

**DEPARTMENT OF CHILDREN AND FAMILIES
DIVISION OF CHILD BEHAVIORAL HEALTH SERVICES**

REFERRAL AND ADMISSION PROCESS

**TRANSITION FROM ONE OUT-OF-HOME
TREATMENT SETTING TO ANOTHER**

This process is designed to streamline the procedures for transitioning children from an existing out-of-home (OOH) treatment setting to another OOH setting. This process replaces the existing process for completing the Step-Down JCR (SDJCR) and the associated progress note (STPDN). The Step-Down JCR and the associated progress note will no longer be available in Absolute following the implementation of this process.

A new treatment plan type, Transition JCR (TRJCR), has been created in ABSolute. The TRJCR is to be completed by the current treating provider for children transitioning from one OOH treatment setting to another.

It is assumed that the current treating OOH provider has much information about the child's response to treatment, progress (or lack thereof), achievements and continued needs. Additional reports are neither necessary nor helpful to successfully transition the child to an alternate OOH treatment setting. Therefore, potential "transition" providers can evaluate the child and make admission decisions by utilizing the most current and meaningful information available. This includes:

- Transition Joint Care Review (TRJCR) - completed by the current treating provider
- Other JCRs and Strengths and Needs Assessments in the child's record
- Progress Notes

REFERRAL PROCESS

STEP I

The current OOH provider, the family and the Case Manager (child/family team) agree that the child needs transition to another OOH treatment setting. If the child/family team has a specific facility in mind, identify that facility by name in the "TRJCR" and document why you believe that this specific facility can meet the child's current needs.

The Case Manager enters a transition progress note (**TROOH**) in the child's Absolute record documenting the following:

- the family/child's **AND** the case manager's agreement with the transition decision **AND**
- the family/child's preferences

The Case Manager should select progress note type **“TROOH”** in ABSolute. Failure to document this information in the progress notes will result in a return of the TRJCR and a delay in the transition.

STEP II***

The current OOH provider completes the Strengths and Needs Assessment and the TRJCR and submits to VO for review. The provider must document progress and continued need on all treatment goals, treatment recommendations, and behavioral management issues. Please include the following:

- Course and progress in treatment
- Achieved goals and objectives
- Improved goals and objectives
- Reasons for lack of progress in achieving goals and objectives (if applicable)

- Challenges during treatment process
 - “systems” issues (i.e., transportation, etc.)
 - changes in milieu
 - reasons for any “regression”

- Strategies for challenges and successes
 - What worked
 - To whom does the child respond well
 - What motivates the child to change
 - What challenges remain
 - What is the child proud of now
 - What are the child’s and family’s goals for the next 6 months

- If the request is for transition to a more intense type of care, document:
 - Why the more intense type of care is necessary at this time
 - What specific needs does this child manifest that cannot be met at your facility
 - Recommendations and strategies for meeting these needs

STEP III

The ValueOptions Care Coordinator (CC) confirms that the Case Manager has entered the “transition” progress note (see Step I above).

If the progress note is missing, the CC will return the TRJCR to the treating provider with a request that the Case Manager complete the progress note. When completed, the providers should resubmit the TRJCR to VO for review.

If the progress note is in the system, the CC completes the review within five (5) business days of submission.

Upon completion of the review, the CC creates a referral for the appropriate LOC and posts the child’s information on the Bulletin Board for provider review.

STEP IV

The OOH providers access the referral on their Bulletin Board, review the clinical information in the child's record and call the Case Manager and the current treating provider to discuss the potential admission.

Existing treating providers and potential admitting providers are strongly encouraged to speak directly with one another, the child and his/her family at this time.

It is the Case Manager's responsibility to facilitate the exchange of information, to schedule the "meet and greet" (if necessary) and to make any transportation arrangements. Some examples of additional information that might be obtained include:

- A conversation with the psychiatrist and/or therapist at the referring OOH setting
- A review of behavior management issues addressed during the child's treatment
- Child Study Team/IEP information

From the date of the bulletin board posting, it is expected that the Case Manager and the potential admitting providers will have exchanged enough information for the providers to make an admission decision within six (6) business days.

It is very important that the accepting provider enter a "scheduled admission date" immediately upon acceptance of the child. This will assure that the child is removed from the Bulletin Board and is no longer available for review by other providers.

***The "TRJCR Training Guide" can be found on the DCBHS and VO web sites. (www.nj.gov/dcf/behavioral or www.vonewjersey.com)

CASE MANAGER **ADMISSION REQUIREMENTS**

It is the responsibility of the Case Manager to assure that the admitting provider receives all the documentation that licensing requires for admission. This may include:

- Immunization records
- List of current medications and a prescription for 30 days of medications
- Pre-treatment clinical form for all psychotropic medications
- Parent or legal guardian needs to be present to sign all necessary consent forms. The legal guardian must have court document to prove guardianship.
- Social security card **and** birth certificate
- Certificate of Need (if needed)
- Name of current primary care physician
- Other private insurance information
- School related information.

TRANSITION JOINT CARE REVIEW (TR-JCR)

ValueOptions has created a new treatment plan type in Absolute called the “Transition JCR” (TRJCR). The treating provider completes the TRJCR when he/she believes that a child needs transition to an alternate OOH treatment setting. The provider can recommend transition to a higher or lower level of care or transition to an alternate facility at the same level of care. The “Step-Down JCR” has been disabled and is no longer available. The TRJCR is the existing JCR with the following questions added on the Transition tab.

1. Describe in detail **ALL** the reasons why this child needs transition to an alternate OOH treatment setting at this time.

2. Why can't this child be returned home (to the community) for continued treatment?

3. Are the Case Manager and the family (the child and family team) in agreement with the recommended transition? If “no,” why not?
 - a. Please document the Case Manager's contact information (name, e-mail address, telephone number and agency name) **and** the dates you spoke to the Case Manager regarding the transition.

4. Describe all the goals that have been achieved, those that have improved and those that have not been achieved during treatment.

5. If you are recommending transition to a more intensive type of care, describe the following:
 - a. Why can't the child continue to be treated at your facility or at the existing level of care?
 - b. What specific needs and behaviors does this child have that warrant a more intensive treatment setting?
 - c. Describe in detail your recommendations and strategies for meeting each need and managing each behavior described in #5b.

6. Describe all other clinical and non-clinical needs that should be addressed. For each need, detail your recommended goals and strategies for meeting these needs.
 - a. For each need listed in #6, describe the challenges any treating provider will face in addressing each need.

- b. Describe the child's and family's goals for the next six (6) months.
 - c. Document the challenges and successes you have experienced in engaging the child and the family in treatment.
 - d. Also, document both the child's and the family's perceptions about the child's:
 - i. Progress (or lack thereof) in treatment
 - ii. Successes in treatment
 - iii. Continued needs
7. What specific challenges have you faced and addressed in treating this child? (For example, transportation issues, changes in milieu, period of regression, etc.)
- a. Detail specific strategies and interventions you have utilized for addressing these challenges and achieving success.
 - i. What worked and what didn't work with this child?
 - ii. What successful coping strategies does this child utilize?
 - iii. To whom does this child respond well?
 - iv. Are there certain "triggers" that should be avoided when interacting with this child?
 - v. What specifically creates feelings of pride and well-being for this child?
 - vi. What strategies and interventions can be utilized to further motivate this child to change?
8. Please document the family's preferences regarding this recommended transition.
- 9A. If you are recommending that the child transition to a specific facility/agency, please include the name and contact information for the facility/agency to which you are recommending transition.
- 9B. Why do you believe this facility/agency is a clinically-appropriate OOH treatment setting for the child at this time?

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