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MILWAUKEE COUNTY DEPARTMENT OF HEALTH & HUMAN SERVICES

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Owner	Beth Lohmann: Integrated Service Coordinator
Policy Area	Community Access to Recovery Services (CARS)

CCS Transition for Youth and Adults

Purpose:

To provide guidance to Comprehensive Community Services (CCS) providers for the transfer of care and records when a young adult transitions from services provided by youth to adult services, or vice versa.

Scope:

This policy applies to the Comprehensive Community Services (CCS) program and its providers.

Policy:

There is one CCS program in Milwaukee County that covers the lifespan. As such, services are sometimes delivered in the department for youth and young adults (Children's Community Mental Health Services and Wraparound Milwaukee Program) and conversely there are other times services are delivered in the department for adults (Community Access to Recovery Services - CARS). There will be occasions that individuals will remain in CCS but their care and documentation of services will require transition. It will be essential at the time of transition to migrate their care and records to ensure continuity of care and compliance with the DHS 36 state statutes.

Procedure:

Identification of a Candidate for Transition

A. A young adult is aging out of youth-based services.

B. A clinical determination is made that the young adult can be best served in the other system.

An example includes an individual who is over the age of 18 and in the adult system, but who has service needs that are more closely aligned with the youth network.

C. After individuals are 18, at each year the Care Coordinator will work with the young adult to consider if transition is appropriate. This will in large part be driven by current symptoms and functioning of the individual.

Initiation of Transition from Youth to Adult

A. If the young adult is served by Children's Community Mental Health Services and Wraparound Milwaukee Program, once the young adult is identified, it needs to be determined if this young adult already has an active Mental Health/AODA Functional Screen or if they need a new one to be completed.

B. The current Care Coordinator will complete the Mental Health/AODA Functional Screen to ensure eligibility for adult CCS services, when a new one needs to be completed.

C. When the young adult is found eligible, the Care Coordinator will notify the appropriate Manager in Children's Community Mental Health Services and Wraparound Milwaukee Program of the intent to transition the young adult's care to the adult-serving department.

D. The appropriate Manager will review the request for clinical necessity and ensure all required paperwork as detailed below in "Transition of Records" is present.

E. If the transition is approved by the appropriate Manager, the current Care Coordinator will meet with the young adult to discern who their new providers in the adult-serving system will be (at a minimum they need to choose a Care Coordination agency).

F. Once a Care Coordination agency is selected by the young adult, the appropriate Manager will notify the CARS CCS Administrative Coordinator who specializes in youth of the transition plan.

    1. Once the adult agency is selected, the youth agency will need to transfer the MH/AODA Functional Screen to the new agency.

G. The CARS Administrative Coordinator who specializes in youth will coordinate the introduction of the current Youth Care Coordinator agency to the receiving Adult Care Coordinator agency via email. The current and receiving agencies will work collaboratively to select a date for a first meeting together. Also, meeting as often as clinically appropriate (See I. below for list of paperwork to be completed at first meeting.)

H. The CARS Administrative Coordinator who specializes in youth will complete necessary items in the Electronic Health Record:

    1. Get the CARS episode open
    2. Update the Youth CCS episode to be the CCS episode in Avatar.
    3. The custom alert in Avatar should be ended.
    4. Ensure the current prescription is active so that Medicaid can be billed
        a. Give the receiving agency a youth transition bundle of service authorizations that includes Screen & Assessment, Service Planning, Service Facilitation, Travel, and NMS001 for 30 days.

b. The receiving agency should request a service authorization for 30 days, for any ancillary services that will continue.

5. Write a progress note in Avatar.
6. Add the consumer to the Adult CCS referral log and also add them to the transfer tab in the referral log.

I. During the transition period (first meeting and subsequent meetings as necessary but within 30 days), the following should be completed by the Adult CCS Care Coordinator:
    1. Receiving adult Care Coordination agency will treat the transition like an annual review process, regardless of the former dates established by youth.
        a. Functional Screen Release of Information, CRA, Annual Continuation Agreement
        b. Diagnosis and HCFA in Avatar
        c. PPS/NOMS bundle
        d. Comprehensive Assessment and Mental Health/AODA Functional Screen, Determination of Need form
        e. Assessment Summary and Wisconsin Recovery Thermometer (WIRT)
    2. Conduct a Recovery Team meeting and create a Scheduled Recovery Plan of Care (RPOC) to include all updated interventions and plan participants.
        a. Ideally, the adult Care Coordination agency will invite the youth CCS care coordinator to the RTM in order to formally end their services and begin the adult services.
        b. In the event that the youth CCS agency cannot attend, the adult agency will notify the youth agency that the RTM and transition process has been completed.

J. The process of transition should be a length of time that meets the need of the consumer. Both the current Youth Care Coordinator and Receiving Adult Care Coordinator can meet together or separately until the consumer is ready to work solely with the Adult Care Coordinator, with a normal period of time not to exceed 30 days.

K. The youth serving provider who will no longer be providing services will need to close the case in their Electronic Health Record.

Initiation of transition from Adult to Youth

A. If the young adult is served by the adult (CARS) department (thus they are over 18 but less than 23), the referring adult Care Coordinator will complete a Service Authorization Request Justification (SARJ) form as CCS to CCS as a Transfer and click "ready for CARS to review".

B. Once the CARS Administrative Coordinator who specializes in youth reviews the SARJ for clinical necessity of the transfer and determines it appropriate, and will also ensure all required paperwork as detailed below in "Transition of Records" is present.

C. The current adult Care Coordinator will notify the adult CARS Administrative Coordinator who

specializes in youth, which care coordination team is preferred by the consumer.

D. The CARS Administrative Coordinator who specializes in youth would contact the Children's Community Mental Health Services and Wraparound Milwaukee Program Manager to notify them of the transition plan.

E. The Children's Community Mental Health Services and Wraparound Milwaukee Program Manager will coordinate the introduction of the current Adult Care Coordinator agency and receiving Youth Care Coordinator agency and select a date for a first meeting together, as often as clinically appropriate (See I. below for list of paperwork to be completed at first meeting.)

F. During or as a result of this meeting, the following should be completed by the Youth CCS Care Coordinator:

    1. If the transition is occurring at the time of annual renewal, then the annual paperwork will need to be completed, as well as the Comprehensive Assessment, Assessment Summary, and Determination of Need.
    2. Ensure an active prescription is in place.
    3. Complete and review the Welcome Packet, Consent Release Authorization, and Releases of Information.
    4. Hold a Child and Family Team Meeting in order to create a Plan of Care with updated providers on the Service Plan.

G. The CARS Administrative Coordinator who specializes in youth will update the CCS episode to be the CCS youth transition episode in the EMR, and close the young adult from the CCS referral log.

H. The Children's Community Mental Health Services and Wraparound Milwaukee Program Managerwill create a custom alert in Avatar to indicate that this young adult is now being served by Youth CCS.

I. The Youth Care Coordination agency will enter their needed Service Authorization Requests as applicable for all current services on the current Plan of Care.

Transition of records

A. An individual is transitioning from youth to adult or vice versa as detailed above.

B. The current Care Coordination provider must provide the receiving Care Coordination provider with PDF copies of records that will be uploaded to the EHR system of the receiving entity. This includes:

    1. Medicaid verification printed
    2. The original Application, Admission Agreement, and Acknowledgement forms
    3. The most current annual agreement, if applicable
    4. Current active prescription
    5. Most recent Consent Release Authorization (CRA)
    6. The most recent Comprehensive Assessment

7. The most recent Assessment Summary
8. The most recent Determination of Need statement (which must be dated on/after the current MH/AODA FS)
9. The most recent CLTS screen or MH/AODA functional screen and the Release of Information.
10. The most recent Plan of Care, including the full life story for youth.
11. Updated Medication Log
12. The most recent PPS or PPS/NOMS

References:

DHS 36

Approval Signatures

Step Description	Approver	Date
	Michael Lappen: BHD Administrator	6/27/2022
	Amy Lorenz: Deputy Administrator, Community	6/8/2022
	Jennifer Wittwer: Director, Community	6/8/2022
	Jennifer Alfredson: Integrated Service Coor	6/8/2022