Administrative Policy

Policy Title: **Outreach and Discharge**

Policy #: **03-003-0050**

Effective Date:	10/31/2024
Approved by:	Telly Delor, Chief Operating Officer
Functional Area:	Client Services
Responsible Leader:	Kathleen Gallagher, Chief Clinical Officer
Policy Owner:	Jason Marocco, Kristen Thompson, and Heidi Fogarty Service Directors
Applies to:	SCCCMH Staff, All Direct Programs, Network Providers, Contracted Providers, Persons Served

Purpose: To ensure that individuals who previously received services from St. Clair County Community Mental Health have appropriate referrals for continuity of care and all responsibilities related to discharge have been completed.

I. Policy Statement

It is the policy of St. Clair County Community Mental Health (SCCCMH) to conduct follow-up and *outreach* with each person who has discontinued services to determine whether further services are needed, appropriate referrals are made, and the individual discontinuing services has a completed Discharge Summary in their file.

II. Standards

A. The organization must have an active outreach and educational effort to ensure all *Network Providers* and community members are aware of the access system and how to use it.

B. The organization must have a regular and consistent outreach effort to commonly underserved populations who include children and families; older adults; homeless persons; members of ethnic, racial, linguistic, and culturally diverse groups; persons with dementia; and pregnant women.

III. Procedures, Definitions, and Other Resources

A. Procedures

Responsibilities

Position	Responsibilities
Primary Caseholder	Perform outreach and discharge actions.
Administrative Support Staff	Perform post-discharge survey of former recipients.

Actions – Outreach

Action Number	Responsible Stakeholder	Details
1.0	Primary Caseholder	1. Make every available effort to develop and complete a discharge or transition plan to ensure continuity of care for an individual who experiences an *unplanned discharge*. 2. Document in the individual's electronic medical record (EMR) all attempts to re-engage the individual. 3. Attempt to re-engage the individual in services and supports by: • Attempting to locate them at their last known residence • Sending an outreach letter • Attempting to contact them using all available resources and stage wise treatment matching interventions, based on the person's current stage of change. 4. Provide education to individuals leaving services against treatment advice (ATA) regarding the risks associated with an early discharge. 5. Complete an updated assessment/intake for *established individuals* who have not received services for 90 days.

Actions – Outreach: When First Scheduled Appointment is a Missed Appointment

Action Number	Responsible Stakeholder	Details
1.0	Primary Caseholder	Perform the following Actions when a *current or prospective person served* misses their first appointment: 1. Within the first seven (7) calendar days: a. An initial call is attempted within 24 calendar hours of the *missed appointment*, ideally at the time of the missed appointment. b. At least one additional phone call is attempted and documented in the person's EMR. Calls should be made at varying times, and if feasible, at times associated with previous successful contacts. c. At least one outreach letter (Exhibit A) specific to the needs/risk level of the person is sent. i. The outreach letter is scanned and uploaded to the person's EMR. ii. The letter should include a date for a face-to-face contact, drop by appointment date/time/location, or day/time to expect a phone call. d. Prospective persons served will receive a Notice of Adverse Benefit Determination outlining the date their case will be closed i. For Individuals with Medicaid (12 days from date of notice). This will conclude the outreach process for prospective persons served. ii. For individuals who are non-Medicaid (30 days from date of Notice). e. For current persons served the outreach process will continue as follows. 2. Between Days 8-14: a. At least two additional phone calls are attempted and documented in the person's EMR. If possible, calls should be made at varying times and at times associated with previous successful contacts. b. When there is signed consent, staff may attempt to reach emergency contact numbers, schools, and other applicable entities. c. If possible, one of the calls should include a voicemail indicating a primary case holder will attempt to visit the person's home in the next 10

Action Number	Responsible Stakeholder	Details
		days to assist with eliminating any engagement barriers. 3. Between Days 14-15: A Notice of Adverse Benefit Determination (Due Process Advance Notice) per Administrative Policy #02-001-0040, Grievance Process and Administrative Policy #02-001-0045, Appeal Process and Second Opinion, when address is known, is mailed to the person outlining the date their case will be closed. The Notice includes all relevant outreach information that has occurred to date (Exhibit B). The Notice of pending case closure will end 30 days after the missed appointment. For cases receiving intensive services, ACT, IDDT, Next Step, Mental Health Court and Home Based Services, Notice of pending case closure will end 60 days after missed appointment. 4. Between Days 16-21: a. When receiving Targeted Case Management, ACT, IDDT, Next Step, Mental Health Court or Home Based Services, a primary case holder will attempt at least one home visit to assist the person in eliminating barriers that may prevent them from attending appointments. b. At least one final phone call is attempted. 5. Between Days 21-28: A final outreach letter is sent (Exhibit C). This letter includes a brief synopsis of all contact attempts and information regarding the pending case closure (if contact cannot be made). 6. By Day 30: The person's record can be closed after a 30-day engagement process occurs and contact has not been made with the person. When receiving ACT, IDDT, Next Step, Mental Health Court or Home Based Services outreach efforts will continue for 60 days prior to discharge summary activities outlined in #7 is completed 7. By Day 31: a. A discharge summary is completed in the EMR to close the person's record. b. A discharge summary is provided to the person if contact information is available. c. A discharge plan may include but is not limited

Action Number	Responsible Stakeholder	Details
		to: i. Instructions to maintain support and treatment outcomes; ii. Relapse prevention and recovery; iii. Instructions for crisis intervention; iv. Notification to other involved providers/supports persons; and v. A summary of a person's strengths.

Actions – Discharge

Action Number	Responsible Stakeholder	Details
1.0	Primary Caseholder	1. Complete a Discharge Summary within OASIS upon determining that one or more of the following criteria has occurred: • person has met goals and objectives • person is being referred elsewhere • person moves out of the county • person is not appropriate for services • person discontinued treatment with or without notice • program ends • person dies. 2. Close cases that are inactive for more than 30 calendar days, except for individuals with cases opened to IDDT, ACT, Next Step, Home Based and Mental Health Court which may remain open for up to 60 days.

Actions – Discharged from Other Facilities

Action Number	Responsible Stakeholder	Details
1.0	Primary Caseholder	1. Outreach to individuals 24 hours for discharge from all facilities, including inpatient psychiatric hospitalizations, known medical hospitalizations, residential treatment, SUD detox or post-detox treatment. 2. Document outreach attempts, contacts made, and all follow up appointments scheduled in the electronic health record via a progress note.

Actions – Thirty Days (30) post discharge

Action Number	Responsible Stakeholder	Details
1.0	Administrative Support Staff	1. Run a monthly report listing individuals who have been discharged (case charts closed) for three months. 2. Contact discharged (closed) individual via telephone survey regarding their satisfaction with services. 3. Share survey results with the SCCCMH Board of Directors and with all staff (via SCCCMH intranet).

B. Related Policies

A. Administrative Policy #02-001-0040, Grievance Process
B. Administrative Policy #02-001-0045, Appeal Process and Second Opinion

C. Definitions

Established Individual /Current Person Served: An individual receiving services through SCCCMH who is authorized for services and has participated in treatment with a primary provider within the SCCCMH network.

Missed Appointment: An appointment either scheduled but not attended or rescheduled by a person served.

Outreach: The documented attempt by the service provider to contact an individual when the individual has not engaged with clinic services as authorized within the

Individual Plan of Service (IPOS) or upon seeking Community Mental Health services at intake. Outreach is a key service element across outpatient programs serving individuals with Mental Illness and tends to vary across outpatient programs.

Prospective Person Served: An individual (or new person served) seeking services through SCCCMH who is not currently authorized for services and has not yet participated in treatment with a primary provider within the SCCCMH Network.

Network Provider: An agency or organization directly operated or under contract with SCCCMH to deliver services to persons served.

Unplanned Discharge: When a person served terminates services before a comprehensive transition plan can be developed and/or completed.

D. Forms

N/A

E. Other Resources (i.e., training, secondary contact information, exhibits, etc.)

N/A

F. References

A. MDHHS Contract, CCBHC Expansion Grant

IV. History

- Initial Approval Date: 04/2003
- Last Revision Date: 11/2024 BY: Jason Marocco
- Last Reviewed Date: 01/2024 BY: Dorothy Molnar-MacAuley
- Non-Substantive Revisions: N/A
- Key Words: outreach, discharge, missed appointment