Section 10.6 Coordination of Care for Referrals to In-Network GSA 1 NARBHA Inpatient and Chemical Dependency (CD) Residential Facilities

10.6.1 Introduction

NARBHA has established in-network inpatient and CD residential services for all NARBHA members eligible for those services across the GSA Region 1 in order to provide accessible and available inpatient/residential treatment. These inpatient beds are located at Mohave Mental Health Clinic (MMHC) in Kingman, West Yavapai Guidance Clinic (WYGC) in Prescott, The Guidance Center (TGC) in Flagstaff, and Community Counseling Center (CCC) in Pinetop. CD residential beds are located at The Guidance Center (TGC) in Flagstaff, West Yavapai Guidance Clinic (WYGC) in Prescott, and Verde Valley Guidance Center (VVGC) in Cottonwood.

Funding for block purchases is equally distributed across GSA 1 based on population, utilization and geographic proximity. Bed availability is for all eligible persons, not just for the inpatient facility's Responsible Agency's (RA's) membership.

Eligible adult persons requiring an emergency admission are admitted to the closest in-network GSA 1 NARBHA facility in the county where the person is located.

Each inpatient and CD residential facility has a defined primary service area; however, individuals may be admitted to any in-network GSA 1 NARBHA facility if the primary facility is full.

In the event that all in-network GSA 1 inpatient and CD residential facility beds in the NARBHA region are full, based on member eligibility, individuals may be eligible for admission to other out-of-network inpatient or CD residential facilities.

In no case may a NARBHA inpatient facility deny an emergency admission to an individual based on geographic or Responsible Agency (RA) enrollment considerations.

For eligible persons presenting outside of the NARBHA geographic service area and who require emergency psychiatric hospitalization, no prior authorization is necessary for admission to the closest inpatient facility. The eligible person will be considered for transfer to a NARBHA in-network GSA 1 facility as soon as possible if the total length of stay is anticipated to be

greater than 72 hours. See DBHS/NARBHA Policy 3.14 Securing Services and Prior Authorization.

10.6.2 References
R9-20-101

10.6.3 Definitions
Emergency Behavioral Health Service

On-call

Licensed Capacity

Inpatient Treatment Program

10.6.4 Objectives
To ensure the proper process for referral of eligible NARBHA members to NARBHA's in-network GSA 1 inpatient facilities and CD residential beds.

10.6.6 Procedures

Primary inpatient facility designations
- Individuals presenting in Mohave County are initially referred to MMHC facility.
- Individuals presenting in Coconino County are initially referred to TGC facility.
- Voluntary individuals presenting in Yavapai County are initially referred to WYGC facility. Individuals presenting for involuntary inpatient care in that area are referred to the Mingus Center facility.
- Individuals presenting in Apache and Navajo Counties are initially referred to CCC facility.

Primary CD residential facility designations
- Individuals presenting in Mohave and Yavapai Counties are initially referred to the WYGC facility.
- Individuals presenting in Coconino, Apache and Navajo Counties are initially referred to the TGC facility.
- Female individuals enrolled as Seriously Mentally Ill (SMI) and with chemical dependency disorders presenting from any area may be referred to the gender-based Verde Valley Guidance Center (VVGC) CD residential treatment facility.

Qualifications for prior authorization denials:

Denials for prior authorization of admissions and continued stays in inpatient facilities are the responsibility of NARBHA.

Qualifications for emergency admission inpatient acceptances:

An in-network inpatient or CD residential facility may not deny the psychiatric appropriateness for emergency admission when an eligible person has been determined to need admission by an RA behavioral health professional.

Concerns about medical stability or fragility should be satisfactorily concluded between the referring RA medical practitioner and the accepting inpatient or CD residential facility medical practitioner.

Referral and admission procedures to in-network GSA 1 inpatient facilities

- Once an RA behavioral health professional has determined the need for admission for inpatient psychiatric care, the RA designated staff contacts the individual's primary facility's designated staff to arrange admission.
- Appropriate "on-call" staff from both agencies, including the medical practitioner of the referring facility and the accepting inpatient facility's medical practitioner, is available as necessary within 15 minutes of the referral to the facility to discuss the referral and to make necessary arrangements to facilitate the transfer and admission of the individual.

Referral and admission procedures to in-network GSA 1 CD residential facilities

- RAs ensure timely transmission of clinical information relevant to the admission to the receiving CD residential facility.
- At this time, it is the responsibility of the RA referring staff to determine the need for CD residential services utilizing ASAM criteria. This service will require prior authorization some time in the future by NARBHA.
  It is the responsibility of the CD residential facility to prioritize the admissions and give the first-available bed to the new referral as per Section 3.19 Special Populations.
- The CD residential facility must provide the RA referring staff with the first available admission date for that referral within 24 hours of the referral.
- In the event that the first available admission date does not fully meet the treatment needs of the member, the referring RA develops interim service plans until the admission date or refers to the other CD residential block-purchased facilities.

Referrals to out-of-network inpatient and CD residential facilities when GSA 1 in-network facility capacity has been exceeded

- Eligible members who have an inpatient hospital or CD residential benefit may receive that service at an out-of-network inpatient or CD residential facility when all NARBHA in-network GSA 1 facility beds are at licensed capacity.
- The cost of care is assigned to the RA where the person is enrolled.
- In order to ensure that NARBHA or the RA does not incur expenses for an out-of-network service, the primary inpatient or CD residential facility may be responsible for a fine that covers the payment of the out-of-network service (including transportation) if it is determined

that there was in-network bed availability at the time the referral was denied for lack of beds or another inappropriate reason.
- Eligible persons in out-of-network inpatient or CD residential facilities are transferred back to an in-network inpatient facility as soon as possible if their anticipated length of stay is going to be longer than 72 hours, unless the service is covered by a Medicare DRG payment which pays a lump sum for the entire episode of care.

Starting Episodes of Care for individuals referred for inpatient facility services.
- In order to ensure receipt of service value and because of the depth of clinical information gathered during an inpatient stay, starting an episode of care in the NARBHA system for eligible persons is the responsibility of the RA inpatient facility, unless otherwise arranged with the referring RA.
- Members who are enrolled as SMI by the inpatient facility's physician are presumed to be SMI by the member's RA for continued services until a new SMI determination is completed.

Inpatient and CD residential facilities' bed management
- NARBHA requires the in-network GSA 1 inpatient and CD residential facilities to manage their bed capacity to ensure that their beds are available and accessible to NARBHA-eligible individuals. Each inpatient and CD residential facility provider must implement internal utilization review procedures to ensure that care is based on DBHS admission and continued stay authorization criteria and for CD residential services on ASAM criteria for this level of care and that individuals are discharged from inpatient and CD facilities when they no longer meet these criteria.
- Each facility has a licensed capacity based on the number of beds approved by licensure.
- Each inpatient facility may begin voluntary admission diversions when bed capacity is two or less than the licensed capacity.
- **Bed-Day Purchases are not daily census caps**. While NARBHA has an approximate number of beds per day that have been purchased as part of a block-purchase, this in no way should be construed as a daily census cap for NARBHA members. Eligible persons should be admitted based on need and overall bed availability, not on the approximate number of beds per day in the block-purchase.
- NARBHA has block-purchased bed-days on an annualized basis and may make mid-year adjustments either or up or down dependent on actual utilization.
- Eligible individuals referred for admission to their primary inpatient or CD residential facility must be admitted to the primary inpatient or CD residential facility if a bed is available.
- Except in the case of T36 referrals, inpatient facilities may not preferentially prioritize or deny admissions before full licensed capacity has been met. (For example, beds may not be saved for unknown potential admissions when a known admission is referred).
- In all cases, Title 36 individuals have priority for inpatient facility beds in the county in which Title 36 proceedings were initiated.
- In the event that an inpatient facility is nearing licensed capacity or at capacity, the medical staff is responsible for decisions regarding capacity management to ensure availability and accessibility.

- Decisions to discharge or to transfer an individual should be based on the acuity of individuals affected by the decision, the legality and logistics of transferring new or existing inpatients and continuity of care considerations.
- Precipitous disruptions in the care of current inpatients in order to admit a new individual are to be avoided if at all possible. Current inpatients may be considered for transfer to accommodate a new admission when there is a need to accept a T36 referral, when a person is from or will be relocating to the RA of the secondary inpatient facility at discharge, when the clinical needs of the person can be appropriately met at the new facility and when the person agrees to the transfer.

Decisions to manage inpatient and CD residential facility capacity may include:
- Discharging current inpatients/residents considered discharge-ready to accommodate new admissions;
- Negotiating timing of admissions based on the safety level of the new admissions (for example, delaying admissions of individuals in secure environments briefly while an inpatient/resident is being discharged);
- Transferring current inpatients/residents to another in-network GSA 1 inpatient or CD residential facility; or
- Referring new admissions to secondary in-network GSA 1 inpatient or CD residential facilities.

Referral to secondary Inpatient and CD residential facilities due to capacity issues
- Process for "referring provider"
  - If an individual has not been admitted yet, the "referring provider" is the clinical provider determining the need for hospitalization or CD residential services;
  - If a current inpatient/resident must be referred to a secondary inpatient or CD residential facility, "the referring provider" is the inpatient or CD residential facility.
- The referring provider is responsible for contacting and communicating with the receiving facility to arrange for admission, transfer and transportation to the facility.
- Distance, facility occupancy, and other considerations are taken into account in making decisions about which individuals to refer/transfer and in choosing which secondary Inpatient or CD residential facility to use.
- When the primary inpatient or CD residential facility is unable to accept an eligible referral:
  - The primary inpatient or CD residential facility contacts the other in-network GSA 1 inpatient facilities to determine alternate bed availability.
  - This information with contact names and phone numbers is given to the referring provider within 15 minutes of the referral for inpatient care or 24 hours for CD residential care.
  - The referring provider then completes the inpatient or CD residential referral process with the secondary inpatient or CD residential facilities.

Notification to other inpatient facilities when near bed capacity maximum

- When an inpatient facility is nearing its bed capacity maximum, the facility should put the other inpatient facilities on alert by contacting the directors of nursing or their designees at each inpatient facility so that they may begin to make accommodations.

Referral to secondary inpatient facility due to involuntary status

Eligible members who were initially involuntary (T36) and convert to voluntary status while at a non-block-purchased inpatient facility, or who have converted to court-ordered status (C36) and who are in need of continued inpatient services should be transferred to the inpatient facility in the region where the member will be receiving outpatient services .

Transportation Responsibilities

- For court-ordered evaluations (COE) or during a COE inpatient stay
  - County law enforcement agencies are responsible for the transportation of Title 36 individuals to and from inpatient facilities for court-ordered evaluations as per county contracts.
  - If the person requires transportation for evaluation of a medical condition, such as to an emergency room for evaluation of chest pain, seizure, etc, the responsible entity is:
    - AHCCCS Health Plan for TXIX/TXXI members,
    - Insurance plans for insured individuals.
    - County or self-pay for all other individuals.
- For transportation needs during voluntary treatment
  - The referring provider (see above definition of “referring provider”) is responsible for arranging and assisting the individual referred for inpatient or CD residential admission.
  - Arrangements for transportation are based on clinical acuity/dangerousness.
  - Medically necessary transportation is a covered service for Title XIX and Title XXI eligible persons. Transportation is arranged for by the referring provider.
  - Since timely discharges are frequently dependent on transportation issues, the arrangement of transportation of a person to his/her home community upon discharge is the responsibility of the inpatient or CD residential facility. The service value/costs of that transportation service are borne by the RA in which the member is enrolled, or the individual, depending on the member’s benefits.

- During voluntary or COT inpatient stay for behavioral health purposes, such as transfers between inpatient facilities or to other agency facilities:
  - For persons with a non-emergency transportation benefit:
    - The inpatient facility, in consultation with the member’s RA, determines the type of transportation based on clinical needs (ambulance, supervised, locked, self, etc.)
    - The inpatient facility arranges transportation so that timing of transport and readiness of the individual is appropriate.
    - The RA of the enrolled member authorizes and pays for transportation.
    - Emergency transportation is never prior authorized.

- For persons without a non-emergency transportation benefit:
  - The inpatient or CD residential facility determines and arranges transportation dependent on clinical needs.
  - The individual or other insurer pays for transportation.

Coordination of care between the inpatient and CD residential facility providers and outpatient providers

- It is the responsibility of the individual's outpatient clinical team to ensure coordination of care and maintenance of continuity of care between inpatient and CD residential services and outpatient settings.
- It is the responsibility of the inpatient and CD residential facility to notify the RA clinical designee about admissions and pending discharges.
- Discharge summaries should be completed within 14 days as per licensure and sent to the RA outpatient clinical team.

Medications

- Individuals in the community, who are referred for inpatient or CD residential facilities, are encouraged to bring their current medications in their original bottles to the facility in order to reconcile medications, dosages and adherence.
- Inpatient and CD residential facilities may, at their discretion, request that members being transferred from one inpatient or CD residential facility to another arrive with enough medications to last until the next pharmacy delivery in order to ensure continued appropriate administration of medications.
- Prescriptions, when needed, are provided at discharge sufficient to last until the first post-discharge follow-up service with the outpatient medical practitioner.

Discharge Planning and Appointments

- Discharge planning is the primary responsibility of the inpatient and CD residential facility treatment team with input and collaboration from the individual's referring RA clinical team.
- If at all possible, the inpatient and CD residential facility will notify the outpatient RA clinical team of discharges 24 hours prior to discharge so that appropriate arrangements may be made.
- To determine if a person hospitalized at a secondary inpatient facility should be discharged from the secondary inpatient facility directly to outpatient services or transferred to the primary inpatient facility for continued inpatient services:
  - If the person was a transfer from a primary inpatient facility to a secondary inpatient facility, the primary inpatient facility must be contacted prior to discharge to determine if the person should be transferred back or discharged to outpatient services directly;
  - For all other persons, the person's RA clinical team should be contacted prior to discharge for discharge planning.
- The first post-discharge follow-up face-to-face clinical service is scheduled prior to discharge at the outpatient provider as part of the discharge plan.

- For inpatient services, the outpatient provider must provide this first post-discharge follow-up service in a timely fashion ideally within 7 days after discharge, but no later than 30 days as clinically appropriate. See Section 3.8 Outreach, Engagement, Re-Engagement and Closure.
- The outpatient provider must prioritize appointments within seven days of discharge with a medical practitioner if a person is discharged on medications and must schedule an appointment with a medical practitioner within a timeframe that ensures that the person does not run out of any needed psychotropic medications and within a timeframe indicated by clinical need, preferably within 7 days, but no later than 30 days from the discharge date. See Section 3.2 Appointment Standards and Timeliness of Service. See Section 3.8 Outreach, Engagement, Re-Engagement and Closure.