Section 3.17 Transition of Persons

3.17.1 Introduction

Persons receiving behavioral health services in the Arizona Department of Health Services/Division of Behavioral Health Services (ADHS/DBHS) system may experience transitions during the course of their care and treatment. Examples of transitions of care include changing service providers, establishing eligibility under Arizona Long Term Care Services (ALTCS), transitioning into adulthood, and moving out of the T/RBHA's 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:

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

3.17.2 References

The following citations can serve as additional resources for this content area:

A.R.S. § 36, Chapter 5
9 A.A.C. 21, Article 5
AHCCCS/ADHS Contract
ADHS/RBHA Contract
ADHS/TRBHA IGAs
Section 3.2, Appointment Standards and Timeliness of Services
Section 3.3, Intake and Referral Process
Section 3.4, Co-payments
Section 3.8, Outreach, Engagement, Re-Engagement and Closure
Section 3.10, SMI Eligibility Determination
Section 3.11, General and Informed Consent to Treatment
Section 3.12, Advance Directives
Section 3.13, Covered Behavioral Health Services
Section 3.18, Pre-petition Screening, Court Ordered Evaluation and Treatment
Section 3.21, Service Prioritization for Non-Title XIX/XXI Funding
Section 3.22 Out-of-State Placements for Children and Young Adults
Section 3.23, Cultural Competence
Section 4.1, Disclosure of Behavioral Health Information
Section 4.4, Coordination of Care with Other Governmental Entities
Section 5.1, Notice Requirements and Appeal Process for Title XIX and Title XXI Eligible Persons
Section 5.2 Member Complaints
Section 5.3, Grievance and Request for Investigation for Persons Determined to Have a Serious Mental Illness (SMI)
Section 5.4, Special Assistance for SMI Members
Section 5.5, Notice and Appeal Requirements (SMI and Non-SMI/Non-Title XIX/XXI)
Section 5.6, Provider Claims Disputes
Section 6.1, Submitting Tribal Fee-for-Service Claims to AHCCCS
Section 6.2, Submitting Claims and Encounters to the RBHA
Section 7.5, Enrollment, Disenrollment and other Data Submission
Section 9.1, Training Requirements
Section 10,
Collaborative Protocol Between Magellan Health Services and Arizona Department of Corrections (ADC)
Collaborative Protocol Between Magellan Health Services and Arizona Department of Juvenile Corrections (ADJC)
Collaborative Protocol Between Magellan Health Services and Child Protective Services (CPS)
Collaborative Protocol Between Magellan Health Services and District I of the Division of Developmental Disabilities (DDD) for Adult Consumers
Collaborative Protocol Between Magellan Health Services and District I of the Division of Disabilities (DDD) Coordination of Child and Family Team Process

Collaborative Protocol Between Magellan Health Services and Maricopa County Juvenile Probation Department (MCJPD)
ADHS/DBHS Practice Protocol, Transition to Adulthood
ADHS/Gila River Health Care Corporation Intergovernmental Agreement
ADHS/Pascua Yaqui Behavioral Health Program Intergovernmental Agreement
Transitioning to Adult Services Practice Improvement Protocol
ADHS/DBHS Policy Clarification Memorandum: Inter-RBHA Coordination of Service
http://tip.fmhi.usf.edu/
Psychotropic Medication Use in Children and Adolescents Practice Protocol
Practice Improvement Protocol 8, The Adult Clinical Team
Practice Improvement Protocol 9, The Child and Family Team
The Arizona Vision and Twelve Principles
ADHS/DBHS Policy Clarification Memorandum: General and Informed Consent to Treatment for Persons under the Age of 18
ADHS/DBHS Practice Protocol, Providing Services to Children in Detention
The Unique Behavioral Health Service Needs of Children, Youth, and Families Involved with CPS Practice Protocol
Information Sharing with Family Members of Adult Behavioral Health Recipients Technical Assistance Document

3.17.3 Scope

To whom does this apply?

All persons, regardless of funding source or behavioral health category, currently enrolled with a T/RBHA and experiencing a transition of care.

3.17.4 Did you know…?

Some persons may experience a transition of payers, but not actually change providers. This could happen for example, when a Title XIX behavioral health recipient moves from an Arizona Health Care Cost Containment System (AHCCCS) acute care Health Plan to the ALTCS program. Many ALTCS Program Contractors for the elderly and physically disabled (ALTCS/EPD) contract with the same behavioral health providers as the T/RBHAs. This kind of transition, where fiscal responsibility changes but not the provider, may be transparent to the person receiving services but could result in administrative changes for the provider (e.g., submitting claims or bills to the ALTCS Program Contractor versus submitting an encounter as a T/RBHA provider).

The ALTCS program is considered a “carve-in model,” a service delivery model that assigns coverage of medical and behavioral health services through a single entity (i.e., Program Contractor). An exception to this “carve-in model” is the delivery of covered behavioral health services for persons eligible for ALTCS through the Division of Developmental Disabilities (DDD).

ALTCS/DDD eligible persons receive covered behavioral health services through the T/RBHAs and their subcontracted behavioral health providers.

Accurate diagnosis of a co-occurring serious mental illness can be difficult when the person has been diagnosed with a developmental disability, which includes Autism and Cognitive Disability. Psychiatric symptoms are often inaccurately attributed to a person's developmental disability rather than a serious mental illness. All diagnoses that can be made of persons of normal intelligence can also be made in a person with a developmental disability. *The Diagnostic Manual: Intellectual Disabilities (DM: ID),* published in 2008, may be a useful resource in the diagnosis of mental illness in a person with a developmental disability

3.17.5 Definitions

Behavioral Health Category Assignment
One of five possible designations (i.e., child non-SED, child with SED, adult diagnosed as SMI, adult non-SMI with general mental health need and adult non-SMI with substance abuse) that is assigned to each person enrolled in the ADHS/DBHS behavioral health system.

Designated T/RBHA
The T/RBHA responsible for the geographic service area where an eligible person has established his/her residence.

Home T/RBHA
The T/RBHA with which the person is currently enrolled.

Independent Living Setting
A setting in which a person lives without supervision or in-home services provided by a T/RBHA or subcontracted provider agency.

Institution for Mental Disease (IMD)
A hospital, nursing facility, or other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care, and related services. An institution is an IMD if its overall character is that of a facility established and maintained primarily for the care and treatment of individuals with mental diseases.

Out-of-area service
The provision of a behavioral health service to a person in a geographic area other than that of the person's home T/RBHA. Out-of-area service provision includes services provided to a person who is discharged from an inpatient or residential setting to a different T/RBHA's area, but who does not live in an independent living setting.

Residence
The place where a person lives on a permanent basis.

Serious Mental Illness (SMI)
A condition of persons who are eighteen years of age or older and who, as a result of a mental disorder as defined in A.R.S. 36-501, exhibit emotional or behavioral functioning which is so impaired as to interfere substantially with their capacity to remain in the community without supportive treatment or services of a long -term or indefinite duration.

In these persons, mental disability is severe and persistent, resulting in a long-term limitation of their functional capacities for primary activities of daily living such as interpersonal relationships, homemaking, self-care, employment and recreation.

Transfer
The closure of a person's record by the home T/RBHA and simultaneous enrollment of the person by a different T/RBHA.

Transition from Youth to Adulthood

- Adult Recovery Team
- Child and Family Team
- Guardian
- Natural Support/Family
- Peer/Recovery Support
- Person-Centered Planning
- Special Assistance

3.17.6 Objectives

To ensure the coordination and continuity of care for all behavioral health recipients experiencing a transition in service providers.

Transition from Youth to Adulthood Objectives ensure:

- The identification of all eligible adolescents and young adults, between the ages of 16 and 24, enrolled in Magellan Health Services of Arizona, the Regional Behavioral Health Authority (RBHA) of Maricopa County; and

That Service Providers support a smooth transition for all Title XIX/XXI children who are turning 18 years of age and transitioning to the adult SMI or GMH/SA behavioral health systems through the development and implementation of initiatives that improve the quality and effectiveness of

programs and services for transition-age youth and young adults in order to strengthen the outcomes for them across the transition domains of employment/career, education, living situation, personal effectiveness/wellbeing, and community-life functioning.

3.17.7 Procedures

3.17.7-A. Transition from Youth to Adulthood

Overview
A critical focus of the ADHS/DBHS service delivery system is the effective and efficient delivery of behavioral health services to transition-aged youth, who are considered a special population who have unique developmental needs, in order to prepare them to move into adulthood.

Whether their mental health challenges began in childhood or presented during their later adolescent years, transition age youth require developmental skills which improve their capacity to complete their education, obtain employment, and achieve independence**.**

Therefore, it is the responsibility of Service Providers to ensure youth and young adults are provided the opportunity to experience a positive transition into the adult world. This process should support independence, interdependence and recovery, and help ensure that youth and young adults are given the support, skills and connections needed to experience future success. Further, it is essential that youth and young adults have the skills to identify their support needs and advocate for themselves. A thorough plan for the transition into adulthood is critical for ensuring that youth become stable and productive adults.

To ensure that transition-aged youth are provided necessary behavioral health services, Magellan Health Services has established a comprehensive transition process with explicit guidelines, requirements and procedures to implement programs and services that smoothly transition youth and young adults from the children's behavioral health system of care into the adult SMI or GMH/SA behavioral health systems of care.

Services Strategies
Youth Transition to Adulthood strategies will encompass the Transition to Independence Process (TIP) system, developed by Hewitt B. "Rusty" Clark, Ph.D., Department of Child and Family Studies, Louis de la Parte Florida Mental Health Institute, University of South Florida, Tampa, Florida as a Best Practice model to serving the needs of youth/young adults. The TIP system is operationalized through seven guidelines and their associated elements that drive the practice level activities and provide a framework for the program and community system to support these functions.

TIP promotes activities that are all done with respect for the youth and family's values, culture and perspective; and its service/treatment planning uses the following guidelines:

- Engage young people through relationship development, person-centered planning, and a focus on their futures.
    - Use a strength-based approach with young people, their families, and other informal and formal key players;
    - Build relationships and respect young persons' relationships with family members and other informal and formal key players;
    - Facilitate personal-futures planning and goal setting;
    - Include prevention planning for high-risk situations, as necessary;
    - Engage young people in positive activities of interest; and
    - Respect cultural and familial values and young persons' perspectives.
- Tailor services and supports to be accessible, coordinated, developmentally-appropriate, and build on strengths to enable the young people to pursue their goals across all transition domains.
    - Facilitate young persons' goal achievement across all transition domains;
        1) Employment and Career
        2) Educational Opportunities
        3) Living Situation
        4) Community Life Functioning
    - Tailor services and supports to be developmentally-appropriate and build on the strengths, and address the needs, of the young people, their families, and other informal key players; and
    - Ensure that services and supports are accessible and coordinated.

- Acknowledge and develop personal choice and social responsibility with young people.
    - Encourage problem-solving methods, decision making, and evaluation of impact on self and others; and
    - Balance one's work with young people between two axioms;

        Maximize the likelihood of the success of young people; and
        Allow young people to contact natural consequences through life experience.
- Ensure a safety-net of support by involving a young person's parents, family members and other informal and formal key players.
    - Involve parents, family members, and other informal and formal key players;

  - Parents, family members, or other informal key players may need assistance in understanding this transition period or may need services/supports for themselves;
  - Assist in mediating differences in the perspectives of young people, parents, and other informal and formal key players;
  - Facilitate an unconditional commitment to the young person among his/her key players; and
  - Create an atmosphere of hopefulness, fun, and a future focus.

- Enhance young persons' competencies to assist them in achieving greater self-sufficiency and confidence.
  - Utilize assessment methods, e.g., functional in-situation assessment;
  - Teach meaningful skills relevant to the young people across transition domains;
  - Use teaching strategies in community settings; and
  - Develop skills related to self-management, problem-solving, self-advocacy, and self-evaluation of the impact of one's choices and actions on self and others.

- Maintain an outcome focus in the TIP system at the young person, program, and community levels.
  - Focus on a young person's goals and the tracking of his/her progress;
  - Evaluate the responsiveness and effectiveness of the TIP system; and
  - Use process measures for continuous TIP system improvement.

- Involve young people, parents, and other community partners in the TIP system at the practice, program, and community levels.
  - Maximize the involvement of young people, family members, informal and formal key players, and other community representatives;
  - Tap the talents of peers and mentors;
  - Hire young adults as peer mentors and peer counselors;
  - Assist young people in creating peer support groups; and
  - Partner with young people, parents, and others in the TIP system governance and stewardship.

Service Providers shall at a minimum become "TIP informed" to better tailor services and supports that are accessible, coordinated, developmentally appropriate and strength-based to enable youth and young adults to pursue their goals across all transition domains.

<u>Medical/Physical Healthcare</u>

Service Providers will follow the applicable guidelines below to assist the youth/young adult to plan for:

- A transfer from a pediatrician to an adult health care provider, if pertinent;
- Obtaining medical coverage, including how to select a health plan and a physician; as well as preparing an AHCCCS application by the youth's 17th birthday, as indicated in *ADHS/DBHS Transition to Adulthood Practice Protocol.; and*
- The transition by providing information on Advanced Directives, as indicated in Magellan Provider Manual 3.12.
- Recommended immunization for the 18-21 year old age group that would include tuberculosis (TB) and meningococcal vaccines.

Safety/Crisis Plans

Service Providers will follow applicable guidelines for ensuring that Safety and Crisis plans are in place, as described in the *Child and Family Team Practice Protocol.* Children's Providers will also coordinate with the adult service provider case manager and/or adult recovery team to ensure the transitioning youth/young adult is aware of the crisis services available in the adult system.

Financial

Service Providers will promote team discussions with the youth/young adult and family/caregiver about any needs for assistance with financial matters such as a payee service. Guidelines will reflect the importance of reviewing and updating any federal and/or state financial forms to reflect the change in status of the youth/young adult to ensure there will be no disruption in the receiving of financial assistance; informing the youth/young adult and family/caregiver on changes related to Social Security benefits and the programs especially designed for young adults and their families, including Social Security Work Incentives planning.

Vocational/Employment/Education

The Child and Family Team will identify vocational and educational needs as early as possible in the transition process. Magellan will ensure that a representative from the adult system will be involved in these meetings to ensure both areas are addressed before, during and after the transition to adulthood. Magellan strongly encourages all Child and Family Team members, including case managers wherever possible, to continue participation in the lives of recipients until age 21 in order to facilitate a smooth transition to adulthood and to provide the best chance for successful outcomes. The youth and legal guardian may also request to retain his/her current Child and Family Team until the youth turns 21.

Guardianship

Service Providers will ensure that the Child and Family Team will discuss guardianship prior to the youth/young adult turning 18, if applicable. If the Child and Family Team decide a guardian is needed, they will arrange for filing the appropriate paperwork prior to the youth/young adult's 18th birthday.

Housing

Service providers will ensure that the Child and Family Team and the Adult Recovery Team address housing needs and options as part of the youth/young adult's planning process. Safety shall be one of the key considerations when reviewing needs in this area.

Family Involvement/Natural Supports/Cultural Considerations

Service providers will ensure that family involvement and culture must be considered at all times in both the Children and Adult Systems of Care. The Child and Family Team and the Adult Recovery Team, through understanding the family culture, will help promote successful transition. Actions will include, but are not limited to:

- Informing families of appropriate family support programs available in both the children and adult behavioral health systems;
- Providing a Family Support Partner Family Mentor and/or Peer Mentor to act as a "Liaison", introducing the youth and family to the adult behavioral health system;
- Helping to recognize, and working together to understand and acknowledge, each family's culture and their roles and patterns related to 'independence'; and/or "interdependence"; and
- Working within complex family dynamics and with families that may be involved with one or more state agencies.
- Engagement of family members and natural supports will be an essential element of treatment in both the children's and adult behavioral health systems. Engagement activities may include, but are not limited to the following:
    - Including family members in treatment meeting with the recipient
    - Incorporating family input into the treatment interventions and plan
    - Incorporating family members and natural supports into crisis and safety plans

Transportation

Service providers will ensure that the family and young adult are aware of the transportation options available through the adult system of care and help ensure continued attendance at service locations and medical and counseling appointments; as well as making certain transportation options are safe.

System Partners

Service providers will promote coordination among all system partners including: Child Protective Services; Division of Developmental Disabilities; Department of Juvenile Corrections; Office of the Courts; Rehabilitation Services Administration and the Department of Education.

This will ensure that the family and youth/young adult has access to all available resources and documentation, such as: copies of birth certificates; social security cards; medical records; any determinations; assessments; IEPs; certificates of achievements; diplomas; GED transcripts; application forms for college; case plans for youth continuing in the foster care system; treatment plans; documentation of completion of probation or parole; guardianship applications and social security applications for benefits.

Choice & Options

In keeping with the Arizona Vision in the children's system and the five principles of Person Centered Planning in the adult system, service providers will encourage those involved in the transition process to ensure that young adults and their caregivers/family are provided with choices and options as they pertain to services available in the adult system of care.

Procedures

Transition Plans

CPNOs/QSPs develop monthly reports that identify youth turning 16 and 17 at least 30 days prior to their birthdays. To aid the CPNOs and QSPs in beginning the Transition Planning process, they will use the following criteria when developing plans for transition age youth:

- CFTs will work with youth/family to assess needed living skills. Assessments will be conducted in the youth's environment.
- Transition Plans will address needed independent living skills, such as budgeting money and maintaining employment, while teaching youth the reciprocal role of supporting others and receiving support from others through development of a social support network for emotional, spiritual and physical support.

- Self-Determination
  - Transition Plans will contain goals that are targeted to improve the youth's life.
  - CFTs will work with the youth/family to develop alternative strategies, aid them in choosing among said strategies to; achieve the goal, implement the strategy and evaluate progress toward the goal.

- Transition Process Values - All Transition Plans will be developed utilizing the process values listed below
  - Engage the youth through relationship development, person centered planning and focus on the future.
  - Services and supports will be tailored to be accessible and developmentally appropriate, built on the youth's strengths with focus on achieving these goals.

- Acknowledgement and development of personal choice and social responsibility to maximize likelihood of personal success while allowing the youth contact with natural consequences.
- Build a safety net of support by involving youths, parents, family members and other informal and formal key players.
- Build youth competencies to assist them in achieving greater self sufficiency and confidence:
  1) Functional in-situation assessment;
  2) Teach the youth skills relevant across Transition Domains;
  3) Use teaching strategies in community settings; and
  4) Develop the youth's skills in self management, problem solving, self advocacy, and self evaluation of the impact of one's choices and actions on self and others.
- Maintain focus on outcomes at youth, program and community levels.

Transition Domains

The Provider Manual Section 3.17.7-A., requires that transition planning begin **at age 16**. It is important that members of the Child and Family Team look at the transition planning as not just a transition into the adult system, but as a transition to adulthood. All Transition Plans will address the following Transition Domains:

- Employment and career;
- Educational opportunities (including career track training);
- Living situation;
- Community life functioning;
  - Daily living
  - Leisure activity
  - Community participation
  - Health
  - Self determination
  - Communication
  - Interpersonal relationships
- Implementation of these concepts for youth 16 or older;
  The Child and Family Team will work with educational providers to ensure that youth with IEPs or 504 plans have clearly defined transition plans in these documents beginning at age 16 as required by IDEA;
- The Child and Family Team, in conjunction with the adult behavioral health provider, will assist the youth/parent/caregiver with the following:
- having the youth actively participate in IEP and transition planning to ensure his/her voice is heard;
- assisting the youth in developing positive relationships with involved school personnel and other agency service providers;

- discussing potential decisions before IEP meetings so the youth is informed and can actively participate in advocating for his/her wishes; and,
- including the youth in decisions that impact his/her life inside and outside the school setting
- Youth with CASII scores of 4, 5, and 6 must all have Transition Plans which address the four Transition Domains to be incorporated into their ISP; and
- CFT's will review Transition Plans every three (3) months with the youth/young adult and their family/guardian.

To anticipate needs, build on strengths and link youth to appropriate supports and services, please refer to the action items listed within Attachment 3.17.1, Magellan Youth Transition to Adulthood Planning Check List Reference Guide.

Strengths, Needs and Culture Discovery (SNCD)

- The Strengths, Needs and Culture Discovery acquires information on the various aspects of both the child and family's life situation through conversations that begin at intake and continue over the course of service delivery, and provides essential information used to develop a strengths-based, individualized service plan which respects the unique culture of the youth and family. The elements of the Strengths, Needs and Culture Discovery include:
  - Identification of strengths, assets and resources that can be mobilized to address youth and family needs for support.
  - Exploration and understanding of the unique culture of the family, so the service plan will be one the youth and family will support and utilize. The family's culture is influenced by family relationships, rituals, social relationships, living environment, work environment, spiritual focus, health, financial situation and other factors.
  - Recording the youth and family's vision of a desired future.
  - Identifying the needs and areas of focus that must be addressed to move toward this desired future.
- Magellan's service expectation is that the Children's System case manager provides the adult provider or adult case manger this informational tool, as it is important for the adult provider or case manager to request this informational tool prior to the youth transitioning into the adult system of care.

Identify Youth Who Will Qualify for SMI Services

- Each CPNO/QSP will provide a monthly report to the Magellan Children's PNO /Service Development Director identifying youth at age 17.
- Each youth's CFT will discuss the need for sending in an eligibility application for SMI program.
- Providers will complete an eligibility packet according to the Magellan Provider Manual, Section 3.10, SMI Eligibility Determination and submit it to the RBHA within 14 days of the CFT decision.

- RBHA Eligibility & Evaluation unit determines if the youth is eligible for SMI program services.
- RBHA Eligibility & Evaluation unit assigns the youth to a clinic closest to their home, or a clinic of their choice.
- Clinic assigns the youth a case manager within 7 days of determination, notifies the PNO/QSP of case manager assignment and sends contact information.
- At the time of transfer to either an SMI clinic or GMH/SA provider, the psychiatrist from the children's system will communicate directly with the receiving psychiatrist in the adult system.
- The children's case manager and/or transition facilitator will attend, with the youth, the youth's first appointment in either the adult SMI clinic or the GMH/SA provider.
- A transfer staffing will occur and be held at the receiving clinic or provider with youth and/or family representation

- In the event that the youth/young adult chooses to continue services with their Children's System Child and Family Team, the RBHA will ensure that:
  - Provisions are made to enable the Children's Provider to meet the requirements for dual licensure and credentialing as outlined in section III. B.; *Use of Adult Funding* of this policy.
  - The Adult Case Manager will continue to act as a system liaison and as a participating member of the Child and Family Team.
  - The youth/young adult will work with the adult Case Manager and Child and Family Team to ensure a clinically appropriate transition into needed adult services by their 22nd birthday.

Identify Youth Who Will Not Qualify For SMI Services

In those cases where SMI eligibility criteria are not met, or when a youth / young adult is determined to no longer meet diagnostic and functional criteria, service providers will ensure that:

- Services are continued depending on Title XIX/XXI eligibility, T/RBHA service priorities and any other requirements described in Provider Manual Section 3.21, Service Prioritization for Non-Title XIX/XXI Funding.
- Written notice of the reason for denial of SMI determination and the right to appeal shall be provided

Identify Staff to Coordinate Services

When the youth/young adult reaches age 17 and is eligible to apply for SMI services, coordination between the Child and Family Team and the assigned adult clinic staff will occur. This includes orienting the youth and his/her family to the adult system and preparing the adult team to make the transition from the Child and Family Team to an Adult Recovery Team. The youth provider, coordinating with the adult provider, should encourage a liaison

(e.g. Family and Peer Mentors) in the adult system to act as an ambassador for the incoming young adult and their involved family and/or caregiver.

- In the event that the youth/young adult chooses to continue services with their Children's System Child and Family Team, the RBHA will ensure that:
  - Provisions are made to enable the Children's Provider to meet the requirements for dual licensure and credentialing as outlined in section III. B.; *Use of Adult Funding* of this policy.
  - The Adult Case Manager will continue to act as a system liaison and as a participating member of the Child and Family Team.
  - The youth/young adult will work with the adult Case Manager and Child and Family Team to ensure a clinically appropriate transition into needed adult services by their 22nd birthday.

- Transition Team staff will do the following:
  - Implement outreach, engagement, assessment, diagnosis and treatment practices and support services that are developmentally appropriate and are responsive to and respectful of the youth/family's racial and/or ethnic cultural traditions, beliefs, and values.
  - Facilitate the inclusion of family, extended family, friends and natural supports as defined by the youth and/or family.
  - Ensure planning and support services promote social inclusion, positive attitudes, beliefs and behaviors thereby reducing stigma associated with mental health challenges.
  - Ensure transition materials are available in English and Spanish.
  - All Transition Plans and the desired outcomes shall be defined within the cultural context of the youth/young adult.
  - Parent/Family/Guardian participation in the Transition process will be encouraged by all Transition Team staff by learning and teaching the principles of dependence vs. interdependence to youth, parents and staff.
  -
  - Facilitate access to mentoring programs for youth who have been raised in foster care.
  - The youth must be involved in the planning and decision making. The Core Team helps the youth create a circle of support and focus their goals utilizing their interests, talents, strengths and aspirations.
  - Develop youth and family advisory capacity to be utilized in any program development for youth in transition.
- Adult Case Manager Involvement
  - Youth's CFT begins to invite adult case manager to CFT/ Transition Team

- PNOs/QSPs will track the number of youth served that have become SMI eligible and have been assigned to a direct care clinic with an assigned adult case manager. The RBHA will ensure that the PNOS will gather current information and the ability to submit a tracking log upon the RBHA's request.
- DCCs and APNOs will track adult case manager attendance at youth's CFTs on a monthly basis.
- Adult case manager will begin attending CFT/ Core Transition Team meetings minimally 6 months prior to youth's 18th birthday. The adult case manager or adult system representative will attend a minimum of two CFT meetings prior to the youth's 18th birthday
- Transition Plan shall address the four Transition Domains:
  1) Employment and career
  2) Educational opportunities (career track training)
  3) Living situation
  4) Community life functioning:
     a. Daily living
     b. Leisure activity
     c. Community participation
     d. Health
     e. Self determination
     f. Communication
     g. Interpersonal relationships

- Youth Involvement

  The youth must be involved in the planning and decision making. The Core Team helps the youth create a circle of support and focus their goals utilizing their interests, talents, strengths and aspirations.

- Strength-discovery and needs assessment.

  If and when the youth/young adult enters the Adult system an adult team member will begin to work with them on an individual basis. This assessment process involves meeting with the young person, reviewing educational and service system records, and meeting with relevant educational and service personnel. The young adult (and their CFT when indicated), along with the adult team member decides who are considered to be key players (e.g., a parent, aunt, vocational rehabilitation counselor, special education teacher, guidance counselor, etc.). As the adult team member gathers information from each of the key players, the focus is on gaining an understanding of the young adult and the family's past and current issues and, more importantly, on learning about their past successes and present strengths and potentials. Magellan will encourage all adult providers to build on the youth's Strength, Needs and Culture Discovery that was initiated from the Children's System of Care and request a copy of

the Strengths, Needs and Cultural Discovery from the Children's provider if not provided in the transition from the Children's System to the Adult System of Care.

- Evidence of attendance will be addressed by the presence of the adult case manager and/or adult team member signature on the CFT notes and written progress notes.
- The Child and Family Team and adult team members will assist the young adult and/or family/caregivers with issues, such as obtaining:
  - A State ID
  - Supplemental Security Income
  - Health Insurance/AHCCCS
  - Guardianship/payee
  - Vocational Training/Rehabilitation
  - Housing
- CPNOs/APNOS and their network and subcontracted providers will ensure that when a young adult has been determined ineligible to receive Title XIX or XXI services, that services are continued as outlined in Provider Manual *Section 3.21. Service Prioritization for Non-Title XIX/XXI* and *Section 3.4 Co-payments*.

Special Considerations

- Special considerations will be made to eligible individuals with developmental disabilities in accordance with The Division of Developmental Disabilities, within the Arizona Department of Economic Security.
- In preparation of the Child and Family Team meeting (CFT), the CFT facilitator shall contact the DES/DDD Support Coordinator to discuss the focus of the meeting, establish ground rules and clearly define roles and responsibilities. The facilitator shall also invite the youth/young adult's Guardian Ad Litem, if one has been appointed by the court, to participate in the Child and Family Team Process.
- The provider shall ask the DES/DDD support coordinator if there are any court orders (i.e., no contact orders) that affect the youth/young adult or the potential membership of the Child and Family Team.
- The CFT facilitator shall make assessment information available to the legally responsible person and the DES/DDD Support Coordinator and shall seek information from DES/DDD to incorporate into the assessment and service planning process. Information to be requested from DES/DDD may include:
  - Youth/Young Adult's current behavioral needs and/or stabilization needs

  - DES/DDD Individual Service Plan Goals
  - The outcome of any previous placements/treatment services
  - Explore potential members for the Child and Family Team; those who might be contrary to the youth/young adult's best interest will need to be explored.
  - Any other issues, including potential barriers, legal requirements or mandates that pertain to this youth or young adult, and any information that will increase understanding of the youth/young adult's unique cultural heritage, to be incorporated in the Individual Service Plan (ISP).

- The CFT will work with the DES/DDD Support Coordinator on the youth/young adult's transition plan into adulthood, to begin when the youth reaches the age of 16.
- For any youth who is currently being served under an IEP plan, collaboration with the IEP team in transition planning is imperative to ensure the alignment of IEP goals with the goals contained in the behavioral health ISP. The CFT, in conjunction with the adult service provider, will consult with the minor's parent/legal guardian or the young adult, if age 18 or older, to obtain their permission to participate in the IEP meeting for the purpose of coordinating transition planning and services between the behavioral health and education systems. For young adults, age 18 and older, where legal guardianship has been established or the right to make educational decisions has been delegated to another responsible person, permission to participate in IEP meetings is obtained from the student's identified legal representative.

- In accordance with the principles of family support, services and support provided to a person with a developmental disability will:
  - Strengthen the family's role as a primary caregiver;
  - Prevent inappropriate out-of-home placement;
  - Maintain family unity;
  - Reunite families with members who have been placed out-of-home; and
  - Include a broad range of supports and services.

Continuity of Services

Use of Children's Funding

- Children's funding for adult provider participation in CFT planning meetings prior to an individual turning 18 requires each participating Direct Care Clinic (DCC) and/or adult service provider to be licensed to provide children's services. Each DCC and/or adult service provider providing children's services at the DCCs is fingerprinted according to R9-20-201.A.1 and must have a valid class one or class two fingerprint clearance card available for review prior to providing any children's services.
- Behavioral health provider agencies may be licensed to provide adult and children's services through the Office of Behavioral Health Licensing (OBHL) according to the

Arizona Administrative Code R9-20 and credentialed according to the Magellan Provider Manual, Section 3.20, Credentialing and Privileging.

- Magellan will ensure that any provider participating in the transition process holds all appropriate licensure and will provide technical assistance as needed**.** Upon service delivery a provider can submit claims for reimbursement as outlined in Section 6.2, Submitting Claims and Encounters to the RBHA.

Use of Adult Funding

- Children's behavioral health provider agencies must be licensed to provide adult services to encounter and bill for CFT planning meetings after an individual turns 18 years of age. This will allow children's provider staff to encounter and continue the CFT process on the Adult Clinical Team
- Behavioral health provider agencies may be licensed to provide adult and children's services through the Office of Behavioral Health Licensing (OBHL) according to the Arizona Administrative Code R9-20 and credentialed according to the Magellan Provider Manual, Section 3.20, Credentialing and Privileging
- Magellan will ensure that any provider participating in the transition process holds all appropriate licensure.
- Upon service delivery a provider can submit claims for reimbursement as outlined in Section 6.2, Submitting Claims and Encounters to the RBHA.

Training

Magellan Employees, CPNOs, APNOs, QSPs

- Transition Team staff will demonstrate sensitivity and responsiveness to individual variation in gender, ethnicity, sexual orientation, social class and other unique orientations and needs of each transitional youth, young adult and his or her family.
- Transition Team staff composition shall reflect the communities they serve.
- Each team shall have bilingual, bi-cultural capability.
- Staff shall attend training in cultural competency annually and demonstrate a working knowledge of service population's cultural worldview.
- Peer Mentors, Family Mentors and Family Support Partners will receive training on how to work with transition age youth.

Providers

- Training on the SMI Determination Policy will be provided to QSP and PNO staff as evidenced by training schedules and sign-in sheets.
- Magellan will send criteria to the Children's Provider Network Organizations and they will perform the following:

  At 16-1/2 years of age, CFT will review the youth's record and discuss the need for SMI Determination.

If the CFT determines the need for a request for SMI Determination, the clinical team will complete the required paperwork and submit to the RBHA Eligibility and Evaluations Unit. This must be done before the youth's 17th birthday.

Youth who become eligible for programs for persons with serious mental illness will be assigned to a clinic and an adult case manager at the time of determination.

The adult case manager will begin to attend the youth's CFT and work with the CFT on the youth's Transition Plan.

- Evidence of attendance will be addressed by the presence of the case manager's signature on the CFT notes.
- The RBHA will require prescribers working with this age group to complete training on working with youth/young adults as it pertains to issues in prescribing psychotropic medication for youth/young adults. Topics covered are as follows:
  - Prescribing that promotes adherence to treatment;
  - Tetragenicity and psychotropic medication;
  - Minimizing side-effects; and
  - Contraception awareness.

Youth Transition to Adulthood Training

- Magellan will provide training to RBHA, provider staff, stakeholders, young adults and families through a stand-alone training (offered quarterly) that includes elements of the Transition to Independence Process (TIP) system and the ADHS revised Practice Protocol "Transition to Adulthood" and the "Youth Involvement in Arizona Behavior Health System Practice Protocol." .
- In order to increase system integration, cross-training for a combined audience of child and adult provider personnel will be initiated by Magellan's Learning Center.
- Training on Youth Transition to Adulthood will be provided to DCCs, QSP and PNO staff as evidenced by training schedules and sign-in sheets.

Child and Family Team Training

- Magellan will ensure all agency clinical and support services staff working with children and adolescents understands the required service expectations and implements the practice elements of the Child and Family Team Practice Protocol.
- To increase system integration, cross-training for a combined audience of child and adult provider personnel will be initiated by Magellan's Learning Center.

- Training on the Child and Family Team will be provided to DCCs, QSP and PNO staff as evidenced by training schedules and sign-in sheets.

Outcomes

CPNOs, APNOs will monitor outcomes that include:

- Improved/stable/supported employment;
- Increased and/or continued education and vocational involvement;
- Increased skill development in all domains of the transitioning young adult's life; and
- Increased self-advocacy.

Fidelity

- Magellan will ensure that CPNOs and APNOs will monitor fidelity through:
  - Chart audits;
  - Customer satisfaction surveys;
  - Functional outcome scores; and
  - Review of System of Care Plans.
  - Routine reporting on the number of "shared" teams

- Magellan will monitor improved outcomes as measured by:
  - Increases in the involvement in educational and vocational activities;
  - Improved availability and access to social activities and supports, and
  - Decreases in homelessness, hospitalizations, frequent crisis services, criminal justice involvement and substance abuse.

3.17.7-B. Transition due to a change of the Behavioral Health Provider or the behavioral health category assignment

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

- 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;

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

- Ensure the transfer of responsibility for court ordered treatment, if applicable;

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

- Ensure that the recipient has enough medications until he/she can be seen at the receiving;

- Continue to render services to the recipient until they begin being seen by the new agency/provider, and not close the recipient from care until they have officially started services at the receiving agency. This should be verified by the transferring and receiving agencies' Single Point of Contacts.

- Once the recipient has started services at the receiving agency, the transferring agency shall complete the online Interagency PNO Client Transfer, form 3.17.1, located in the Forms and Attachments section of the Magellan Provider Manual.

- This requirement also applies to transfers between systems; transfer from a children's provider to an adult provider(s).

Resources available to the provider include:

Transfer Protocol Between Provider Network Organizations, attachment 3.17.2
Interagency PNO Client Transfer, form 3.17.1

3.17.7-C. Transition to ALTCS Program Contractors

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 T/RBHAs 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 T/RBHA. To determine if a person is ALTCS/EPD eligible, providers may call Magellan Customer Service at 1-800-564-5465. 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 T/RBHA 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 T/RBHA becomes enrolled in the ALTCS Program, the behavioral health provider must:

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

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

- 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;

- 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;
- Transfer responsibility for any court ordered treatment;

- Coordinate the transfer of records to the ALTCS program contractor; and

- Provide information as follows:
  - For Title XIX eligible 21-64 year olds, the number of days the person has received services in an Institution for Mental Disease (IMD) in the contract year (July 1 – June 30);

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

  - 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.

3.17.7-D Transition to CRS Program contractors

Once a person is determined eligible and becomes enrolled with the Children's Rehabilitative Services (CRS) Program, behavioral health providers must submit claims or encounters for Title XIX covered services to the AHCCCS CRS Program Contractor. These claims or encounters must not be submitted to the RBHA.

To determine if a person is CRS eligible, providers may contact the United CRS Member Services number at 1-800-348-4085. Providers may also contact the Magellan Health Plan Liaison at 1-800-564-5465 for additional assistance in determining CRS eligibility.

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.

The behavioral health provider may continue to provide non-Title XIX covered services funded through the SAPT or CMHS Block Grant to persons who meet the Grant's population requirements (please see Section 3.19, Special Populations) as funding is available.

All restrictions on these funds, and adherence to priority population requirements, as specified in Section 3.19, Special Populations must be applied to this population. The member must be a child/adolescent with a Serious Emotional Disturbance (SED) or an adult with a Serious Mental Illness (SMI) to receive CMHS-funded services; SAPT funds may only be expended on members with a diagnosed Substance Use Disorder.

The RBHA and provider(s) are required to receive prior approval from ADHS for any flex fund expenditures exceeding $1,525.00 per member per contract year (see PM Form 3.13.1, SAPT/CMHS Flex Fund Request).

These non-Title XIX covered services must be encountered to the RBHA. The RBHA must successfully submit a State-Only 834 enrollment for these members prior to encountering for these services.

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

- Include the member in transition planning and provide any available information about changes in physician, services, etc.;
- Ensure that the clinical and fiscal responsibility for Title XIX behavioral health services shifts to the CRS Program Contractor;
- Provide information to the CRS Program Contractor regarding the person's on-going needs for behavioral health services to ensure continuity of care during the transition period; Review the current treatment plan and, if needed, coordinate the development of a revised treatment plan with the clinical team and the receiving CRS provider and/or case manager; Transfer responsibility for any court ordered treatment;
    - Coordinate the transfer of records to the CRS program contractor; and Provide information as follows:
        - For Title XIX eligible 21-64 year olds, the number of days the person has received services in an Institution for Mental Disease (IMD) in the contract year (October – September 30);

- For all persons, the number of hours of respite received in the contract year October 1 – September 30); and

- 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.

3.17.7-E Inter-T/RBHA Transfer

How is T/RBHA responsibility determined for adults?
For adults (persons 18 years and older), T/RBHA 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 T/RBHA with the exception of persons who are unable to live independently but are involved with DDD. However, T/RBHAs may agree to coordinate an Inter-T/RBHA 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 T/RBHA 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 T/RBHA service area, covered services remain the responsibility of the home T/RBHA.

How is T/RBHA responsibility determined for children?
For children (ages 0-17 years), T/RBHA 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 T/RBHA has responsibility.

How is T/RBHA responsibility determined for persons who are temporarily residing in another T/RBHA's geographic service area (GSA)?
The home T/RBHA remains fiscally responsible for all services provided to an enrolled person who is visiting or otherwise temporarily residing in a different T/RBHA's geographic service area (GSA) as long as the person, or legal guardian for a child, maintains a place of residence in the home T/RBHA'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 T/RBHA may proceed with an Inter-T/RBHA 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 T/RBHA or their contracted providers must:

- Provide needed crisis services;
- Ascertain the person's enrollment status with all T/RBHAs and determine whether the person's residence in the current area is temporary or permanent;
- If the person is enrolled with another T/RBHA, notify the home T/RBHA within 24 hours of the person's presentation. The home T/RBHA or their contracted providers is fiscally responsible for crisis services and must: Make arrangements with the T/RBHA at which the person presents to provide needed services, funded by the home T/RBHA;
- Arrange transportation to return the person to the home T/RBHA area; or
- Determine if the person intends to live in the new T/RBHA'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 T/RBHA 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-T/RBHA transfer can proceed.

If the person is not enrolled with any T/RBHA and lives within the service area of the T/RBHA in which the person presented for services, behavioral health providers must notify the T/RBHA to initiate an enrollment.
For Maricopa County, contact Magellan Customer Service at 1-800-564-5465

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

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

- In the event that a T/RBHA or provider receives a referral regarding a hospitalized person whose residence is located outside the T/RBHA's geographic service area, the T/RBHA or provider must immediately coordinate the referral with the person's designated T/RBHA.

When is an Inter-T/RBHA Transfer required?

An Inter-T/RBHA transfer must be completed under the following circumstances:

- An adult person voluntarily elects to change his/her place of residence to an independent living setting from one T/RBHA's area to another. Only adult persons who are able to live independently can be transferred to another T/RBHA, 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 T/RBHA in which the supervised setting is located;

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

- The parent(s) or legal guardian(s) of a child change their place of residence to another T/RBHA's area; or

- The court of jurisdiction of a dependent child changes to another T/RBHA's area.

Inter-T/RBHA 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-T/RBHA transfer?

The home T/RBHA or its contracted providers must initiate a referral for an Inter-T/RBHA 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 T/RBHA during an Inter-T/RBHA transfer?

Within 14 days of receipt of the referral for an Inter-T/RBHA transfer, the receiving T/RBHA or its subcontracted providers must:

- Schedule a meeting to establish a transition plan for the person. The meeting must include:
- The person or the person's guardian or parent, if applicable;

- Representatives from the home T/RBHA;
- Representatives from the Arizona State Hospital (AzSH), when applicable;
- The behavioral health provider and representatives of the CFT/adult clinical team;
- Other involved agencies; and
- Any other relevant participant at the person's request or with the consent of the person's guardian.
- Establish a transition plan that includes at least the following:
- The person's projected moving date and place of residence;
- Treatment and support services needed by the person and the timeframe within which the services are needed;
- 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;
- Information to be provided to the person regarding how to access services immediately upon relocation;
- The enrollment date, time and place at the receiving T/RBHA and the formal date of transfer, if different from the enrollment date;
- The date and location of the person's first service appointment in the receiving T/RBHA's GSA;
- The individual responsible for coordinating any needed change of health plan enrollment, primary care provider assignment and medication coverage;
- The person's behavioral health provider in the receiving T/RBHA's GSA, including information on how to contact the behavioral health provider;
- Identification of the person at the receiving T/RBHA who is responsible for coordination of the transfer, if other than the person's behavioral health provider;

- 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,

- 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-T/RBHA transfer?
The consumer, family, guardian, state agency staff or other health provider staff is responsible for initiating an Inter-T/RBHA transfer.

What are the Behavioral Health Provider's responsibilities during an Inter-T/RBHA transfer?
As part of an Inter-T/RBHA transfer, the behavioral health provider must:

- 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;

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

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

- Transfer responsibility for any court ordered treatment;

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

- Provide information as follows:
  - For Title XIX eligible 21-64 year olds, the number of days the person has received services in an Institution for Mental Disease (IMD) in the contract year (July 1 – June 30);

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

  - 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-T/RBHA transfer?

When an Inter-T/RBHA transfer occurs, the person must be disenrolled from the home T/RBHA and enrolled in the receiving T/RBHA contingent upon the date the person expects to relocate to the receiving T/RBHA's geographic service area, but no later than 30 days of the referral by the home T/RBHA (see Section 7.5, Enrollment, Disenrollment and Other Data Submission). This timeframe allows sufficient time for the receiving T/RBHA 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 T/RBHAs to transfer the person, the T/RBHAs must collaborate to ensure appropriate re-engagement activities occur (see Section 3.8, Outreach, Engagement, Re-Engagement and Closure) and proceed with the inter-T/RBHA transfer, if appropriate.

Who is responsible for care during an Inter-T/RBHA transfer?
In an Inter-T/RBHA transfer, the home T/RBHA 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 T/RBHA (see Section 3.8, Outreach, Engagement, Re-engagement and Closure). The receiving T/RBHA must not delay the timely processing of an Inter-T/RBHA transfer because of missing or incomplete information.

Courtesy Dosing of Methadone
A person receiving methadone administration services who is not a recipient of take-home medication may receive up to two courtesy doses of methadone from a T/RBHA or its contracted providers while the person is traveling outside of the home T/RBHA area. All incidents of provision of courtesy dosing shall be reported to the home T/RBHA. The home T/RBHA 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-T/RBHA transfer may file an appeal in accordance with Section 5.5, Notice and Appeal Requirements (SMI and Non-SMI/Non-Title XIX/XXI).

Inter-T/RBHA transfers after crisis enrollments
When a person presents for crisis services, providers must first deliver needed behavioral health services and then determine eligibility and T/RBHA enrollment status. Persons enrolled after a crisis event may not need or want ongoing behavioral health services through the T/RBHA. Providers must conduct re-engagement efforts as described in PM Section 3.8, Outreach, Engagement, Re-engagement and Closure, 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-T/RBHA transfer must not be initiated. Persons who will receive ongoing behavioral health services will need to be referred to the appropriate T/RBHA and an inter-T/RBHA transfer initiated, if the person presented for crisis services in a GSA other than where the person resides.

Inter-T/RBHA transfers when persons do not inform the home T/RBHA 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 T/RBHA prior to moving to another service area. When behavioral health recipients inform their provider or T/RBHA less than 30 days prior to their move or do not inform their provider or T/RBHA of their move, the designated T/RBHA must not wait for all of the documentation from the previous T/RBHA before scheduling services for the behavioral health recipient.

3.17.7-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 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, as long as the medical director of the behavioral health provider initiating the transfer has established that:

- There is no reason to believe that the person will suffer more serious physical harm or serious illness as a result of the transfer;
- The person is being transitioned to a level and kind of treatment that is more appropriate to the person's treatment needs; and
- 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:
  - A summary of the person's needs;
  - A statement that, in the medical director's judgment, the receiving behavioral health provider can adequately meet the person's treatment needs;
  - A modification to the individual service plan, if applicable;

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

3.17.7-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 Closure. 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 T/RBHAs, if applicable, to ensure appropriate services/placement and necessary re-engagement activities occur upon discharge**.**

3.17.7-H. Transitions of persons receiving behavioral health services from Indian Health Services (IHS)

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