Chapter Title Clinical	Section # C		Subject # 340.1
Subject Title Service Delivery	Adopted 06/02/03	Last Revised 3/4/24	Reviewed 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; 6/30/2020; 9/16/21; 10/5/2021; 9/9/22; 9/12/23; 3/4/24

PROCEDURE

Application

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

1. Screening

1.1. 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 identifies as, or is screened as, being in crisis (emergent) enhanced screening or assessment, as appropriate, shall occur immediately. If a screening reveals an urgent need, the assessment must be completed within one day and within 14 days for requests of a routine nature. 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 provide adverse benefit determination or action notice and 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 when referring outside of the agency. Access Therapist or assigned Care Coordinator will follow up to ensure the person gets connected to the outside referral. 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 13 days from the assessment date for first service.

1.2. If during a screening unsafe substance use, including problematic alcohol use, is identified, the clinician shall provide a brief intervention and then

provide a comprehensive assessment and then treatment or referral to appropriate treatment.

2. Person Served Orientation/Ability to Pay Process

2.1. Upon arrival for screening and/or intake 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.

2.1.1. When providing services through telehealth, the screening and assessment will occur first and then Ability to Pay Specialist or designee will follow up via phone/telehealth to obtain financial information and complete orientation with persons served.

2.2. 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.

2.3. Orientation materials shall include consent to treat, an explanation of the rights and responsibilities of the person served, person served handbook including grievance and appeals procedures and advanced directives, standards of conduct (code of ethics), person-centered planning and the role in the person centered planning process of the person served, agency services and activities, hours of operation, access to after-hours services and privacy practices, provider listing (including substance use services if requested), office closures, email/text procedure, policies on use of tobacco/illegal/legal substances and weapons on The Right Door properties.

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

3. Persons Served Education

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.

4. Care Coordination

4.1. For the services provided without a case manager component to them, a care coordinator will be assigned as needed to assure quality care coordination and monitoring. Care coordinators and primary clinicians shall coordinate care across the spectrum of health services, including access to high-quality physical health (both acute and chronic) and behavioral health care, as well as social services, housing, educational systems, and employment opportunities as necessary to facilitate wellness and recovery of the whole person. The benefits of care coordination are achieved primarily through referrals and through the exchange of important person served information like health, social, emotional and spiritual needs as well as preferences on treatment (where information exchange is contemplated in the agreement and consented to by the consumer).

4.2. Care Coordination activities include, but are not limited to:

4.2.1. Organization of all aspects of a beneficiary's care.

4.2.2. Management of all integrated primary and specialty medical services, behavioral health services, physical health services, and social, educational, vocational, housing, and community services.

4.2.3. Information sharing between providers, patient, authorized representative(s), and family.

4.2.4. Resource management and advocacy.

4.2.5. Maintaining beneficiary contact, with an emphasis on in-person contact (although telephonic contact may be used for lower-risk beneficiaries who require less frequent face-to-face contact).

4.2.6. Appointment making assistance, including coordinating transportation.

4.2.7. Development and implementation of care plan.

4.2.8. Medication adherence and monitoring.

4.2.9. Referral tracking.

4.2.10. Use of facility liaisons.

4.2.11. Use of patient care team huddles (short, daily meetings where the care team can discuss schedules, address care coordination needs, and problem solve).

4.2.12. Use of case conferences.

4.2.13. Tracking of test results.

4.2.14. Requiring discharge summaries.

4.2.15. Providing patient and family activation and education.

4.2.16. Providing patient-centered training (e.g., diabetes education, nutrition education, etc.).

4.2.17. Monitoring authorizations for SUD services

4.2.18. Connection of beneficiary to resources (e.g., smoking cessation, substance use disorder treatment, nutritional counseling, obesity reduction and prevention, disease-specific education, etc.)

5. Health Screens

5.1. A Registered Nurse shall provide an annual health screen to all persons served under the Certified Community Behavioral Health Clinic (and offered to all persons) by The Right Door or contracted provider. Health screens will focus on healthy lifestyle, nutrition, and chronic medical condition screening. Nurses will screen and then provide follow up education, coordination of care with primary care provider and specialty referrals as needed.

5.2. Health screens may be provided in any of the three office locations, via telehealth (but will need to come in at some point for vitals, weight, height, waist circumference) or at a person's residence.

5.3. Health screens need to be in the treatment plan.

5.3.1. For persons served not open to Medication services: The program is "Primary Health Screen." Clinicians shall authorize as 4 units of RN services.

5.3.2. If person served is already open to Medication Services program the annual health screen is already included in the bundled services.

5.4. The following is reviewed at the time of the health screen:

5.4.1. BMI. If abnormal, education will focus on nutrition and exercise in an age/developmentally appropriate format.

5.4.2. Waist Circumference. When waist is more than 35" for women or more than 40" for men, education must be provided. Education will focus on heart disease information.

5.4.3. Smoking status. Smoking cessation options will be provided.

5.4.4. Vital Signs. If high blood pressure, discuss education on heart disease.

5.4.5. Substance Use. Review of alcohol, marijuana and recreation drug use. Education on SUD services and referrals.

5.4.6. Depression screening and follow up.

5.4.7. Chronic health condition screening and follow up.

5.4.8. Stress level screening and follow up.

5.4.9. Sleep status and follow up on education on sleep hygiene.

5.4.10. Child Well Being. If areas of concern education to family/guardian and referral as needed.

6. Monitoring

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

6.2. Periodic reviews, at a frequency determined within the person-centered plan (but not less than every 6 months), shall be used to evaluate and

monitor the satisfaction with services and progress toward identified goals of the person served.

6.3. Assessment scales (i.e. LOCUS, PHQ-9, PHQ-9A, CAFAS, PECFAS, DECA, ABA scales, UCLA, GAD-7, Columbia Suicide Severity Rating Scale), at a frequency as required by the utilized assessment scale, shall be used to evaluate and monitor effectiveness of services, symptoms and progress.

6.4. 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. Community-based clinicians will monitor care coordination while Care Coordinators will monitor care coordination for office-based clinicians. When multiple services are authorized, there shall be a concerted effort to eliminate duplication of services.

7. External Referrals

7.1. If in the course of assessment and/or person-centered planning it is deemed necessary to refer a person served outside of the agency for care, the primary worker/care coordinator will assure that the person served (and families or caregivers/guardians of the persons served who are children and youth), according to the preference of the person served, obtains appointments with external providers. The primary worker/care coordinator will do this by:

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

7.1.2. 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/care coordinator will assist the person served in rescheduling the appointment.

7.1.3. Assisting the person served, according to their preference, in problem solving any barriers to getting their appointments, i.e. transportation.

7.2. 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.

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

7.3.1. Education

7.3.2. Vocational counseling and training

7.3.3. Job development and placement

7.3.4. Financial counseling

7.3.5. Legal counseling

7.3.6. Spiritual counseling

7.3.7. Nutritional education counseling

8. Internal Referrals

When a primary worker or person served, through ongoing assessment, identified that a different or more appropriate service 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.

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

8.2. 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.

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

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

8.4. Current supervisor will review the assessment update as appropriate prior to clinician sending the staff change form.

8.5. 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.

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

8.7. Transferring clinician will complete any outstanding paperwork due within 30 days post scheduled transfer session.

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

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

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

8.10. Prior to or at transfer session, previous clinician will complete Periodic Review and new clinician will complete Treatment Plan and add authorizations for new program.

8.11. Two exceptions:

8.11.1. 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 “My Therapy Groups” 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.

8.11.2. Medication Services: Introduction is made at the time of the initial appointment with the prescriber.

8.12. 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.

8.13. 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.

8.14. All internal transfers will occur within 14 days of program/staff change form being completed (unless person served requests otherwise or is clearly noted in plan of service).

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

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

8.15.2. Original primary clinician completes assessment update and any paperwork due within 30 days.

8.15.3. The two staff meet with the person served/family to do the person-centered plan addendum. The transferring/referring supervisor reviews and signs (if required) the addendum. Note: Steps 1, 2 and 3 may be interchangeable or occur concurrently, depending on the circumstances with the person served/family.

8.15.4. The receiving clinician and supervisor complete their portion of the form and the supervisor signs (if required).

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

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

8.16.1. The two staff meet with the person served/family for a joint first meeting and "warm hand off." The warm hand off can be declined by persons served. 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.

8.16.2. The supervisor of the program in which the referral to a new worker occurs will update the primary worker in the electronic health records or will send program staff change form to Medical Records.

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

9. Missed or Cancelled Appointments

9.1. Each worker shall address and document missed or cancelled appointments.

9.2. 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 (or earlier), the clinician is responsible for sending or requesting that Medical Records send the agency letter to the person served. If no response is obtained from the person served within 14 days of sending the letter, a review of the case for closure to services will occur, including an adverse benefit notice.

9.3. 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.

10. Termination of Services

10.1. The primary clinician will first discuss closure/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.

10.2. The primary clinician shall then discuss termination of services forthe 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 services of the person served/family with all involved staff. If a person served receives other contracted or internal services, the primary clinician must also discuss termination with all involved staff/providers.

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

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

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

10.3.3. Person served/family specifically requests that their services be terminated.

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

10.3.5. 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).

10.3.6. Death of the person served.

10.3.6.1. Organization policy will be followed when the death of a person served occurs.

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

10.4. 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 services in the future if needed. This will include a transition plan that reflects appropriate community resources, services and referrals.

10.5. The primary worker completes the adverse benefit determination or action notice, signs it, and messages the supervisor that the person served is closing.

10.6. Medical Records will print and mail out the adverse benefit determination or action notice.

10.7. Once the adverse benefit determination notice/action notice expires, the staff completes the discharge summary document in the Electronic Health Record. Supervisor will sign the discharge summary document.

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

10.9. Exceptions to Providing an Advance Notice/Adverse Benefit Determination

10.9.1. 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:

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

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

10.9.1.3. 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

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

10.9.2. 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).

11. Administrative Closures

11.1. Medical Records can assist in an administrative closure. The following should be reviewed:

11.1.1. Is there an initial assessment in the chart?

11.1.1.1. If an initial assessment was started, was an interim plan letter was sent?

11.1.1.1.1. If the interim plan was sent, we can close administratively because this letter includes appeal rights.

11.1.1.1.2. If interim plan was not sent, did they authorize any services?

11.1.1.1.2.1. If services were authorized and they are still valid, they cannot be administratively closed until the clinician completes an action notice.

11.1.1.1.2.2. If they did not authorize services, they can be admin closed.

11.2. Then the current process for discharging once the action notice time frame has elapsed should occur. The clinician will get a reminder to do the discharge summary.

12. Update Status of Person Served

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

13. Follow-up to Emergency Room and Inpatient Stays for Mental Illness and Substance Use

13.1. Inpatient Psychiatric Hospitalizations for Children and Adults with Mental Illness

13.1.1. Face-to-face follow-up contact should occur and be documented within 24 hours of discharge from inpatient stay and should be coordinated and scheduled during discharge planning. Telehealth can be utilized if medically necessary.

13.1.2. After the appointment that occurred within 24 hours of discharge (referred to as “Day 1” of discharge) an additional follow-up appointment will occur within day 2-7 from the discharge date.

13.1.3. Services the Qualify for follow-up:

13.1.3.1. Assessment Update

13.1.3.1.1.1. Post-hospitalization there may be an assessment update or assessment tool update.

13.1.3.1.1.1.1. Adults 18+ with mental illness will receive a LOCUS score update at the very least. This will be recorded by progress note (H0031-WX).

13.1.3.1.1.2. Adults may alternatively receive a full assessment update and PCP change as required between transfers to lower or higher level of care.

13.1.3.1.1.3. Children (17 – 6 years of age) will receive a PECFAS or CAFAS assessment update.

13.1.3.2. Crisis Services

13.1.3.2.1. 90839: psychotherapy for crisis, 1st 60 min

13.1.3.2.2. 90840: psychotherapy for crisis, each additional 30 min (Add-on code only)

13.1.3.3. Screening, Assessment and Diagnosis

13.1.3.3.1. 90791: Psychiatric Diagnostic Evaluation

13.1.3.3.2. 90792: Psychiatric Diagnostic Evaluation with Medical Services

13.1.3.3.3. H0002: BH Screening to determine eligibility for admission to tx program

13.1.3.3.4. H0031: Mental Health Assessment, by non-physician (intake/update assessment)

13.1.3.3.5. H0031-WX: LOCUS Assessment (progress note and modifier used to document)

13.1.3.3.6. H2000: Comprehensive multidisciplinary evaluation

13.1.3.4. Outpatient Mental Health and Substance Use Services

13.1.3.4.1. Psychotherapy:

13.1.3.4.1.1. 90832: Individual therapy, adult or child, 20-30 minutes

13.1.3.4.1.2. 90833: 90833 (30 min), 90836 (45 min) 90838 (60 min) evaluation and management and psychotherapy add-on codes only

13.1.3.4.1.3. 90834: Individual therapy, adult or child, 45 minutes

13.1.3.4.1.4. 90837: Individual therapy, adult or child, 60 minutes

13.1.3.4.1.5. 90847: Family Psychotherapy including patient, 50 mins

13.1.3.4.1.6. 90849: Multiple-Family group psychotherapy

13.1.3.4.1.7. 90853: Group psychotherapy, (other than of a multiple-family group) adult or child, per session

13.1.3.4.1.8. 99201-99205: New patient, Medication Review (10 min – 60 min)

13.1.3.4.1.9. 99211-5 – Established patient, Medication review/Admin

13.1.3.4.1.10. 99341 – 99345 – New Patient home visits - Assessments - Health Psychiatric Evaluation

13.1.3.4.1.11. Psychological testing, Other assessments, tests

13.1.3.4.1.12. 99347-99350 – Established patient home visits - Assessments - Health Psychiatric Evaluation Psychological testing, Other assessments, tests

13.1.3.4.1.13. H0034: Medication training and support, per 15 minutes

13.1.3.4.1.14. H0036: Homebased - Community psychiatric supportive treatment, face-to-face, per 15 minutes

13.1.3.4.2. Psychiatric Rehabilitation:

13.1.3.4.2.1. G0176: Activity Therapy, such as music, dance, art or play therapies not for recreation, related to the care and treatment of the patient’s disabling MH problems, per session (45mins or more)

13.1.3.4.2.2. H0039: Assertive community treatment, face-to-face, per 15 minutes

13.1.3.4.3. Specific Substance Use service:

13.1.3.4.3.1. H0004: Outpatient Care, Behavioral health counseling and therapy, per 15 minutes

13.2. Emergency Room Discharge for Children and Adults with Mental Illness

13.2.1. Face-to-face follow-up contact should occur and be documented within 24 hours of discharge from emergency room stay and should be coordinated and scheduled during discharge planning. Telehealth can be utilized if medically necessary.

Kerry Possehn, Chief Executive Officer	Date		