Section 10.3 Discharge Planning

10.3.1 Purpose

NARBHA enrolled persons, regardless of payer source, receiving inpatient services must have proactive discharge planning that identifies and assesses post-discharge clinical and social needs in order to arrange necessary services and resources for appropriate and timely discharge from a facility.

The intent of this policy is to outline requirements for improving the coordination of post discharge services, reducing unnecessary stays, increasing the management of inpatient admissions and decreasing unplanned or emergency readmissions within 30 days of discharge.

10.3.2 Terms:

Definitions for terms are located online at http://www.azdhs.gov/bhs/definitions/index.php. The following terms are referenced in this section:

Durable Medical Equipment (DME)
Health Care Professional
Inpatient Services
Nursing Facility
Primary Care Physician
Title XIX Eligible Person
Title XXI Eligible Person

10.3.3 Procedures

a. NARBHA providers must implement a discharge planning process to address the post-discharge clinical and social needs of the member upon discharge. The process shall be initiated by a qualified health care professional as soon as possible before, upon or immediately after admission and updated periodically during the inpatient admission to ensure accurately determined continuing care needs. The discharge plan must be appropriately documented in the person's medical record and must be completed before discharge occurs. NARBHA ensures that its subcontracted providers have a process that includes:
   i Proactive discharge assessment by qualified healthcare professionals identifying and assessing the specific post discharge bio-psychosocial and medical needs of

the eligible person prior to discharge. This process shall include the involvement and participation of the eligible person and representative(s), as applicable. The person and representative(s), as applicable, must be provided with the written discharge plan with instructions and recommendations identifying resources, referrals and possible interventions to meet the person's assessed and anticipated needs after discharge.

ii The coordination and management of the care that the eligible person receives following discharge from an acute setting. This may include:

(1) Providing appropriate post discharge community referrals and resources or scheduling follow up appointments with the person's primary care provider and/or other outpatient healthcare providers within 7 days or sooner of discharge;

(2) Coordination of care involving effective communication of the eligible person's treatment plan and medical history across the various outpatient providers to ensure that the member receives medically-necessary services that are both timely and safe after discharge. This includes access to nursing services and therapies;

(3) Coordination with the member's outpatient clinical team to explore interventions to address the member's needs such as case management, disease management, placement options, and community support services.

(4) Access to prescribed discharge medications;

- Medications requiring prior authorization may be requested by the inpatient facility prior to discharge in order to ensure member access to medications as per ADHS/DBHS Provider Manual NARBHA Section 3.15 Psychotropic Medication Prescribing and Monitoring and Form 3.16.1 Psychotropic Medication Prior Authorization.

(5) Coordination of care with the acute care plan when applicable; and

(6) Post discharge follow up contact to assess the progress of the discharge plan according to the member's assessed clinical (physical health care) and social needs.

iii NARBHA Care Management

(1) For members admitted to acute care facilities, when notified by the Health Plan of an acute admission, a NARBHA care manager notifies the Responsible Agency, as per the **NARBHA "No Place Like Home" Protocol**.

- Notification of acute care admissions to the Members assigned RA will serve to improve coordination of care between acute care and behavioral health providers. This will enable the BH provider to provide appropriate follow up and outreach/peer support to the member as well as interaction with providers involved in the member's aftercare plan as appropriate. The goal of increased coordination of care is to reduce emergency department visits and readmissions to acute care.

(2) For members at risk for psychiatric re-admissions, when notified by an in-network psychiatric hospital that a member has been admitted for a second time within a twelve month period and meets the NARBHA high risk criteria, the NARBHA care manager will provide intensified care management as per the **NARBHA Spotlight Protocol**.

- The protocol ensures that clinical activities, discharge planning, coordination of care and outreach occur prior to discharge in order to reduce readmissions with thirty days.
- Activities include reviewing the Arizona Controlled Substances Pharmacy Monitoring Program, referral to substance abuse treatment, referrals to Stanford Chronic Disease Self-Management Program, engagement with a peer run organization, offers for vocational rehabilitation services and housing assistance, referral to primary care services at a NARBHA integrated care clinic, consideration of long-acting injectable antipsychotic medications, a PCP post-discharge appointment within 7 days and a behavioral health medical practitioner appointment within 7 days of discharge.

b. Access to Durable Medical Equipment (DME):

i Individuals who are discharged from the Arizona State Hospital (AzSH) must be provided with the same brand and model of glucometer and supplies the individual was trained on while in the hospital.

c. A discharge plan that is documented in the member's medical record.

d. Monitoring

i Prior authorization requests for inpatient hospitalization and other out-of-home facility services require submission to NARBHA of an updated individual service plan with pro-active discharge criteria and a discharge plan as per ADHS/DBHS Provider Manual NARBHA Section 3.14 Securing Services and Prior Authorization 3.14.3-C.

ii NARBHA Quality Management Department monitors discharge planning as per the NARBHA Desktop Protocol for Utilization Management Record Review.

e. Reporting:

i NARBHA results are reported in the Medical Management/Utilization Management Committee as a standing agenda item when completed, the outcomes of such audits with plans for corrections when discharge planning standards are not met.

10.3.4 References

AHCCCS/ADHS Contract
ADHS/RBHA Contracts
AHCCCS Medical and Policy Manual (AMPM) Chapter 1000, Policy 1020, Section C