Section 3.17 Transition of Persons

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I. STATEMENT OF PURPOSE:

Persons receiving behavioral health services in the Arizona Health Care Cost Containment System (AHCCCS) may experience transitions during their care and treatment. Examples of transitions of care include changing service providers, transitioning into adulthood, and moving out of the Tribal Regional Behavioral Health Authority's (TRBHA) geographic service area. During transitions of care, behavioral health providers must ensure that services are not interrupted and that the person continues to receive needed behavioral health services. Coordination and continuity of care during transitions are essential in maintaining a person's stability and avoiding relapse or decompensation in functioning. The intent of this section is to:

1. Identify the situations that require a transition of care:
2. Describe expectations for providers when initiating or accepting a transition of care for an enrolled person; and
3. Identify resources to assist behavioral health providers in supporting a person who is experiencing a transition of care.

II. REFERENCES:

The following Pascua Yaqui (PY) Centered Spirit Program (CSP) Provider Manual sections can serve as additional resources for this content area:

Section 3.2, Appointment Standards and Timeliness of Services
Section 3.3, Intake and Referral Process
Section 3.8, Outreach, Engagement, Re-Engagement and Closure
Section 3.10, SMI Eligibility Determination
Section 3.18, Pre-petition Screening, Court Ordered Evaluation and Treatment

Section 3.21, Service Prioritization for Non-Title XIX/XXI Funding
Section 4.1, Disclosure of Behavioral Health Information
Section 5.1, Notice and Appeal Requirements (SMI and Non-SMI/Non-Title XIX/XXI)
Section 5.5, Notice and Appeal Requirements (SMI and Non-SMI/Non-Title XIX/XXI)
Section 7.5, Enrollment, Disenrollment and other Data Submission

The following citations and AHCCCS document are resources for this content area:

A.R.S. § 36, Chapter 5
9 A.A.C. 21, Article 5
AMPM Chapter 900 – Quality Management and Performance Improvement Program
AMPM Section 960: Tracking and Trending of Member and Provider Issues
AHCCCS/TRBHA Intergovernmental Agreement (IGA) 2021

III. STANDARDS:

To ensure that Quality of Care (QOC) concerns involving TRHBA members are documented and investigated; to ensure T/RBHA members' health, safety, and well-being is preserved during and after said investigation

IV. PROCEDURES:

A. Transition from child to adult services:

Planning for the transition into the adult behavioral health system must begin for any child involved in behavioral health care when the child reaches the age of 16. Planning must begin immediately for youth entering behavioral health care who are 16 years or older at the time they enter care.

A transition plan that starts with an assessment of self-care and independent living skills, social skills, work and education plans, earning potential and psychiatric stability must be incorporated in the child's individualized service plan (ISP).

What elements should be addressed as part of the child's transition plan?

Not all children transfer to the adult Serious Mental Illness (SMI) or General Mental Health/Substance Abuse (GMH/SA) system, but for children who do, providers must ensure a smooth transition. To accomplish a smooth transition, providers must develop a clear and explicit process and procedure that will ensure and support the delivery of children's and adult services during the transition period. Providers must ensure that adult system staff attend and are a part of the Child and Family Team (CFT) (during the four to six months prior to the child turning 18) to provide information and be part of the service planning, development and coordination effort that needs to take place so the

individualized needs of that child can be met on the day they turn 18 years of age.

Some of the elements to be addressed by the CFT and/or behavioral health providers as part of a transition plan include:

1. Identifying the child's behavioral health needs into adulthood;

2. Identifying personal strengths that will assist the child when he/she transitions to the adult system;

3. Identifying staff that will coordinate services after the child reaches age 18, including any changes in the behavioral health provider, clinical team, guardian or family involvement;

4. Identifying and collaborating with other involved state agencies and stakeholders to jointly establish a behavioral health service plan and prevent duplication of services;

5. Establishing how the transition will be implemented;

6. Planning for where the child will reside upon turning 18 and how he/she will support him/herself. If an SMI eligibility determination is made, consider initiating a referral for housing, if needed;

7. Identifying the need for referrals to and assistance with applications for Supplemental Security Income (SSI), Rehabilitation Services Administration (RSA), SMI eligibility determination, Title XIX and Title XXI eligibility, housing, guardianship, training programs, etc. In addition, the team and/or behavioral health provider should assist in gathering necessary information to expedite these applications/determinations when the time comes to actually apply, including obtaining medical and school records to substantiate these needs. The team and/or behavioral health provider begin to develop a timeline and task list for when appointments are needed;

8. Identifying the need for transportation to appointments and other necessary activities;

9. Identifying special needs that the child may have and/or whether or not the child will require special assistance services;

10. Identifying whether the child has appropriate life skills, social skills and employment or education plans;

11. Taking necessary action if the child is not eligible for Title XIX or Title XXI benefits and/or Social Security Disability Income (SSDI) and is not determined to have a SMI; and

12. Identifying supports needed to be in place for a successful transition.

The services that have been planned, developed and provided for the child can continue to be provided after the child has turned 18 years of age, assuming that continuation of these services is the choice of the young person when he/she reached the age of majority. Providers shall properly encounter and receive payment for the provision of services of staff involved, including adult system staff, according to TRBHA procedures included in *Section 10.0, TRBHA Specific Requirements* (see http://www.azahcccs.gov/bhs/provider/index.htm for a listing of TRBHA provider manuals)

Providers are responsible for the provision of services for Title XIX/XXI eligible members 18 years of age through 20 years of age (who are still a part of the Early Periodic Screening, Diagnosis, and Treatment (EPSDT) program) regardless of their designation as SMI or GMH/SA. Services include case management services and all other covered services that the person's treatment team determines to be needed to meet individualized needs

What needs to happen during the year before the child transitions to adult services?

When a child receiving behavioral health services reaches the age of 17, behavioral health providers must determine whether the child is potentially eligible for services as an adult with a Serious Mental Illness. If so, behavioral health providers must refer the child for an SMI eligibility determination pursuant to *Section 3.10, SMI Eligibility Determination*.

1. When a child receiving behavioral health services reaches age 17 1/2, the CFT and/ Assist the child and/or family or guardian in applying for potential benefits (e.g., SSI, food stamps, etc.);

2. Assist the child and/or family in applying for Title XIX or Title XXI benefits; if the child and/or family is already eligible, determine if eligibility will continue for the child once he/she turns 18;

3. Address any new authorization requirements for sharing protected health information due to the child turning 18 (as described in *Section 4.1, Disclosure of Behavioral Health Information*) to ensure that the clinical team can continue to share information;

4. Ensure that the child's behavioral health category assignment is changed consistent with *Section 7.5, Enrollment, Dis-enrollment and other Data Submission*. Once the child's behavioral health category assignment has

been changed, ongoing behavioral health service appointments must be provided according to the timeframes for routine appointments in *Section 3.2, Appointment Standards and Timeliness of Services*; and

5. Upon turning 18 years of age, if the person is not eligible for services as a person determined to have a Serious Mental Illness or the person has been determined ineligible for Title XIX or Title XXI services, behavioral health providers can continue to provide behavioral health services consistent with *Section 3.21, Service Prioritization for Non-Title XIX/XXI Funding, Persons Determined to Have a Serious Mental Illness (SMI),* or the behavioral health provider must:

B. <u>Transition due to a change of the behavioral health provider or the behavioral health category assignment</u>:

Upon changes of a person's behavioral health provider or behavioral health category assignment, the behavioral health provider must:

1. Review the current individual service plan and, if needed, coordinate the development of a revised individual service plan with the person, clinical team and the receiving behavioral health provider;

2. Ensure that the person's comprehensive clinical record is transitioned to the receiving behavioral health provider;

3. Ensure the transfer of responsibility for court ordered treatment, if applicable; and

4. Coordinate the transfer of any other relevant information between the behavioral health provider and other provider agencies, if needed.

C. <u>Transition from Quality of Care (QOC) concern facilities to non-QOC facilities</u>.

Once a QOC has been identified with a contracted facility, the clinical team will determine if either adult or minor clients reside at or receive services at that facility. The Quality Management team will discuss the following with the clinical team to assess issues of quality of care and risk to the client(s) receiving services or in placement with the QOC-concern facility/provider.

1. Identification of the Quality of Care issues;

2. Initial assessment of the severity of the Quality of Care issue;

3. Prioritization of action(s) needed to resolve immediate care needs when appropriate;

4. Results of onsite visits with the provider/facility, direct interviews with members, direct care staff, and witnessing of a reportable event, when applicable and appropriate.

If the Quality Management and Clinical team determine that the health, safety, or welfare of the client are at risk, the Quality Management team will:

1. Actively participate in meetings focused on ensuring the health and safety of members;

2. Actively participate in meetings scheduled to develop work plans and corrective action plans to ensure placement setting or service sites compliance with Arizona Department of Health Services (ADHS) licensure and/or AHCCCS requirements;

3. Participate in scheduled and unscheduled monitoring of placement services that are in an Immediate Jeopardy status, have serious identified deficiencies that may affect health and safety of members or as directed by AHCCCS;

4. Assist in the identification of technical assistance resources focused on achieving and sustaining regulatory compliance; and

5. Monitoring placement setting or service sites upon completion of the activities and interventions to ensure that compliance is sustained.

If the team determines that immediate placement in another facility is necessary, the team and/or behavioral health provider will:

1. Schedule a meeting to establish a transition plan for the person. The meeting must include:

    a. The person or the person's guardian or parent, if applicable;

    b. The behavioral health provider and representatives of the CFT/adult clinical team;

    c. Other involved agencies; and

    d. Any other relevant participant at the person's request or with the consent of the person's guardian.

2. Establish a transition plan that includes at least the following:

   a. The person's projected moving date and place of residence;

   b. Treatment and support services needed by the person and the timeframe within which the services are needed;

   c. A determination of the need to request a change of venue for court ordered treatment and who is responsible for making the request to the court, if applicable;

   d. Information to be provided to the person regarding how to access services immediately upon relocation;

   e. The individual responsible for coordinating any needed change of health plan enrollment, primary care provider assignment and medication coverage;

   f. Identification of any special authorization required for any recommended service (e.g., non-formulary medications) and the individual who is responsible for obtaining needed authorizations; and,

   g. If the person is taking medications prescribed for the person's behavioral health issue, the location and date of the person's first appointment with a practitioner who can prescribe medications. There must not be a gap in the availability of prescribed medications to the person.

3. Identify supports needed to be in place for a successful transition.

D. <u>Transition to ALTCS program contractors</u>:

This section does not apply to persons enrolled in the Arizona Long Term Care Services/Division of Developmental Disabilities (ALTCS/DDD). ALTCS/DDD eligible persons receive all covered behavioral health services through TRBHAs and their contracted providers.

Once a person is determined eligible and becomes enrolled with the Arizona Long Term Care Services/Elderly or Physically Disabled (ALTCS/EPD) Program, behavioral health providers must not submit claims or encounters for Title XIX covered services to the TRBHA. The behavioral health provider must, however, continue to provide and encounter needed non-Title XIX covered SMI services (e.g. housing) to persons determined to have a Serious Mental Illness.

Behavioral health providers who contract as an ALTCS provider must not submit encounters for an ALTCS/EPD enrolled person to the TRBHA after a person

transfers to ALTCS, but must submit bills/claims for payment to the ALTCS Program Contractor who in turn submits the encounters to AHCCCS.

When a person who has been receiving behavioral health services through the TRBHA becomes enrolled in the ALTCS Program, the behavioral health provider must:

1. Include the member in transition planning and provide any available information about changes in physician, services, etc.;

2. Ensure that the clinical and fiscal responsibility for Title XIX behavioral health services shifts to the ALTCS Program Contractor;

3. Provide information to the ALTCS Program Contractor regarding the person's on-going needs for behavioral health services to ensure continuity of care during the transition period;

4. Review the current treatment plan and, if needed, coordinate the development of a revised treatment plan with the clinical team and the receiving ALTCS provider and/or case manager;

5. Transfer responsibility for any court ordered treatment;

6. Coordinate the transfer of records to the ALTCS program contractor; and

7. Provide information as follows:

   a. For Title XIX eligible 21-64 year old persons, the number of days the person has received services in an Institution for Mental Disease (IMD) in the contract year (July 1 – June 30);

   b. For all persons, the number of hours of respite received in the contract year (July 1 – June 30); and

   c. Whether there is a signed authorization for the release of information contained in the comprehensive behavioral health record pursuant to *Section 4.1, Disclosure of Behavioral Health Information*.

E. Inter-TRBHA transfer:

How is TRBHA responsibility determined for adults?

For adults (persons 18 years and older), TRBHA responsibility is determined by the adult person's current place of residence, except in the following situation:

Persons who are unable to live independently must not be transferred to another TRBHA with the exception of persons who are unable to live independently but are involved with DDD. However, TRBHAs may agree to coordinate an inter-TRBHA transfer for individuals unable to live independently on a case-by-case basis. Persons involved with DDD who reside in a supervised setting are the responsibility of the TRBHA in which the supervised setting is located. This is true regardless of where the adult guardian lives. When an ALTCS/DDD member is placed temporarily in a group home while a permanent placement is being developed in the home TRBHA service area, covered services remain the responsibility of the home TRBHA.

How is TRBHA responsibility determined for children?

- For children (ages 0-17 years), TRBHA responsibility is determined by the current place of residence of the child's parent(s) or legal guardian; and
- For children who have been adjudicated as dependent by a court, the location of the child's court of jurisdiction determines which TRBHA has responsibility.

How is TRBHA responsibility determined for persons who are temporarily residing in another TRBHA's geographic service area (GSA)?

The home TRBHA remains fiscally responsible for all services provided to an enrolled person who is visiting or otherwise temporarily residing in a different TRBHA's geographic service area (GSA) if the person, or legal guardian for a child, maintains a place of residence in the home TRBHA's GSA and intends to return. If the person, or legal guardian for a child, continues to reside in the new location after 3 months, the provider or TRBHA may proceed with an inter-TRBHA transfer if the person, or legal guardian for a child, is consulted and agrees to the change. Only persons who are able to live independently, with the exception of persons who are unable to live independently but are involved with DDD, can be transferred.

Crisis services must be provided without regard to the person's enrollment status. When a person presents for crisis services, the TRBHA or their contracted providers must:

1. Provide needed crisis services;
2. Ascertain the person's enrollment status with all TRBHAs and determine whether the person's residence in the current area is temporary or permanent;
3. If the person is enrolled with another TRBHA, notify the home TRBHA within 24 hours of the person's presentation. The home TRBHA or their contracted providers is fiscally responsible for crisis services and must:

a. Make arrangements with the TRBHA at which the person presents to provide needed services, funded by the home TRBHA;

b. Arrange transportation to return the person to the home TRBHA area; or

c. Determine if the person intends to live in the new TRBHA's geographic service area and if so, initiate a transfer. Persons who are unable to live independently but clearly express an intent/desire to permanently relocate to another service area can be transferred. However, the home TRBHA must make arrangements for housing and consider this a temporary placement for three months. After three months, if the person continues to clearly express an intent/desire to remain in this new service area, the inter-TRBHA transfer can proceed.

If the person is not enrolled with any TRBHA and lives within the service area of the TRBHA in which the person presented for services, behavioral health providers must notify the TRBHA to initiate an enrollment.

If the person is not enrolled with any TRBHA and lives outside of the service area of the TRBHA at which the person presented for crisis services, the TRBHA must enroll the person, provide needed crisis services, and initiate the inter-TRBHA transfer. If the person is not enrolled with a TRBHA, lives outside of the service area in which he/she presents and requires services other than a crisis or urgent response to a hospital, the TRBHA or their contracted providers must notify the designated TRBHA associated with the person's residence within 24 hours of the person's presentation. The designated TRBHA must proceed with the person's enrollment if the person is determined eligible for services. The designated TRBHA is fiscally responsible for the provision of all medically necessary covered services, including transportation services, for eligible persons.

<u>What if a TRBHA or provider receives a referral for a hospitalized person</u>?

In the event that a TRBHA or provider receives a referral regarding a hospitalized person whose residence is located outside the TRBHA's geographic service area, the TRBHA or provider must immediately coordinate the referral with the person's designated TRBHA.

<u>When is an inter-TRBHA transfer required</u>?

An inter-TRBHA transfer must be completed under the following circumstances:

1. An adult person voluntarily elects to change his/her place of residence to an independent living setting from one TRBHA's area to another. Only adult persons who are able to live independently can be transferred to

another TRBHA, with the exception of persons who are unable to live independently but are involved with DDD. Adult persons involved with DDD who reside in a supervised setting are the responsibility of the TRBHA in which the supervised setting is located;

2. DDD transfers an adult person who is unable to live independently, but involved with DDD, to another placement;

3. The parent(s) or legal guardian(s) of a child change their place of residence to another TRBHA's area; or

4. The court of jurisdiction of a dependent child is changed to another TRBHA's area.

Inter-TRBHA transfers are not to be initiated when a person is under pre-petition screening or court ordered evaluation (see *Section 3.18, Pre-petition Screening, Court-Ordered Evaluation and Court-Ordered Treatment*).

What are the timeframes for initiating an inter-TRBHA transfer?

The home TRBHA or its contracted providers must initiate a referral for an inter-TRBHA transfer within the following timeframes:

- At least 30 days prior to the date on which the person will move to the new area; or
- If the planned move is in less than 30 days, immediately upon learning of the person's intent to move.

What are the responsibilities of the receiving TRBHA during an inter-TRBHA transfer?

Within 14 days of receipt of the referral for an inter-TRBHA transfer, the receiving TRBHA or its subcontracted providers must:

1. Schedule a meeting to establish a transition plan for the person. The meeting must include:

   a. The person or the person's guardian or parent, if applicable;

   b. Representatives from the home TRBHA;

   c. Representatives from the Arizona State Hospital (AzSH), when applicable;

   d. The behavioral health provider and representatives of the CFT/adult clinical team;

e. Other involved agencies; and

f. Any other relevant participant at the person's request or with the consent of the person's guardian.

2. Establish a transition plan that includes at least the following:

a. The person's projected moving date and place of residence;

b. Treatment and support services needed by the person and the timeframe within which the services are needed;

c. A determination of the need to request a change of venue for court ordered treatment and who is responsible for making the request to the court, if applicable;

d. Information to be provided to the person regarding how to access services immediately upon relocation;

e. The enrollment date, time and place at the receiving TRBHA and the formal date of transfer, if different from the enrollment date;

f. The date and location of the person's first service appointment in the receiving TRBHA's GSA;

g. The individual responsible for coordinating any needed change of health plan enrollment, primary care provider assignment and medication coverage;

h. The person's behavioral health provider in the receiving TRBHA's GSA, including information on how to contact the behavioral health provider;

i. Identification of the person at the receiving TRBHA who is responsible for coordination of the transfer, if other than the person's behavioral health provider;

j. Identification of any special authorization required for any recommended service (e.g., non-formulary medications) and the individual who is responsible for obtaining needed authorizations; and,

k. If the person is taking medications prescribed for the person's behavioral health issue, the location and date of the person's first appointment with a practitioner who can prescribe medications.

There must not be a gap in the availability of prescribed medications to the person.

Who is responsible for initiating an inter-TRBHA transfer?

Behavioral Health Clinicians (BHCs) are responsible for initiating the inter-TRBHA transfer.

What are the BHC's responsibilities during an inter-TRBHA transfer?

As part of an inter-TRBHA transfer, the BHC must:

1. Schedule a meeting to establish a transition plan for the person. Include the person in transition planning and provide any available information about changes in physician, services, etc.;

2. Provide information regarding the person's on-going needs for behavioral health services to ensure continuity of care during the transition period;

3. Review the current treatment plan and, if needed, coordinate the development of a revised treatment plan with the clinical team and the receiving provider;

4. Transfer responsibility for any court ordered treatment;

5. Coordinate the transfer of records to the new behavioral health provider; and

6. Provide information as follows:

    a. For Title XIX eligible 21-64 year old persons, the number of days the person has received services in an Institution for Mental Disease (IMD) in the contract year (July 1 – June 30);

    b. For all persons, the number of hours of respite received in the contract year (July 1 – June 30); and

    c. Any signed authorizations for the release of information contained in the person's comprehensive clinical record pursuant to *Section 4.1, Disclosure of Behavioral Health Information*.

What are the timeframes for completing an inter-TRBHA transfer?

When an inter-TRBHA transfer occurs, the person must be disenrolled from the home TRBHA and enrolled in the receiving TRBHA contingent upon the date the person expects to relocate to the receiving TRBHA's geographic service area, but no later than 30 days of the referral by the home TRBHA (see *Section 7.5,*

Enrollment, Disenrollment and Other Data Submission). This timeframe allows sufficient time for the receiving TRBHA to arrange for services and plan the person's transition. If the person is not located or does not show up for his/her appointment on the date arranged by the TRBHAs to transfer the person, the TRBHAs must collaborate to ensure appropriate re-engagement activities occur (see *Section 3.8, Outreach, Engagement, Re-Engagement and Ending an Episode of Care and Disenrollment*) and proceed with the inter-TRBHA transfer, if appropriate.

Who is responsible for care during an inter-TRBHA transfer?

In an inter-TRBHA transfer, the home TRBHA and its contracted providers retain responsibility for service provision and coordination of care until such time as a person's record is closed for that TRBHA (see *Section 3.8, Outreach, Engagement, Re-engagement and and Ending an Episode of Care and Disenrollment*). The receiving TRBHA must not delay the timely processing of an inter-TRBHA transfer because of missing or incomplete information.

Courtesy dosing of methadone or buprenorphine:

A person receiving methadone or buprenorphine administration services who is not a recipient of take-home medication may receive up to two courtesy doses of methadone or buprenorphine from a TRBHA or its contracted providers while the person is traveling outside of the home TRBHA area. All incidents of provision of courtesy dosing shall be reported to the home TRBHA. The home TRBHA shall reimburse the behavioral health provider providing the courtesy doses upon receipt of properly submitted bills or encounters.

Appeals for out-of-area service provision:

Persons determined to have a Serious Mental Illness who are the subject of a request for out-of-area service provision or inter-TRBHA transfer may file an appeal in accordance with *Section 5.5, Notice and Appeal Requirements (SMI and General*).

Inter-TRBHA transfers after crisis enrollments:

When a person presents for crisis services, providers must first deliver needed behavioral health services and then determine eligibility and TRBHA enrollment status. Persons enrolled after a crisis event may not need or want ongoing behavioral health services through the TRBHA. Providers must conduct re-engagement efforts as described in *Section 3.8, Outreach, Engagement, Re-engagement and Ending an Episode of Care and Disenrollment*, however; persons who no longer want or need ongoing behavioral health services must be disenrolled (i.e., closed in the Client Information System) and an inter-TRBHA transfer must not be initiated. Persons who will receive ongoing behavioral health services will need to be referred to the appropriate TRBHA and an inter-

TRBHA transfer initiated, if the person presented for crisis services in a GSA other than where the person resides.

Inter-TRBHA transfers when persons do not inform the home TRBHA of a move to another geographic service area (GSA):

Timeframes specified in *Subsection 3.17.7-D* cover circumstances when behavioral health recipients inform their provider or TRBHA prior to moving to another service area. When behavioral health recipients inform their provider or TRBHA less than 30 days prior to their move or do not inform their provider or TRBHA of their move, the designated TRBHA must not wait for all of the documentation from the previous TRBHA before scheduling services for the behavioral health recipient.

F. Transitions of persons receiving court ordered services:

This section pertains to court ordered treatment under A.R.S. § 36, Chapter 5 (see *Section 3.18, Pre-petition Screening, Court-Ordered Evaluation and Court-Ordered Treatment)*. A person ordered by the court to undergo treatment and who is without a guardian may be transferred from one behavioral health provider to another behavioral health provider, so long as the medical director of the behavioral health provider initiating the transfer has established that:

1. There is no reason to believe that the person will suffer more serious physical harm or serious illness as a result of the transfer;

2. The person is being transitioned to a level and kind of treatment that is more appropriate to the person's treatment needs; and

3. The medical director of the receiving behavioral health provider has accepted the person for transition.

The medical director of the behavioral health provider requesting the transition must have been the provider that the court committed the person to for treatment or have obtained the court's consent to transition the person to another behavioral health provider as necessary.

The medical director of the behavioral health provider requesting the transition must provide notification to the receiving behavioral health provider allowing sufficient time (but no less than 3 days) for the transition to be coordinated between the behavioral health providers. Notification of the request to transition must include:

1. A summary of the person's needs;

2. A statement that, in the medical director's judgment, the receiving behavioral health provider can adequately meet the person's treatment needs;

3. A modification to the individual service plan, if applicable;

4. Documentation of the court's consent, if applicable; and

5. A written compilation of the person's treatment needs and suggestions for future treatment by the medical director of the transitioning behavioral health provider to the medical director of the receiving behavioral health provider. The medical director of the receiving behavioral health provider must accept this compilation before the transition can occur.

Transportation from the initiating behavioral health provider to the receiving behavioral health provider is the responsibility of the initiating behavioral health provider.

G. Transitions of persons being discharged from inpatient settings:

Discharge planning and communication with the Adult Clinical Team or CFT must begin at admission to ensure a smooth transition for behavioral health recipients being discharged from inpatient settings. Furthermore, re-engagement activities must occur for persons who are discharged from inpatient settings in accordance with *Section 3.8, Outreach, Engagement, Re-engagement and Ending an Episode of Care and Disenrollment.* If a behavioral health recipient will be moving to a GSA other than where he/she has been receiving inpatient treatment services, coordination must occur between TRBHAs, if applicable, to ensure appropriate services/placement and necessary re-engagement activities occur upon discharge.

H. Transitions of persons receiving behavioral health services from Indian Health Services:

American Indian persons may choose to receive behavioral health services through a RBHA, TRBHA or at an IHS or 638 tribal provider. TRBHA providers must respond to referrals in accordance with Section 3.3, Referral and Intake, and ensure necessary coordination of care occurs.

I. Additional CARF-related documentation of transition plans:

Because CSP programs are CARF-accredited, some information in addition to what is required by AHCCCS above needs to be included in all transition plans. This includes the following:

1. Evidence the plan was developed with the input and participation of the person served, the family/legal guardian, when applicable or permitted, a legally authorized representative as appropriate, personnel, the referral source, and other community services as appropriate or permitted;

2. Identification of the person's current progress in his or her own recovery or move toward well-being and gains achieved during program participation;

3. Identification of the person's need for support systems or other types of services that will assist in continuing his or her own recovery, well-being, or community integration;

4. Information on the person's medication(s) when applicable;

5. Referral source information such as contact name, telephone number, locations, hours, days of services, when applicable;

6. Communication of information on options available if symptoms recur or additional services are needed, when applicable;

7. Evidence that documents provided to external programs/services to support a person's transition include the identified strengths, needs, abilities, and preferences of the person served; and

8. Evidence that persons who participate in the plan receive copies of the plan, when permitted.