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Clinical	C		340.1
Subject Title	Adopted	Last Revised	Reviewed
Service Delivery	06/02/03	12/6/19	09/05/06; 4/7/10; 2/13/14; 9/12/16; 4/25/17; 6/23/17; 2/14/19; 11/4/19; 12/6/19

PROCEDURE

Application

This procedure shall apply to the clinical services of The Right Door for Hope, Recovery and Wellness.

Screening

At the time of initial contact, an Access Therapist or designee shall obtain and document necessary demographic, insurance, presenting problem and preference information, and the person served shall be offered a screening appointment on the same day as the request is made with a clinician. If the person served cannot be seen the same day as the request for services, then they will be seen no later than 10 business days from the time of request. The person served will be informed of the program they are being referred to at the time of screening if they qualify for services. If the person served does not qualify for services, an Access Therapist or designee will connect the person served to a more appropriate service provider whenever possible. The Access Therapist or designee should always try to provide a warm handoff. The Program Manager or Program Supervisor will assign a primary clinician to work with and coordinate services for the referred person served. The primary clinician will follow up with the person served and set an initial appointment within five business days.

1.0 Person Served Orientation/Ability to Pay Process

1.1. Upon arrival for intake and assessment, the person served and/or their legal representative shall meet with the Ability to Pay Specialist or designee to review orientation materials, the fee schedule/financial obligations and insurance guidelines, and complete the financial determination.

1.2. At any time, a person served may request an explanation of fees and financial obligations, regardless of the source of payment. Requests shall be forwarded and handled by the Fiscal Department.

1.3. Orientation materials shall include an explanation of the rights and responsibilities of the person served, person served handbook including grievance and appeals procedures, standards of conduct, person-centered planning and the role in the PCP process of the person served, agency services and activities, hours of operation, access to after-hours services and privacy practices.

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1.4. All involved staff members shall ensure that documentation is completed at each step of the intake process.

2.0 Persons Served Education

The Right Door for Hope, Recovery and Wellness plans, supports and coordinates individual and family education activities and resources.

The Right Door for Hope, Recovery and Wellness shall provide education and training to the person served, family and/or caregiver specific to the assessed needs of the person served, their abilities and their preparedness.

3.0 Monitoring

3.1. Progress notes shall be used to summarize the progress of the person served towards identified goals. A progress note shall be completed after each face-to-face contact with the person served, non-face-to-face contacts or pertinent collateral contacts.

3.2. Periodic reviews, at a frequency determined within the person-centered plan, shall be used to evaluate and monitor the satisfaction with services and progress toward identified goals of the person served.

3.3. Assessment scales (i.e. PHQ, PHQ-A, CAFAS, PECFAS, DECA, ABA scales), at a frequency deemed appropriate by the clinician, shall be used to evaluate and monitor effectiveness of services and progress.

3.4. The primary worker will monitor the progress of the person served of all services authorized in the Person-Centered Plan. This includes coordinating with other providers. When multiple services are authorized, there shall be a concerted effort to eliminate duplication of services.

4.0 External Referrals

4.1. If in the course of assessment and person-centered planning it is deemed necessary to refer a person served outside of the agency for care, the primary worker will assure that the person served (and families or caregivers/guardians of the persons served who are

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children and youth), according to the preference of the person served, obtains appointments with external providers. The primary worker will do this by.

4.1.1. Documenting in the record when the outside referral was first provided as well as the planned date of the appointment.

4.1.2. Following up with the external provider to ensure that the person served made the appointment and documenting date of confirmed appointment. If the person served did not make the appointment, then the primary worker will assist the person served in rescheduling the appointment.

4.1.3. Primary worker will assist the person served, according to their preference, in problem solving any barriers to getting their appointments, i.e. transportation.

4.2. The primary worker will always ensure that appropriate releases of information for the authorization of the release of confidential records of the person served are in place before communicating with any external provider in accordance to all privacy and confidentiality laws.

4.3. The following services will be available to all people served by SUD Services, either internally or through the referral process (a resource list is included in all SUD orientation and annual service packets):

- Education
- Vocational counseling and training
- Job development and placement
- Financial counseling
- Legal counseling
- Spiritual counseling
- Nutritional education counseling

5.0 Internal Referrals

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When a primary worker or person served, through ongoing assessment, identified that a different or more appropriate serve would be beneficial, the person served shall be transferred or referred to the team which can provide the identified service. If the services are not available from within the agency, the person served shall be referred to another community resource.

5.1. Primary staff discusses transfer/referral with their own supervisor.

5.2. When possible/feasible, primary staff discusses possible transfer/referral with person served/family to ensure person served is agreeable and/or informed about the potential change. Note: If a person served has a guardian or other significantly involved support or caregivers, the involvement of these individuals must also be considered, and included when appropriate, throughout the transfer/referral process.

5.3. Clinician will send an email to direct supervisor with explanation of requested program, including CAFAS, symptoms, goals to work, etc. The supervisor will then forward this email to the supervisor of the new program.

5.3.1. For ABA, behavioral supports, and OT, an ABA referral form also needs to be sent to the new program supervisor.

5.4. If the new supervisor approves the transfer/referral, clinician then updates the assessment to reflect the updated information and disposition with the explanation of change in the disposition.

5.5. Clinician will send program staff change form adding new program.

5.6. New program supervisor assigns the person served to a clinician.

5.6.1. For Outpatient, supervisor and previous clinician will set up the transfer meeting together, which will determine the new clinician.

5.7. Transfer meeting to be set up between current clinician and new clinician. This meeting is for both clinicians to attend.

5.8. At transfer session, previous clinician will complete Periodic Review and new clinician will complete Treatment Plan and add authorizations for new program.

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5.9. Two exceptions:

5.9.1. Referrals for groups: If the person served/family is joining a group, the referring clinician is responsible for informing the group facilitator of the new referral for group. Group facilitator will add the person to the applicable group on the Mygroup section of the Dashboard. Also, introduction may be made at the first group and after the documentation is completed, as opposed to a separate meeting.

5.9.2. Medication Services: Introduction is made at the time of the initial psychiatric evaluation with the psychiatrist.

5.10. Once the transfer/referral occurs, the referring clinician and referring supervisor follow up with the receiving clinician and receiving supervisor to ensure services are occurring as scheduled.

5.11. Once the transfer/referral occurs, the receiving supervisor conducts follow-up with the receiving clinician, including discussions in supervision, to ensure that the person served/family transfer/referral occurred as planned and that services are occurring as scheduled for the new person served/family.

5.12. All internal transfers will occur within 10 calendar days.

5.13. Transfer or referral documentation process for referring between service type/programs:

5.13.1. The original primary clinician completes the referral transfer form in the electronic health record.

5.13.2. The two staff meet with the person served/family to do the PCP addendum. The transferring/referring supervisor reviews and signs the addendum. Note: Steps 1 and 2 may be interchangeable or occur concurrently, depending on the circumstances with the person served/family.

5.13.3. The receiving clinician and supervisor complete their portion of the form and the supervisor signs.

5.13.4. Any and all meetings, phone calls and/or letters send concerning the transfer/referral are documented in the person served/family record.

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5.14. Transfer or referral documentation process for referring between workers with the same service type/change of primary clinician within same service:

5.14.1. The two staff meet with the person served/family for a joint first meeting and "warm hand off." This is to introduce the person served/family to the new staff, to become acquainted with each other and to have a discussion on current services of the person served/family, a general review of the plan, type and frequency of the services being provided and status towards goals.

5.14.2. The receiving clinician submits a change of status email informing Medical Records of the change in primary worker.

5.14.3. Any and all meetings/phone calls and/or letters sent concerning the transfer/referral are documented in the record of the person served/family.

6.0 Missed or Cancelled Appointments

Each worker shall address and document missed or cancelled appointments.

6.1. For any missed (no shows) or cancelled appointments, the primary clinician should attempt at least two times to follow up and reschedule. These follow-up attempts must be documented. After the second time, the clinician is responsible for sending or requesting that Medical Records send the agency "Outreach Letter" to the person served.

6.2. The specific circumstances of the person served should be considered when providing follow-up contacts to ensure that they are occurring in clinically appropriate ways.

7.0 Termination of Services

7.1. The primary clinician will first discuss termination with the person served/family whenever possible (unless person served is not physically available for meeting, e.g., or is unable to be found/contacted). Note: If a person served has a guardian or other significantly involved support or caregivers, the involvement of these individuals *must also be considered,* and included when appropriate, throughout the termination process.

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7.2. The primary clinician shall then discuss termination of the person served/family with their supervisor. Note: If a person served receives other services, the primary clinician must also discuss/consult regarding the termination of the person served/family with all involved staff.

7.3. Termination processes shall continue if supervisor determines that the person served/family meets at least one of the following criteria for discharge:

7.3.1. Person served/family has achieved all treatment goals to the satisfaction of the person served.

7.3.2. Person served/family no longer meets medical necessity for services.

7.3.3. Person served/family specifically requests that they be terminated from services.

7.3.4. Person served/family has left the service area.

7.3.5. Person served/family has not returned for services, despite primary clinician's assertive attempts to try and connect with the person served/family (by phone, letters and unscheduled home visit attempts when appropriate).

7.3.6. Death of the person served.

7.3.6.1. A discharge summary is to be completed by the clinician when a death of a person served occurs.

7.4. The primary worker completes any final meetings with the person served/family, whenever possible, to "wrap up" services and to discuss referral to services or resources outside of the agency, if needed, and discuss the process for reconnecting with CMH services in the future if needed. This may include an aftercare plan that reflects appropriate community resources, services and referrals.

7.5. The primary worker completes the advance/adequate notice, signs it, and messages the supervisor that the person served is closing. Staff starts the discharge summary document in the Electronic Health Record.

7.6. If the supervisor approves the termination, then the supervisor will forward the message to Medical Records and the primary worker.

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7.7. Medical Records will print and mail out the advance/adequate notice and track the termination within a separate termination database.

7.8. Medical Records will create a flag on the person served that they are in the process of closing and enter a start and end date on the flag.

7.9. Once the elapsed time has passed, Medical Records will message staff informing them that they can complete the discharge summary.

7.10. Medical Records will then close the program and episodes.

7.11. Staff completes the discharge summary, messaging supervisor for review if needed.

7.11.1. NOTE: IF THE DISCHARGE SUMMARY NEEDS TO BE CO-SIGNED BY THE SUPERVISOR, THE STAFF WILL ADD THEM AS A CO-SIGNOR.

7.12. Exceptions to Providing and Advance Notice

7.12.1. An advance notice is required if you are terminating all agency services (i.e., terminating for the purpose of closing the case completely), **UNLESS** one of the following occurs:

7.12.1.1. Closing due to death of the person served; or

7.12.1.2. Person served/parent/guardian has signed a clear written statement that they no longer wish to receive services; or

7.12.1.3. The whereabouts of the person served are unknown and the post office returns the mail of The Right Door for Hope, Recovery and Wellness directed to the person served, indicating no forwarding address; or

7.12.1.4. Person served has been accepted for services by another CMH.

7.12.2. In the above cases where an advance notice will **NOT** be sent, the supervisor will notify Medical Records by noting it on the termination “request” form and will include the reason why a notice is not needed (noting one of the 4 reasons above).

8.0 Update Status of Person Served

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The primary worker of each person served shall ensure that changes in the demographic information of program services of the person served are kept current in the clinical record.

9.0 Follow-up to Inpatient Stays

Face-to-face follow-up contact should occur within 24 hours of discharge from inpatient stay and should be coordinated and scheduled during discharge planning.

Kerry Possehn, Chief Executive Officer	Date		