510 PRIMARY CARE PROVIDERS

EFFECTIVE DATE: May 13, 2016

The Division contracts with health plans and delegates the responsibility of implementing this policy. The Division provides oversight and monitoring of delegated duties.

520 MEMBER TRANSITIONS

EFFECTIVE DATE: April 1, 2016

The Division identifies and facilitates coordination of care for all members during changes or transitions between the Division and other AHCCCS Contractors. The Division receives a daily roster (notification) from AHCCCS which includes a list of members that are being disenrolled from the Division or enrolled with the Division. The Division receives the notification prior to the effective date. The Division uses this notification to identify members and to assist with the transition. Members with special circumstances (such as those listed below) may require additional or distinctive assistance during a period of transition.

A. Medical conditions or circumstances such as:

1. Pregnancy (especially women who are high risk and in third trimester, or are within 30 days of their anticipated delivery date)

2. Major organ or tissue transplantation services which are in process

3. Chronic illness, which has placed the member in a high-risk category and/or resulted in hospitalization or placement in nursing, or other facilities, and/or

4. Significant medical conditions (e.g., diabetes, hypertension, pain control or orthopedics) that require ongoing specialist care and appointments.

B. Members who are in treatment such as:

1. Chemotherapy and/or radiation therapy, or

2. Dialysis.

C. Members with ongoing needs such as:

1. Durable medical equipment including ventilators and other respiratory assistance equipment

2. Home health services

3. Medically necessary transportation on a scheduled basis

4. Prescription medications, and/or

5. Other services not indicated in the State Plan, but covered by Title XIX for Early and Periodic Screening, Diagnosis and Treatment eligible members.

D. Members who at the time of their transition have received prior authorization or approval for:

1. Scheduled elective surgery(ies)

2. Procedures and/or therapies to be provided on dates after their transition, including post-surgical follow-up visits

3. Sterilization and have a signed sterilization consent form, but are waiting for expiration of the thirty-day period

4. Appointments with a specialist located out of the Contractor service area, and

5. Nursing facility admission.

Transitions to EPD Contractors

A. The Division initiates a transition to an EPD Contractor via a Member Change Report indicating the member is no longer eligible for the Division.

B. Upon notification, the Division provides relevant information to the receiving EPD Contractor.

C. The Enrollment Transition Information (ETI) form is transmitted by the Division's Transition Coordinator for all Division members.

D. The Division is responsible for covering the member's care resulting from the lack of ETI transmission to the EPD. Contractor

E. The Division provides medical records and notifies members, subcontractors or other providers.

Transition from EPD Contractor to DDD

A. Upon notification, the Division should anticipate an ETI from the EPD Contractor.

B. The EPD Contractor provides medical records and will notify members, subcontractors or other providers.

C. The Division provides new members with handbooks and emergency numbers,

D. The Division follows up as appropriate for the needs identified on the ETI form.

Transition from DDD to Acute Care AHCCCS Contractor

A. When AHCCCS determines a member is determined to no longer need long term care through ALTCS or the ALTCS-Transitional program, and the member is determined eligible for acute care enrollment, he/she will be transitioned to an

Acute Care AHCCCS Contractor.

B. Upon notification, the Division provides relevant information to the receiving Acute Care AHCCCS Contractor.

C. The Enrollment Transition Information (ETI) form is transmitted by the Division's Transition Coordinator for all Division members.

530 MEMBER TRANSFERS BETWEEN FACILITIES

REVISION DATE: 11/22/2017
EFFECTIVE DATE: May 13, 2016
REFERENCES: A.R.S. § 36-2909(B), 42 CFR 422.113, 42 CFR 438.114

Transfers Following Emergency Hospitalization

A. Transfers initiated by the Administrative Services Subcontractors (AdSSs) of the Division of Developmental Disabilities (Division) between inpatient hospital facilities may be made when all of the following conditions are present:

1. The attending emergency physician, or the provider actually treating the member, determines that the member is sufficiently stabilized for transfer and will remain stable for the period of time required for the distance to be traveled. Such determination is binding on the AdSS responsible for coverage and payment. The AdSSs must comply with Medicaid Managed Care guidelines regarding the coordination of post stabilization care (42 CFR 438.114, 42 CFR 422.113).

2. The receiving physician agrees to the member transfer.

3. Transportation orders are prepared specifying the type of transport, training level of the transport crew, and level of life support.

4. A transfer summary accompanies the member.

B. Transfer to a lesser level of care facility (e.g. Tertiary to Secondary or Primary, or Secondary to Primary Hospital, or transfer to a Skilled Nursing Facility) may be made, when one or more of the following criteria are met:

1. Member's condition does not require full acute hospital capabilities, or

2. Member's condition has stabilized or reached a plateau and will not benefit further from intensive intervention in the transferring facility, and

3. The receiving physician agrees to a member transfer, and

4. Transportation orders are prepared specifying the type of transport, training level of the transport crew and level of life support, and

5. A transfer summary accompanies the member.

C. For transfers initiated by the AdSSs, the attending emergency physician or the attending provider treating the member and the AdSSs Medical Director or designee is responsible for determining whether a particular case meets criteria established in policy The Division Medical Director in the event of a request for a decision on the transfer of a particular member, the Division will apply the criteria listed in this subsection and A.R.S. 36-2020(B)

Neonate Transfers Between Acute Care Centers

Acutely ill neonates may be transferred from one acute care center to another, given certain conditions. The chart that follows provides the levels of care, conditions appropriate for transfer, and criteria for transfer.

LEVEL OF CARE		TRANSFER CRITERIA
FROM	**TO**	
PRIMARY	**SECONDARY**	1. The nursing and medical staff of the sending hospital cannot provide: a. The level of care needed to manage the infant beyond stabilization to transport, or b. The required diagnostic evaluation and consultation services needed. 2. Transport orders are prepared which specify the type of transport, the training level of the transport crew and the level of life support. 3. A transfer summary accompanies the infant.
	TERTIARY	Same as above
SECONDARY	**TERTIARY**	Same as above
	PRIMARY	Same as below
TERTIARY	**TERTIARY (RARE)**	1. The sending and receiving neonatalogists (and surgeons, if involved) have spoken and have agreed that the transfer is safe. 2. The infant is expected to remain stable, considering the period of time required for the distance to be covered. 3. Transport orders are prepared which specify the type of transport, training level of the transport crew, and 4. A transfer summary accompanies the infant.
	SECONDARY	Same as above
	PRIMARY	Same as above

540 OTHER CARE COORDINATION ISSUES

REVISION DATE: 7/15/2016, 7/3/2015, 10/1/2015, 10/1/2014
EFFECTIVE DATE: July 3, 1993
REFERENCES: A.R.S. §§ 8-546, 15-765, 36-552(C), 36-558(A), 36-560(B); A.A.C. R9-28-509; and, Social Security Act § 1915 (k).

Acute Medical Care

The Support Coordinator, along with Health Care Services (HCS), ensures coordination of care for each member. Each subcontracted health plan has an identified liaison to assist with the coordination of care for Division members enrolled through the Arizona Long Term Care System (ALTCS) program.

The Support Coordinator will:

A. Contact the health plan liaison when a member has a concern related to medical services received or needed from the subcontracted health plan; and,

B. Contact HCS when there are issues that cannot be resolved with the liaisons.

Children's Rehabilitative Services

The Support Coordinator, along with Health Care Services (HCS), ensures coordination of care for each member receiving medical and behavioral health services from Children's Rehabilitative Services (CRS).

The Support Coordinator will:

A. Contact the CRS liaison when a member has a concern related to medical or behavioral health services received or needed from CRS; and,

B. Contact HCS when there are issues that cannot be resolved with the liaison.

Behavioral Health

When the Planning Document indicates a need for behavioral health services, the Support Coordinator shall initiate and coordinate such services with the Regional Behavioral Health Authority (RBHA). Additional information is available on the Arizona Division of Health Services/Division of Behavioral Health Services (ADHS/DBHS) website for each RBHA Provider Manual.

A. Qualified Behavioral Health Professional Consult (QBHP)

The Support Coordinator shall complete an initial consultation and quarterly consultations thereafter with the qualified behavioral health professional for all members receiving/needing behavioral health services. Quarterly consultations are not required for members who are stable on psychotropic medications and are not receiving any other behavioral health services.

B. Behavioral Health Treatment Plan (From RBHA Provider)

The Behavioral Health Treatment Plan from the RBHA Provider becomes part of the Division's Planning Document. The Support Coordinator must include outcomes relevant to a Behavioral Health Treatment Plan on the Division's Planning Document.

C. Child and Family Teams

The Child and Family Team (CFT) is a group of people that include, at a minimum, the child and the family, a behavioral health representative, the Support Coordinator, and any members important in the child's life who are identified and invited to participate by the child and family. The size, scope, and intensity of involvement of the team members are determined by the CFT outcomes, with oversight by the behavioral health representative.

Residential Placements

At the time of placement, the Support Coordinator is responsible for the following:

A. If a member's behaviors pose a danger to residents or staff, the Division will share this information with the parents/ guardians of other residents in the home. The agency director, designee, or Division staff will only provide non-personally identifiable information to the guardian.

B. For a member currently in placement or using out-of-home respite and potentially at risk, the Support Coordinator along with the Individual Support Plan (ISP) team will identify the appropriate person to inform the family of the risk.

In cases of emergency placement, the checklists capturing potential safety concerns for everyone in the home must be available to the guardian/family of the member moving in.

Department of Child Safety

The Support Coordinator is responsible for coordinating services with the Department of Child Safety (DCS) Case Manager when a child eligible for Division services is in the custody of DCS.

Department of Economic Security Vocational Rehabilitation

The Support Coordinator/Employment Specialist is responsible for submitting and coordinating referrals to DES Vocational Rehabilitation for employment related services.

Arizona Department of Education/ Local Education Agency

The Division shall coordinate services with the Arizona Department of Education Local Education Agency (LEA) under three distinct circumstances:

A. When the Division makes an out-of-home placement for educational purposes (A.R.S. §15-765, www.azleg.gov);

B. When the Division makes an out-of-home placement of a member receiving public education for other than educational purposes; and,

C. When a child receiving early intervention services (day treatment and training) from the Division reaches ages two years six months and two years nine months, in order to plan for preschool transition.

Residential Placement for Educational Reasons (A.R.S.§15-765)

A.R.S. § 15-765 allows for residential placements for children for educational reasons. It is not intended to provide long term or permanent residential placements for children. These placements should be for a limited period of time and only for the purpose of accomplishing specific educational goals that promote the child's ability to benefit from a special education program in a less restrictive environment. A.R.S. § 15-765 www.azleg.state.az.us/arizonarevisedstatutes.asp requires that residential placement be made for educational reasons only and not for other issues, such as family matters.

In the event the child may need some level of intervention beyond what is available through the Local Education Agency, a representative from the school should collaborate with the family or legal guardian to identify resources available to the child, This may include services covered by either private insurance or the Arizona Health Care Cost Containment System (AHCCCS) behavioral health benefits. If the child is currently not enrolled in AHCCCS but may be eligible through Title XIX/XXI (KidsCare), the Public Education Agency should assist the family in the enrollment process.
When an out-of-home placement is considered, priority should be given to placement in the home school district so the child can maintain placement, transition into the district when specific behavioral, or meet educational goals. Exceptions may exist for children with unusually complex educational needs that cannot be met in the home district, for example, in remote areas of the State. However, these reasons must be clearly documented before the placement is approved.

When the Individual Education Program (IEP) indicates that out-of-home placement for educational purposes may be necessary, the Support Coordinator shall immediately notify the District Program Manager for involvement in the placement process. If placement is to be made out of the Division District where the child resides, the Support Coordinator/originating District Program Manager must contact the District Program Manage in the receiving District in order to facilitate appropriate placement and services.

When requesting residential services for educational reasons through the Division, the following documentation must be provided by the requesting school district to the Support Coordinator. Copies of this documentation shall be placed in the case file. This information is then forwarded to the District Program Manager (DPM) and Central Office.

A. A letter of request for services.

B. Parental signature for consent for evaluation and services.

C. A copy of the Individual Education Program (IEP) that includes:

1. Documentation of least restrictive environment considerations, including the specific reasons why the child cannot be educated in a less restrictive environment;

2. Specific services requested, such as residential placement;

3. Length of time for the placement. For example, six months, one school year; and,

4. The exit criteria (goals which when accomplished will indicate that the child is ready to return home or to the home school district).

A. If the member is being placed outside the state and is eligible for the ALTCS, the AHCCCS must approve the placement in advance.

Incomplete documentation of the educational reasons for requesting residential placement will result in a delay. The Division Central Office may also deny the request.

Following approval and placement in an out-of-home setting for educational purposes, the need for placement shall be reviewed every 30 days after placement by the respective planning processes (Individual Education Program/Individualized Family Services Plan/Person Centered Plan meetings). The results of the review shall be documented in the progress notes. Requests for continuation of the placement must be submitted to the Division Central Office for approval by June 15 of each year. Requests for continued placement shall contain the same information and be submitted in the same manner as required for initial placements.

During the 30-day reviews, all parties shall consider progress according to the goals and objectives of the treatment plan and the Individual Educational Program (IEP) exit criteria. Each review shall also include a discussion surrounding the type of educational and behavioral health supports that would be needed to return the child to a less restrictive placement.

Anticipated transitional supports shall be discussed during the 30-day reviews. The Local Education Agency (LEA) and the Regional Behavioral Health Authority (RHBA) shall both strive to ensure that the necessary educational and Title XIX/XXI behavioral health supports shall be available to the child and family at time of discharge.

Any proposed change in a residential placement for educational reasons must be made through the IEP review process. Changes in placement must be consistent with the goals of the child's IEP and recommended by the team. Placements may not be changed for reasons other than those related to educational purposes. When a child's parents move to a new school district, the District that placed the child must notify the new school District of the placement arrangements.

The new District has the responsibility to review the appropriateness of the placement and use the IEP process to make any recommended changes.

When a child is promoted to a high school district, the District that placed the child must treat the promotion as a change of placement and must include the high school District in the IEP review process.

When the team determines that a child needs Extended School Year Services, no change in the residential placement may be made unless specified in the IEP.

Transition to the Community

A. When the child's treatment goals and the IEP exit criteria have been met, the Division, LEA, RBHA, family or legal guardian and residential provider shall collaborate on the necessary planning for transition to a less restrictive setting. At that time, the IEP shall be revised and the treatment plan updated.

B. The Division, LEA, RBHA and family or legal guardian shall coordinate with the residential facility provider to schedule a discharge date.

C. The Division, LEA and the RBHA shall ensure the agreed upon educational and Title XIX/XXI behavioral health supports are in place for the child and family upon discharge.

Post-discharge, the Division, the LEA and the RBHA shall continue to monitor the child's status in the less restrictive placement. Communication between the Division, the LEA and the RBHA shall continue in order to monitor and support the child's successful integration in the new setting.

Coordination of Care Between The Division And The School System

In addition to the review and annual due dates for the Planning Documents, the Support Coordinator is responsible for ensuring the overall provision of care in coordination of care with other agencies for each member, including educational services. It is important that the Support Coordinators and Support Coordinator Supervisors understand the appropriate ways to coordinate care with a local school system.

It is also important to develop working relationships with the various school districts within the proximity of the Support Coordinator's assigned Division office. This includes identifying the appropriate teachers and the school hierarchy for addressing any issues that may arise. The development of these relationships before serious concerns occur will assist in resolving issues in a more collaborative and timely manner.

The Support Coordinator should work with the family to identify the dates and times for meeting with the school, and participate in the development of the IEP. Coordinating the efforts of the education plan with the Division's Planning Documents can ensure these plans complement each other and provide better care for the member. If the family does not remember to invite the Division staff to the IEP meeting, the school representative should be invited to the Division's Planning Meeting.
When the Division identifies an educational need, the Support Coordinator will take the following steps:

A. Discuss identified need with the family;

B. Within five working days of obtaining the family's agreement, contact the local schoolteacher and/or principal to inquire about the identified educational need;

C. Contact the District Program Administrator/District Program Manager within two working days of contacting the school to request support with their counterpart in the local school district if the teacher and/or principle have not responded;

D. Contact the Division's Central Office within two weeks to request support in coordination with the Special Education Division of the Arizona Department of Education when there has not been a response from the local school district;

E. As appropriate, raise the general issue(s) at the Arizona Department of Education (ADDE) through Central Office; and,

F. Follow up with the member or the representative regarding whether or not the need has been/was met.

Discharge Planning

Discharge planning is a systematic process for the transition of a member from one health care setting to another or the transition of a medically involved member from one residential placement to another. The key to successful discharge planning is communication between member, family/caregiver and health care team. Depending on the specific needs of the member, the following people may participate in the discharge planning process:

A. Member/family/caregiver;

B. Primary care provider/specialist;

C. Discharge Coordinator/Social Worker/Quality Assurance Nurse;

D. Utilization Review Nurse (hospital, Division or Health plan);

E. The Division Discharge Planning Coordinator;

F. The Division Support Coordinator; and;

G. Other Planning Team members, as necessary.

In order to ensure that Support Coordinators and District Nurses are aware of hospitalizations of ALTCS eligible members, the Medical Services Representative will e-mail the Support Coordinator and District Nurse identified in Focus when notified of an admission. It is the responsibility of the Support Coordinator to notify the Division's District Nurse or Discharge Planning Coordinator of transfers of medically-involved members, or the hospitalization of a non-ALTCS eligible member.
The discharge planning process is applicable in health care settings, and in the transfer of a medically involved member from one Child Developmental Home, Adult Developmental Home, Group Home, and Intermediate Care Facility for Individuals with an

Intellectual Disability or Nursing Facility to another. The process will generally include the following activities:

A. Complete a Division Discharge Plan Assessment, e.g., nursing assessment;

B. Review of discharge orders written by doctor;

C. Ensure that the member/family/caregiver has received proper training to carry out the discharge orders;

D. Ensure that all necessary equipment and supplies have been ordered and will be available when needed;

E. Ensure that transportation arrangements have been made;

F. Reinstate applicable service(s) that may have been interrupted, or initiate services now determined needed (update Planning Documents);

G. The District Nurse or Discharge Planning Coordinator will complete a Utilization Review Nursing Worksheet – Health Care Services, and send copies to the Support Coordinator and Health Care Services (HCS); and,

H. Notification and/or signatures as required on the *Utilization Review Nursing Worksheet* – HCS form:

1. Health Care Services Representative (District Nurse and/or Discharge Planning Coordinator);

2. District Program Manager or designee (to be notified about all changes of placement);

3. Medical Director (to be notified by HCS of level of care changes); and,

4. The Division Assistant Director/designee (signature also required for placement in a planning document).

Members with Medical Needs

Members are considered to be medically involved when they require two or more hours per day of skilled nursing care. Thorough discharge planning for people who are medically involved ensures continuity of a members' services when the member is moving from one setting to another. Placement and services should be appropriate and established prior to the member being discharged.
The Support Coordinator, District Nurse, and/or the Discharge Planning Coordinator will work together to initiate the discharge planning process. Their communication can include a Planning Document. Convening a Planning Team meeting is at the discretion of any member.

The following procedures shall be implemented for all members who are medically involved:

A. The District Nurse will verify hospitalization notification and/or transfer intentions with the Support Coordinator;

B. The District Nurse or Discharge Planning Coordinator shall follow the hospitalization and keep the Support Coordinator updated on the member's condition and the concerns expressed by the member/family/caregiver; and,

C. A Planning Team meeting should be called prior to discharge for complex cases. The hospital discharge planner is considered the lead in this meeting, and should assemble the family/caregiver, attending physician, primary care provider (if possible), social services, the Support Coordinator and Division Nurse, and the health plan utilization review nurse. Other disciplines may be included, particularly if their role influences the member's discharge status/planning (i.e., Department of Child Safety or Adult Protective Services).

D. If placement is an issue:

1. A nursing assessment will be updated/completed, to assess the nursing/medical needs of the member and identify the appropriate type of facility/residence.

2. If behavioral health is a need, referral to the Regional Behavioral Health Authority (RBHA) should be made by the Support Coordinator to initiate assessment and their participation in the discharge planning process.

3. Based on the Planning Documents, the Support Coordinator will work with the appropriate staff to arrange for the facility/residence which will provide for the identified needs.

E. If the Division is expected to pay for a Planning Document placement, a thorough review is required, including HCS, before any admission is made. All placements in Planning Document(s) must have the approval of the Assistant Director. These facilities are restrictive environments, therefore, placement is temporary and transitional, occurring only after the following alternative options have been eliminated:

1. In-home supports;

2. Individually Designed Living Arrangement; and,

3. Community based placements, e.g.; Group Home; Child Developmental Home (CDH); or Adult Developmental Home (ADH).

See Division Medical Policy Manual for more information on Planning Document.

A. For those members who are returning to a Planning Document, the District Nurse or Discharge Planning Coordinator shall participate in the planning process. The entire planning process shall be completed before the discharge/transfer is made.

B. In the absence of a Planning Meeting, the District Nurse and/or Discharge Planning Coordinator will coordinate the discharge orders, caregiver training, equipment/supplies, home health care, and transportation.

C. The Division Nurse or Discharge Planning Coordinator shall complete a *Utilization Review Nursing Worksheet* –upon discharge, and send copies to the Support Coordinator and HCS.

D. The Discharge Plan shall take precedence over any Planning Document objectives that are in conflict. If there is a conflict, a new Planning Document shall be developed as soon as possible. The member/responsible person, primary care provider, or any other attending physician involved shall resolve disagreements. The medical records and a summary of the disagreement may be sent to the Discharge Planning Coordinator to be reviewed. The Division's Medical Director may be contacted to review the case and assist in the resolution of the disagreement.

E. The member's primary care provider shall be given the opportunity to participate in the discharge planning and review the completed Planning Document.

Nurse Consultation to Determine Medical Needs

The District Nurse or Discharge Planning Coordinator may be contacted directly by the Support Coordinator to review a member's hospitalization or transfer plans to determine if medical discharge planning is needed. A *Utilization Review Nursing Worksheet* should be completed by the District Nurse or Discharge Planning Coordinator and submitted with appropriate documentation to HCS and the Support Coordinator indicating if skilled nursing needs have been identified.

Members Without Medical Needs

For non-medically involved members who are being discharged from a hospital or skilled nursing facility, the following procedures shall be implemented:

A. The Support Coordinator shall assess for medical needs prior to discharge. If needed the District Nurse or Discharge Planning Coordinator will complete a Nursing Assessment - HCS to plan and recommend an appropriate level of care;

B. If the member is non-medically involved, the Support Coordinator will:

1. Ensure that training of caregivers has taken place;

2. Assess for and authorize in-home supports as appropriate;

3. Make arrangements for equipment, supplies, medications, etc. through appropriate systems; and,

4. Ensure that follow-up instructions are in place.

C. In those situations where a residential setting will change, the Planning Document process shall be an essential part of discharge planning.

Foster Care Discharge Planning

For all members in foster care, the following discharge planning procedures shall be implemented:

A. The Support Coordinator, District Nurse or Discharge Planning Coordinator will assess for medical needs prior to hospital discharge. If medical needs are present, the nurse will complete a Utilization Review Nursing Worksheet – HCS, and coordinate a plan of care, training for caregivers, and equipment and supply needs. A Nursing Assessment - HCS will be updated/completed to determine home based nursing services and/or placement needs.

B. The District Nurse or Discharge Planning Coordinator must be notified:

1. Prior to any foster child being admitted to or discharged from a planning document or Nursing Facility (NF).

2. Prior to any foster child that is medically involved, receiving home based nursing services, or being considered for a change in placement.

C. The Planning Team must be notified prior to this change of placement. The District Nurse or Discharge Planning Coordinator will complete the *Utilization Review Nursing Worksheet* – HCS, and coordinate plan of care, training, and equipment and supply needs. The District Nurse or Discharge Planning Coordinator will notify HCS of changes in placement. The Support Coordinator will notify the District. Specific to a planning document admission, the personal authorization of the Assistant Director (or designee) is required.

D. Children in foster care whose cases have been transferred from DCS to the Division may also require the participation of court appointed special advocates, attorneys, guardian ad litems, or other professionals from the juvenile court.

Discharge/Transition of Members with Severe Behavioral Challenges

When a member with severe behavioral health challenges is placed into a psychiatric hospital setting, the Support Coordinator will begin discharge planning immediately and District Personnel will attend a hospital staffing within 72 hours. Support Coordinators shall, if possible, attend all subsequent hospital staffings. Prior to discharge, the Support Coordinator will:

A. Involve staff responsible for contracting with Provider Agencies as soon as possible;

B. Begin the appropriate Planning Process; and,

C. Ensure that staff from the behavioral health system is invited to all planning sessions.

Use of the Discharge/Transition Checklist for Individuals with High Risk Behavioral Challenges is mandated when planning discharge from an inpatient setting for members with severe behavioral challenges. The form can also be used when someone with behavioral challenges moves from one setting to another. The form is intended to provide

reminders to the team about important areas to consider and should be used to plan for the discharge/move.

The Emergency Contact Plan is intended to record very basic information about the person that would be helpful to others coming in to assist in a crisis situation, such as crisis mobile team members or police officers. The form should be completed at the discharge/transition-planning meeting and updated as necessary. The representative from the behavioral health system should assist in filling out the form and the same information should, if possible, be on file with the Regional Behavioral Health Authority (RBHA). The Emergency Contact Plan should be kept in an easily accessible place in the setting, but it should never be posted.

The Emergency Contact Plan does not take the place of the Behavior Plan. Begin development of the behavior plan prior to discharge, so that the person is discharged with at least a rough draft of the plan that eventually gets submitted to the Program Review Committee. This initial plan may be called a "crisis plan." It should have information about precursors/antecedents and creative strategies for preventing challenging behaviors. It should give staff ideas for teaching replacement behaviors, and it should let staff know whom to call when a crisis occurs.

550 MEMBER RECORDS AND CONFIDENTIALITY

REVISION DATE: 11/17/2017
EFFECTIVE DATE: May 13, 2016
REFERENCES: A.A.C. R9-22-501 et seq; 42 CFR 431.300 et seq

All AHCCCS providers and Administrative Service Subcontractors (AdSS) must protect member information in accordance with federal and state laws, rules, Division of Developmental Disabilities (Division) and AHCCCS policies, and contracts.

Consistent with R9-22-501 et seq, AHCCCS, contractors, providers, and non-contracted providers must safeguard the privacy of records and information about members who request or receive services from the Division and the AdSS.

Information from, or copies of, medical records may be released only to authorized individuals, and processes must be in place to ensure that unauthorized individuals cannot gain access to, or alter, medical records.

Original and/or copies of medical records must be released only in accordance with federal or state laws or court orders. AdSS and the AdSS providers must comply with the Health Insurance Portability and Accountability Act (HIPAA) requirements and 42 CFR 431.300 et seq.

570 COMMUNITY COLLABORATIVE CARE TEAMS

REVISION DATE: 7/3/2015
EFFECTIVE DATE: June 31, 1993

Community Collaborative Care Teams collaborate and coordinate care for members eligible for Arizona Long Term Care System (ALTCS) who demonstrate inappropriate sexual behavior and/or aggressive behavior, who have been unresponsive to traditional ALTCS and behavioral health services and who have a co-occurring behavioral health condition or physical health condition.