Chapter Title Clinical	Section # C		Subject # 340
Subject Title **Coordination of Care**	Adopted 7/28/03	Last Revised 7/22/19	Reviewed 6/20/05; 7/24/06; 8/21/07; 6/29/09; 7/12/10; 6/27/11; 5/29/12; 5/28/13; 7/28/14; 5/18/15 5/23/16; 6/26/17; 6/25/18; 7/22/19; 7/27/20; 8/23/21

POLICY

Application

This policy shall apply to the services and supports of The Right Door for Hope, Recovery and Wellness persons served.

1.0 Initial Assessment

In order to ensure continuity and coordination of supports, services and health care, each person served will be assigned a primary case coordinator or therapist.

1.1 The primary case coordinator/therapist will assure that each assigned person served receives:

1.1.1 Orientation
1.1.2 Assessment(s)
1.1.3 Person Centered Plan Pre-planning
1.1.4 Person Centered Plan within legally required time frame specifying the delivery of supports and services
1.1.5 Coordination and linkages with other providers working with person served
1.1.6 Transition and discharge planning
1.1.7 Integrity and completeness of the medical record

2.0 Health and Safety

The planning and the provision of supports and services for all persons served shall consider the presence of health and safety issues. Supports and services shall be delivered in such a manner as to limit or avoid significant risk to the health and safety of the person served, and in coordination with the health care providers of the person served.

3.0 Coordination of Health Care Services and Supports

Medical and other health care services that are provided by The Right Door for Hope, Recovery and Wellness shall be coordinated with the primary physician of the person served and other health care providers for the purpose of ensuring safety, accessibility, coordination, quality, efficacy, and efficiency of care.

4.0 Linkage to Appropriate Care

The primary case coordinator/therapist shall link the person served to other providers as indicated by the person-centered assessment of the person served and monitor and problem solve issues regarding service provision, including person served and guardian satisfaction of services.

The primary case coordinator/therapist shall prepare written transition and discharge plans to ensure a seamless transition when a person served is transferred to another level of care or

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service, either within or outside of The Right Door for Hope, Recovery and Wellness, and shall be responsible for communicating with those services, programs, and/or providers, as allowed by the person served or their guardian or legal representative, to ensure a coordinated transition.

4.1 Linkage to Appropriate Care – Danger to Self or Others

When case coordinators/therapists assess a person served to be a danger to self or others, that staff shall immediately respond and provide crisis response services and as appropriate, make referrals to agencies or resources that can best prevent any harm to the person served and others.

When a person is discharged or removed from a service for aggressive and/or assaultive behavior, follow-up will occur within 24 hours post-discharge to ensure linkage to appropriate care.

5.0 Transition and Discharge

Transition services are critical for the support of the ongoing recovery or well-being of the person served. Transition or discharge planning is initiated as soon as clinically appropriate in the person-centered planning and service delivery process and assists persons served to move from one level of care to another within our organization or to obtain services that are needed but are not available within the organization. Transition planning will occur according to organization policy and procedures.

Transition may include planned discharge, movement to a different level of service or intensity of contact. The transition plan is developed with and for the person served and other interested parties to guide the person served in activities following transition/discharge to support the gains made during participation in services. It is prepared with the active participation of the person served when they move to another level of care. The transition plan is meant to be a plan that the person served uses to identify the support that is needed to prevent a recurrence of symptoms or reduction in functioning. It is expected that the person served and appropriate parties receive a copy of the transition or discharge plan.

References

CARF Standards, Transition/Discharge
MDHHS/CMHSP and Managed Specialty Supports and Services Contract, Person Centered Planning Practice Guidelines and Collaboration with Community agencies; Section 6.4.3

Melissa McKinstry, Board Chairperson	Date		