# BAY-ARENAC BEHAVIORAL HEALTH AUTHORITY
# POLICIES AND PROCEDURES MANUAL

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| **Chapter: 4** | **Care and Treatment Services** | | |
| **Section: 7** | **Treatment Plan of Service and Treatment Monitoring** | | |
| **Topic: 5** | **Transition, Transfer and Discharge** | | |
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## Policy

It is the policy of Bay-Arenac Behavioral Health Authority (BABHA) to have a procedure for transitioning, transferring or discharging from services and supports. In addition, providers contracting with BABHA operate consistent with this policy.

## Purpose

This policy and procedure was developed to describe the process for transitioning an individual into a different level of care, transferring a person to a new service provider or discharging an individual from all services. The procedure that should be followed is described along with information on the process of coordinating information to a new or existing provider.

## Education Applies to

☐ All BABHA Staff
☒ Selected BABHA Staff, as follows: Clinical Management and All Clinical Staff
☐ All Contracted Providers: ☐ Policy Only ☐ Policy and Procedure
☒ Selected Contracted Providers, as follows: Primary or Core Service Providers
☐ Policy Only ☒ Policy and Procedure
☐ Other:

## Definitions

- After Care Plan: A plan for follow-up care provided to the individual when they are discharged from the BABHA Provider Network.
- Discharge**:** When an individual leaves all services (completely) from the BABHA Provider Network; this can happen without notice (unplanned) or planned throughout the course of treatment.
- Primary Clinician: Clinical staff of a BABHA internal core program or contracted core service provider who is responsible for care management for an individual receiving services from the BABHA Provider Network; functions performed including linking/referrals, authorizations for release of information, consent to treat, ability to pay assessment, treatment planning, Plan of Service, coordination of both in-network and out of network care, BH-TEDS reporting, etc.

- Provider Network: The system of direct operated programs and contracted service providers (both individuals and agencies) established by BABHA to provide specialty and other behavioral health services in Arenac and Bay Counties.
- Suspension of Treatment or Inactive Status**:** If there will be no services provided by any clinician (including prescribers), program or agency in the BABHA Provider Network for period of time but the individual is not being discharged from the BABHA Provider Network. Typically, a planned or known absence with intent to return.
- Transfer/Transition**:** A move between levels of care, core service programs and/or provider agencies within the BABHA Provider Network. Includes incarceration, long term hospitalization or other placement if the BABHA provider network continues to provide at least residential or hospital liaison services or is the county of financial responsibility (COFR).
- Transition Plan: A type of Plan of Service Addendum to address the medical necessity for and coordination of a Transition or Transfer, as well as the individuals input and satisfaction.
- Warm Hand-Off: A practice of interactive communication at the time an individual is transferring. This allows the opportunity for dialogue and exchange of clinical information between the discharging program and the admitting program. Information exchanged can include but is not limited to relevant historical data that may include previous care, treatment, and services. This type of interaction is intended to maximize coordination during the time of transition or transfer of care. This Warm Hand Off is expected to occur through a face-to-face contact. This is particularly important when an individual is exiting one program/service and entering a different program/service, as it will provide an opportunity to ensure that the individual is appropriate for the receiving program and there is no lapse in services. It also provides the individual an opportunity to meet the new worker and begin to build therapeutic rapport while being supported by the transferring clinician.

## Procedure

1) Planning for Transitions, Transfers and Discharges
   a) Given the multiplicity of needs characteristic of persons with serious mental illness, serious emotional disturbance, developmental disability and co-occurring disorders, the majority of individuals served will require ongoing treatment and support. Intensity of service will vary according to individual needs. Some individuals may enter and leave services and later return throughout their lives. Others may require services on a limited

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basis until a capacity for independent functioning is achieved or returned, such that a specific service(s) are no longer required.

b) Discharge/transition planning begins at the start of treatment and is ongoing. It is expected that there will be early and active involvement and input from the individual, guardian, family, referral sources, and other community agencies as necessary. As an individual, guardian, or family approach the need for a different level of care or have completed care, the primary clinician helps identify service options that are available, within BABHA or the community that will address continuing care needs.

c) Any changes in treatment shall be done in the context of the Plan of Service and with input and agreement from the individual. Transition and discharge criteria are documented in the Plan of Service and throughout treatment on progress notes and reviews of progress.

2) When an individual meets one of the following criteria, they are considered suitable for transition or transfer:

a) Progress has been made toward achievement of goals, as covered in the individual's Plan of Service and the individual and the primary clinician, in consultation with prescriber services as appropriate, mutually agree that the individual or family are ready to move to a lesser level of care or to discontinue some of the services being provided while they continue to work on their goals.

b) The individual's symptoms and/or needs have increased and services identified in the Plan of Service do not appear to be intense enough to address the symptoms and the individual and the primary clinician, in consultation with prescriber services as appropriate, mutually agree that a higher level of care or new services are needed to address the symptoms and/or needs.

c) The identified child turns 18 and thus is no longer eligible for Children's Services, when clinically appropriate.~~es~~. As medically necessary, a warm t~~T~~ransfer from children services to adult services would ~~take~~ be initiated at least 3 months prior to their 18th birthday ~~place as medically necessary~~.

d) The individual will remain in the same level of care but needs or has requested a change in program or provider agency within the BABHA Provider Network.

e) The individual loses Medicaid or Healthy Michigan eligibility and must transition out of specialty behavioral health services, only if that services is not covered by General Funds (assuming the individual does not have the ability to directly pay for specialty services).

f) The individual moves out of the BABHA service area but BABHA will be the CMHSP of financial responsibility.

g) The individual is placed in long term hospitalization or residential placement outside of the BABHA service area, if BABHA remains the CMHSP of financial responsibility.

h) The individual expects to be incarcerated for 89 days or less, and the individual will be receiving some services, i.e., psychiatric services, the BABHA Jail Liaison will be following the individual while in jail, etc.

i) A planned or known absence will occur of 89 days or less duration, such as extended vacation, parental custody arrangement, etc.

3) When an individual meets one of the following criteria, they are considered suitable for a planned discharge:

a) Achievement of goals, as covered in the individual's Plan of Service, and/or the individual and the primary clinician, in consultation with prescriber services as appropriate, mutually agree that the individual is ready for discharge.

b) The individual no longer meets medical necessity criteria for specialty behavioral health services for adults with severe mental illness, children with serious emotional disturbance or adults/children with intellectual and developmental disabilities.

c) The individual no longer qualifies for General Fund services due to level of need and does not have Medicaid coverage or third party/insurance coverage (assuming the individual does not have the ability to directly pay for specialty services).

d) The individuals have met the program specific discharge criteria for their services, including children's programs, infant mental health, children stable on medications, emergency services, case management, ACT, residential services or North Bay Center. See Attachment: Program Specific Discharge Criteria for specific criteria for each program.

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e) The child or adolescent's total current Child Adolescent Functional Assessment Scales (CAFAS) or Preschool Early Childhood Functional Assessment Scales (PECFAS) score is 40 or less without a score of 30 on any of the subscales.

f) The identified child/youth is placed in long-term residential care outside of the catchment area and is not expected to return to the parent/guardian's home and BABHA is not the CMHSP of financial responsibility.

g) The individual or family leaves the BABHA service area and BABHA is not the CMHSP of financial responsibility for future services.

h) The individual withdraws voluntarily from participation in the program.

i) The individual chooses to withdraw upon expiration of his/her deferment or court order.

j) The individual expects/plans to be completely absent from treatment (i.e., will not be receiving any services from the BABHA Provider Network) for 90 days or longer for any reason, including incarceration.

4) When an individual meets one of the following criteria, they are considered suitable for an unplanned discharge:

a) The individual has moved from their last known address and cannot be found .

b) Individuals who (are not court-ordered) are functionally refusing treatment by:

i) Being unresponsive to contacts via telephone, letter, or face to face;

ii) Not engaging with the service provider, refusing to complete or agree to a Plan of Service or failing to follow the course of treatment (e.g. not attending recommended outpatient therapy, not participating in skill building services, etc.); or

iii) Having 90 days or more of unexpected/unplanned treatment inactivity.

c) The individual dies.

5) The following procedures are to be followed by the primary clinician for the discharge of an individual:

a) Planned discharges should be completed through face-to-face contact with the individual through a person-centered planning process, i.e., discussed during reviews of progress, annual planning meetings or a transition meeting, and addressed in the Plan of Service. The individual must understand the reason for and be in agreement with the discharge.

b) For planned discharges, a Warm Hand-Off will be performed by the primary clinician as feasible, appropriate and requested by the individual to ensure a successful discharge:

i) Signature on Authorizations to Release Information must be obtained from the individual to ensure clinical information can be submitted to a receiving service provider, if any.

ii) The individual will be assisted in accessing community resources by making referrals and assisting with scheduling follow-up appointment.

(1) This includes assisting with accessing services in a new county outside of the BABHA service area, if requested by the individual. In those instances when BABHA may be the responsible payer, the discharging program/agency supervisor will notify their Director of Integrated Healthcare regarding the potential need for a County of Financial Responsibility (COFR) agreement.

(2) When feasible, the primary clinician maintains contact with the individual or guardian until service transfer is arranged

iii) Care will be coordinated with the primary care physician for continuation of medications (if feasible, warranted and requested by the individual).

iv) The individual will be provided with contact information for the Access Center to address any future service need.

c) For individuals that are determined to be stable on his/her current medication regime, will not be receiving any other services through the BABHA provider network, only require medication maintenance care, and has the financial resources to pay for services, the following discharge steps will also be completed:

i) The primary clinician will ensure the individual has a primary health care provider and if not, assist the individual with establishing one.

ii) With the permission of the individual, the primary clinician or the current prescriber or designee will contact the primary health care provider to discuss medications and confirm acceptance and the willingness of the primary health care provider to prescribe the medications.

iii) Once this has been established, the primary clinician will forward the Discharge Summary and any other pertinent information to the primary health care provider and confirm receipt.

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d) For unplanned discharges (not involving a death), the primary clinician will attempt to re-engage the person in services through outreach efforts in accordance with BABHA's Cancellation and No-Show Guidelines policy and procedure (see C04-S07-T08: "Cancellation and No Show Guidelines"). Attempts at outreach and engagement will be documented in the clinical record.

e) Unless the Discharge is due to a death, the individual will receive an Action Notice at least 12 calendar days in advance of completion of the Discharge Summary. (See Policy and Procedure C03-S03-T12 "Grievance and Appeals") The Notice can be given to the individual at a session or via mail. The Notice will be copied to all other service providers in the BABHA Provider Network who are providing services to the individual.

f) If the Discharge is due to a death, a Death Report must be completed. In some instances, an Incident Report and a Death Report may be required (See C02:S03:T06 Reporting and Investigation of Adverse Events). The Death Report will be copied to all other service providers in the BABHA Provider Network who are providing services to the individual.

g) If the individual participates in a Medicaid waiver (i.e., SED, CW, HSW, Autism Benefit, 1915i) additional notices to the PIHP and the MDHHS are required.

h) If the individual is a child with serious emotional disturbance, a CAFAS must be completed at the time of discharge (see C04:S03:T10 Assessment Tools and Clinical Outcome Measures for Infants, Children and Youth with SED.

i) A Discharge Summary will be completed within 14 days of the expiration of the Action Notice warning period. The Date of Discharge is the date of the last service provided by any provider in the BABHA Provider Network. Discharge Summaries are not required if the Discharge is due to a death.

j) Completion of the Discharge Summary automatically generates an After-Care Plan, which is to be given or mailed to the individual being discharged, unless the Discharge is due to a death.

k) An End of Service Survey will be given or sent to the individual being discharged for return to BABHA, unless the Discharge is due to a death.

l) Program admissions and staff assignments must be closed for services and providers:

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i) A BH-TEDS Discharge Record must be generated when prompted at the time the Discharge Summary is signed.

ii) All clinical documentation must be completed prior to the initiation of the discharge documentation process. Once staff and program/agency assignments in the EHR are closed, access to the record is restricted.

iii) Any remaining service authorizations must be terminated through the electronic health record. The EHR does not complete this automatically upon completion of a Discharge Summary, however the EHR does complete this automatically upon completion of a Death Report.

iv) Program admissions and staff assignments must be closed through the electronic health record. The EHR does this automatically once the overall Admission to the BABHA Provider Network is closed or upon completion of a Death Report.

(1) The primary clinician is responsible for ensuring the program assignments for each program and provider agency are closed.

(2) In some instances, provider agencies which are primary/core providers will have already closed their own program assignments.

v) If the Discharge is not due to a death, the overall Admission to the BABHA Provider Network must be closed in the BABHA electronic health record by the clinical supervisor or their designee for BABHA internal programs, or the BABHA Records Specialist for primary provider agencies in the BABHA Provider Network. Agencies who are the primary clinician for an individual will ensure the Record Specialist is notified of discharges through the EHR messaging system or another method. A Death Report automatically closes the Admission.

6) The following procedures are to be followed by the primary clinician for the transition or transfer of an individual

a) Transitions and transfers should be completed through face-to-face contact with the individual through a person-centered planning process, i.e., discussed during reviews of progress, annual planning meetings or a transition meeting, and addressed in the Plan of Service. The individual must understand the reason for and be in agreement with the discharge.

i) As a rule, if a Clinical Assessment or Plan of Service will be expiring within 30-45 days, it is expected any needed transfers between programs/agencies will be performed at the time of the annual review, after the annual update of the Clinical Assessment and the annual review of the Plan of Service have been completed by the transferring program/agency.

b) Whenever an individual's care is transferred from one clinician, program or agency within the BABHA Provider Network to another, a Warm Hand Off should occur. The primary clinician assigned at the transferring program or agency is responsible for facilitating the transition to the receiving program or agency.

i) Signature on Authorizations to Release Information must be obtained from the individual if required by BABHA policy to ensure clinical information can be submitted to a receiving service provider, if any.

ii) Referral forms may be required for certain programs or provider agencies in the BABHA Provider Network. Additional considerations are:

(1) For individuals placed in a state hospital, the BABHA Hospital Liaison should be involved in the placement or notified immediately upon placement.

(2) For out of county residential placements, the BABHA Residential Liaison should be involved in the placement or notified immediately upon placement if they will be required/expected to follow the individual in that setting.

(1) Those who are incarcerated should be brought to the attention of the BABHA Court/Jail Liaison immediately so the individual can receive follow-up services while in the jail.

iii) If BABHA Provider Network prescriber services are being transitioned or discontinued, care will be coordinated with the receiving psychiatrist or primary care physician (if feasible, warranted and requested by the individual) for continuation of medications.

(1) If a child who is prescribed medication ages out of Children's Services and is being transferred to Adult Services when clinically appropriate, the discharging program is responsible for scheduling the appointment with an Adult Psychiatrist within 30 days of the child's last appointment with his or her Children's Services staff member.

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(2) If BABHA Provider Network prescribing services are ~~ending~~pending, the primary clinician will ensure the individual has a primary health care provider for continuation of medications and if not, assist the individual with establishing one.

(a) With the permission of the individual, the primary clinician or the current prescriber or designee will contact the primary health care provider to discuss medications and confirm acceptance and the willingness of the primary health care provider to prescribe the medications.

c) If the current Clinical Assessment is still valid (i.e., less than a year old) and the transfer or transition between clinicians or program/agency reflects a lateral transfer relative to the level of care or type of service, a new Clinical Assessment or Clinical Assessment Update will not be routinely performed.

i) If medically necessary, an assessment update may be performed, as long as the reason for the assessment is documented in the clinical record.

ii) If the transfer or transition reflects a new level or type of service, such as outpatient therapy for someone who previously received only case management, the appropriate specialized assessment, such as a psychiatric evaluation, may be done. The transferring party with authorize such as an assessment as requested by the receiving party.

iii) If the individual is a child with serious emotional disturbance, a CAFAS may be required at the time of transition or transfer (see C04:S03:T10 Assessment Tools and Clinical Outcome Measures for Infants, Children and Youth with SED).

d) Assuming there is a current (i.e., not expired or about to expire) Plan of Service in place for the individual, the primary clinician of the transferring program/agency will complete a Plan of Service Addendum. The addendum will document the medical necessity (i.e., clinical justification) for the change, the individual's input and satisfaction and the logistics/coordination of the transition or transfer.

i) The transition planning section of the Plan of Service Addendum must be completed.

ii) Existing goals must be revised or a new goal added to reflect the transition or transfer which is occurring. This includes individuals:

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(1) In a state hospital placement who will be followed by the BABHA Hospital Liaison.

(2) In an out of county residential placement who will be followed by the BABHA Residential Liaison.

(3) Who are incarcerated who will be seen by the BABHA Jail liaison.

(4) Whose services are being suspended due to a planned or known absence of 89 days or less in duration (absence from treatment lasting 90 days or more requires a Discharge).

(a) The Plan of Service transition plan must include care and treatment strategies while the individual is absent from services.

iii) Existing service authorizations which will no longer be needed must be end-dated. 45 days' worth of the appropriate (new) services will be authorized, indicating that this is a "new authorization" which will alert the receiving program/agency through the EHR.

iv) The Plan of Service Addendum should be signed by the individual, if unable to be signed, the reasons documented. An action notice is required as a component of the addendum process especially for transitions and transfers.

(1) The individual will be given or mailed a copy of the addendum.

(2) The individual will receive an Action Notice in conjunction with the completion of the Plan of Service Addendum. (See Policy and Procedure C03-S03-T12 Grievance and Appeals). If services are only being suspended/de-activated for 89 days or less, the notice must state the services are being suspended.

(3) If the individual does not sign the Plan of Service Addendum, they must be mailed a separate action notice for their signature.

v) If the individual participates in a Medicaid waiver (i.e., SED, CW, HSW, Autism Benefit) additional notices to the PIHP and the MDHHS may be required.

vi) The Plan of Service Addendum with the transition plan should be copied to other service providers in the BABHA Provider Network who are providing care for the individual, and/or a message sent through the EHR or encrypted email.

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(a) If a community primary care physician is assuming responsibility for prescribed medications, the primary clinician will forward the Plan of Service Addendum and any other pertinent information to the primary health care provider and confirm receipt.

vii) The receiving program/agency will complete another Plan of Service Addendum as necessary to define any new goals and objectives to be achieved through the new service or provider, as well as any authorizations needed for the time period after the initial 45 days' worth of authorizations expire.

e) Program admissions and staff assignments must be closed for services and providers which are ending.

i) A BH-TEDS Admission, Update or Discharge Record should not be completed for transitions and transfers as it is not required.

ii) All clinical documentation must be completed by the transferring clinician, program or agency prior to the initiation of the transition or transfer process. Once staff and program/agency assignments in the EHR are closed, access to the record is restricted.

iii) The supervisor or designed of the primary clinical staff at the transferring program/agency is responsible for starting the receiving program/agency's program assignment in the EHR so they can view information and receive notifications regarding the individual. The face to face Warm Hand Off appointment is considered the clinician caseload or program/agency assignment end date for the transferring party and the assignment start date for the receiving party.

iv) If a face to face Warm Hand Off appointment does not occur, the staff and program assignment in the EHR should not be closed by the transferring clinician, program or agency until the receiving program has notified the transferring program that the individual had their first face to face appointment with the receiving party. At the time of this notification, the transferring clinician, program or agency will close their staff and program assignments in the EHR

ii) Each individual who has not been discharged from the entire BABHA provider network must have a primary clinician and program assignment at any given time, as each individual receiving BABH network services must have a responsible clinician.

(1) If an individual is in state hospital or residential placement outside the BABHA service are or incarceration, the Hospital Liaison, Jail Liaison or Residential Liaison as appropriate becomes the assigned primary clinician.

(2) If an individual transitions to medications only, a clinic nurse or designee becomes the assigned primary clinician.

(3) Program assignments are to remain open during a period of suspended or inactive treatment as the last case holding clinician or program/agency remains responsible for completing the discharge process if the individual does not return to services.

(a) Suspension of services through the Plan of Service and associated action notice does not alter the allowed duration of the Plan of Service (which must be updated at least annually) or the need to update the Clinical Assessment, Assessments for Personal Care Services, BH-TEDS Update Records and other clinical documentation which is required on an annual or other specified basis.

7) Discharge and/or Transfer for Aggressive or Assaultive Behavior

a) If an individual is discharged and/or transferred from a program for aggressive and/or assaultive behavior, every effort will be made to link the individual to the most appropriate service(s) following the procedures outlined above. If the warm hand off cannot occur face-to-face due to safety considerations, the discharging program will facilitate the warm hand off via telephone with the receiving program. In addition, the discharging program will contact the individual within 72 hours of discharge for a status check to ensure that he/she has been connected with the receiving program and will document the results of the contact on a progress note.

8) A Discharge Summary will include the following information (but not limited to):

a) A summary of the presenting problems

b) The total history of the current episode of care including procedures, care, treatment, medications, and services provided including community resources or referrals provided to the individual or guardian

c) Progress toward goals, including final status with respect to goals, objectives, and services in the current treatment plan achieved during program participation

d) Identify continuity of medications, if applicable

e) Satisfaction with services

f) Evaluation of whether aftercare (post discharge) services are needed

g) Instructions to the individual or guardian on how to obtain aftercare services, or support systems that will assist in continuing his or her recovery, well-being, or community integration, and recommendations on who may provide aftercare services

h) The reason for discharge including continued care needs related to physical and psychosocial domains

i) Relevant bio-psychosocial status at discharge

j) Referral information, including what services were arranged and with whom

**Attachments**

Transition Transfer Discharge Grid

Program Specific Discharge Criteria

**Related Forms**

Adequate Action Notice (G:/Clinical Services/Master Clinical Files)
Advanced Action Notice (G:/Clinical Services/Master Clinical Files)
Transfer/Discharge Form
Children's Services Transfer Form
Discharge Checklist (G:/Clinical Services/Master Clinical Files)

**Related Materials**

Cancellation and No Show Guidelines (C4:S7:T8)
Grievance and Appeal (C3:S3:T12)
Saginaw Meadows Crisis Residential Treatment Program-Exit/Discharge and Follow Up (C4:S4:T32)

**References/Legal Authority**

CARF - General Program Standards - D. Transition/Discharge

# BAY-ARENAC BEHAVIORAL HEALTH AUTHORITY
# POLICIES AND PROCEDURES MANUAL

| | | | |
|---|---|---|---|
| **Chapter: 4** | **Care and Treatment Services** | | |
| **Section: 7** | **Treatment Plan of Service and Treatment Monitoring** | | |
| **Topic: 5** | **Transition, Transfer and Discharge** | | |
| **Page: 15 of 16** | **Supersedes Date:**<br>**Pol: 8-15-13,3-18-04**<br>**Proc: 8-3-17, 6-20-13,1-24-12, 7-11-11,**<br>**9-20-10, 11-11-09, 9-16-08, 8-15-06, 8-17-05, 7-20-04** | **Approval Date:**<br>**Pol: 7-20-17**<br>**Proc: 6-30-2023** | _____<br>***Board Chairperson Signature***<br><br>_____<br>***Chief Executive Officer Signature*** |
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| **SUBMISSION FORM** | | | | |
|---|---|---|---|---|
| **AUTHOR/ REVIEWER** | **APPROVING BODY/ COMMITTEE/ SUPERVISOR** | **APPROVAL/ REVIEW DATE** | **ACTION**<br>**(Deletion, New, No Changes, Replacement or Revision)** | **REASON FOR ACTION**<br>**- If replacement list policy to be replaced** |
| M. Bartlett | MMPRC | 09/16/08 | Revision | To meet the 2009 NPSGs |
| M. Swank | G. Lesley | 11/11/09 | Revision | To address CARFs general program standards concerning transition/discharged or removed for aggressive and/or assaultive behavior. |
| M. Swank | CLT | 09/20/10 | Revision | To address changes in CARFs general program standards for 2011 concerning unplanned transitions or discharges |
| M. Swank<br>P. Baker | CLT | 07/11/11 | Revision | To consolidate several policies and procedures dealing with discharge, transfer, and termination into one universal document. |
| D. Tomczak | PNLT | 01/24/12 | Revision | To include the use of ECHO, the electronic health record used across the provider network. |
| D. Cranston<br>B. Roszatycki | PNLT | 06/30/13 | Revision | Revised per the 2012 CARF Survey – replaces the following C4-S4-T15, C4-S4-T17, C4-S4-T22, C4-S4-T23, C4-S4-T24, C4-S4-T25, C4-S7-T6, C4-S11-T6, C4-S12-T17, C4-S12-T18, C4-S13-T4, C4-S14-T5, C4-S15-T4, C4-S16-T5, C4-S17-T5 |
| K. Amon; J. Pinter | SLT; Primary Network Providers | 8/13/17 | Revision | Revised to no longer require a Discharge Summary for transfers and transitions and to require a POS Addendum instead; updated to reflect current workflow. |
| H. Beson | C. Pinter | 6/30/23 | Triennial Review | Changed to add "when clinically appropriate" for transfers out of children's services. |