

Effective Date: 6/25/2004
Revised Date: 2/4/2008
Review Date:

North Sound Mental Health Administration

Section 1500 – Clinical: Intra-network Consumer Transfers and Coordination of Care

Authorizing Source: Per NSMHA

Cancels:

See Also:

Responsible Staff: Quality Manager

Approved by: Executive Director

Signature:

Date: 3/3/2008

POLICY #1510.00

SUBJECT: INTRA-NETWORK CONSUMER TRANSFERS AND COORDINATION OF CARE

PURPOSE

To assure continuity and coordination of care for Medicaid and other North Sound Mental Health Administration (NSMHA)-eligible consumers between provider agencies.

POLICY

There are certain services within the NSMHA region that are offered by some providers, but not others. It is the policy of NSMHA to ensure that consumers, upon their request, are transferred to the provider(s) who has/have the capacity to meet their service needs. In some cases, it is appropriate for consumers to remain enrolled with a given provider for some of their services, augmented by specific services from another provider(s). The following procedure differentiates and describes the transfer and coordination processes.

Generally, consumers will transfer to another agency when the services requested are duplicative of the services they are currently receiving. If the services requested augment the current services, then coordination of care between agencies shall be considered unless the consumer requests transfer of all care.

Each agency in the North Sound Mental Health Administration region shall have a process in place for providing services as a secondary agency including: designating a contact person, setting assessment appointments, clinical management of care and data management.

PROCEDURE

Transfers

Prior to initiating a consumer transfer from one agency to another, the consumer or legal guardian shall be requested to sign a release of information allowing clinical documentation to be shared between the agencies involved. The transfer process cannot be fully facilitated by the clinician without a release of information. During the transfer process the consumer will have charts open in both agencies. The transferring agency retains overall responsibility for consumer care until completion of the transfer process. Completion occurs when the receiving agency indicates to the initial agency (1) that it accepts responsibility for overall consumer care (including medication management, if applicable) and (2) that the initial agency can close its consumer chart. When a consumer transfers from one NSMHA agency to another, the start and end dates of the outpatient authorization and residential approval, if applicable, remain the same.

If the plan is to transfer the client to a specific program that has limited capacity, such as Wraparound or Intensive Outpatient for Adults/Older Adults, then the transferring clinician must first contact the other agency to determine if space is available. If space is not available, the agency shall not transfer the

consumer unless he/she still requests the transfer for regular outpatient services at the other agency. If space is available, the transferring agency clinician shall complete the appropriate referral form to NSMHA for approval. If NSMHA approves the service, the transferring clinician shall follow the transfer process as described below.

The transferring agency primary clinician coordinates transfer of the consumer to the receiving agency by (a) assisting the consumer through coordination with Volunteers of America-Western Washington (VOA) ACCESS and the receiving agency's scheduler to transfer all applicable Management Information System (MIS) data and to schedule the initial assessment appointment at the new agency; (b) sending completed authorization for release of information; and (c) providing the following items to the receiving agency prior to the consumer's initial assessment appointment at the receiving agency:

1. Most recent assessment
2. Most recent Child and Adolescent/Level of Care Utilization System (CA/LOCUS) form
3. Global Appraisal of Individual Needs – Short Screener (GAIN-SS) form
4. Current treatment plan
5. Health and Medical Information form
6. Behavioral and Development form, if applicable
7. Progress notes covering the last 30 days of treatment with additional progress notes when clinically indicated
8. The last three prescriber notes, if applicable
9. Last psychiatric evaluation, if applicable
10. Last Treatment Plan (180-Day) Review, if applicable
11. Medication list (current and historical), if applicable

The ACCESS Clinician completes the ACCESS Call Record. The ACCESS Clinician contacts the scheduler at the receiving agency and follows standard procedures for obtaining an appointment and transferring the MIS information to the new agency. At this point the consumer will be open at both the transferring and receiving agencies.

The receiving agency must offer the consumer an initial assessment appointment within the standard ten business days (not to exceed 14 calendar days) from the date the referral is made and must follow all other procedures and requirements for new consumers except where otherwise noted. Since the consumer is in an open authorization period, the assessment does not need to establish eligibility per the state's Access to Care Standards.

If the consumer does not attend their assessment appointment at the receiving agency, the receiving clinician contacts the transferring clinician notifying them that the consumer did not show. Receiving clinician follows assessment "no show" protocol and closes the case if indicated. The transferring clinician attempts to follow up with the consumer and closes the case if indicated.

If the receiving clinician accepts the consumer into services, the receiving clinician contacts the transferring clinician noting that the receiving agency (a) has accepted responsibility for treatment, including medication management, if applicable, and (b) that the transferring agency may close its record. The primary clinician at the transferring agency sends closing documents to MIS for entry.

When prescriptive services are being transferred, the transferring agency will provide the consumer with a prescription for medications for up to 60 days unless this is not clinically indicated and the two agencies

have agreed to an alternative plan. The receiving agency will schedule a medication evaluation within 30 days unless otherwise indicated by the mutually agreed upon plan.

If the receiving clinician believes the transfer warrants further discussion, the receiving clinician first discusses the issues with the consumer and then contacts the receiving agency's clinical director. The receiving agency's clinical director contacts the transferring agency's clinical director. Agency clinical directors discuss and develop a plan for the best way to meet the consumer's need. A plan is developed within 30 days of consumer's assessment date at the receiving agency. The transferring agency retains responsibility for the consumer's care during this period of time. An agency's decision not to serve a consumer should occur only in rare instances.

Receiving and transferring clinicians follow through with agreed upon plan. If agreed upon plan for referral is community resources, one agency will be identified to case manage the referral. The case will not be closed until appropriate resources are in place, provided the consumer is willing to follow through with referrals.

Coordination between agencies:

Prior to initiating additional services at another agency, the consumer or legal guardian shall be requested to sign a release of information allowing clinical information to be shared between the agencies involved. Coordination of care between agencies cannot be facilitated by the clinician without a release of information. The primary agency clinician shall then contact the agency where the desired service is located (secondary agency).

If the secondary agency is unable to accommodate the request because the service is at capacity, the primary agency shall be directed to check back at a later date. Waiting lists shall not be utilized. If the secondary agency agrees to provide the requested service to the consumer, all agencies involved in providing services for a single consumer shall ensure there is a clear understanding of which agency is primary and what services each agency is providing. The primary agency maintains responsibility for the consumer's care including crisis management.

The primary agency clinician coordinates services by (a) calling the designated contact at the secondary agency to arrange an initial appointment for assessment and assuring all applicable MIS data is available, (b) sending completed authorization for release of information, and (c) providing the following items to the receiving agency prior to the consumer's assessment appointment at the other agency:

1. Most recent assessment
2. Most recent CA/LOCUS
3. GAIN-SS
4. Current treatment plan
5. Current consumer and clinician crisis plans
6. Health and Medical Information form
7. Behavioral and Development form, if applicable
8. Progress notes covering the last 30 days of treatment with additional progress notes when clinically indicated
9. The last three prescriber notes, if applicable
10. Last psychiatric evaluation, if applicable
11. Last Treatment Plan (180-Day) Review, if applicable
12. Medication list (current and historical), if applicable

If the secondary agency, upon completion of the assessment, confirms that they will provide the requested service(s), the secondary agency's clinician shall contact the primary agency to 1) notify the primary agency of the provision of the requested service and 2) identify who will be responsible for the consumer's care and be the ongoing point of contact at the secondary agency. The secondary agency will also need to set up an outpatient episode or special episode, but shall not set up the episode as the primary outpatient episode.

If the secondary agency, upon completion of the assessment, determines that they will not provide the requested service(s), the secondary agency's clinician discusses the issues with the consumer and contacts the secondary agency's clinical director. The secondary agency's clinical director contacts the primary agency's clinical director. Agency clinical directors discuss and develop a plan for the best way to meet the consumer's need. A plan is developed within 30 days of consumer's assessment date at the receiving agency. An agency's decision not to serve a consumer should occur only in rare instances.

All agencies involved in a consumer's care must maintain a complete clinical chart. The secondary agency may obtain copies of certain documents from the primary agency with a release of information, but shall complete their own versions of the following documentation:

1. Release of information between the primary agency and the secondary agency providing service
2. Initial assessment
3. Current treatment plan – the plan should be complete and identify any needs being addressed by other agencies in addition to those being addressed by clinician's own agency
4. Progress notes
5. Documentation of coordination of care such as phone calls, exchange of relevant clinical information, etc.
6. Treatment Plan (180-Day) Reviews

The secondary agency does not complete a new crisis plan, CA/LOCUS form, GAIN-SS form or Telesage. This information, along with other documents provided prior to assessment, shall be provided to the secondary agency by the primary agency.

The primary agency is also responsible for maintaining a current authorization as medically necessary. However, the secondary agency shall also be aware of the authorization end date and communicate with the primary agency regarding the necessity of continued services. If the primary agency ends an episode of care or does not request reauthorization of services, this information shall be communicated to the secondary agency prior to disposition. The consumer may request a transfer to the secondary agency or another agency.

In cases where transfer to the secondary agency is requested, the primary agency clinician shall contact the secondary agency clinician to arrange transfer of care. This transfer process shall not go through ACCESS as an intake assessment has already been completed. The secondary agency becomes the primary agency and shall close the current outpatient episode and open a new one as the primary agency. The transferring agency shall ensure that the receiving agency has all required documentation as indicated previously and the receiving agency shall complete (e.g. crisis plan, CA/LOCUS form, GAIN-SS form, Telesage) and update (e.g. treatment plan) forms as needed to maintain a complete clinical record. The primary clinician at the transferring agency sends closing documents to MIS for entry.

For those consumers for whom prescriptive services are being transferred or the two agencies do not agree on the necessity of transfer, follow the regular transfer procedure for these situations. Also, if the consumer wants to transfer to an agency other than the secondary agency, follow the regular transfer process.

If the consumer will no longer be receiving services from the secondary agency, the secondary agency shall notify the primary agency and use the appropriate disposition code. The disposition code used shall be one that will not be transmitted to NSMHA indicating the end of an episode of care.

ATTACHMENTS

1510.01 – Guidelines for Transfer or Coordination of Care by Service