supervised Group Living and Transitional Living facilities is overseen by the Chief Medical Officer, Chief Clinical Officer, Executive Director, Director and Program Manager, with input from the group home supervisors, residential treatment teams, and outpatient providers, as appropriate.

Supervised Group Living Team and Transitional Living Teams will meet bi-weekly with the Outpatient Treatment Team to discuss upcoming discharges. Attendance will include:

Program Manager of ICT Team/OP Care Managers, Director Supervised Group Living, Managers of Supervised Group Living and Care Manager of Supervised Group Living, Program Manager of Transitional Living and Care Manager/Peer of Transitional Living

Discharge planning is initiated 60-90 days prior to the planned discharge as consumers make progress on identified goals or meet the criteria of their substance use program. Ability to perform independent living skills may reach a point where involvement in the supervised group living/transitional living program is no longer necessary for the consumer.

**The criteria for planned discharge may involve:**

* Goals for treatment have been met at this level of care.
* Graduating from the substance use program.
* Releasing or transferring a resident to a less intensive level of care does not pose any threat to themselves or others.
* Follow-up goals and treatment plans for lesser level of care have been established.

If a decision is jointly reached by the consumer, psychiatrist/psychiatric nurse practitioner, chief clinical officer and residential treatment team that the consumer no longer requires supervised group living /transitional living services, involvement in supervised group living/transitional living placement will be terminated. Appropriate referrals to other agencies or other Hamilton Center, Inc. programs and/or services will be determined at that time.

**Transition Planning**

* + Supervised Group Living/Transitional Living and Outpatient teams will meet to discuss discharges and potential discharges at a minimum bi weekly, beginning at a minimum 60 days prior to consumer discharge. Interim communication will occur when necessary during this time.
  + Supervised Group Living/Transitional Living and Outpatient teams will work collaboratively to create a discharge plan for consumers at a minimum 60 days prior to consumer discharge. The discharge plan will include housing, follow up services, referrals and other necessary services and needs of the consumer.
  + An Outpatient Care Manager will be assigned to work with reintegrating the consumer back into the community 45 days prior to the planned discharge.
  + The Supervised Group Living/Transitional Living Care Manager in collaboration with the Outpatient Care Manager will be responsible for furnishing the new living quarters with necessities.
  + The assigned Care Manager will begin to work with the consumer at their current placement, meeting with them at least weekly to begin establishing rapport. More frequent contact may be required and will be determined by the treatment teams during this discharge planning process.
  + Once discharged, the consumer will be seen face to face by the Outpatient Care Manager, at least twice per week for the first 30 days of discharge to assure all needs are met.
  + If the consumer is discharged to a location or facility not associated with Hamilton Center, the Supervised Group Living/Transitional Living Care Manger will follow up weekly for at least 30 days after discharge to ensure the consumer has transitioned into their new environment.
  + For 30 days after consumer has discharged, the Supervised Group Living/Transitional Living team will staff the discharged consumer at least bi-weekly to ensure all needs are met and the consumer is successful with their discharge plan.

If a consumer is discharged from the Supervised Group Living/transitional living program for non-compliance with rules, assaultive or self-destructive behavior, or other reasons, a reasonable alternative placement will be obtained by the treatment team. The outpatient team will be notified immediately.

If a consumer leaves the facility AMA (Against Medical Advice), the residential treatment team including the supervisor through the Chief Clinical Officer will be notified immediately. The psychiatrist/psychiatric nurse practitioner will be notified as soon as possible. If on a court commitment, notification will be made to the court and appropriate law enforcement agency.

The consumer’s record will contain the reasons for the referral, transfer or discharge, documentation that the psychiatrist/psychiatric nurse practitioner was notified, and all records of linking the resident to other agencies or services. Transfers to other programs or services within Hamilton Center, Inc. as well as discharges will be documented in the electronic medical record for the consumer using the Internal Referral Form or Discharge Summary and Transition Checklist.

Documentation of discharge or transfer will be made within the Electronic Medical Record