Title: Program Transfer and Referral Policy

Prepared By: Clinical Director

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Purpose:

To define the process and protocols for transferring consumers to services to more appropriately meet their needs.

Scope:

This procedure applies to all employees (including full-time employees, part-time employees, contractual providers, volunteers, students, and/or interns) of Huron Behavioral Health (HBH) and all consumers served.

Information:

- HBH makes every effort to place consumers in the most appropriate and least restrictive services possible and to meet the medical necessity guidelines as defined in the Medicaid Provider Manual.
- A consumer's services are determined and authorized through the Person Centered Planning (PCP) process (see also "PCP Policy" - QI.1.05 and "PCP Procedure" QI.2.18). As needs change throughout the course of treatment, additional services or reduced services may be appropriate. If services are changed, the primary worker must complete a referral record in the Electronic Medical Record (EMR) to document the changes in services.

Policy:

1. The primary worker is responsible for determining when referrals and transfers are appropriate and also for documenting all referrals and transfers in the consumer's case record. Specific cases should be discussed during staff meetings and with the program supervisor, as well as with other program supervisors who are impacted by the referral/transfer. The primary worker, their supervisor, and the receiving program supervisor will typically meet to discuss the consumer's progress toward their goals and to evaluate the need for:
   - Current services
   - Changing services to a more intensive service program
   - Changing services to a less intensive service program
   - Referring the consumer to services outside of the agency
2. If it is determined that a consumer no longer requires a current service, the treatment team will review the case, determine recommendations, and implement the necessary transition and follow-up activities.
3. Current services should continue until the consumer begins receiving the recommended services.
4. If services defined in the individual's PCP are reduced, suspended, or terminated, Medicaid consumers must be notified in writing at least ten (10) calendar days prior to the proposed effective date (note – for General Fund consumers the requirement is 30 days before the action occurs) using the Advance Notice form (in EMR). (See also "Appeals and Grievance Procedure" RR.2.36.)
5. The Primary Worker must complete a "Referral Form" (in EMR).

Definitions/Acronyms:

Definitions:

Discharge – a "discharge" from services is when a consumer's case has been closed and services are no longer being provided by HBH.

Program Change – is a term used to identify when a consumer's services change. A change can also mean additional service(s) are added or removed

Transfer – is a term used when a consumer leaves the services of one program and begins services in a different program or in an additional program

Acronyms:

COA – Council On Accreditation
EMR – Electronic Medical Record
HBH – Huron Behavioral Health
PCP – Person Centered Plan

Forms:

Referral Form (in EMR)
Advance Notice Form (in EMR)

Records:

Records of transfers are retained in HBH's EMR system in the consumer case record in accordance with the "HBH Record Retention & Storage Policy" (QI.1.23).

Reference(s) and/or Legal Authority

COA standards
QI.1.05 Person Centered Plan (PCP) Policy
QI.1.23 HBH Record retention & Storage Policy
QI.2.18 PCP Procedure
RR.2.36 Appeals and Grievances Procedure

Change History:

Change Letter	Date of Change(s)	Changes
None		Old procedure brought into new Controlled Documentation format with minimal content changes.
A	05/25/06	Added form numbers (#4 & "Forms" section) to reflect new regional Advance & Adequate forms (removed 90-267 & 90-268 and added 100-013, 100-014, 100-015, 100-016), added "AAM" to "Acronym" section.
B	09/11/07	Revised to include the new regional "Transfer/Program Change/Discharge Form" (90-1001) and removed all references to the old HBH forms (90-051 & 90-038), added "EMR' to "Acronym" and "Records" sections, added "Definitions"
C	01/28/09	Reviewed and revised to comply with COA 8th Edition Standards and present practices – removed COA chapter-specific reference (G9 & S5), reworded numerous sentences without changing content, added reference to RR.2.6 (Appeals & Grievance Procedure) 2 places,
D	06/05/13	Reviewed and revised to comply with 8th edition COA standards – in #4 removed "standardized regional" and "from Access Alliance of Michigan (AAM)", in #5 changed "file it in" to "forward to be scanned into", in "Forms" section removed "(regional form)' from 90-1001, deleted second sentence in "Records" section which referred to Gallery/EMR and added "in EMR" to first sentence, removed "CMHC" and "AAM" from "Acronym" section.
E	05/31/16	Removed form numbers and changed names of forms to match current EMR form names, in "Policy" section #4 removed "the appropriate adequate or" and added "12 calendar days", #5 removed reference to scanning the document into the consumer's case record and entering CMHC demographic data, in "Forms" section removed "Adequate Notice Form" made several additional minor grammatical/wording changes/corrections throughout document without changing sentence content.
F	03/13/18	In "Policy" section #4 changed "twelve (12) calendar days prior to the change" to "at least ten (10) calendar days prior to the proposed effective date (note – for General Fund consumers the requirement is 30 days before the action occurs)", made several minor wording/grammatical changes/corrections throughout document without changing sentence content.