Community Mental Health Partnership of Southeast Michigan/PIHP	*Policy* **Transition Planning for Individuals Being Released from State Facilities**
Committee/Department: **Clinical Performance Team**	**Local Policy Number (if used)**
Implementation Date **11/05/2024**	**Regional Approval Date** **07/24/2024**

Reviewed by:	**Recommendation Date:**
ROC	06/12/2024
CMH Board:	**Approval Date:**
Lenawee	06/27/2024
Livingston	06/25/2024
Monroe	07/24/2025
Washtenaw	06/21/2024

I. PURPOSE

To ensure consistency across the region in meeting standards of good clinical practice in transitioning people with severe and persistent mental illness, intellectual and developmental disabilities, and serious emotional disturbance from state facilities back to the community.

II. REVISION HISTORY

DATE	MODIFICATION
10/07/2013	Written to meet the requirements of the Application for Participation. Regional entity effective January 1, 2014.
01/23/2017	Reviewed per CMHSPM policy.
11/23/2020	Reviewed for any needed updates
07/24/2024	3-year review

III. APPLICATION

This policy applies to:

☒ CMHPSM PIHP Staff, Board Members, Interns & Volunteers
☒ Regional Partner CMHSP Staff, Board Members, Interns & Volunteers
Service Providers of the CMHPSM and/or Regional CMHSP Partners:
☒ Mental Health / Intellectual or Developmental Disability Service Providers
☐ SUD Treatment Providers ☐ SUD Prevention Providers
☐ Other as listed:

IV. DEFINITIONS

Community Mental Health Partnership of Southeast Michigan (CMHPSM): The Regional Entity that serves as the Prepaid Inpatient Health Plan (PIHP) for Lenawee, Livingston, Monroe and Washtenaw for mental health, developmental disabilities, and substance use disorder services.

Community Mental Health Services Program (CMHSP): A program operated under chapter 2 of the Mental Health Code as a county community mental health agency, a community mental health authority, or a community mental health organization.

Regional Entity: The entity established under section 204b of the Michigan Mental Health Code to provide specialty services and supports.

State Facility: A center or hospital operated by the Michigan Department of Community Health which provides services for people with serious mental illness, serious emotional disturbance and/or persons with developmental disabilities.

V. POLICY

Transition planning for individuals being discharged from State Facilities shall be individualized, person-centered, strength–based, collaborative, comprehensive, timely, orderly, and focused on the safety of both the consumer/individual served and the public.

VI. STANDARDS

A. The CMHSP is responsible for planning and implementing community placement for each of its consumers/individuals served who are being discharged from a State Facility and who do not object to being so.

B. The CMHSP will begin the Transition Planning process within 30 days of admission.

C. CMHSP designated staff will make efforts to ensure that the Transition Planning process is a collaborative team endeavor involving CMHSP clinicians, State Facility staff, the consumer/individual served, family members, guardians and potential post-discharge care providers.

D. CMHSP is responsible for ensuring that the Transition Planning process includes practices that incorporate:
   1. engaging all involved and interested parties;
   2. conducting regularly scheduled meetings;
   3. including consumer/individual served/guardian preferences wherever possible;
   4. educating and training post-discharge caregivers/providers;
   5. supporting post-discharge medical necessity;
   6. incorporating relapse planning;
   7. post-discharge relationship building.

E. The CMHSP will take the lead in arranging and facilitating periodic Transition Planning meetings with involved individuals to assess consumer/individual served status and move the planning process forward.

F. Designated CMHSP staff will assess the need for and implement educational and training activities for family members and potential post-discharge care providers regarding the consumer/individual's needs, service options, and relationship building. When applicable, consumer/individual served-specific information regarding past relapse triggers and the associated signs and symptoms will be included in the training.

G. The Transition Plan will include a post-discharge plan to reduce the likelihood of re-admission to a community hospital or State Facility.

H. CMHSP staff will ensure that efforts are made to engage the consumer/individual served and/or their legal representative in voicing preferences for a post-discharge living arrangement, such as location and other related issues.

I. A consideration of community options will include standards and principles of medical necessity, least restrictive setting, and the safety of the person and those in the surrounding community.

J. The Transition Plan will assess and honor the factors that contribute to a person's feelings of safety, respect, respect from others, and engagement with service providers.

K. The Transition Plan will include relationship-building strategies wherever indicated.

L. The Transition Plan will include an assessment of the consumer/individual's post-discharge medical needs, and the CMHSP will be responsible for ensuring that necessary medical appointments are arranged and integrated into the consumer/individual's Individual Plan of Service (IPOS).

M. The Transition Planning group will ensure that written instructions for potential providers of care are completed either as part of the Transition Plan or as part of the IPOS.

N. As indicated, there will be a safety/support plan in place for the consumer/individual served prior to discharge that addresses individualized needs for assistance with medication adherence, personal safety, environmental safety, and services that match the consumer/individual's needs.

O. The CMHSP will ensure that all post-discharge supports and service providers are competent in meeting the needs unique to individuals exiting State Facilities while utilizing Culture of Gentleness principles.

P. The CMHSP will make efforts to arrange for pre-discharge visits to the person's home, including at least one overnight visit, when indicated.

Q. The CMHSP will arrange for and facilitate post-discharge team meetings with current service providers to evaluate and revise the IPOS as needed.

VI. EXHIBITS

None

VII. REFERENCES

A. Current MDCH/CMHSP Managed Mental Health Supports and Services Contract
B. Guide to Prevention and Positive Behavior Supports in a Culture of Gentleness, Michigan Department of Community Health Behavioral Health and Developmental Disabilities Administration, June 2011
C. The Discharge Planning Process – State Operated Programs, Division of Development Disabilities, 2012
D. CMS Updates Guidance for Hospital Discharge Planning, Center for Medicare Advocacy, Inc., 2013
E. Protocols for Use, Center for Positive Living Supports, 2010