ADMIT-TRANSITION-DISCHARGE CLINICAL USER GUIDE

Purpose: To provide guidance on the process of admission to clinical treatment programs, transition processes, and discharge from treatment. To provide guidance on person served engagement and person-centered care planning during times of engagement and transition. To provide guidance on timelines and processes for engagement, monitoring, and transition. To ensure tracking of program enrollment and seamless transition between service providers and levels of care.

Definitions:

Episode: Previously an Avatar term newly redefined as a duration in which a person served is engaged with an intervention provided by the Mental Health Plan (MHP). For purposes of this guide "episode' refers to a "treatment episode."

Clinical Program: Organized/predefined entity performing Specialty Mental Health Services (SMHS) or activities focused on improvement in functioning and symptom management for Medi-Cal, Medicare, and uninsured Fresno County residents. Duration of service or intervention is known as a "treatment episode."

Request for service: When a community member requests behavioral health assessment or treatment, which may be in person, by phone, or in writing. A request for service may be made directly to a program or via the Access Line or by specific authorized people or bodies. An Access Form may need to be completed when a request for service is made (Please follow Access Form guidelines on when to complete an access form)

Timeliness of Access: To meet timely access to care, providers must offer a person served an assessment appointment within 10 business days of the request date for a non-urgent non-psychiatry service, 15 business days of the receipt date for a non-urgent psychiatry service, 48 hours of the request date for urgent care services that do not require prior authorization and 96 hours of the request date for urgent care services that do require prior authorization.

Intake: Occurs after a person served is referred to the MHP/Program. Intake may include activities such as completion of intake forms (Ex: consent to treat, Notice of Privacy Practices, ROI's, etc.), scheduling of the assessment, or beginning an assessment.

Admission (Admitted): Enrollment in any clinical program in the Mental Health Plan (MHP) for the purpose of being triaged, assessed for, providing SMHS including Mental Health Assessment.

Assessment: Medi-Cal Mental Health Assessment may occur during intake or after intake.

Transitions and "the warm hand off": Movement of the person served between providers, programs, levels of care and/or Evidence Based Practices (EBPs); a process that could take about 4 weeks, is person served driven, involves natural supports as identified by the person served, includes referring parties when appropriate, the treatment team, and other community partners involved in the care of the person served. (CARF, Section 2.D.2)

Discharge Summary and Plan: A clinical form located in the EHR, and available in paper/electronic format, used to document the course of treatment and reasons for departure from the program or Mental Health Plan. Discharges may be planned or unplanned. The Discharge Summary and Plan is completed when moving from program to program or when discharging from the MHP (CARF, Section 2.D and 2.D.2). There are two types of Discharges: Planned Discharges and Unplanned Discharges.

> Discharge – Planned: The person served is leaving a program, EBP, or service and can participate in, or is aware of, the transition. The person served participates in the decision about resources, next steps, supports needed and participates in the writing of the Discharge Summary and Plan.
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> Discharge – Unplanned: The person served is unable to be located, is deceased, or otherwise unable to participate in their discharge from the program/service.
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> Notice of Adverse Benefit Determination (NOABD) Termination Notice: Avatar Form. For unplanned discharges, a provider will issue a NOABD Termination Notice to the person served. Scenarios can include when a person is not participating/engaging in treatment, not adhering to program rules, or no longer meeting medical necessity for SMHS and does not want to participate in the transition to lower levels of care. A provider will issue a NOABD Termination Notice at least 10 days prior to termination of services.

Assertive Outreach: Outreach attempts that are persistent, thorough, exhaust all avenues, are sensitive to readiness and stage of change and that acknowledge the person served might not be ready to engage with the system of care. Attempts are specific and tailored to the individual and may include attempts to visit the individual's residence or other places the individual is known to frequent such as places of work, leisure, or worship.

Outreach may include consulting with wellness centers, crisis centers/programs, local inpatient units, previous providers, homeless shelters, and other agencies to determine if the individual has been seen at those locations or in the community. All efforts and types of attempts are specific to the individual, are clinically based (not protocol-based), are person centered and clearly documented in the chart.

Access Request and Access Form

An Access Request is also known as a Request for Services. When a community member requests Mental Health Services or Substance Use Disorder Services the request may be in person, by phone, in writing or a third-party referral to the MHP. The Access Form is the mechanism by which DBH tracks data for compliance with timeliness of access as required by regulation. (Please follow Access Form guidelines outlining when to complete an access form)

Referral

The Client Referral form in Avatar tracks an individual's movement through the system of care. The referral form is also used to assess the flow of referrals to and from various agencies/ programs and is an indicator of program utilization. The referral for also demonstrates care coordination efforts.

When linking a person served to various resources or another treatment programs the referral form is used. For agencies and programs that require receipt of a referral packet the "Clinical Communications Form" in Avatar may be used to collect needed items for a referral that needs to be printed or emailed.

Referrals, when at all possible, should be sent, received, and approved in Avatar. Referrals need to have an approval decision within one working day. The receiving program confirms with the referring party that the referral has been received and approved. The person served is notified by phone that a referral has been received and that they should expect a phone call in the next two working days, that they will be seen within five working days (or earlier if there is an expressed need), and who to contact if they are not contacted. An assessment must be offered to, and ideally initiated with, the person served within 10 business days.

Admission

Once a referral is received and approved, the practitioner meets with the person served and completes the intake process. This intake date is the date to be used for the admission date to the program:

- Assign to caseload
- Establish relationship
- Complete informed consent and consent to treat
- Schedule Assessment, begin/complete an assessment, or review existing assessment
- Complete clinical measures
    - Children's Mental Health – Ex: CANS, PSC-35
    - Adult Services - Ex: Reaching Recovery tools, PHQ-9
- Collaboratively complete Treatment Plan of care with the person served using the CANS or Reaching Recovery data. Treatment Planning includes explaining the goals to be achieved, the timeline for achieving those goals, explaining resiliency,

introducing the expectation of recovery, and establishing that the transition and/or graduation from services will be planned process
- Complete any program specific or EBP required outcomes
- Establish contact schedule, set reoccurring appointments, and set up appointments in the EHR
- Collect/review/update Releases of Information (ROI)
- Complete the Admission, Transition, Discharge (ATD) form in Avatar
- Identify primary contact for the program and provide information about reaching the primary contact, the agency, and crisis information.

At times the intake process may take more than one meeting. It is important that the person served has the opportunity to communicate about what has brought them to services at this time, what their life will look like once they have received the assistance they are requesting and leave this session with hope for the future. This is essential for relationship building. Completing the Treatment Plan with the person served ensures the individual's needs, as they see them, are being addressed, and activates the opportunity to bill Medi-Cal/Medicare for services.

A follow up phone session, telehealth appointment, or in person visit may be required to complete the intake process in a timely manner.

After the intake process, the practitioner completes the service by completing the admission form, contacting the referring party to "close the loop" on the referral advising them that the person has been admitted. The referring party, upon notification will remove the person served from their caseload and complete any paperwork needed to remove the individual from the referring program/service.

Transition and Discharge

Transition Planning and completion of the Discharge:

For planned discharge, the person served, and treatment team will engage in the transition planning process to assist with the transfer to other services, supports, or self-help. The person served works with the provider to develop a transition plan. The transition plan is developed over time with the practitioner and involves reviewing successes, identifies areas of needed continued support and the informal agencies and supports needed, reviews relapse plans, enlists the comment of support from the natural support systems (family, friends, support groups, faith groups, social clubs). Planning for discharge, or step down, begins during the intake process, and is discussed, developed, and tracked throughout treatment.

The goals to be attained are established at the onset of service and benchmarks for successful discharge are discussed and documented. The beginning phase of treatment focuses on relationship building and truly understanding what the person served wishes to achieve and the resources they have used to overcome past difficulties. The middle phase of treatment focuses on collaborating with natural support persons, clarifying roles, and garnering resources, and reaching objectives. The end phase of treatment focuses on

celebrating successes, developing a plan for transition out of the program, and discharging from the program.

During the end phase of treatment successes are celebrated and a plan for future services, supports, and resources are developed. The person served documents the resources and contacts needed for sustained recovery as part of their transition plan. Transitions are individualized and may take time to ensure that the person served is connected with the identified resources. The Transition Plan is a living document created with the person served over the course of treatment. It may take up to four weeks to communicate with the new provider, complete a case consultation, and for the person served to receive their first visit with the new provider.

Once the transition to the new provider/resources is complete the ATD form is completed, the person served is removed from the practitioner caseload, and discharged from the program.

Process:

1. The transition process is client driven. Transition planning and the development of a written transition plan may take time (around 4 weeks is typical)

2. Transition planning begins at intake with discussion and planning for improved wellbeing.

3. The Recovery Needs Level (RNL) for Adults and the CANS and PSC-35 for children are completed at admission used in treatment planning. These and other tools are used periodically throughout care and discussed with the person served. During the transsion planning process these tools are again administrated and discussed with the client and process is reviewed and achievements are highlighted. The RNL and CANS are completed as part of this discussion as the person served is transitioned from the program.

4. The practitioner will discuss the findings of all clinical tools with the person served; when a change in service level is indicated, the practitioner will also present the results to the treatment team for discussion and develop a tentative transition plan with the person served. The transition plan will develop through the course of the transition planning process with the person served, will be documented in a case note as it occurs and should be written out for the person served as a resource.

5. Service levels will generally be decreased by only one level. Changes in more than one level of care are possible with approval from supervisory staff, or the MHP, and should be considered on a case-by-case basis with person served voice and choice paramount in the decision making. All transitions of care and level changes should be discussed with all members of the treatment team and natural supports that are engaged in the care of the person served.

6. If the clinical tools or indicators suggest transition to a higher level of care, the team will initially consider a strategy to increase services for agreed upon period of time with increased supports in an attempt to support the person served at the current level of service and with their existing provider. A review of progress using the appropriate tools should be completed to determine if a change of level is still indicated. The goal is to support and stabilize and prevent the need for a higher level of care when possible. If the person served continues to demonstrate the need for a higher level of care, and the need is unlikely to be resolved at the current level of care with the current provider, then the transition process begins, and a written transition plan will be developed by the person served in conjunction with the team.

7. When transitioning to a different level of care or a different program the current team will work with the person served and their identified natural supports, treatment programs, and other community organizations to ensure a seamless supportive process through the development of a written transition plan.

8. Complete any needed referrals in Avatar.

9. There should be consultation between all treating providers, irrespective of the providers agency affiliation. This ensures a person centered and seamless care coordination process across the system of care. The person served may be assisted to their first appointment with the new provider as needed. Overlapping coordinated services may be required for some complex cases.

10. When the person served is ready to discharge from the program/discontinue services:
    - Complete the Discharge Summary and Plan in Avatar.
    - Confirm the referral was received and ensure that the person served accessed services or that there is a plan in place to ensure the person served is able to access the services.
    - Complete the Admit/Transition/Discharge (ATD) form in Avatar once the party you are referring to has accepted responsibility for the person served.
    - Remove from practitioner caseload and any Evidence Based Practices provided once the linkage to other services is completed.

11. As with all treatment services the process and planned discharges are person served driven and be completed using Collaborative Documentation.

<u>The written Discharge Summary and Plan</u>

<u>Discharge Scenarios:</u>

Reason	Type of Discharge	Action Steps

In process of sentencing at a correctional facility	Planned	• Up to 30 days observation • Alert jail health services • If sentenced, complete transition to jail health services, transition care and remove from caseloads, discharge from program
Moving out of the area	Planned Unplanned	• Plan a transition to services convenient with new location • Discharge once individual moves • Attempt to contact by phone and offer support, NOABD Termination Notice letter to person served, discharge from program
Completed treatment (no formal supports required)	Planned	• Transition to community recovery supports as needed then discharge from program and remove from caseload
Increased Recovery to Mild/Moderate presentation of symptoms	Planned	• Transition to Health Care Plan • Complete Bidirectional Form • Ensure linkage
No longer wants service from the MHP	Planned Unplanned	• Transition and discharge, remove from caseload • Ensure intensive outreach has been completed and documented • Send NOABD Termination Notice to person served, discharge from program, remove from caseload
Changing to a provider outside of the MHP	Planned Unplanned	• Transition and discharge, remove from caseload • Ensure intensive outreach has been completed and documented • Send NOABD Termination Notice to person served, discharge from program, remove from caseload
Death	Unplanned	• Discharge from program follow protocol for discharging deceased clients • Complete incident report

Discharge

Unplanned Discharge:

If the individual is unable to be located the practitioner will conduct assertive outreach. If still unable to locate the person served, and in compliance with program policies and approval practices, send NOABD Termination Notice to notify the person served of attempts to contact them. Include any additional information about accessing crisis services and how to reconnect with services that is not included in the standard language on the NOABD.

When an unplanned discharge occurs, the practitioner must provide necessary notifications, clarify the reasons for the unplanned discharge, determine whether further services are needed, and offer to refer to needed services. (CARF, 2.D.6)

Document efforts in the EHR, mail communication, complete the Discharge Summary and then discharge from the program using the ATD Form and remove from caseloads.

The Discharge Summary and Plan Summary includes (CARF, 2.D.5), (CARF, 2.D.3):

The Discharge Summary and Plan is a clinical document located in the medical record that summarizes and finalizes a treatment episode. It includes:

- Date of admission
- Description of the services provided
- Presenting condition
- Goals and objectives that were achieved
- Reason for discharge
- Clinical status of the client at last service
- Recommendations for services and/or supports (if appropriate)
- Date of discharge from the last program attended
- A description of person served progress in recovery or move toward well-being/gains achieved: Strengths, Needs, Abilities, and Preferences (SNAP)

The practitioner engages the person served in supported decision making and complete the Discharge Summary and Plan in the words of the person served. The Discharge Summary and Plan guides and supports the transition out of service or to the next program(s).

Admission to Evidence Based Practice, assignment to Level of Care, and assignment to Caseloads

The Admission, Transition, and Discharge ADT Form can be used for the following:

- Admit and Discharge from a treatment program
- Admit to an Evidence Based Practice
- Admit/Discharge to a Level of Care
- Discharge to the Managed Care Plans (MCP)

Caseloads Form

- Assign/adjust caseload assignment

See Avatar User Guide - Admission, Transition, Discharge (ATD) for more information.
See Caseloads Training Video – Caseloads

Service Coding and Billing

Admission, Transition and Discharge activities are functions that may be performed during a Specialty Mental Health Service (SMHS) and may be claimable to Medi-Cal. Practitioners should refer to the DBH Clinical Guide for MH Service Coding.