GUAM BEHAVIORAL HEALTH AND WELLNESS CENTER		
TITLE: Transition Policy	**POLICY NO:** CL-AP-06	Page **1** of **5**
RESPONSIBILITY: Clinical Services		
APPROVED BY: 6/21/19 DIRECTOR THERESA C. ARRIOLA	**DATE OF ORIGINAL APPROVAL:** 2/7/2014	
	LAST REVIEWED/REVISED: JUN 21 2019	

PURPOSE:

To provide a guideline for a consistent and seamless transition of youth and adult consumers to the next level of care.

POLICY:

A. The Guam Behavioral Health and Wellness Center shall ensure a smooth transition of care and/or discharge of consumers from one level of care to another. It shall communicate up-to date information regarding care, treatment, services, condition, and recent or anticipated changes to the receiving program or provider and completing the transition of care plan and/ or discharge summaries.

B. Transition of adolescent to Adult Mental Health Outpatient Program (AMHOP) begins at age 16 ½ yrs. However, can also begin at a later date based on the youth's level of developmental functioning, based on clinical evaluation (i.e., physical, emotional, academic, and social), and current treatment needs.

C. Consumers under Project Tulaika shall begin transitioning to Adult Mental Health Outpatient Program (AMHOP) when they reach the age of 24 ½ years old.

D. All consumers being transitioned to a different level of care in another program should have a written transition plan that includes but not limited to the following;
   1. Consumers current progress in his or her recovery
   2. Gains achieved during program participation
   3. Includes strengths, needs, abilities and preferences
   4. Includes information on the continuity of the consumers' medication(s) when applicable
   5. Includes referral information, such as contact name, telephone numbers, locations, hours and days of services when applicable

DEFINITIONS:

A. **Transition**: The process of moving from one level of care or service/support to another, changing from child/adolescent service systems to adult systems.
B. **Transition Plan**: A document developed with the full participation of the youth/consumer that (a) focuses on a successful transition between programs or service phases/levels/steps or (b) focuses on successful transition to a community living situation. It details how the youth/consumer will maintain the gains made during the services and support ongoing recovery and/or continued well-being at the next phase/level of care.
C. **Project Tulaika:** A healthy transitions program which aims to create a seamless transition of youth and young adults ages 16 – 25 years with Serious Emotional Disturbance (SED) or Serious Mental Illness (SMI) and improve their life trajectories.

PROCEDURE:

General Guideline for Transition and Documentation

1. The referring Lead provider shall complete all documents required by the receiving program prior to referral and initiation of transition (reference CL admission/transition checklist form)

2. The referring Lead Provider (LP) shall complete the referral note in the Service Referral section in AWARDS, inform the receiving program head of such referral and coordinate the transition meeting or case presentation.

3. The referring Lead provider shall present the case to the receiving team, or to the assigned lead provider for determination of appropriateness of referral and or transition.

4. Disposition of the referral or outcome of the referral shall be documented in AWARDS Service Referral section.

Children and Adolescent Services to Adult Outpatient Program;

1. The assigned CASD's Wrap Coordinator shall initiate the transition process by formally referring the youth to the Adult Outpatient Program's Team Facilitator and schedule the transition meeting.

2. CASD's Wrap Coordinator will present the case to the Adult Outpatient receiving team for Lead Provider (LP) assignment based on child/adolescent's primary needs at least a year prior to an anticipated transition.

3. CASD recommendation will be considered for placement with the Adult Services, if the placement is appropriate. If the child/adolescent is still in school (SPED), CASD will remain the Lead Provider and work conjointly with the assigned secondary provider assigned with the Adult Outpatient Program.

4. CASD and Adult Mental Health LP will develop and complete the Individualized Transition Plan (ITP) conjointly with consumer, parents and guardian.

5. CASD Lead Provider will ensure all necessary documentation and assessments required by Adult Outpatient program in the checklist is completed and provided to Adult Outpatient Lead Provider prior to full transition.

6. CASD Wrap Coordinator will document in AWARDS outcome of transition meeting using the ITT form, and discharge consumer upon completion of transition.

7. If the youth turns 18 years old and does not want Adult Mental Health Services, the WRAP Coordinator shall close the consumer's chart by documenting the consumer's declination of services in a progress note and completing the chart closure form.

Transition from CASD to SERENITY, Step-Down Home

The following is the procedure moving from Outpatient to a Higher Level of Care:

1. CASD Wrap Coordinator must complete and submit Referral Form for SERENITY to the Administrator for review and disposition. Both the youth and parent/guardian must sign the form acknowledging process of referral.
2. CASD Wrap Coordinator must submit forms and documents required on the Admission Checklist. If a youth is under the temporary legal custody of Child Protective Services (CPS), a Power of Attorney must be prepared prior to admission.
3. CASD Wrap Coordinator will conduct a case presentation to SERENITY staff and Administrator to determine appropriateness of admission.
4. CASD Wrap Coordinator will document in AWARDS outcome of transition meeting using the ITT form, and discharge youth from CASD Program upon completion of transition.

Transition from SERENITY to CASD.

1. Once the youth has met his/her level of care treatment goals and/or an appropriate placement has been identified to support youth in an Outpatient setting, a Wrap Meeting will be held to discuss disposition and discharge planning.
2. When deemed appropriate for discharge, the Wrap Coordinator will ensure all necessary documents have been completed such as Transition Summary as well as an updated Wrap Plan and Safety Plan if applicable.
3. Wrap Coordinator will create a referral to CASD on AWARDS utilizing the clone feature for continued Care Coordination until Psychiatric Services have been completed.
4. The Wrap Coordinator shall ensure the Physical Custody Release Form has been completed and discharge youth from SERENITY Program.

Adult Outpatient Program & Project Tulaika to Residential Recovery Program (RRP)

1. The Lead Provider from the referring team will coordinate to schedule a Master Multidisciplinary Treatment Plan (MMTP) meeting with consumer, family members, guardian, and other service providers to determine the consumer's appropriate level of care.

2. Once RRP is determined to be the most appropriate level of care after the MMTP meeting, The Lead Provider will ensure that all agency-required assessments (e.g. complex assessment, ANSA, PHQ, Psychological Assessment/Evaluation), and all other pertinent documents shall be completed prior to submitting an electronic referral to Residential Recovery Program (RRP).

3. The referring team or lead provider of the consumer shall present the case to the RRP clinical team to determine eligibility.

4. The referring team's lead provider will prepare and complete the Admission Packet within 2 weeks once the RRP team determines that the consumer is eligible to the program and a bed is available. Admission Packet must be submitted to the RRP manager prior to the start of transition.

5. A transition plan shall be created for the consumer, which will include the move-in date to the home.

6. If the consumer does not meet the criteria or eligibility for RRP placement, a recommendation to other community services will be provided as appropriate. If there is no bed available in the appropriate RRP unit as determined by the assessment, the consumer will be placed on the wait list.

7. Once the consumer is ready to move to RRP, completed the transition process and has moved to the assigned home the Lead Provider of the AMHOP will discharge the consumer and complete the discharge summary form in the electronic behavioral health record. Once the transition process is completed and the consumer has moved in to his/her assigned home, the Lead Provider from the Adult Outpatient Program will complete the electronic discharge form.

Residential Recovery Program (RRP) to Outpatient Program

1. Once the consumer has met all his/her treatment goals in the RRP program and is ready to be discharge an MDTT evaluation will be held to discuss disposition and discharge planning.

2. The RRP Lead provider (LP) shall make the referral to the AMHOP and shall present the case to the Adult outpatient team for determination of eligibility and assignment of the Outpatient LP.

3. The RRP LP shall be create a transition plan by identifying the current progress of the consumer's own recovery or move toward well-being, gains achieved during program participation, consumer support system, strength, needs, abilities and preferences.

4. The RRP LP shall update the treatment plan in consultation with the MDTT that specifies measureable goals and objectives the consumer will work toward in the next level program level.

5. The Residential Program Manager (RPM) or a designee shall attend the transition meeting to gather all necessary information to ensure a smooth transition.

6. The Lead provider shall discharge the consumer upon completion of transition.

Crisis Stabilization Unit to Adult Outpatient, Project Tulaika, and/or Child Adolescent Services

1. All new consumers admitted at the crisis stabilization unit shall be assigned to an Outpatient Lead Provider or Project Tulaika Lead Provider for adult consumers and a Wrap Coordinator for the Youth.

2. The Crisis Stabilization social worker shall coordinate with the outpatient lead provider and/or Wrap Coordinator for discharge planning meeting conducted at the Crisis Stabilization Unit with the Psychiatrist, and other Providers.

3. Crisis Stabilization Social Worker and the assigned AMHOP Lead Provider or Project Tulaika Lead Provider shall collaborate to identify the needs and goal of the consumer during the discharge-planning meeting.

4. The service plan and all assessments shall be updated and completed prior to the planned discharge.

Project Tulaika to Adult Mental Health Outpatient Program

1. Project Tulaika shall begin transitioning consumers to AMHOP when the consumer reaches 24 ½ years old.

2. Project Tulaika's Lead Provider shall initiate the transition process by making contact with the AMHOP Team Facilitator for case presentation and case assignment.

3. Project Tulaika's Lead Provider will ensure all necessary documentation and assessments required by AMHOP's transition checklist in the checklist is completed and provided to the AMHOP Lead Provider prior to full transition.

4. Project Tulaika's Lead Provider will document in AWARDS the outcome of transition meeting using the ITT form, and discharge consumer upon completion of transition.

RELATED POLICY (IES):

SUPERSEDES: Transitioning from Children to Adult Services; CL-11.; 02/07/2014; Director Rey M. Vega

ATTACHMENT(S):

FCL-AP-06 Transition Admission Checklist

GUAM BEHAVIORAL HEALTH & WELLNESS CENTER
790 Gov. Carlos G. Camacho Rd. Tamuning, Guam 96913
TEL: (671) 647-5330 FAX: (671) 649-6948

TRANSITION ADMISSION CHECKLIST

Name of Consumer: _____ Age:_____ Referring Program: _____
Lead Provider: _____ Referred To: _____
Date: _____

Required Documents Completed	Program	Yes	No	Comments
Face Sheet / Photo	All	☐	☐	
Inventory Listing	All	☐	☐	
Complete Referral in AWARDS to include a Clinical Summary	All	☐	☐	
Transition Plan	All	☐	☐	
MDTT/ Wrap/ Service Plan	AMHOP/RRP	☐	☐	
PHQ, ANSA, Psychological Assessment	AMHOP/RRP	☐	☐	
Case Presentation	AMHOP/RRP	☐	☐	
Immunization Record	CASD	☐	☐	
Insurance Card	CASD	☐	☐	
Medical Questionnaire	CASD	☐	☐	
Parental Consent and Agreement	CASD	☐	☐	
Risk Assessment	CASD	☐	☐	
Youth Agreement	CASD	☐	☐	
CANS and CASII Assessments	CASD	☐	☐	
Wrap Plan to include stay at Serenity	CASD	☐	☐	

OFFICE USE ONLY:

Submittal of Forms: ☐ Accepted ☐ Pending ☐ Declined

Comments:

_____

_____

Submitted Date: _____ Time: _____ Staff: _____

Approved By:

_____ _____

PRINT & SIGN DATE

GUAM BEHAVIORAL HEALTH AND WELLNESS CENTER
REVIEW AND ENDORSEMENT CERTIFICATION

The signatories on this document acknowledge that they have reviewed and approved the following:

[x] Policies and Procedure
[] Program plan
[ ] Protocol/Form

Submitted by: Clinical Committee

Policy No: CL-AP-06

Title: Consumer Transition Policy

Reviewed/Endorsed	**Date**	**Signature**
	5/10/2019	
Title	Reina Sanchez Acting Clinical Administrator	
Reviewed/Endorsed	**Date**	**Signature**
	5/15/2019	
Title	Dr. Ariel Ismael Medical Director	
Reviewed/Endorsed	**Date**	**Signature**
	5/17/19	
Title	Jeremy Lloyd Taitano Acting Nurse Administrator	
Reviewed/Endorsed	**Date**	**Signature**
Title	*Shermalin Pineda* *Manager Residential Recovery Program*	
Reviewed/Endorsed	**Date**	**Signature**
	5/15/19	
Title	*Sylvia Quinata* *Adult Counseling Supervisor*	
Reviewed/Endorsed	**Date**	**Signature**
	5.15.19	
Title	Annie Unpingco CASD Administrator	

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GUAM BEHAVIORAL HEALTH AND WELLNESS CENTER
REVIEW AND ENDORSEMENT CERTIFICATION

Reviewed/Endorsed	**Date**	**Signature**
	5/28/19	Marilyn Miral
Title	MARILYN MIRAL Supervisor. Community Support Services	
Reviewed/Endorsed	**Date**	**Signature**
	5/17/19	
Title	Athena Duenas Supervisor Drug and Alcohol Program	
Reviewed/Endorsed	**Date**	**Signature**
	05/24/2019	
Title	Maria Teresa Aguon Program Manager Healing Hearts	
Reviewed/Endorsed	**Date**	**Signature**
	5/23/19	
Title	Helen Onadera Tulaika Project Director	
Reviewed/Endorsed	**Date**	**Signature**
	6.4.19	Fegurgur PsyD.
Title	Dr. Mary Fegurgur *Psychology Section*	
Reviewed/Endorsed	**Date**	**Signature**
	5/30/19	
Title	Carissa Pangelinan *Deputy Director*	

DOH#051519-009-88