

SUBJECT: CONTINUUM OF CARE/TRANSFER/REFERRAL PROCESS

EFFECTIVE  
DATE: 06-02-10 (replaces 11-08-02)

APPROVED BY:

Reviewed (no changes): \_\_\_\_\_  
\_\_\_\_\_

Executive Director

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POLICY

It is the policy of McIntosh Trail CSB that the provision of care in a continuous manner is essential to fulfill our organizational mission and philosophy. Our policy of continuity of care is intended to provide continuous and appropriate care over time and assure the provision of these services. The timely and orderly transfer to the appropriate services is provided per our policy of continuing care for consumers.

PROCEDURE

- I. Intra-agency Continuity of Care
  - A. At the first point of contact with the consumer, screening is initiated. The consumer is given referrals to external agencies if the needs of the consumer are beyond the scope of what the agency can provide. Once a consumer is admitted to services, the Biopsychosocial process is initiated.
  - B. Once the Biopsychosocial process begins, the assessor assists in coordinating services for each consumer served. The assessor ensures the implementation of the individual plan, orients the person to his/her services, promotes the participation of the consumer served on an ongoing basis in involving him/her in plans, goals and status, identifies and addresses any gaps in services to be provided, shares information on how to access community resources, advocates for the consumer as needed, communicates information on progress to the consumer and others as appropriate, facilitates the transition process and arrangements for follow-up, involves family or legal guardian as appropriate, coordinates services outside of McIntosh Trail, and identifies the process for after hours.
  - C. If the consumer and assessor determine additional needs for services within the same level of care, an additional goal and/or intervention is added to the Treatment Plan dated and initialed by the assessor.
  - D. If a consumer moves to a different service site within the same level of care, then the Case Coordinator of the transferring site calls the Director of the receiving site to clarify the transfer. The transferring Case Coordinator schedules an appointment with the receiving site and assures that the consumer is informed of this appointment. Documentation of the status of the consumer and the reason for the transfer is completed.

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PROCEDURE (CONTINUED)

- E. If the consumer and assessor determine that needs are better met in a more intense or less intense LOC (level of care), then the assessor assures admission to that LOC, completes MICP for authorization and prepares the record for transfer.
- II. Inter-Agency Continuum of Care
- A. Each consumer needing adjunct services available in the community through another agency(ies) is referred to the appropriate provider(s).
  - B. Completion of the referral is documented in a progress note.
  - C. Follow-up/monitoring will be determined by the case coordinator based on the significance of the external service to the Individualized Service Plan and the ability of the consumer to follow through on his/her own initiative.
  - D. The consumer is not transferred until the external provider agrees to accept the consumer and the consumer is sufficiently stabilized for transfer.
  - E. If referral to an external provider effectively ends services at McIntosh Trail, the case coordinator maintains the consumer's case until that referral is complete. Discharge from McIntosh Trail is documented using the Transition Discharge Form.
- III. Continuity between the Community Service Board (CSB) and West Central Georgia Regional Hospital (WCGRH) and the CSB:  
The Community Service Board maintains continuity of all consumer admissions, discharges, and continued stays in public facilities subject to the conditions outlined in the "Memorandum of Understanding Between the West Central Georgia Regional Hospital and McIntosh Trail Community Service Board".
- The terms of the Memorandum of Understanding between West Central Georgia Regional Hospital and McIntosh Trail Community Service Board is implemented as outlined in Attachment 2.

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PROCEDURE (CONTINUED)

McIntosh Trail CSB contracts with Anchor for hospitalization of children and adolescents.

A. Anchor Hospital - Child and Adolescent:

1. Admissions:

The Community Service Board (CSB) staff will:

- a. Screen the consumer; include the biopsychosocial assessment, dependent upon crisis situation;
- b. Obtain signed pre-admission parental waiver and consent for hospitalization;
- c. In absence of parental consent for hospitalization;
  1. Contact Family and Children Services for temporary custody; or
  2. Contact Department of Child and Youth Services if consumer is committed; or
  3. 1013 completion by physician, psychologist, clinical social worker, clinical nurse specialist in psychiatric/mental health.
- d. Complete or obtain, if available:
  1. Child and adolescent referral;
  2. Previous psychological testing;
  3. Existing individual service plan;
  4. School records, if available;
  5. Education and activity form, signed;
  6. Immunization history;
  7. Mental status evaluation (if Biopsychosocial not completed);
  8. Notification of an infectious disease;
  9. Arrange transportation;
  10. Notify the hospital and give information;
  11. Any other pertinent information;
  12. Any needed release of information forms, signed.

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PROCEDURE (CONTINUED)

A. Anchor Hospital - Child and Adolescent (Continued)

Anchor staff will:

- A. Process the screened individual through admission, if properly screened in the community;
- B. Contact the CSB regarding any questions and conjoint planning regarding the most appropriate services needed by the consumer;
- C. Process the unscreened admission per Anchor admission criteria. If the consumer is admitted, the hospital will inform the CSB. If the individual is not admitted, Anchor will link the individual to the CSB or another resource as appropriate.

2. Treatment Planning:

The Community Service Board will:

- A. Assure contact with Anchor treatment staff in reference to consumer.
- B. Provide Anchor with appropriate consumer information;
- C. Maintain appropriate contact with Anchor staff to give input into the treatment and discharge processes;
- D. Be involved in the discharge process.

3. Discharge Process:

Anchor will discharge the consumer if the following exists:

- a. The consumer has received the services needed as indicated by the referral and conjoint planning;
- b. Further services needed by the consumer are available and linked in the community;
- c. Anchor will link the consumer/family/guardian to the CSB by scheduling first appointments with the case manager for follow-up in the community.
- d. Anchor will complete and forward the consumer discharge summary to the CSB in a timely manner.