



*Creating solutions, **One** person at a time*

ACCESS AND UTILIZATION MANAGEMENT  
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To: PBH Children's Mental Health Providers- PRTF, Residential IV-Secure, Residential Level II-Family Type, Residential II-Program Type, Residential Level III-Group Living, Community Support, Intensive In Home, MST, and Day Treatment Providers

From: Chris Jacobson, PBH UM Director

Date: July 17, 2009

RE: Residential Level III-IV Discharge/Transition Planning Guidelines  
PBH ACCESS Communication Bulletin FY-0910-UM-01

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In anticipation of the upcoming Residential Level III and IV service changes, PBH Utilization Management has developed a set of guidelines for Child and Family Teams to consider while developing discharge/transition plans for consumers entering or exiting Residential III or IV Services over the next several months. The guidelines are intended to assist Child and Family Teams in developing comprehensive, child centered and family focus plans that clearly delineate:

- Child and family service needs (school, a place to live, treatment, medication management, family involvement, etc),
- Team member responsibilities (identification of needs, linkage to services, and monitoring of care), and
- Time frames for meeting goals related to discharge or transition home or an alternative residential level of care.

If you have questions or comments about this or any other issue, please contact PBH MH/SA Utilization Management [UtilizationM@pamh.com](mailto:UtilizationM@pamh.com) or call 704-743-2100.

cc. Chris Jacobson, MSW PBH UM Director  
Kristin Baker, MD- PBH Clinical Director

## **PBH MH/SA Discharge/Transition Planning Guidelines**

Purpose: Although some Residential Level III Group Type service may remain, the intent is to reduce the use of this service and decrease lengths of stay. Accordingly, all Person Centered Plans should be specific regarding assessment of progress (i.e., how progress is being measured). Examples of how the Child and Family Team may measure progress may include: if progress is not evident after \_\_\_ days what alternatives will be considered, or if after \_\_\_ days progress is being made how Child and Family Team will prepare consumer / natural supports for transitioning.

What to include in a new Complete, Annual or Updated Person Centered Plan requesting Level III:

1. Detailed step down plan including what Child and Family Team will be doing over the next several months to assess alternative level of care and move towards discharge/transition. Plan should identify who is responsible for referrals, linkage, service coordination, monitoring, completion of applications or other documentation, etc.
  - Ex. Over the next 30 days Child and Family Team will track consumer's behaviors, incidents, etc. to determine progress or lack of progress towards goals, Child and Family Team will determine plan for increasing therapeutic leave and contact with family, etc.
  - Child and Family Team will meet every 2 weeks to discuss progress, needed services, and begin Updated PCP process as well as contacting potential providers. 60 days prior to transition, level of care will be determined, Updated PCP will be developed and submitted to UM for review and Child and Family Team will begin applications to this level of care (make referrals to MST, IIHS, identified respite provider, etc.).
  - 30 days prior to end of Level III services Child and Family Team will set up follow up appointments, have applied to all applicable providers, etc. and have determined specific discharge date/dates new services will start.
2. For consumer transitioning home, Plan should identify plans for therapeutic leave, plans for family therapy, will family need respite when returning home, etc. so that families may be as prepared as possible to have these children back in the home.
3. Plan should also address the following areas:
  - School needs: Will consumer transition to new school? Child and Family Team's plans for coordinating this in the new setting (for

consumers who were in the Level III setting during the last school year).

- Daily activities needs: Will consumer be linked to community activities? If transitioned home are guardians available during the day, etc.? Does the consumer require tutoring or monitoring with completing homework or any other school related activities the Level III provider may have been doing with them.
  - What alternative services are being considered? What are these decisions being based on?
  - Any assessments / testing that Child and Family Team feels will be necessary to assess appropriate level of care. Ex: If Child and Family Team feels consumer may need to transition to PRTF, consumer may need a new psychological evaluation.
  - Specifically, Plan should include what behaviors Child and Family Team will be using to measure readiness to transition out of Level III setting that are realistic for consumer to achieve and follow service definition requirements.
4. During this transition period from Level III to alternative services, PBH will allow the following:
- Up to 40 total units per month of CS to coordinate transition, have additional meetings, develop Plan updates, coordinate additional assessments / testing that may be necessary.
  - Updated PCPs to be submitted 60 days prior to start date requesting the services that will be necessary upon transition out of Level III services. This allows UM to determine medical necessity for the request and Child and Family Team to start linkage to new services.
  - PBH will allow 30 days overlap in IIHS/MST, outpatient therapy services and Level III to allow for smooth transition for consumer returning to the home.