Title 1 **Northern Lakes Policies**
Part 107 **Supports and Services – NLCMHA Provided**
Subpart A **General**
Policy No. **107.101**
Subject **Transition/Discharge Planning**

Applicability

Policy applies to all Northern Lakes CMHA activities, operations, and sites and to all employees except members of the Northern Lakes CMHA Board of Directors.

Policy

Transition/Discharge Planning is an ongoing process that begins at the time of initiation of service and continues throughout the course of service delivery. This process shall be done in a manner that ensures continuity of care and promotes the person's rights in accordance with this and other policies/procedures. It ensures appropriate clinical care/services to persons as authorized through utilization of the Michigan Medicaid Specialty Services and Supports Contract.

Following the development of the person's Individual Plan of Service (IPOS), planning for the person's need for transition to a different level of care or to another provider within the Northern Lakes CMHA service array or for discharge from Northern Lakes CMHA shall occur as frequently as indicated by a current assessment of the person's clinical condition, needs, choices, and preferences. At a minimum, transition/discharge planning shall occur at the same frequency as the person's clinical progress/status is reviewed as specified in the person's IPOS.

Transition/Discharge planning decisions shall be based on a person's right to receive services suited to his or her condition, person-centered and family-focused practice, medical necessity criteria, and specific population or functional assessment measures.
A person shall not be transitioned to another level of care or to another provider or discharged without prior planning and the informed consent of the person and the person's legal representative when applicable.

When the person is not participating in services and has not responded to outreach by phone, mail, or in-person attempts he/she may be transitioned or discharged without prior planning and informed consent.

Persons involved in planning for a transition or for discharge shall include all of the following:

1. The person and the person's legally empowered representatives if applicable,
2. Other individuals as identified by the person,
3. The primary assigned provider responsible for developing the IPOS,

4. All personnel designated to implement services authorized in the person's individual plan of services, and
5. Providers who will provide the service to which the person will be transitioned.

If the person is transitioned within the Northern Lakes CMHA service array, the person's IPOS shall be modified in a timely manner to incorporate the new service in amount, scope, frequency, duration, commencement date, and the identity of the new service.

If the person is to be discharged from Northern Lakes CMHA, a written discharge plan shall be developed in partnership with and with the informed consent of the person and his or her legally empowered representative prior to the termination of services unless the person is not participating in services, has not responded to outreach efforts, or has died. In all cases a termination summary shall also be written.

Procedures

Transition:

1. Refer to Policy - Transition of Minors.

2. Refer to Policy - Choice, Change of Provider.

3. Refer to Policy – Transition of Service Due to Provider Availability.

4. Transition to a Different Level of Care: Transition to a different level of care occurs within the Person-Centered Planning process. It considers the clinical condition of the person, choice of person/guardian (see MDHHS Person-Centered Planning Revised Practice Guideline item 7C) and the principle of least restrictive clinically appropriate service. The transition may be to a higher intensity or a lower intensity. Transitions may be in clinical service, housing/living arrangements, employment services, etc.

5. Transition to a Different Service or Provider: Transition may occur to a different provider or clinical treatment within the same level of care. This is based on the person's needs and desires and may involve location, a specialty service, e.g. DBT or PMTO, an internal or external provider.

Discharge:

1. Discharge According to Plan: If Discharge is the result of a completed episode of treatment and/or supports, some planning and linkage to natural supports and community resources has likely occurred in the final stages of intervention. If not, it occurs in collaboration with the person and their supports at discharge. At a minimum, with proper authorizations to release information, the Northern Lakes CMHA provider with primary case responsibility notifies the referral source and the primary care provider of the discharge.

   When persons have completed some services, but continue to receive others, generally the provider concluding services will be responsible for the "Transfer/Service

Transition", communication and linkage. There may be specific circumstances where this varies based on the person's desire and the plan of service.

2. Discharge Not According to Plan: If discharge is the result of an incomplete episode of treatment and/or supports, planning and linkage to natural supports and community resources may not have occurred. Outreach efforts must occur in advance to consider discharge. Outreach efforts must include phone calls, written communication, and for community based service the provider must attempt face to face contacts at the person's residence or in the community. If efforts are unsuccessful, a closing letter for all services and Advance Notice (to terminate services) must be sent. If no communication occurs within 10 calendar days of the letter/notice then a discharge document is prepared. It is the responsibility of the person taking this action to inform all other service providers of the discharge status.

3. Discharge Secondary to Relocation: When relocation is an issue, as the discharge planning occurs, the clinician and person review continuing treatment and/or support needs and develop a plan to access continuing treatment. With the person's consent the clinician provides linkage to the new provider once appropriate releases of information are obtained. Address, phone numbers and any needed specific information is provided to the person. If the person is taking psychotropic medication prescribed by a Northern Lakes CMHA psychiatrist, the persons involved (psychiatrist, therapist, case manager, agency nurse) collaborate with the person, family, and primary care provider to arrange for uninterrupted availability of psychotropic medication. If the person/parent/guardian does not agree to linkage to a new provider, they are provided names, addresses, and phone numbers of providers in or near the new location.

   If Northern Lakes CMHA continues to be the County of Financial Responsibility for their care, Northern Lakes CMHA makes the necessary arrangements according to our County of Responsibility Policy.

   If Northern Lakes CMHA is not financially responsible, yet the person needs and wishes continued service, Northern Lakes CMHA provides linkage to mental health services in the new community.

4. Discharge After Relocation is Known: If the person moves in advance of notification of Northern Lakes CMHA, Northern Lakes CMHA attempts to locate the person and facilitate transfer at that time.

5. If Northern Lakes CMHA is unable to locate the person, but has knowledge of the location, the primary provider will send phone, address and contact information for the CMHA in the new area to the last known address of the person with a letter advising the person of the CMHA in their new area.

6. Discharge planning is consistent across all locations of service including persons who are located out of their own residence (jail, group home, foster placement, etc.).

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