PerformCARE®	Policy and Procedure
Name of Policy:	Pre-discharge planning meeting requirements for Community Residential Rehabilitation-Host Home (CRR-HH)/CRR-ITP Providers to assure clinically appropriate planning for after care or transfer occurs prior to discharge
Policy Number:	CM-CAS-048
Contracts:	☒ All counties ☐ Capital Area ☐ Franklin / Fulton
Primary Stakeholder:	Clinical Department
Related Stakeholder(s):	All Departments
Applies to:	Associates
Original Effective Date:	10/01/09
Last Revision Date:	03/24/25
Last Review Date:	03/26/25
OMHSAS Approval Date:	N/A
Next Review Date:	03/01/26

Policy: Clinically appropriate treatment for the Member is expected to be the priority for all Providers. In order to assure a coordinated and orderly discharge, CRR-HH/CRR-ITP Providers will schedule and facilitate a pre-discharge planning meeting with all team members prior to giving notice of discharge at least 45 days prior to the anticipated discharge date. It is expected that Providers give as much notice as possible but not less than 30 days' notice prior to discharge.

It may be clinically appropriate at times for the Member to need an Inpatient Hospitalization while in CRR-HH/CRR-ITP Treatment. It is expected that the Member will return to a CRR-HH/CRR-ITP upon discharge from the Inpatient unit and no formal discharge will occur or be requested while the Member is in the hospital. The treatment team should reconvene upon the Member's discharge from Inpatient care and return to CRR-HH/CRR-ITP to discuss ongoing treatment and the possible need for additional or alternative treatment options. It is expected that this policy be followed if the treatment team determines that a discharge from the CRR-HH/CRR-ITP is clinically indicated.

Purpose: To establish process for pre-discharge planning meeting prior to CRR-HH/CRR-ITP Provider issuing a removal/discharge.

Definitions: **Team Members:** Are defined as the Member and Parent/Guardian, as well as any behavioral health or community support systems including but not limited to PerformCare CRR/CRR-ITP Care Manager, TCM, JPO, C&Y,

CASSP/ county designee(s), school, and others identified by the Member and/or Parent Guardian.

Acronyms: **CASSP:** Children and Adolescent Service System Program Coordinator/county designee
CRR-HH: Community Residential Rehabilitation-Host Home
CRR-ITP: Community Residential Rehabilitation-Host Home-Intensive Treatment Program
C&Y: Children and Youth
JPO: Juvenile Probation Officer
TCM: Targeted Case Manager

Procedure:

1. Effective discharge planning begins upon admission to CRR-HH/CRR-ITP. Discussion of potential after-care plans should be part of every Treatment Team review meeting based on the Member's goals and anticipated after care plan. Part of all 30-day treatment team meetings are required to include the establishment of discharge plan that includes discharge goals, tentative discharge date and tentative after care recommendations.
2. If the Members' attending Psychiatrist, Psychologist or Clinical Director determines that the CRR-HH/CRR-ITP has met the Member's needs at that level of care, or may not be able to meet the Member's treatment needs:
    2.1. CRR-HH/CRR-ITP staff contacts PerformCare Care Manager and provides a clinical update which includes at a minimum the attending Psychologist, Psychiatrist or Clinical Director's clinical rationale for determining that the CRR-HH/CRR-ITP cannot meet Member's behavioral health treatment Needs.
    2.2. Within 3 days of the determination that the CRR-HH/CRR-ITP cannot meet the Member's needs, the CRR-HH/CRR-ITP contacts all Team Members (Member, Parent/Guardian, PerformCare CRR Care Manager, TCM, JPO, C&Y, CASSP/county designee(s), school, and others requested by Member and/or Parent/Guardian) to schedule a pre-planning discharge meeting. The meeting must be scheduled at least 45 days prior to the anticipated discharge date.
3. The CRR-HH/CRR-ITP initiates the pre-discharge planning meeting by providing the team with the attending Psychologist, Psychiatrist or Clinical Director's clinical rationale for discharge, and if applicable, include specifically why the CRR-HH/CRR-ITP cannot meet the Member's needs. The team discusses clinical concerns and determines if any additional supports can be added to assist CRR-HH/CRR-ITP with meeting Member's behavioral health treatment needs. For example, the team may explore revisions of the treatment plan, incorporating specialized adjunct outpatient services, transfer to another CRR-HH /CRR-ITP within the agency or another CRR-HH/CRR-ITP

Provider, as well as possible utilization of Mental Health Inpatient in cases where there is significant risk to self or others. In some situations, the CRR-HH/CRR-ITP may be asked to obtain services of a consultant. At rate setting, CRR-HH/CRR-ITP Programs typically include cost of clinical consultant and specialized services when developing budgets.

4. The team determines if the Member should receive additional supports, whether the CRR-HH/CRR-ITP should obtain the services of a consultant, or the Member should be transferred to another CRR-HH/CRR-ITP or Level of Care. If discharge is determined to be the appropriate plan, the CRR-HH/CRR-ITP gives a formal written 30-day notice to all team members, which includes an anticipated discharge date, the attending Psychologist, Psychiatrist, or Clinical Director's Clinical rationale, and a summary of the discharge plan as determined by the team meeting.
    4.1. Transfer to another CRR-HH/CRR-ITP provider. All CRR-HH /CRR-ITP providers will be aware of the process for transfer, per *CM-CAS-057 Children's Service Provider Transfer Process.* It is the responsibility of the current CRR-HH/CRR-ITP Provider to send out referrals for transfer prior to the Member's discharge. This includes transfer of pertinent clinical records to the accepting program, as well as a list of all of the Member's medications.
    4.2. Discharge to a different Level of Care. All CRR-HH/CRR-ITP providers will be aware of the referral process for step down LOC. This includes scheduling an outpatient medication management appointment prior to discharge and assuring that the member is provided a prescription adequate through the scheduled after care medication appointment.
5. The CRR-HH/CRR-ITP Provider will continue to provide ongoing behavioral health treatment of the Member and their family as included in the current treatment plan, during the 30-day notice period, in addition to assuring that adequate aftercare treatment is in place prior to discharge.
6. **Under No Circumstance should a CRR-HH/CRR-ITP ask the Juvenile Probation Officer or Children and Youth Services Agency to remove the Member from CRR-HH/CRR-ITP and transfer to Detention or Shelter**. Agencies will be advised to disregard such requests. Behavioral health treatment is not provided in Detention or Shelter Programs. Members who present immediate significant risk to self or others should be assessed for Mental Health Inpatient for stabilization and return to the CRR-HH/CRR-ITP setting as described in the policy statement above.
7. The CRR-HH /CRR-ITP Provider is expected not to discharge the Member home in the interim to finding another CRR-HH/CRR-ITP, or to finding an alternative Level of Care (i.e., RTF, etc.) since it has been

determined by the team, including the CRR-HH/CRR-ITP Provider that the Member meets medical necessity for out of home treatment.

Related Policies: *CM-CAS-057 Children's Service Provider Transfer Process*

Related Reports: None

Source Documents and References: None

Superseded Policies and/or Procedures: None

Attachments: None

Approved by:

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Primary Stakeholder