SANTA BARBARA COUNTY
DEPARTMENT OF
Behavioral Wellness
A System of Care and Recovery

Departmental
Policy and Procedure

Section	Clinical	**Effective:**	9/13/2017
Sub-section	Practices and Services	**Version:**	1.1
Policy	Client Discharge and Continuity of Care for Mental Health Services	**Last Revised:**	8/8/2018
Policy #	8.303		

Director's Approval _____ **Date** 8/17/18
Alice Gleghorn, PhD

Division Chief's Approval _____ **Date** 8/21/18
Ana Vicuna, LCSW

Supersedes: CL-8.303 Discontinuation of Client Mental Health Services signed 9/14/2017 by A. Gleghorn

Audit Date: 8/9/2021

1. PURPOSE

1.1. To establish standardized procedures for the mutual and unilateral discontinuation of mental health services for a client served by a Santa Barbara County-operated program or contracted service provider in accordance with state and federal laws and regulations, ethical standards for the discontinuation of therapeutic services, and the most up-to-date clinical theory regarding positive discharge from clinical services. Additionally, this policy is based on recommendations made by the California Department of Health Care Services (DHCS) and the California Board of Behavioral Sciences (BBS).

2. DEFINITIONS

The following terms are limited to the purposes of this policy:

2.1. Case closing – to discharge the client from the current admission. A client may return to services and be readmitted if clinically appropriate.

2.2. Licensed Practitioner of the Healing Arts (LPHA) – an individual employed or contracted by the county who is licensed in the state of California as a: physician (MD/DO); nurse practitioner (NP); physician's assistant (PA); master's level registered nurse (MSN); registered pharmacists (RPs); licensed clinical psychologists (LCPs); licensed clinical social workers (LCSW); licensed professional clinical counselors (LPCC); licensed marriage and family therapist (LMFT); and license-eligible practitioners working under the supervision of a licensed clinician.

2.3. Severe and Persistent Mental Illness (SPMI) – a condition in persons aged 18 or older who currently or at any time in the past year have had a diagnosable mental, behavioral, or emotional disorder (excluding developmental and substance use disorders) of sufficient duration to meet diagnostic criteria specified within the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) that has resulted in serious functional impairment, which substantially interferes with or limits one or more major life activities such as maintaining interpersonal relationships, activities of daily living, self-care, and employment.

2.4. Team-based Care – a multi-disciplinary approach in which all clinic/program members share joint responsibility in providing services, supports and treatments to clients. Each treatment team carries together an assigned caseload of clients, and each team member – based on his/her role, expertise and scope of practice – contributes towards a client's success, recovery and goal achievement. In Team-based Care, members of the treatment team (1) recognize, respect and value each other's role within the team-based structure; (2) demonstrate proficiency in his/her specific role; (3) work collaboratively to improve client-centered care and outcomes; and (4) participate in shared decision-making.

2.5. Warm hand-off – a transfer of care that is conducted in person or over the phone, between two members of a treatment team or from one provider to another, with the client and/or family present. Warm handoffs can help (1) engage patients and families and encourage them to ask questions, (2) allow patients to clarify or correct the information exchanged, and (3) ensure a smooth and positive transition in care.

3. POLICY

3.1. It is the policy of the Santa Barbara County Department of Behavioral Wellness (hereafter "the Department") to encourage client recovery in the least restrictive setting possible, support transitions to lower levels of care, and ensure warm hand-offs to other providers. Whenever possible, the decision to discontinue mental health services (i.e. close cases/discharge) is made in concert and collaboration with the client and treatment team members. However, a client's case may be closed for a variety of other reasons, including when a client is no longer participating in treatment and has not responded to attempts to engage in service.

3.2. Addressing the discontinuation of treatment is an important phase of the therapeutic process. For discontinuation to be handled properly, discussions between treatment team members and the client should occur in advance with transition goals and expectations set at the very beginning of treatment.

3.3. The decision to discontinue treatment should be made in a team-based setting. Once a determination to end treatment is reached, the assigned treatment team member will issue a *Letter of Intent (LOI)* (see Attachment A) to the client to formally end treatment services. Unless otherwise specified by the Team Supervisor, LOIs are not issued for clients that have not engaged in services for more than 181 days.

1. A bilingual English/Spanish Letter of Intent (LOI) form will be used for clients whose primary/preferred language is Spanish (see Attachment D).

3.4. Issuing a LOI provides clarity to the client on what the plan is, including what transition support will be provided, and it clarifies that clinic staff do not have an ongoing responsibility after the transition is completed. Moreover, closing a client's case in the electronic health record supports a more accurate account of ongoing caseloads. This information is essential to the operations of all clinics and service sites to ensure adequate resources are leveraged to meet the needs of clients open to the system.

3.5. The transition period between care settings may be a vulnerable time for clients and their families. Best practice advocates for the provision of prescriptions for psychotropic medication to avoid unnecessary disruptions, support a positive transition and ensure continuity of care. Prescribers should use discretion to manage the benefits and risks associated with prescribing certain medications, particularly habit-forming and controlled medications, when coordinating transitional prescriptions. Client's current disposition, addiction history, and individual risk factors should be considered when deciding which medications to prescribe and for how long, and the clinic team should ensure continuity until the client has changed providers.

4. REASONS FOR DISCHARGE/DISCONTINUATION OF SERVICES

4.1. Discontinuation of services will be based on one (1) or more of the following criteria:

1. The client does not meet criteria for Severe and Persistent Mental Illness (SPMI)[1] as determined by a LPHA in comprehensive assessment or updated assessment.
2. Discharge is clinically indicated as treatment goals have been realized.
3. The client's mental health needs can be met in a lower level of care (e.g. community-based provider, primary care physician).
4. The client requests discontinuation of current services.
5. A new client denies services before a treatment plan is completed.
6. The client is no longer eligible for services because (1) the client's insurance carrier has changed (e.g. private insurance), (2) the client does not have Medi-Cal/Medicare, or (3) the client is not considered unserved/underserved.
7. The client's Medi-Cal county of residence is not Santa Barbara County (NOTE: this is not applicable to clients placed out-of-county or minors placed out-of-county who qualify for an AB 1299 waiver).
8. The client does not keep scheduled appointments for 60 or more days and does not communicate with the treatment team to explain the reasons for the no-shows or to reschedule appointments. Additionally, clinic staff have made two (2) or more documented attempts to contact the client to determine his/her intent to continue services without success.
9. The client's case has been inactive for 180 or more days.
10. The client has exhibited threatening and/or assaultive behavior that cannot be redirected or managed safely within the program.

[1] For more information on SPMI and admission criteria, please refer to the Department's "Clinical Documentation Manual".

4.2. Treatment team members will maintain medical records for each client that adequately explains the reasons for any decisions made regarding the discontinuation of services. Documentation must include objective, specific details, including but not limited to dates and times staff attempted contact; dates and times of missed appointments, etc.

4.3. If a team is considering discontinuation for other reasons, such as threats and/or aggressive behavior that cannot be redirected or poses a safety risk to staff and other clients, collaboration with supervisors and managers is strongly advised.[2] All discussions regarding the plan to discontinue services for these reasons must be documented. When possible and if appropriate, treatment team members should attempt to discuss the implications of threatening and aggressive behavior with the client, including discontinuation of services, and provide guidance on how to avoid this from occurring. All discussions and attempts to address behavior concerns with clients will be documented. In the event a client is discharged for threatening and/or aggressive behavior, team members will attempt to connect the client to community resources.

5. LETTER OF INTENT

5.1. When a decision has been made to discontinue services and close a client's case, the assigned treatment team member will issue a *Letter of Intent (LOI)* (see Attachment A).

5.2. Unless otherwise specified by the Team Supervisor, LOIs are not issued for clients that have not engaged in any service (including medication support and crisis services) for more than 181 days.

5.3. Prior to issuing a LOI, the assigned treatment team member will:

1. Confirm that information in the LOI matches and accurately represents the documentation currently in the client's electronic medical record;
2. Check the letter for correct spelling and dates;
3. Confirm the letter is written in the client's primary/preferred language;
4. If the client is no longer engaging in services, ensure that the client is not open to any other service/program (i.e. medication support, crisis intervention); and
5. If the client did not show for any scheduled appointments, confirm that staff attempted to contact the client by phone, written correspondence, or both to reschedule the appointment.

5.4. All LOIs must be reviewed and approved by a Team Supervisor or manager prior to being mailed or delivered.

[2] Please refer to the Department's policy FS-16.003 "Management of Disruptive, Threatening and Assaultive Behavior" for further details.

5.5. The LOI will be presented to the client at the next scheduled appointment. If the client is not in contact with the clinic, the LOI is mailed to the last known address on file, even if it is known that the client no longer lives at that address.

5.6. If the client is homeless and does not have a mailing address, but clinic staff are aware of the client's whereabouts or locations frequented by the client (i.e. local library), staff will attempt to hand delivery the letter. If clinic staff are unable to deliver the letter after two (2) attempts, staff will close the client's case via the electronic medical record. All attempts to deliver the letter (including dates, times, locations visited, etc.) will also be documented in the electronic health record.

5.7. Once approved, all completed and signed LOIs will be filed in the client's electronic health record by the Team Supervisor or a designee.

6. DISCHARGE PROCEDURES

In this section, various common discharge scenarios are offered. Each scenario is presented with a brief bulleted summary followed by a more-detailed procedural explanation. Please review each procedural explanation carefully and use the brief bulleted summary for quick reference only. If faced with a complex discharge case, please contact your immediate supervisor or manager for consultation and assistance.

For quick summarization of this section, please see the *Client Discharge Procedures: Most Common Scenarios* (see Attachment B) table. For additional assistance, please refer to the Quality Care Management (QCM) Frequently Asked Questions (FAQ) (see Attachment C).

6.1. Scenario #1

Scenario	Procedure
Following assessment of a continuous client, it is determined that the client no longer meets SPMI criteria	• Treatment team discusses and reaches consensus that client no longer meets SPMI criteria. Discussion is documented in the EHR. • Treatment team documents discussion with client on discharge and plan for transition. • Treatment team issues LOI. Includes rationale for discharge, transition plan and date of discontinuation (60 days from date LOI issued) • Staff schedule transition sessions over next 60 days (recommend 3 sessions) • Staff provide referrals to community-based resources, offer to attend appointment with client • Medical staff prescribe current medications (as appropriate) and make a medication transfer plan • Treatment team completes discharge summary in CG, discharge MORS or CANS, and closes the client in ShareCare • FSP programs complete a Discontinuation of Partnership form and any other required FSP tracking documentation

If a comprehensive assessment or an assessment update is completed for a continuous client, and it is determined that the client no longer meets SPMI criteria:

1. The treatment team discusses the client's case and reaches consensus that the client no longer meets SPMI criteria. This team discussion is documented in the client's electronic health record (EHR).
2. The treatment team will document a conversation with the client regarding the determination of level of care and the plan for transition.
3. A *Letter of Intent (LOI)* (see Attachment A) will be provided to the client, which describes the reason for discontinuation of services, a transition plan, and a date that services will be discontinued. This discharge date will be 60 days from the date the LOI is issued.
4. If the client is a Medi-Cal beneficiary and is in disagreement with the discharge, a Notice of Adverse Benefit Determination[3] (formerly known as Notice of Action or "NOA") will be provided instead of an LOI.
5. Staff will schedule transition sessions to support ongoing recovery and reduce risk of deterioration for up to 60 days. The California Board of Behavioral Sciences (BBS) recommends 3 transitions sessions.
    a. This step can be skipped if the client has not been meeting regularly with the treatment team members (not including medication staff).
6. Staff will provide referrals to community providers, network providers, and/or the Recovery Learning Center (RLC) and offer assistance in linking the client to the provider.
7. Staff will offer to visit the new location with the client and potentially attend an appointment with client.
8. Medication support staff will contact potential new providers to support transfer of medications. These contacts and plans will be documented.
9. Prescribers will provide prescriptions of current medications as appropriate.
10. Immediately following transition, the treatment team will complete a discharge summary in Clinician's Gateway, a discharge Milestones of Recovery Scale (MORS) or Child and Adolescent Needs and Strengths (CANS), and close the client in ShareCare.
    a. For Full Service Partnership (FSP) programs, the treatment team must complete a Discontinuation of Partnership form at discharge and any other FSP tracking documentation that is required.

[3] Please refer to policy QCM-4.010 "Notices of Adverse Benefit Determination" for further details.

6.2. Scenario #2

Scenario	Procedure
Client is participating in services and no longer meets SPMI criteria because treatment goals have been met	• Treatment team discusses and reaches consensus that client no longer meets SPMI criteria. Discussion is documented in the EHR. • Treatment team documents discussion with client on goal achievement and plan to discontinue services. • Treatment team issues LOI. Includes rationale for discharge, transition plan and date of discharge (60 days from date LOI issued) • Staff schedules transition sessions over next 60 days (recommend 3 sessions) • Staff provide referrals to community-based resources, offer to attend appointment with client • Medical staff prescribe current medications (as appropriate) and make a medication transfer plan • Treatment team completes discharge summary, discharge MORS or CANS, and closes the client in ShareCare • FSP programs complete a Discontinuation of Partnership form and any other required FSP tracking documentation

If a current client is participating in services and no longer meets SPMI criteria because treatment goals have been met:

1. The treatment team discuss the client's case and reaches consensus that the client no longer meets SPMI criteria because treatment goals have been met. This team discussion is documented in the client's electronic health record (EHR).
2. In a progress note, the treatment team documents discussions with the client on how the client has met his/her treatment plan goals and/or has improved functioning and the plan to discontinue services.
3. A *Letter of Intent (LOI)* (see Attachment A) will be provided to the client, which describes the reason for discharge, a transition plan, and a date that services will be discontinued (i.e. 60 days from the date the LOI is issued).
    a. If the client is a Medi-Cal beneficiary and is in disagreement with the discharge, a Notice of Adverse Benefit Determination[4] (formerly known as Notice of Action or "NOA") will be provided instead of the LOI.
4. Staff will schedule transition sessions to support ongoing recovery and reduce risk of deterioration for up to 60 days. The California Board of Behavioral Sciences (BBS) recommends 3 transitions sessions.
    a. This step can be skipped if the client has not been meeting regularly with treatment team members (not including medication staff).
5. Staff will provide referrals to community providers, network providers, and/or the Recovery Learning Center (RLC) and offer assistance in linking the client to the provider.
6. Staff will offer to visit the new location with the client and potentially attend an appointment with client.

[4] Please refer to policy QCM-4.010 "Notices of Adverse Benefit Determination" for further details.

7. Medication support staff will contact potential new providers to support transfer of medications. Medication support staff will follow up with potential providers to determine a medication transfer plan. These contacts and plans will be documented.
8. Prescribers will provide prescriptions of current medications as appropriate.
9. Immediately following transition, the treatment team will complete a discharge summary in Clinician's Gateway, a discharge Milestones of Recovery Scale (MORS) or Child and Adolescent Needs and Strengths (CANS), and close the client in ShareCare.
    a. For Full Service Partnership (FSP) programs, the treatment team must complete a Discontinuation of Partnership form at discharge and any other FSP tracking documentation that is required.

6.3. Scenario #3

Scenario	Procedure
Client receiving ongoing services declines further services	• Treatment team documents reason the client is declining services • Treatment team issues LOI. Includes reason for discharge (client declines) and date of discharge (same day LOI issued) • Treatment team completes discharge summary, discharge MORS or CANS, and closes the client in ShareCare • FSP programs complete a Discontinuation of Partnership form and any other required FSP tracking documentation

If a current client receiving ongoing services declines further services:

1. The treatment team will document the reason the client states he/she is declining services.
2. A *Letter of Intent (LOI)* (see Attachment A) will be provided to the client, which describes the reason for discharge (client declines) and the date that services will be discontinued. The discharge date will be the same day the LOI is issued.
3. The treatment team will complete a discharge summary in Clinician's Gateway, a discharge Milestones of Recovery Scale (MORS) or Child and Adolescent Needs and Strengths (CANS), and close the client in ShareCare.
    a. For Full Service Partnership (FSP) programs, the treatment team must complete a Discontinuation of Partnership form at discharge and any other FSP tracking documentation that is required.

6.4. Scenario #4

Scenario	Procedure
New client declines services prior to completion of a treatment plan	• Treatment team documents reason the client is declining services • Treatment team issues LOI. Includes reason for discharge (client declines) and date of discharge (same day LOI issued)

If a new client declines services prior to completion of a treatment plan:

1. The treatment team will document the reason the client states he/she is declining services.
2. A *Letter of Intent (LOI)* (see Attachment A) will be provided to the client, which describes the reason for discharge (client declines) and the date that services will be discontinued. The discharge date will be the same day the LOI is issued.

6.5. Scenario #5

Scenario	Procedure
Client has not attended an appointment or contacted staff in 60 days	• Treatment team ensures that at least two (2) documented attempts made to contact client in previous 60 days • Treatment team issues LOI. Includes reason for discharge (lack of contact) and date of discharge (10 days from date LOI issued) • Treatment team completes discharge summary in CG, discharge MORS or CANS, and closes the client in ShareCare after 10 days • FSP programs complete a Discontinuation of Partnership form and any other required FSP tracking documentation

If a client has not attended an appointment or contacted staff in 60 days:

1. The treatment team will ensure that there are at least 2 (two) attempts to contact the client. The two attempts must be documented. This should be done over the course of the previous 60 days. If this is not done, the treatment team will make the attempts before moving on to the next step.
2. A *Letter of Intent (LOI)* (see Attachment A) will be provided to the client, which describes the reason for discharge (lack of contact) and the date that services will be discontinued. The discharge date will be 10 days from the date the LOI is issued.
3. After 10 days, the treatment team will complete a discharge summary in Clinician's Gateway, a discharge Milestones of Recovery Scale (MORS) or Child and Adolescent Needs and Strengths (CANS), and close the client in ShareCare.
    a. For Full Service Partnership (FSP) programs, the treatment team must complete a Discontinuation of Partnership form at discharge and any other FSP tracking documentation that is required.

6.6. Scenario #6

Scenario	Procedure
Client is not identified as part of target population (i.e. the client does not have Medi-Cal/Medicare and is not unserved/ underserved)	• Treatment team discusses and reaches consensus that client is identified as part of target population. Discussion is documented in the EHR • Treatment team documents discussion with client on lack of eligibility and plan for transition • Treatment team issues LOI. Includes reason for discharge (ineligibility) and date of discharge (60 days from date LOI issued) • Staff schedules transition sessions over next 60 days (recommend 3 sessions) • Staff provide referrals to community-based resources, offer to attend appointment with client • Medical staff prescribe current medications (as appropriate) and make a medication transfer plan • Treatment team completes discharge summary, discharge MORS or CANS, and closes the client in ShareCare • FSP programs complete a Discontinuation of Partnership form and any other required FSP tracking documentation

If an ongoing client is not identified as part of the target population for county mental health services because he/she does not have Medi-Cal/Medicare and is not an unserved or underserved community member (this determination is made by the LPHA with consultation with the clinic supervisor):

1. The treatment team discusses the client's case and reaches consensus that the client is not identified as part of the target population. This team discussion is documented in the client's electronic health record (EHR).
2. The treatment team will document a conversation with the client regarding the lack of eligibility for continuing services and the plan for transition.
3. A *Letter of Intent (LOI)* (see Attachment A) will be provided to the client, which describes the reason for discharge and the transition plan with a date that services will be discontinued. This discharge date will be 60 days from the date the LOI is issued.
4. Staff will schedule transition sessions to support ongoing recovery and reduce risk of deterioration. The California Board of Behavioral Sciences (BBS) recommends 3 transitions sessions.
    a. This step can be skipped if the client has not been meeting regularly with treatment team members (not including medication staff).
5. Staff will provide referrals to community providers, network providers, and/or the Recovery Learning Center (RLC) and offer assistance in linking the client to the provider
6. Staff will offer to visit the new location with client and potentially attend an appointment with client.

7. Medication support staff will contact the new provider to support transfer of medications. Medication support staff will follow up with potential providers to determine a medication transfer plan. These contacts and plans will be documented.
8. Prescribers will provide prescriptions of current medications as appropriate.
9. Immediately following transition, the treatment team will complete a discharge summary in Clinician's Gateway, a discharge Milestones of Recovery Scale (MORS) or Child and Adolescent Needs and Strengths (CANS), and close the client in ShareCare.
    a. For Full Service Partnership (FSP) programs, the treatment team must complete a Discontinuation of Partnership form at discharge and any other FSP tracking documentation that is required.

ASSISTANCE

Careena Robb, LMFT, QCM Coordinator

Ana Vicuña, LCSW, Division Chief of Clinical Operations

ATTACHMENTS

Attachment A – Letter of Intent (LOI)

Attachment B – Client Discharge Procedures: Most Common Scenarios

Attachment C – QCM Frequently Asked Questions (FAQs)

Attachment D – Bilingual English/Spanish Letter of Intent (LOI)

REFERENCE

California Board of Behavioral Sciences
Closure/Termination Ethics

California Association of Marriage and Family Therapist
Code of Ethics, Page 2, Sections 1.3.1., 1.3.2, 1.15.
https://www.camft.org/images/PDFs/CodeOfEthics.pdf

California Code of Regulations
Title 9, Sections 1710.360 – Notification of Beneficiaries
Title 9, Section 1850.210 – Fair Hearing and Notice of Action

RELATED POLICIES

Accessing a Welcoming and Integrated System of Care and Recovery

Client Problem Resolution Process

Management of Disruptive, Threatening and Assaultive Behavior

Notices of Adverse Benefit Determination

Second Opinion

REVISION RECORD

DATE	VERSION	REVISION DESCRIPTION
8/8/2018	1.1	• Removed 5.7.1, instruction to send completed LOIs to QCM for logging. Team Supervisor or a designee will be responsible for filing completed LOIs into client's electronic health record. • Changed policy title.

Culturally and Linguistically Competent Policies

The Department of Behavioral Wellness is committed to the tenets of cultural competency and understands that culturally and linguistically appropriate services are respectful of and responsive to the health beliefs, practices and needs of diverse individuals. All policies and procedures are intended to reflect the integration of diversity and cultural literacy throughout the Department. To the fullest extent possible, information, services and treatments will be provided (in verbal and/or written form) in the individual's preferred language or mode of communication (i.e. assistive devices for blind/deaf).