

Partners In Recovery	POLICY AND STANDARDS
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Applicable Arizona Department of Health Services Behavioral Health Licensing Rule(s):

Direct Care Clinics (DCC) Policy:

Policy Number:	PRG - 2001
Policy Name:	Transfer of Care & Service Level Assessment/Assignment
Date of Inception:	
Previous Approval Date:	N/A
Current Approval Date:	

Partners In Recovery Approval(s):

		Date
		Date
		Date

Cross Reference(s)

Case Closure and Re-engagement Activity Requirements Prior to Disenrollment policy; ACT Admission/Transfer and Discharge procedure document

Policy Statement

Partners In Recovery understands that recipients may transfer from one clinic to another clinic for various reasons as defined in this policy and has established standards for ensuring that recipients are assigned to an appropriate level of care.

Purpose

To expedite the process by which recipients with a serious mental illness may transfer to another clinic once a transfer has been requested. Behavioral health recipients will be allowed to transfer between Provider Network Organization (PNO) managed clinics and Magellan managed clinics and between providers within the PNO. Recipients will be informed in writing of the ability to choose their PNO. Magellan will continue to manage the provider network outside of the PNO at the DCC. Choice is defined as movement between clinical teams. A clinical team will be defined according to R9-21, i.e., the person, case manager, nurse, doctor, and the vocational specialist. Requests to change an individual discipline will result in a transfer to a new clinical team unless the request for a change is a new case manager also assigned to the recipient's current clinical team. To describe the process for assigning consumers to an appropriate level of care.

Scope

Partners In Recovery Direct Care Clinics

Key Terms

Policy Terms & Definitions are available should the reader need to inquire as to the definition of a term used in this policy.

To access the *Policy Terms & Definitions Glossary* in MagIC, click on the below link:

Policy Terms & Definitions Glossary

Standards

- I. Required Procedures for Initiating Transfers Between PNO's, and Direct Care Clinics/Case Management Teams According to the Following:
 - A. A person or their guardian may request a transfer to a new site or clinical team or informs the case manager of his/her choice to receive services from a PNO or at another Magellan managed clinic.
 1. Upon a person or guardian's request for transfer, the Case Manager/Clinical Liaison will notify the receiving clinic of the impending transfer and document the notification in a progress note.

2. Documentation regarding the request must be completed in a progress note in Claim Trak by the referring staff member and the staff member who initially received it.
 3. Within seven (7) business days the referring Case Manager/Clinical Liaison shall compile necessary documents to be transferred to the receiving Clinic/Case Management Team.
- B. The specific type of service is not available at the consumer's current clinic or on the consumer's current team (step-up or step-down).
1. Following a discussion with the consumer and the Clinical Team to determine the most appropriate location for the consumer, the Clinical Director of the sending site will contact the Clinical Director at the identified clinic and initiate a referral.
 2. Documentation regarding the request must be completed in a progress note in Claim Trak by the referring staff member and the staff member who initially received it.
 3. Within seven (7) business days the referring Case Manager/Clinical Liaison shall compile necessary documents to be transferred to the receiving Clinic/Case Management Team.
- II. Assessing for Level of Service
- A. Partners In Recovery consumers shall be assessed as to the appropriate level of service in a manner that is consistent with the Department of Behavioral Health Services Case Management Plan. Assessment of service level must be a team process and discussed with the consumer:
- B. For a newly enrolled consumer eligible for SMI services, assignment to a level of service shall be completed as follows:
1. Evaluator assesses consumer status and makes recommendations for specific assessments to be completed at the clinical team level;
 2. Consumer assigned to local site based on ease of access and/or specialty team designation, which includes evaluation of previous services provided in other states, systems of care, children's systems, etc
 3. Local Site assigns Clinical Coordinator who assigns Clinical Liaison/Case Manager, who schedules consumer for recommended and/or required evaluations;
 4. Assessments are completed by specialists within the site and forwarded to the Prescriber;
 5. Prescriber reviews all evaluations and completes Psychiatric Evaluation within 30 days from assignment;
 6. Clinical Liaison/Case Manager updates the Functional Assessment within 90 days of the consumer's site assignment date and the written assessment is entered in the consumer's record within seven (7) days of being completed;
 7. The Behavioral Health Medical Practitioner will then assign the consumer to a service level based upon the criteria in Section III (below) as well as a discussion with

the consumer. This includes an evaluation of previous services provided in other states, systems of care, children's systems, etc.

- C. For current consumers, the Behavioral Health Medical Practitioner will screen consumers to determine whether or not a service level change is needed at each appointment. Additionally, the consumer will be reviewed for a service level change when:
1. The clinical team or the consumer requests such a review;
 2. The consumer's Service Plan is being reviewed as needed (no less than every 6 months for consumers who are eligible for SMI services; otherwise no less than every year) and the written service/treatment plan entered in the consumer's record within seven (7) days of being completed;
 3. An annual PART E is completed.
 4. **When there is a change in service level this will be documented in the next ISP/Review.**
- D. During each review, the Behavioral Health Medical Practitioner will:
1. Include the consumer in the determination of Service Level;
 2. Assess the consumer according to the criteria in Sections II, III and IV, below;
 3. Document the need for service level change, if change is needed, in the Psychiatric Progress Note or the Annual Psychiatric Update.
- E. Changes in level of acuity may result in the need for an increase or decrease in: intensity, frequency, and duration of contact, and a modification in the type of services provided. If so, this will be documented in the **next ISP/Review**.
- F. If a consumer's increased acuity level does not return to baseline within 3 months, or the consumer continues to decompensate, then the service level will be re-evaluated and modified accordingly. If the consumer is in Connective Treatment, the Behavioral Health Medical Practitioner will function as the primary contact and supportive therapist until the consumer is transferred to Supportive Treatment. There will be a low threshold for modifying the level of service when the acuity level is increased in persons in connective treatment due to the relative limited and minimal supportive services utilized.

III. Service Level Descriptions: Consumers will be assigned to an Assertive, Supportive or Connective treatment, according to outline below.

Criteria for Assigning Service Levels

- A. Assertive Community Treatment teams (ACT)
1. Within the ACT service level there are specialized Teams. The current specialty ACT teams are below. Please contact ACT Manager for updates to specialty teams.

Specialty ACT Team	Location
Homeless	Washington
Supervisory Care Home	1300 North Central
18-25 Year Old Transition Youth	West Camelback
Spanish-Speaking	West McDowell
Forensics (2)	1300 North Central
Arizona State Hospital Outpatient	1300 North Central

2. An Assertive Treatment Team shall maintain a maximum caseload of 12 consumers per clinical staff member.
 3. Referral Criteria for ACT: see ACT Admission/Discharge/Transfer policy.
 4. Transfers between and to ACT teams are expected to be completed in less than 21 days.
- B. Supportive Treatment
1. Within the Supportive service level there are specialized Teams. The current specialty teams are listed below. Contact Regional Clinical Director for updates to specialty teams.

Specialty Team	Location
Homeless	Washington
Supervisory Care Home	South Central
Arizona State Hospital Inpatient	1300 North Central
Pregnancy & Addiction	Metro

2. Case Managers working on a Supportive Treatment team shall have a maximum caseload of 30 consumers.
3. Referral Criteria for Supportive Treatment Team: Qualifying SMI DSM-IV diagnosis, severe or moderate functional impairment, and at least one of the following:
 - a) More intensive services may be needed but have been rejected despite many attempts at persuasion and/or outreach;

- b) A history of hospitalizations but no recent crisis episodes; or
 - c) Significant difficulty in managing extended periods, i.e., six months or more of recovery without additional supports and professional care.
 - d) The consumer shall be referred to supportive treatment if the consumer does not meet criteria for ACT or Connective Treatment or caseloads.
4. Transfers between and to supportive teams are expected to be completed in less than 30 days.
 5. Discharge Criteria: The consumer may be discharged from Supportive Treatment and transferred to Connective Treatment if the following criteria are met:
 - a) The consumer resides in independent housing;
 - b) The consumer has had no hospital, crisis episode or incarceration for past twelve months;
 - c) The consumer has been gainfully employed for past six months or is retired with suitable income, or satisfied with current income and involved in meaningful community activities (for example, those who are 65 and older, those whose primary daytime activity is caring for children and household, those who are in school full time, etc.); and
 - d) Able to independently access community self-help services for substance abuse recovery support and/or has developed a social recovery support network.
- C. Connective Treatment
1. Clinical Coordinators serving consumers in Connective Treatment shall have a maximum caseload of 70 consumers.
 2. Referral Criteria for Connective Treatment: Qualifying SMI DSM-IV diagnosis, moderate functional impairment, and at least one of the following:
More intensive services may be needed but have been rejected, despite many attempts at persuasion and or outreach; An extended period with no hospitalization; Documented extended stability with no major crisis episodes; Documented ability to manage illness and life with minimal assistance; Largely self-manage disability and medications; Have a developed social recovery support network if substance use if the assessment/treatment plan indicated substance use, abuse or dependence.
 3. Transfers between and to connective teams are expected to be completed in less than 30 days.
 4. Consumers receiving Connective treatment services are primarily those who require only ongoing medication monitoring to maintain continued stability. A BHMP prescribes medication and provides ongoing monitoring no less than once every 90 days. Consumers transferred to Connective Treatment will continue to receive

services from their current BHMP. Connective treatment is designed to serve consumers who are in the maintenance phase of their recovery.

5. If a consumer in Connective Treatment is in need of case management services, the Clinical Coordinator will provide that service intermittently as needed unless the consumer requires a higher level of service to meet their need, as in Section V, below. Consumers in Connective Treatment are also eligible to receive services from other service providers as needed. The consumer must be included in the decision to move to Connective Treatment.
6. Discharge Criteria: Consumers are discharged from Partners In Recovery services pursuant to the Case Closure and Re-engagement Activity Required Prior to Disenrollment policy.

D. Clinic Assignment

1. The Clinical Director at the sending clinic contacts the Regional Director for assistance in determining where the consumer will be directed.
2. Determination of the most appropriate location for the consumer will be made through joint discussions between, at a minimum, the Clinical Director of the sending clinic, Regional Director of the sending clinic and the Clinical Director and the Regional Director of the potential receiving clinic.
3. The Clinical Director of the sending clinic will ensure that documentation is prepared and delivered within 24 hours. This will be documented in Claim Trak.
4. The recipient will be notified of the decision by the sending clinic and will be assigned to the receiving clinic within 24 hours. This will be documented in Claim Trak.

E. If the Case Manager and/or Clinical Liaison and the Behavioral Health Medical Practitioner (BHMP) conclude that the requested transfer would place the person at imminent risk for harm and/or the receiving clinic is not taking any additional referrals to the clinical team, the BHMP can request approval from the Medical Director to delay the transfer until the risk is ameliorated and/or the receiving site is accepting referrals. The Medical Director shall issue a decision to the BHMP within five (5) business days.

F. Persons pending transfer due to a clinics temporary lack of capacity will be transferred in order of initial request date when the clinic resumes accepting referrals. Under these circumstances, any person unable to transfer to a site initially requested will be offered the option of transferring to an alternative open site that may better meet their individual needs.

G. It shall be the responsibility of the BHMP to:

1. Inform the Medical Director of the reason(s) for concern about the request of transfer;
2. Determine what, if any, changes should be made regarding services which would eliminate the imminent risk for harm and provide a timeframe under which the transfer would be completed, including the necessary revisions in the Individual

Service Plan (ISP) to accomplish the transfer. If the reason for the requested delay is due to the receiving clinic being closed to new referrals, the BHMP must provide the Medical Director with the projected date for transfer. The Clinical Director is responsible for entering information regarding the delay in the Unmet Needs database;

3. Inform the persons of his or her right to appeal; and
 4. Document all correspondence regarding the person's request for transfer in the progress notes section of the medical record.
- H. Prior to transfer of care, the Clinical Coordinator shall:
1. Review and update accordingly any and all documentation in the medical record to ensure completion of documentation at the time of transfer. All transfer activities should be documented in the medical record.
 2. Prepare a transfer packet to include the following medical record information:
 - a) Transfer of Care Cover Sheet
 - b) Documentation of the BHMP's recommendation for level of service (progress note indicating transfer of care/service level change)
 - c) It is expected that other relevant information can be accessed via the electronic medical record (Claimtrak).
- I. The Clinical Director shall:
1. Review transfer documentation to assure all documents have been included;
 2. Notify the Clinical Director at the receiving site; and have the transfer documentation delivered to the receiving Clinical Director.
 3. Ensure that the entire transfer process is documented in the electronic medical record (Claimtrak).
- J. Within one day of receipt of a transfer packet, the Clinical Director shall enter a progress note in the person's medical record indicating a transfer packet was received and note deficiencies, if any, with the packet.
- K. The Clinical Director shall assign the person to a Clinical Coordinator at the receiving site within one (1) business day.
- L. The receiving Clinical Coordinator shall attempt to schedule an appointment for the person to be evaluated by the newly assigned BHMP within 30 calendar days for supportive and connective and 21 days for assertive, or as clinically indicated. If this is not feasible due to BHMP schedules, the site administrator or Clinical Director will consult with the Regional Medical Director to find an alternative solution.
- M. Within three (3) business days of initial assignment, the receiving Clinical Coordinator shall contact the referring Clinical Coordinator to:
1. Provide the date and time of the first appointment with the newly assigned BHMP;

2. Schedule a date and time for the referring Case Manager/Clinical Liaison to transfer the medical record. The medical record may be transferred not earlier than two (2) business days prior to the initial appointment with the newly assigned BHMP;
 3. Schedule a date and time for the transfer staffing (this may occur on the same date as the transfer of the medical record); and
 - The purpose of the transfer staffing is to introduce the person to the newly assigned Case Manager/Clinical Liaison and BHMP to review the services the person is currently receiving as outlined in the ISP.
 4. All coordination of transfer activities shall be documented in Claim Trak and filed in the progress note section of the person's medical record.
- N. The referring Case Manager/Clinical Liaison shall contact the person to inform him/her of the date of the initial appointment and transfer staffing.
1. The person shall be encouraged to attend the transfer staffing, however, a person's refusal to attend a transfer staffing shall not delay transfer of care to the receiving clinical team. In addition, the receiving medical staff does not have to be present for the transfer to occur.
 2. The referring Case Manager/Clinical Liaison shall ensure the person has adequate transportation to the transfer staffing.
 3. The Case Manager/Clinical Liaison or another member of the clinical team must attend the transfer staffing to ensure proper coordination of care.
- O. Prior to the date of transfer, the referring Case Manager/Clinical Liaison shall maintain all required communication and provide all treatment required for the person as outlined in the ISP.
- P. The referring Case Manager/Clinical Liaison shall assure the person has transportation to the initial appointment with the newly assigned BHMP.
- Q. Prior to the date of transfer of the medical record, the sending Case Manager/Clinical Liaison shall inform the Office Manager of the intent to transfer and the anticipated transfer date via email.
- R. Prior to the date of transfer, the referring Case Manager/Clinical Liaison shall review the medical record to ensure all required documentation is complete and current.
1. If the information is incomplete or not current, the Case Manager/Clinical Liaison will complete/update the documentation within 30 days of the transfer.
 2. Missing or expired medical record documentation shall not interfere with or prevent a transfer from occurring.
- S. The Office Manager/Assistant shall enter medical record tracking information into the tracking system prior to removing the medical record from the site. The Office Manager/Assistant at the receiving site must sign the attached "Consumer Chart Transmittal Form" noting the number of volumes being received and makes the necessary changes to the clinical team affiliations in the tracking system.

- T. The medical record shall be delivered by the referring Case Manager/Clinical Liaison or designee.
- U. Transfer is complete once the medical record has been transferred to the receiving site. If the person fails to keep the scheduled appointment with the newly assigned BHMP, it is the responsibility of the receiving Case Manager/Clinical Liaison to engage in outreach efforts to determine the reason for the missed appointment and assist in rescheduling the missed appointment.

Associated Partners In Recovery Clinic Forms & Attachments

Transfer Cover Sheet

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