ACCESS

Community Health & Research Center

Policy Name: Policy Section/ Number:	Created By:	Initial Date:	Current Date:	Pages:
Transition and Discharge Planning Section __/# ____	Ana Dutcher Quality Assurance Manager	7/29/2013	6/9/2020	Page **1** of **6**

Approved By: Mohamad Khraizat	**Title: Health Operations Manager**
Signature: Mohamad Khraizat	**Date:** 6-9-2020

I. **POLICY:** It is the policy of Arab Community Center for Economic and Social Services Community Health and Research Center (ACCESS CHRC) that transition and discharge planning process assists the persons served to move from one level of care to another within the organization or to obtain services that are needed but are not available within the organization.

The transition process is planned with the active participation of each person served and if applicable, their guardian. Transition may include planned discharge, movement to a different level of service or intensity of contact, or a re-entry program in a criminal justice system.

II. **PURPOSE:** The purpose of this policy is to delineate and describe program standards and expectations of the ACCESS Transition and Discharge Planning as set forth and standardized across the funding sources.

III. **APPLICATION:** This policy applies to all ACCESS employees, interns and volunteers who provide support and treatment on behalf of the ACCESS Community Health and Research Center.

IV. **DEFINITIONS:**

Discharge Plan: a clinical document written by the program personnel who are involved in the services provided to the person served and is completed when the person leaves the program (planned or unplanned). It is a document that is intended for the record of the person served and released, with appropriate authorization, to describe the course of services that the program provided and the response by the person served. It must include the rationale for discharge, the treatment status and a statement regarding instruction given to the person regarding aftercare and follow-up.

Individual: An individual receiving services and supports

Individualized Plan of Service (IPOS/PCP): An orderly arrangement into a person's clinical agenda of specific treatment/services/supports, developed by mental health professionals to address the identified prioritized mental health needs of individuals receiving assistance in a mental health setting: The IPOS/PCP, the fundamental document in the recipient's record, must be authenticated by the dated signature of the professional named as responsible for its implementation. The IPOS/PCP consists of a treatment plan, a support plan, or both.

Medical Necessity: The clinical appropriateness of a course of treatment/specific services as suitable to the needs of Medicaid beneficiaries, using approved clinical criteria and professional judgment.

Person-Centered Planning (PCP): A process for planning and supporting the individual receiving services that:

a. Builds on the individual's capacity to engage in activities that promote community life, is strength-based, and honors the individual's preferences, choices, and abilities
b. Involves family/significant others, friends, and professionals
c. Must be incorporated into the existing service delivery system as a routine part of the intake, assessment/evaluation, development, implementation, monitoring and systematic periodic review, and revisions as indicated on the Individualized Plan of Services

Recovery: A process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential.

Transition Plan: a document developed with and for the person served and other interested participants to guide the person served in activities following transition/discharge to support the gains made during program participation.

Urgent/Crisis: A situation in which an individual is determined to be at risk of experiencing an emergency in the near future if he or she does not receive care, treatment, or services

V. DISCHARGE CRITERIA MENTAL HEALTH

A. Diagnosis - The patient is assessed, post admission, as not having met the diagnostic criteria for Mental Health Outpatient Services as defined by the current DSM.

B. Dimensional Discharge Criteria - Must meet specifications in one of the following dimensions

1. The patient has met their goals that were established by him/her and the treatment team
2. The person is able to recognize signs and symptoms of their illness,
3. The person understands his/her self-defeating relationship and unhealthy coping skills.
4. The person has consistently missed their appointments with assigned staff for the past 90 days and there is documentation for the attempts to reach out
5. Biomedical Conditions and Complications (one of the following must apply):
6. The person's biomedical problems, if any, have diminished or stabilized to the extent that they can be managed through outpatient appointments at the patient's discretion.
7. There is a biomedical condition that is interfering with treatment and requires treatment in another setting.
8. Emotion/Behavior Conditions and Complications (one of the following must apply)
    1. The person's emotional/behavioral problems have diminished or stabilized to the extent that they can be managed thoroughly outpatient appointments at his or her indiscretion.
    2. A psychiatric/emotional/behavior condition exists that interferes with treatment and treatment in another setting is recommended.

C. Recovery Environment (one of the following must apply)

1. The person's social system and significant others are supportive of recovery to the extent that the patient can adhere to a self-directed treatment plan without substantial risk of regression
2. The person is functioning adequately in areas of employment, social functioning or primary relationships
3. The person's social system remains non-supportive or has deteriorated and the patient is having difficulty coping with this environment. This non- supportive environment is placing the patient at substantial risk of regression. Thus the patient is in need of a more intensive level of care.

VI. PROCEDURES:

A. ACCESS proactively attempts to connect the persons served with the receiving service provider and contact the persons served after formal transition or discharge to gather needed information related to their post-discharge status. Discharge information is reviewed to determine the effectiveness of its services and whether additional services were needed.

B. The transition services are critical for the support of the individual's ongoing recovery or well-being. Transition planning may be included as part of the person-centered plan. The transition plan and/or discharge summary are a combined document that clarifies whether the information relates to transition or pre-discharge planning or identifies the person's discharge or departure from the program.

C. When individuals have reached a point of readiness for transition or discharge, a final review and reassessment is in order. Ideally, all cases or episode-of-care closures and transitions are anticipated and consistent with the individual plan.

D. ACCESS staff will plan the transition with the client, support system and the other team members, and use it as an opportunity for the members of the team to share their experiences in working together for the success of the individual and family. It provides closure and a chance to wish them well as they continue on their recovery journey, perhaps to return at some point in the future, perhaps never to be seen again.

E. Identified needs may be specific to the individual's age, gender, disability/disorder, or other special circumstances

F. Referrals may be made for other services available through different funding sources

1. Community services
2. Community employment services
3. Medical services
4. Medication management
5. Recreation/community living services

6. Relapse prevention and advocacy groups
7. Self Help: exercise program schedule, books to read, etc.
8. Self Help groups including names of groups, location, and number of groups to attend.
    i. Alcoholics Anonymous, Narcotics Anonymous, etc. Specific groups and number of groups should be specified
    ii. Antabuse/Trexan with length of time committed to using and arrangements for refill
    iii. Other organizations, identified as to name and attendance
9. Vocational/Educational with name and plan for attendance

G. ACCESS will ensure that the individuals and families understand the recovery process and are accepting of the risk of relapse or recurrence and the possibility that mental illness and addictive disorders may require additional treatment or supports at some future point in time. The agency is designed so that individuals do not face barriers to reassessment, re-entry into services, and re-activation of service plans should that become necessary.

H. ACCESS staff will ensure a smooth or seamless transition when a person served is transferred to another level of care, another component of care, or an aftercare program, or is discharged from the program for various reasons, including no longer meeting the medical necessity criteria.

1. When Transition is necessary, a referral is completed and submitted to the Supervisor of that department/service
    i. Prior to transfer/assignment, all alerts and documentation is reviewed for appropriateness of the referral as well as in preparation for the assignment
    ii. It is required that communication takes place between the team members to ensure all pertinent information is addressed and the newly assigned staff is prepared for the new assignment.

2. If discharge is imminent, appropriate referrals are made to outside entities and the client is informed of all the steps in case thee need to return for services.

I. The written transition plan:

1. Is prepared or updated to ensure a seamless transition when a person served
2. Is transferred to another level of care or an aftercare program
3. Prepares for a planned discharge
4. Identifies the person's current
5. Progress in his or her own recovery or move toward well-being.
6. Gains achieved during program participation.
7. Identifies the person's need for support systems or other types of services that will assist in continuing his or her recovery, well-being, or community integration
8. Includes information on the continuity of the person's medication(s),when applicable

9. Includes referral information, such as contact name, telephone number, locations, hours, and days of services, when applicable
10. Includes communication of information on options and resources available if symptoms recur or additional services are needed, when applicable
11. Developed with the input and participation of o The person served
12. The family/legal guardian, when applicable and permitted o A legally authorized representative, when appropriate o Team members
13. The referral source, when appropriate and permitted
14. Given to individuals who participate in the development of the transition plan, when permitted

J. A discharge summary is a tool that facilitates continuity of care and serves to document a baseline which may be helpful for future service provision.

K. For all persons leaving services, a written discharge summary is prepared to ensure that the person served has documented treatment episodes and results of treatment. The discharge summary

1. Includes the date of admission
2. Describes the services provided
3. Identifies the presenting condition
4. Describes the extent to which established goals and objectives were achieved
5. Describes the reasons for discharge
6. Identifies the status of the person served at last contact
7. Lists recommendations for services or supports
8. Includes the date of discharge from the program

L. When an unplanned discharge occurs, follow-up is conducted as soon as possible to:

1. Provide necessary notifications
2. Clarify the reasons for the unplanned discharge
3. Determine with the person served whether further services are needed
4. Offer or refer to needed services

M. It is important to identify and pass on information about a person's strengths, needs, abilities, and preferences to other treatment providers to ensure continuity of care. This may be done by sharing the transition plan, the discharge summary, or other comparable documents.

N. When a transition plan or discharge summary is provided to external programs/services to support a person's transition or discharge, it includes the person's identified

1. Strengths
2. Needs

3. Abilities
4. Preferences

O. When a client has a new need or has decided to return for services, the entire process is started from Screening, Orientation, Assessments, Person Centered Planning, linking and Coordinating with community resources, keeping the focus on the new transition and discharge criteria.

VI. QUALITY ASSURANCE/IMPROVEMENT

ACCESS reviews and monitors adherence to this policy as one element of the Quality Improvement Performance Improvement Plan-Goals and Objectives. The agency's quality improvement program must include measures for both the monitoring of and continuous improvement of the program or process described in this policy

VII. COMPLIANCE WITH ALL APPLICABLE LAWS

Agency staff, contractors, and subcontractors are bound by all applicable local, state, and federal laws, rules, regulations, and policies, all federal waiver requirements, state, and county contractual requirements, policies, and administrative directives in effect and as amended.

VIII. LEGAL AUTHORITY AND REFERENCES

Michigan Mental Health Code, as Revised 1996: Section, 330, 1228

Michigan Department of Community Health, Substance Abuse Administration Manual, Revised January 1, 2008

Agency policies refer to the most recent policy at the time of writing:

Grievance Process FY 2013

Individual Plan of Service Person Centered Planning FY 2013 ® Local Dispute Resolution Process for Persons without Medicaid FY 2012 © Michigan Department of Community Health Medicaid Fair Hearings FY 2013 © MDCH Treatment Rights - Second Opinion

MDHHS/CMHSP Managed Specialty Supports and Services Contract:

Person-Centered Planning Best Practice Guidelines

Grievance and Appeal Technical Requirement

IX. EXHIBITS

None