When a Change in Level of Care Results in a Transfer Between Programs

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Problem Statement and History:

This project was chosen to investigate the criteria, process, procedures and policies in place for transferring patients of the Charleston Dorchester Mental Health Center (CDMHC) between programs due to a change in their level of care in efforts to make the process more consistent and prevent or reduce gaps in care for our patients.

The Charleston Dorchester Mental Health Center is the largest of the 17 centers within the South Carolina Department of Mental Health (SCDMH.) The mission of SCDMH is to support the recovery of those with mental illness. The programs at each center can vary. The Levels of Care are important to help place patients in the programs, receiving the services that will support their recovery. In 2012, John Magill, the State Director of SCDMH created the Future is Now (FIN) Committee to prepare SCDMH for changes coming with managed care. The current Levels of Care (Appendix 1) used at CDMHC were created in 2012 and adopted by the FIN committee for use across the state. These guidelines are fluid and patients may move between levels of care throughout their treatment at CDMHC. The patients' current level of care is determined by the treatment team (client, psychiatrist and clinician.) It is important to note that a change in level of care does not always indicate a change in program or counselor. The changes in level of care that result in transfer between programs have the greatest potential to cause gaps in a patient's treatment.

Data Collection and Analysis:

For the purpose of this project transfers between Medication Management Only (MMO), Regional Case Management (CM), and Assertive Community Treatment like (ACT-like) were

reviewed, as they require a change in clinician and have the potential for a gap in services. The correlation between program and level of care is:

- Medication Management Only-Level 1
- Regional Case Management-Level 2, 3, 4 (short term)
- ACT- like-level 4 (long term)

A brief survey was sent to staff and informal conversations were held to determine their understanding of the current levels of care, the transfer process and these criteria for a patient needing to be transferred to Act-like or MMO. The center's shared drive and the SCDMH Policies and Procedures were reviewed in efforts to locate these criteria and the current policies regarding transfers. The Medicare Mental Health Services booklet and billing guide (Medicare), Commission on Accreditation of Rehabilitation Facilities (CARF) manual and the South Carolina Department of Health and Human Services Medicaid Policy Manual for Community Mental Health Services (Medicaid) were reviewed, as well. Medicare and Medicaid are two of SCDMH's largest payer sources and their guidelines influence service provision and policies within the department. CDMHC is CARF accredited; therefore our policies must meet their standards in addition to those set forth by Medicare and Medicaid.

Medicare addressed services they will provide payment for and the eligible professionals that they will reimburse for providing the services. They did not address levels of care for patients.

The CARF manual does address program criteria and indicates that entry criteria, transition criteria and exit or discharge criteria should be documented (CARF International,

2015, p. 101). While transition and discharge planning are discussed with the patient as part of the initial clinical assessment (ICA), on the patient's plan of care and indicated in the current levels of care, the centers written criteria for transition to MMO or ACT-like was not easily accessible. The manual indicates the criteria for an ACT team including broad criteria for clients to be served by the team. "The program provides psychosocial services directed primarily to adults with serve and persistent mental illness who often have co-occurring problems, such as substance abuse, or are homeless or involved with the judicial system." (CARF International, 2015, p. 152). It should be noted that CDMHC does not have a traditional ACT team as defined by CARF, but an ACT-like team. The CARF manual also addresses criteria for Outpatient Treatment (CDMHC's CM) but does not clearly outline patient criteria. For the purpose of this project the criteria for a patient to be in CM would be an individual that meets inclusion criteria for admission to the center, but not criteria for the MMO or ACT-like programs. The CARF manual provides some guidelines for Medication Monitoring (CARF International, 2015, pp. 299-302), but not criteria that a patient would need to meet to be an MMO program.

The only level of care the Medicaid manual specifically addresses is MMO. "Medical Management Only is a level of care provided to clients who due to their level of functioning and psychiatric stability do not require ongoing psychotherapeutic intervention." (South Carolina Department of Health and Human Services, 2005, p. 111). It goes on to indicate that clients are placed in this program based on the judgement of the physician; the case will be managed by "medical staff" except in a crisis situation when a mental health professional may see the patient. The physician must assess the client at least annually to determine if patient continues to be appropriate for the MMO level of care. In the interim medical staff would provide services to patient. Progress and any significant changes should be documented every 90 days. The

physician is responsible for discontinuing MMO services if they determine the patient needs additional services.

A SCDMH policy regarding the transfer of patient cases between programs due to a change in levels of care was not found. The Medical Records Transfer Policy (Appendix 2) addresses how the transfers of charts within CDMHC should be handled. According to this 2011 policy the procedure is to:

1. Have clinical staffing with supervisor for appropriateness of transfer.
2. Staff transfers at the weekly transfer meeting. If accepted a new clinician is assigned. Receiving supervisor notifies receiving clinician. Referring supervisor notifies referring clinician.
3. The patient will be personally introduced to the new receiving clinician (if possible) by the referring clinician or supervisor. Referring clinician is responsible for patient's treatment needs until transfer is complete.
4. The medical records manager is notified and the change is entered in CIS/ EMR.

Once the transfer is approved the referring clinician or supervisor audits the chart (within 5 business days) and makes any corrections that can be made. Plan for transfer is documented on the POC and the discharge transition plan. The plan for transfer should also be documented in a CSN or generic note.

The brief survey sent out had a limited response, but it was similar to the information gathered in informal conversations. There are inconsistencies with understanding of the centers levels of care and the transfer policy process. In regards to levels of care, many clinicians

responded with "mmo, regional and act-like." Two clinicians reported having a copy of the levels of care and one admitted to not using it. When asked specifically about the transfer policy and transfer, most clinicians said they "notify their supervisor and they take care of it." Most clinicians reported criteria for MMO to be, "they are stable or they refuse to attend therapy but attend doctors appointments" but were less clear on the criteria for act-like. Clinicians with an understanding of act-like criteria were ACT-like clinicians. When asked how they knew the information responses ranged from "experience at a previous job" to "from working here." These responses indicate a need for more regular review of policy and written criteria for each program.

Criteria or guidelines for patients being referred to MMO and ACT-like were not easily accessible on the center's shared drive. This information was obtained by asking an Act-like supervisor and the nurse managers. Criteria for act-like (Appendix 3) include multiple hospitalizations, needing interventions one or more times a week, and/ or needing help with medications. The nurse manager provided a power point originally developed by the centers former QI director (updated by current nurse manager) for a nursing training. While the power point addresses the following criteria for a patient to be the MMO program and the processes for transfer in and out of the program, it is not a document that is easily accessible to other staff.

Criteria for MMO: For patients who, due to their level of functioning and psychiatric stability (documented 6 months or greater), do not require ongoing psychotherapeutic interventions.

This is similar to the standards set forth in the Medicaid manual with the exception of documented 6 months of stability. The Medicaid manual does not indicated a specific period of time a patient must be stable before transfer to MMO.

Observation of, participation in the transfer process, review of transfers documented on the transfer log and discussions with staff have led to the identification of 6 main reasons a change in level of care results in a transfer between programs.

1. Patient has completed goals, but continues to need medication (CM or ACT-like to MMO.)
2. Patient has multiple hospitalizations, frequent visits to the ED, frequent arrests, perhaps needs help with pill minders (CM/ MMO to ACT-like.)
3. Patient no longer has multiple hospitalizations, frequent visits to the ED, frequent arrests, does not need weekly treatment but needs bi-weekly or monthly treatment (ACT-like to CM.)
4. Patient no longer has multiple hospitalizations, frequent visits to the ED, frequent arrests, does not have treatment goals only needs meds (ACT-like to MMO.)
5. Patient chooses not to participate in therapy but attends PMAs and has medication needs. (CM or ACT-like to MMO.)
6. Patient is hospitalized or identifies therapy goals (MMO to CM.)

The transfer process that occurs varies; it is difficult to tell if this is due to the patient, the physician, the clinician, the supervisor or the program. The length of time from identifying the need to transfer and meeting with new clinician also varies as discovered in review of the transfer log (Appendix 4).

The transfer closure log for January 1, 2015 through June 30, 2015 was reviewed. There were 303 total transfers, 187 were transfers where a change in level of care indicated the patient's care needed to be transferred to another program. Of these, there were 178 unique

transfers and 9 patients were listed as transferring between programs multiple times. These charts were reviewed and data collected on the amount of time the process took from the date the need to transfer was identified, to the date a new clinician was assigned, to the date of the first scheduled appointment with the new clinician. Please see the table below:

Transfer Between	number of transfers	# need is clearly identified	# need is NOT clearly identified	# with scheduled appt w/ new CM	# without scheduled appt w/ new CM	Average # days from need identified to date assigned	Average # days from date identified to first scheduled appt	Average # days from date assigned to first scheduled appointment
ACT-like to CM	30	29	1	29	1	24.3	61.7	35.8
ACT-like to MMO	5	4	1	3	2	27.5	278.7	250.7
CM to ACT-like	17	12	5	17	0	47.7	38.25	17.3
CM to MMO	96	70	26	35	61	72.4	133.3	71.4
MMO to ACT-like	9	7	2	9	0	10	43.9	29.3
MMO to CM	30	28	2	27	3	18.6	48.9	28.9
Total	187	150	37	120	67	33.4	100.8	72.2
Percent		80%	20%	64%	36%			

** # of days is calendar days not business days.*

**unable to include charts where need to transfer was not in charts or where follow up has not been scheduled in calculations*

On average, the transfer process from date the need to transfer to a new program is identified to the first scheduled appointment with the new clinician is greater than 3 months, those being transferred into MMO having the highest average. The length of time to the first scheduled appointment with the new clinician if of greatest concern when the transfer is occurring due to an increase in level of care indicating an increased need for treatment. There are several reasons for the delay, as discovered through participation in the transfer process.

1. Nursing was and continues to be short staffed. Nursing staff provide services not only to MMO patients, but to any patient in the center requiring an injection or nursing assessment.
2. Centralized scheduling began at CDMHC in February 2015. It is expected that charts reviewed for the second half of the year would be scheduled in a more timely fashion for those patients transferring to CM and ACT-like services.
3. Nursing staff does not have the scheduling support that CM does. This is expected to change in the near future as a nursing admin position has been approved.
4. Specifically related to transfers in and out of the MMO program, there is often a delay in transfer due to the clinician or nurse not being aware the chart has been put into or taken out of MMO status by the physician.

It is important to note that many patients transferred during the period reviewed were seen by a physician, possibly a nurse at least once from the time the need to transfer was identified and the first appointment was scheduled with the newly assigned clinician. They were not without support during this time. Ideally the length of time from a new clinician being assigned to the first scheduled appointment would be no more than 10 business days (2 weeks) for clients being assigned to CM or ACT-like and 30 days for those being assigned to MMO. Reducing this time period ensures the patient does not have a break in continuity of care.

Implementation Plan:

The mission of the South Carolina Department of Mental Health is to support the recovery of those with mental illness. It is the goal of the Charleston Dorchester Mental Health Center to carry out that mission with a patient centered approach. Reevaluating the transfer process between programs is one way to ensure our patients receive the services they want/ need

with as little interruption as possible. A key to doing this will be training and communication to staff of what the policies, procedures and criteria for each level of care and program are, and making that information easily available to them outside of training and staff meetings. Initially, it is proposed that the current policy and process (Appendix 2) be revamped and possibly separated. A new process, similar to one recently implemented for transfer between the Charleston and Dorchester clinics (Appendix 5) be implemented for transfers between programs at the Charleston clinic. A check list (Appendix 6) be made available to clinicians, nurses and supervisors to ensure required staffing and documentation is completed before the case is taken to transfer meeting. Physicians should be required to notify the clinician or nurse of record when they put a case or remove a case from MMO status. This will prompt the clinician or nurse to complete the transfer paperwork so the case can be presented at the next transfer meeting. The center's transfer meeting is held weekly and attended by the Regional Coordinators for both CM teams, a nurse manager, an Act-like supervisor and an intake supervisor. It is suggested that these individuals also work together to develop and propose new policy and procedure, develop the checklist for clinicians and present to Senior Management.

Evaluation, Future Planning and Summary:

This project has revealed that there are flaws in the current process to transfer charts between programs resulting in frustration for clinicians, supervisors and gaps in treatment for our patients. While the above implementation plan is a start to reduce these issues there are many changes on the horizon. Due to coming changes in the way South Carolina Medicaid Managed Care Organizations reimburse mental health services, DMH has contracted with MTM Services

to help us become more efficient and effective in service delivery. This includes introducing a new outcome measure, Daily Living Activities-20, and creating a new level of care system for us to continue to provide the services needed to support recovery of those with mental illness with better outcome management and consistency among treatment needs.

REFERENCES

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Contemporary Management Solutions, INC. (2013, January 1). *Mental Health Services Billing Guide.* Retrieved January 28, 2016, from www.cms-billing.com: http://www.cms-billing.com/forms/NHIC_Medicare_B_Mental_Heatlh_billing_guide_2008.pdf

Department of Health and Human Services. (2015, January 1). *Medicare Mental Health Services.* Retrieved January 28, 2016, from Centers for Medicare & Medicaid Services: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Mental-Health-Services-Booklet-ICN903195.pdf

South Carolina Department of Health and Human Services. (2005, February 1). Healthy Connections Community Mental Health Provider Manual, updated Jan 1, 2016. Columbia, Sc, USA.

Appendix 1

Level I	Level II	Level III	Level IV	Level V
Medication Management Only (MMO) Clients who have strengths and abilities to function in all domains. Regular psychotropic medication is needed to sustain these strengths and abilities. Ongoing reviews for potential discharge to primary care provider Clients who adhere to prescribed medications and have been offered interventions to build skills and enhance functioning, but have refused such. Ongoing review of need for interventions to build/enhance skills.	Clients who have used strengths for satisfactory functioning in most domains. Skills and/or confidence in ability to consistently use skills. Requires periodic therapeutic supportive interventions to reinforce strengths and skill application. Requires more than medication management only. Ongoing reviews for potential move to MMO	Client has strengths to address domains of functioning. Have implemented/ demonstrated skills. POC objectives describe continuing enhancement and/or mastery of skills in some functional domain. POC has been updated to reflect change/progress/ achievement of goals identified at admission.	Client engaged in services to address POC goals/objectives. May be newly admitted client. May be longer term client with concrete problem in daily functioning or symptoms. This may be a recurrent or newly identified problem in a client who previously experienced a greater ability to function. May be a client with serious mental illness who requires frequent interventions to support functioning in multiple domains (e.g. ACT-Like)	Client's psychiatric symptoms grossly impair functioning on all domains. Client needs interventions to stabilize acute symptoms. Client may express thoughts of harm to self or others. Clinical and medical staff evaluation to determine community and/or inpatient/ placement (CAF) interventions.
Frequency of contact: Minimum = 1q3-4 mos. Caseload Cap – 1Rn:200	Frequency of contact: Minimum = 1q2 mos. Caseload Cap – 1MHP:120 adults	Frequency of contact: Minimum = monthly Caseload Cap – 1MHP:80 adults 1MHP:60/children	Frequency of contact: Minimum = weekly Caseload Cap – 1MHP:35 adults 1MHP:35 children	Frequency of contact: Minimum = daily until stabilized Caseload Cap – N/A

Appendix 2

Charleston Dorchester Mental Health Center

Effective March 15, 2011

(revision of Policy dated 5/09; 03/10)

MEDICAL RECORD TRANSFER POLICY
(Internal)

Policy:

It is the policy of the Center to maintain continuity of care when clients need internal transfers. An "internal transfer" is defined as a movement of the client, with an open/active medical record from one program service area to another, excluding initial referrals from the intake unit.

Staffing Procedures:

1. A clinical staffing will occur to determine:
   - if the transfer is in the client's best interest
   - if client sufficiently stable, including not actively homicidal or suicidal, to effect a smooth transfer
   - if the client is involved and aware of reasons for transfer and date of transfer

   In Charleston, the staffing will occur first with immediate supervisor and then at the weekly transfer meeting. In Dorchester, the staffing will occur with immediate supervisor and then at the weekly supervisor meeting.

2. Once the transfer is approved, the referring supervisor initiates contact with the clinic intake supervisor or designee to initiate the transfer process. The intake supervisor or designee will then staff the case at the clinic's transfer/supervisor meeting. The date of transfer and name of receiving staff is determined. The referring supervisor will share this information with the referring Case Manager (CM) and the receiving supervisor will share the information with the receiving CM.

3. The client will be personally introduced to receiving CM (by sending CM or supervisor, if possible) to ensure a smooth transition. ***The client's treatment/medication needs during the transfer process are the responsibility of the referring clinician (or manager, if clinician is on extended leave or has left employment) until notification that transfer is complete.***

Documentation and Auditing Procedures:

1. The staffing results/plan for transfer will be documented on the Plan of Care (POC) and on the Discharge Summary or Transition Plan (form C-52) by the sending CM. The CM should also document the transfer plan on a clinical note (i.e. SPD or TCM) or on a generic note in EMR.

2. The electronic medical record of the client being transferred will be audited by referring CM and supervisor before transfer so that all documentation meets the Center, DMH and DHHS standards. The audit needs to be completed within 5 business days from date of approval to transfer.

Medical Records Procedures if Transferred Outside of Clinic (I.e. From Chas. Clinic to Dorch. Clinic):

1. If an older volume exists, the medical record is to be given to Medical Records Manager (or designee) for transfer. The record and C-52 form is sent via interoffice mail to other clinic (C-52 form and audit sheet only for electronic only records). Medical Records will log transfers to other clinic when sending record. This Medical Records Manager (or designee) notifies (via email) receiving CM and supervisor and receiving medical records manager that medical record has been sent. (The medical record must be received by Medical Records in the new service area within five business days of transfer approval).

2. Upon delivery, the receiving Medical Records Manager (or designee) enters the change in CM, doctor, and office/location in CIS/EMR. This records manager also alerts (via email) the sending medical records manager, CM and supervisor, and the receiving CM and supervisor that the record has been received and transferred.

Medical Records Procedures if Transferred Within Clinic:

1. The medical records manager (or designee) enters the change in CM, doctor, and office/location in CIS/EMR. The medical records manager (or designee) alerts (via email) the sending CM and supervisor, and the receiving CM and supervisor that the record has been transferred.

2. When an unplanned transition occurs, such as a change in CM and/or physician, the client will be personally informed of the transition by CM or referring supervisor. (A face-to-face contact is preferable). The medical records manager (or designee) follows the same procedures as above to transfer record to new CM/doctor.

3. Supervisors can transfer client records in EMR among their own teams (temporarily or permanently), but must notify Medical Records Manager (or designee) via email, so the office, location, and MD can also be changed in CIS.

Deborah S. Blalock, M.Ed., LPCS
Executive Director

March 15, 2011
Date

Appendix 3

ACT-Like Clients can be characterized by one or more of the following factors:

- engaged in services to address POC goals/objectives
- serious mental illness requiring frequent interventions to support functioning in multiple domains
- would benefit from contact at an average frequency of one or more times per week on average
- May have a significant recent history of inpatient hospitalizations or frequent visits to local Emergency Departments. This includes patients with multiple admissions or a single prolonged admission indicative of a sustained need for enhanced support and contact to re-establish and safely maintain community tenure. This would include patients coming for intake following discharge from GWB or other long-term institutions.
- recent history of lack of successful stabilization while being served at prescribed frequency of contact of a lower LOC.
- Patients experiencing recurrent or newly-identified concrete problem in daily functioning or symptoms.
  - This may include those needing help with medications to remain stable, whether it is a pill minder, weekly or more than weekly visits to remind patient to take meds, help with learning how to manage meds such as calling the pharmacy, patients who would likely overtake their meds if we did not keep them here and supervise what they receive each month.
  - Such problems in functioning may be due to a Personality Disorder. In the alternative, a referral to DBT while remaining on a Regional team may also be appropriate.
- Newly admitted "first-break" patients for whom more intensive early intervention may reduce the likelihood of a later heightened dependence on services (unless assigned to First-Break team).
- While recognizing involuntary nature of some referrals, there needs to be some willingness to engage in treatment at this designated frequency. A patient who avoids treatment is not inherently an ACT-Like patient unless otherwise at risk as detailed above.

Appendix 4

	Transferred from Program to Program	Date Need to Transfer Identified	Date New Clinician Assigned	First Scheduled Appointment with New Clinician	# of Days from Need to Transfer Identified to Date Assigned	# of Days from Need to Transfer Identified to First Scheduled Appointment	# of Days from Date Assigned to First Scheduled Appointment
1	cm to act-like	3/11/2015	3/16/2015	3/31/2015	5	20	15
2	cm to mmo	5/26/2015	6/29/2015	none	34	na	na
3	cm to mmo	3/10/2015	3/16/2015	3/27/2015	6	17	11
4	act-like o cm	1/2/2015	1/20/2015	3/6/2015	18	63	45
5	cm to act-like	1/6/2015	1/20/2015	2/10/2015	14	35	21
6	act-like to cm	1/29/2015	3/2/2015	3/3/2015	32	33	1
7	cm to mmo	5/20/2015	5/26/2015	9/24/2015	6	127	121
8	mmo to cm	2/27/2015	3/9/2015	3/19/2015	10	20	10
9	cm to mmo	6/9/2015	6/15/2015	none	6	na	na
10	cm to mmo	2/12/2015	3/23/2015	4/16/2015	39	63	24
11	cm to mmo	5/6/2015	6/29/2015	none	54	na	na
12	cm to mmo	3/24/2015	6/22/2015	none	90	na	na
13	cm to mmo	4/9/2015	6/15/2015	none	67	na	na
14	cm to mmo	2/2/2015	3/16/2015	6/16/2015	42	134	92
15	cm to mmo	4/14/2015	4/27/2015	5/12/2015	13	28	15
16	cm to mmo	10/14/2014	1/12/2015	none	90	na	na
17	act-like to mmo	4/8/2015	4/27/2015	11-Jun	19	430	411
18	act-like to cm	6/17/2015	6/22/2015	10/29/2015	5	134	129
19	cm to mmo	6/1/2015	6/1/2015	12/9/2015	0	191	191
20	mmo to act-like	3/31/2015	4/13/2015	4/28/2015	13	28	15
21	cm to act-like	3/19/2015	4/27/2015	6/8/2015	39	81	42
22	cm to mmo	6/2/2015	6/29/2015	none	27	na	na
23	cm to act-like	12/23/2014	1/20/2015	5/21/2015	28	149	121
24	mmo to act-like	1/29/2015	1/26/2015	2/2/2015	-3	4	7
25	act-like to cm	6/16/2015	6/22/2015	7/20/2015	6	34	28
26	mmo to cm	4/16/2015	5/11/2015	6/11/2015	25	56	31
27	act-like to cm	3/26/2015	4/6/2015	4/23/2015	11	28	17
28	cm to mmo	5/26/2015	6/8/2015	none	13	na	na
29	mmo to cm	4/16/2015	4/20/2015	5/4/2015	4	18	14

	Transferred from Program to Program	Date Need to Transfer Identified	Date New Clinician Assigned	First Scheduled Appointment with New Clinician	# of Days from Need to Transfer Identified to Date Assigned	# of Days from Need to Transfer Identified to First Scheduled Appointment	# of Days from Date Assigned to First Scheduled Appointment
30	cm to mmo	4/6/2015	6/1/2015	none	56	na	na
31	mmo to cm	3/24/2015	6/8/2015	6/23/2015	76	91	15
32	cm to mmo	3/9/2015	3/30/2015	9-Apr	21	31	10
33	cm to act-like	2/23/2015	3/2/2015	3/3/2015	7	8	1
34	cm to mmo	12/2/2014	3/23/2015	none	111	na	na
35	cm to mmo	7/14/2014	6/11/2015	6/24/2015	332	345	13
36	act-like to cm	1/6/2015	1/26/2015	3/16/2015	20	69	49
37	mmo to cm	1/26/2015	1/12/2015	2/13/2015	-14	18	32
38	mmo to cm	2/5/2015	5/4/2015	6/4/2015	88	119	31
39	cm to mmo	5/22/2015	6/8/2015	none	17	na	na
40	cm to mmo	9/16/2014	3/30/2015	none	195	na	na
41	cm to mmo	3/11/2015	3/23/2015	none	12	na	na
42	mmo to cm	1/16/2015	1/26/2015	2/5/2015	10	20	10
43	act-like to cm	not in chart	6/22/2015	7/8/2015	na	na	16
44	act-like to cm	4/1/2015	4/6/2015	4/20/215	5	na	na
45	mmo to cm	1/14/2015	1/26/2015	2/2/2015	12	19	7
46	mmo to cm	5/27/2015	6/1/2015	6/9/2015	5	13	8
47	cm to mmo	10/29/2014	1/12/2015	9/17/2015	75	323	248
48	cm to mmo	1/29/2015	2/9/2015	none	11	na	na
49	cm to mmo	10/24/2014	3/23/2015	none	150	na	na
50	cm to mmo	6/1/2015	6/2/2015	none	1	na	na
51	mmo to cm	not in chart	2/2/2015	3/9/2015	na	na	35
52	act-like to cm	12/22/2014	1/20/2015	2/18/2015	29	58	29
53	cm to mmo	2/23/2015	3/23/2015	none	28	na	na
54	cm to mmo	4/23/2014	5/4/2015	none	376	na	na
55	cm to act-like	not in chart	4/27/2015	4/30/2015	na	na	3
56	cm to mmo	12/17/2014	not assigned	none	na	na	na
57	act-like to cm	1/8/2015	3/2/2015	3/27/2015	53	78	25
58	act-like to cm	1/7/2015	1/26/2015	none	19	na	na
59	cm to mmo	4/8/2015	5/18/2015	none	40	na	na
60	cm to act-like	5/22/2015	6/1/2016	5/29/2015	376	7	0
61	cm to mmo	3/9/2015	5/18/2015	none	70	na	na

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62	act-like to mmo	1/30/2015	3/23/2015	2/9/2016	52	375	323
63	act-like to cm	4/10/2015	5/26/2015	6/18/2015	46	69	23
64	cm to mmo	10/29/2014	1/12/2015	none	75	na	na
65	mmo to cm	3/19/2015	5/11/2015	6/3/2015	53	76	23
66	act-like to cm	1/6/2015	1/12/2015	2/18/2015	6	43	37
67	mmo to act-like	2/17/2015	2/23/2015	3/3/2015	6	14	8
68	cm to mmo	2/11/2015	5/18/2015	none	96	na	na
69	mmo to cm	1/23/2015	2/9/2015	2/26/2015	17	34	17
70	act-like to cm	1/7/2015	2/2/2015	2/13/2015	26	37	11
71	cm to act-like	4/14/2015	4/20/2015	4/27/2015	6	13	7
72	cm to act-like	not in chart	4/27/2015	4/29/2015	na	na	2
73	cm to mmo	4/20/2015	6/22/2015	none	63	na	na
74	cm to mmo	not in chart	2/9/2015	2/12/2015	na	na	3
75	cm to mmo	not in chart	3/23/2015	none	na	na	na
76	cm to mmo	11/14/2014	3/23/2015	none	129	na	na
77	act-like to mmo	5/27/2015	6/22/2015	none	26	na	na
78	cm to act-like	not in chart	2/9/2015	2/18/2015	na	na	9
79	cm to mmo	10/16/2014	3/23/2015	7/23/2015	158	280	122
80	cm to mmo	5/18/2015	6/29/2015	none	42	na	na
81	cm to mmo	not in chart	2/23/2015	none	na	na	na
82	cm to mmo	not in chart	4/13/2015	none	na	na	na
83	cm to mmo	11/3/2014	1/26/2015	3/2/2015	84	119	35
84	act-like to cm	9/23/2014	3/30/2015	4/17/2015	188	206	18
85	act-like to cm	1/7/2015	1/20/2015	2/13/2015	13	37	24
86	cm to mmo	not in chart	5/18/2015	9/23/2015	na	na	128
87	cm to act-like	12/15/2014	1/12/2015	1/28/2015	28	44	16
88	cm to act-like	6/24/2015	6/29/2015	7/9/2015	5	15	10
89	cm to act-like	3/11/2015	3/16/2015	3/20/2015	5	9	4
90	cm to mmo	not in chart	4/6/2015	none	na	na	na
91	cm to mmo	not in chart	3/23/2015	none	na	na	na

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92	cm to mmo	not in chart	3/2/2015	none	na	na	na
93	act-like to cm	4/16/2015	5/4/2015	6/10/2015	18	55	37
94	act-like to cm	1/2/2015	1/12/2015	2/5/2015	10	34	24
95	cm to mmo	11/13/2014	2/23/2015	none	102	na	na
96	act-like to cm	3/20/2015	6/1/2015	6/24/2015	73	96	23
97	cm to mmo	11/5/2014	2/2/2015	none	89	na	na
98	cm to act-like	not in chart	1/20/2015	2/3/2015	na	na	14
99	cm to mmo	4/15/2015	6/29/2015	none	75	na	na
100	cm to mmo	6/3/2015	6/15/2015	none	12	na	na
101	act-like to cm	5/22/2015	6/29/2015	11/13/2015	38	175	137
102	cm to mmo	11/25/2014	1/12/2015	none	48	na	na
103	cm to act-like	not in chart	1/20/2015	1/30/2015	na	na	10
104	cm to mmo	4/1/2015	6/1/2015	6/19/2015	61	79	18
105	cm to mmo	4/9/2015	4/20/2015	4/23/2015	11	14	3
106	act-like to cm	6/29/2015	6/29/2015	8/13/2015	0	45	45
107	cm to mmo	10/14/2014	3/23/2015	4/9/2015	160	177	17
108	mmo to cm	6/16/2015	6/22/2015	8/13/2015	6	58	52
109	act-like to cm	2/25/2015	3/2/2015	3/17/2015	5	20	15
110	cm to mmo	1/7/2015	2/2/2015	none	26	na	na
111	cm to mmo	not in chart	4/27/2015	none	na	na	na
112	mmo to cm	12/18/2014	1/5/2015	none	18	na	na
113	cm to mmo	6/8/2015	6/15/2015	none	7	na	na
114	cm to mmo	12/22/2014	1/12/2015	4/10/2015	21	109	88
115	mmo to cm	5/19/2015	6/8/2015	6/9/2015	20	21	1
116	cm to mmo	12/10/2014	3/30/2015	5/13/2015	110	154	44
117	act-like to cm	6/25/2015	6/29/2015	7/2/2015	4	7	3
118	cm to mmo	3/20/2015	3/30/2015	4/23/2015	10	34	24
119	cm to mmo	6/12/2014	3/23/2015	none	284	na	na
120	cm to mmo	not in chart	3/2/2015	none	na	na	na
121	mmo to cm	5/15/2015	6/1/2015	1/15/2016	17	245	228
122	mmo to cm	6/22/2015	6/29/2015	7/10/2015	7	18	11
123	mmo to cm	5/18/2015	5/18/2015	5/19/2015	0	1	1
124	mmo to cm	4/24/2015	6/1/2015	6/2/2015	38	39	1
125	cm to mmo	not in chart	3/16/2015	none	na	na	na

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126	cm to mmo	not in chart	5/11/2015	none	na	na	na
127	cm to mmo	not in chart	3/23/2015	4/6/2015	na	na	14
128	act-like to cm	6/17/2015	6/22/2015	7/30/2015	5	43	38
129	cm to mmo	not in chart	2/17/2015	none	na	na	na
130	cm to mmo	not in chart	1/26/2015	7/29/2015	na	na	184
131	cm to mmo	5/5/2015	5/18/2015	5/20/2015	13	15	2
132	cm to mmo	3/4/2015	3/16/2015	1/19/2016	12	321	309
133	act-like to cm	5/26/2015	6/1/2015	8/13/2015	6	79	73
134	mmo to act-like	5/27/2015	6/1/2015	8/27/2015	5	92	87
135	cm to mmo	not in chart	6/1/2015	8/13/2015	na	na	73
136	cm to mmo	not in chart	3/3/2015	none	na	na	na
137	act-like to mmo	not in chart	3/23/2015	none	na	na	na
138	cm to mmo	not in chart	5/4/2015	none	na	na	na
139	cm to mmo	10/31/2014	3/30/2015	none	150	na	na
140	cm to mmo	2/9/2015	6/8/2015	6/30/2015	119	141	22
141	cm to mmo	5/26/2015	6/1/2015	none	6	na	na
142	cm to mmo	not in chart	4/20/2015	none	na	na	na
143	cm to mmo	not in chart	2/23/2015	4/20/2015	na	na	56
144	cm to mmo	12/31/2014	1/12/2015	5/8/2015	12	128	116
145	cm to act-like	12/8/2014	1/12/2015	1/20/2015	35	43	8
146	act-like to cm	1/22/2015	3/2/2015	4/20/2015	39	88	49
147	act-like to cm	3/23/2015	4/6/2015	4/29/2015	14	37	23
148	cm to mmo	not in chart	5/18/115	none	na	na	na
149	cm to mmo	5/1/2015	6/1/2015	none	31	na	na
150	cm to mmo	not in chart	3/23/2015	none	na	na	na
151	mmo to act-like	12/4/2014	1/26/2015	1/27/2015	53	54	1
152	cm to mmo	not in chart	3/30/2015	none	na	na	na
153	mmo to cm	2/17/2015	2/23/2015	3/30/2015	6	41	35
154	cm to mmo	not in chart	5/26/2015	none	na	na	na
155	cm to mmo	3/16/2015	3/16/2015	none	0	na	na
156	act-like to cm	5/21/2015	5/26/2015	6/22/2015	5	32	27
157	mmo to cm	not in chart	6/1/2015	6/16/2015	na	na	15
158	cm to mmo	9/26/2014	3/23/2015	5/21/2015	178	237	59
159	cm to mmo	11/21/2014	3/2/2015	none	101	na	na

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160	mmo to cm	4/21/2015	5/4/2015	6/11/2015	13	51	38
161	cm to mmo	10/24/2014	3/23/2015	none	150	na	na
162	cm to mmo	1/14/2015	3/16/2015	4/6/2015	61	82	21
163	cm to mmo	5/15/2015	6/15/2015	none	31	na	na
164	cm to act-like	1/2/2015	1/26/2015	2/6/2015	24	35	11
165	act-like to cm	1/15/2015	1/26/2015	3/12/2015	11	56	45
166	cm to mmo	not in chart	3/30/2015	4/9/2015	na	na	10
167	cm to mmo	12/2/2014	1/12/2015	3/11/2015	41	99	58
168	mmo to act-like	6/1/2015	6/1/2015	6/12/2015	0	11	11
169	mmo to cm	5/27/2015	6/1/2015	none	5	na	na
170	mmo to act-like	not in chart	6/1/2015	6/19/2015	na	na	18
171	cm to mmo	4/30/2015	5/4/2015	none	4	na	na
172	mmo to cm	6/11/2015	6/15/2015	9/16/2015	4	97	93
173	cm to mmo	8/19/2014	5/4/2015	none	258	na	na
174	cm to mmo	11/17/2014	1/26/2015	5/14/2015	70	178	108
175	cm to mmo	not in chart	3/16/2015	9/1/2015	na	na	169
176	mmo to cm	2/10/2015	4/20/2015	4/28/2015	69	77	8
177	act-like to cm	6/29/2015	6/29/2015	7/10/2015	0	11	11
178	mmo to act-like	not in chart	4/20/2015	4/29/2015	na	na	9
125 b	mmo to act-like	4/28/2015	4/24/2015	8/10/2015	-4	104	108
15 b	mmo to cm	6/2/2015	6/8/2015	6/30/2015	6	28	22
17 b	mmo to cm	6/5/2015	6/8/2015	6/18/2015	3	13	10
24 b	act-like to mmo	4/14/2015	4/27/2015	5/15/2015	13	31	18
37 b	mmo to cm	1/7/2015	1/12/2015	none	5	na	na
48 b	mmo to cm	4/27/2015	5/11/2015	6/11/2015	14	45	31
51 b	cm to mmo	12/17/2014	1/5/2015	1/26/2015	19	40	21
56 b	mmo to cm	5/15/2015	5/18/2015	5/20/2015	3	5	2
56 c	cm to mmo	12/17/2014	3/23/2015	none	96	na	na

Appendix 5

Transferring between Charleston and Dorchester Clinic

Step 1: Clinician identifies that patient has moved to Dorchester(Charleston) County, updates address in EMR, and discusses the transfer with patient.
Step 2: Clinician completes the transfer form in EMR and alerts their supervisor.
Step 3: Chart audit is completed by clinician or supervisor, and any errors found are corrected/addressed.
Step 4: Supervisor emails the Intake Supervisor of the receiving county and attaches the audit to the email.
Step 5: The Intake Supervisor will determine what team the case is going to and forward the audit to the supervisor for that team. (In Charleston, the Intake Supervisor will put the patient on the transfer log and send the audit to the transfer meeting).
Step 6: The receiving supervisor will change the chart into the new therapist's name and codes as soon as possible.

Appendix 6

Transfer Checklist

Program being transferred to:

- MMO
- Act-like
- Regional CM

Documentation completed:

- Discussed with patient
- Staffed with MD
- Staffed with Supervisor
- Progress Summary Completed (if not due use the "other ps")
- Discharge Transition Summary complete on the consent tab in EMR

For the supervisor

- Audit Completed
- Corrections made
- Case put on transfer log.