Policy Name: STATE HOSPITAL CARE COORDINATION

Policy Number: CL206

Effective Date: 1/1/2020

Revision Dates: 5/14/2020; 10/25/21

Reviewed Date: 7/30/2019

Executive Board Approval Dates: 11/1/2019; 1/15/2021; 3/18/2022

PURPOSE

To establish standards to ensure the provision of Care Coordination to non-Medicaid Individuals who are discharging from a State Hospital.

POLICY

The Salish Behavioral Health Administrative Services Organization (SBH-ASO) shall work with the State Hospital's discharge team(s) and community partners to identify potential placement options and resolve barriers to placement, and to assure that Individuals will be discharged back to the community after the physician/treatment team determines the Individual is ready for discharge.

PROCEDURE

The SBH-ASO is responsible for coordination for assigned Individuals from admission through discharge. An SBH-ASO Care Manager will act in the role of liaison for all non-Medicaid Individuals.

A. SBH-ASO is responsible for coordinating discharge for assigned Individuals, which may include American Indian/Alaskan Native fee for service individuals, and works to complete the work in alignment with requirements of the State Hospital MOU or Working Agreement.
    a. SBH-ASO Liaison participates in meetings and staffings as scheduled to coordinate discharge.
    b. SBH-ASO Liaison works to identify existing agency relationships and facilitates care coordination with treatment providers and supports during discharge planning.
    c. SBH-ASO Liaison coordinates care with the Peer Bridger program to facilitated continuity in transitions of care.

B. The SBH-ASO liaison works to ensure individuals are medically cleared, if possible, prior to admission to a State Psychiatric Hospital or 90/180 Community Civil Commitment Facility.
C. The SBH-ASO liaison uses best efforts to divert admissions and expedite discharges by using alternative community resources and mental health services, within available resources.
D. The SBH-ASO Care Managers coordinate care for any inpatient admission to identify additional resources and discharge supports to divert from state hospital and/or long-term inpatient placement.
    a. Diversion activities include:
        i. An SBH-ASO Care Manager is assigned upon admission to develop a discharge plan and explore alternative options of care.
        ii. The SBH-ASO generates a weekly report of individuals whose inpatient care episode exceeds 20 days. This report is reviewed by the Liaison in consultation with Clinical Director and/or Medical Director to explore alternative options for care.
        iii. The SBH-ASO Liaison is assigned to provide additional coordination to explore alternative options to long-term inpatient care.

1. The SBH-ASO liaison works with the State Hospital discharge team to identify potential placement options and resolve barriers to placement, to assure that individuals will be discharged back to the community after the physician/treatment team determines the individual is ready for discharge.
    a. SBH-ASO makes a good faith effort to schedule prescriber and other provider appointments within seven calendar days of an Individual's discharge. Appointment times are communicated back to the Facility, including for Individuals discharging from the State Hospital's Forensic Units.
2. The SBH-ASO and its Providers monitor and track Individuals discharged from inpatient hospitalizations on Less Restrictive Alternatives (LRA) under RCW 71.05.320 to ensure compliance with LRA requirements (see SBH-ASO Monitoring of Conditional Release, Less Restrictive, Assisted Outpatient Treatment Order Policy).
3. The SBH-ASO coordinates with Providers to offer behavioral health services to Individuals who are ineligible for Medicaid to ensure compliance with LRA requirements.
    a. SBH-ASO Liaison provides review of court reporting of LR/CR and coordinates care with the appropriate entities to provide continuity of care.
4. The SBH-ASO responds to requests for participation, implementation, and monitoring of Individuals receiving services on conditional release consistent with RCW 71.05.340. The SBH-ASO coordinates with Providers to facilitate access to mental health services to Individuals who are ineligible for Medicaid to ensure compliance with conditional release requirements (RCW 10.77.150 and 71.05.340).

5. Non-Medicaid Conditional Release Individuals in transitional status in Pierce or Spokane County will transfer back to the region they resided in prior to entering the State Hospital upon completion of transitional care. Individuals residing in the Salish RSA prior to admission and discharging to another RSA will do so according to the agreement established between the receiving RSA and the SBH-ASO. The Agreements shall include:
    a. Specific roles and responsibilities of the parties related to transitions between the community and the State Hospital.
    b. Collaborative discharge planning and coordination with cross-system partners such as residential facilities, community MH or SUD providers, etc.
    c. Identification and resolution of barriers which prevent discharge and systemic issues that create delays or prevent placements in the Salish RSA.
    d. SBH-ASO/Providers shall screen individuals and assist in Medicaid enrollment in partnership with State Hospital financial services.
    e. When Individuals being discharged or diverted from state hospitals are placed in a long-term care setting, the SBH-ASO partners with Providers to:
        a) Coordinate with DSHS Aging and Long-Term Services Administration (ALTSA) Home and Community Services (HCS) and any residential provider to develop a crisis plan to support the placement. The model crisis plan format is available on the HCA website.
        b) Coordinate with HCS and any residential provider in the development of a treatment plan that supports the viability of the HCS placement when the Individual meets access to care criteria.

6. The SBH-ASO implements a program that follows program and reporting standards found in the Peer Bridger Exhibit of the HCA BH-ASO contract.