

## **320-V BEHAVIORAL HEALTH RESIDENTIAL FACILITIES**

REVISION DATE: 4/22/20

EFFECTIVE DATE: October 1, 2019

REFERENCES: A.R.S. §§ 32-2061, 32-2091, 32-3251 et seq., and 36-501;

A.A.C. R9-10-101, 702, 707, 708, 715, 814; International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM)

**PURPOSE:** This policy establishes requirements for the provision of care and services in a Behavioral Health Residential Facility (BHRF).

### **DEFINITIONS**

**Adult Recovery Team (ART)** - A group of individuals who, following the nine Guiding Principles for Recovery-Oriented Adult Behavioral Health Services and Systems, collaborate and are actively involved in an assessment of the member, service planning, and service delivery. At a minimum the team consists of the member, guardian (if applicable), advocates (if assigned), and a qualified behavioral health representative. The team may also include members of the enrolled member's family, physical health, behavioral health or social service providers, representatives or other agencies serving the member, professionals representing various areas of expertise related to the member's needs, designated representatives or other persons identified by the enrolled member.

**Behavioral Health Condition** - Mental, Behavioral or Neurodevelopmental Disorder (F01-F99) diagnosis defined by International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM).

**Behavioral Health Residential Facility** - As specified in A.A.C. R9-10-101, a health care institution that provides treatment to a member experiencing a behavioral health issue that limits the member's ability to be independent or causes the member to require treatment to maintain or enhance independence.

**Behavioral Health Paraprofessional** - As specified in A.A.C. R9-10-101, an individual, who is not a behavioral health professional, who provides behavioral health services at or for a health care institution according to the health care institution's policies and procedures, who:

1. If the behavioral health services were provided in a setting other than a licensed health care institution, would be required to be licensed as a behavioral professional under A.R.S. Title 32, Chapter 33; and
2. Is provided supervision by a behavioral health professional.

### **Behavioral Health Professional (BHP):**

1. An individual licensed under A.R.S. Title 32, Chapter 33, whose scope of practice allows the individual to:
  - a. Independently engage in the practice of behavioral health as defined in A.R.S. § 32-3251, or

- b. Except for a licensed substance abuse technician, engage in the practice of behavioral health as defined in A.R.S. § 32-3251 under direct supervision as defined in A.A.C. R4-6-101;
2. A psychiatrist as defined in A.R.S. § 36-501;
3. A psychologist as defined in A.R.S. § 32-2061;
4. A physician;
5. A behavior analyst as defined in A.R.S. § 32-2091;
6. A registered nurse practitioner licensed as an adult psychiatric and mental health nurse; and
7. A registered nurse.

**Behavioral Health Technician (BHT)** – As specified in A.A.C. R9-10-101, an individual, who is not a behavioral health professional, who provides behavioral health services at, or for, a health care institution according to the health care institution’s policies and procedures, who:

1. If the behavioral health services were provided in a setting other than a licensed health care institution, would be required to be licensed as a behavioral professional under A.R.S. Title 32, Chapter 33; and
2. Is provided with clinical oversight by a behavioral health professional.

**Behavioral Health Residential Facility Staff** - Any employee of the BHRF agency including but not limited to Administrators, Behavioral Health Paraprofessionals, Behavioral Health Professionals (BHP) and Behavioral Health Technicians.

**Child and Family Team (CFT)** - A defined group of individuals that includes, at a minimum, the child and his or her family, a behavioral health representative, and any individuals important in the child’s life that are identified and invited by the child and family to participate. This may include teachers, extended family members, friends, family support partners, healthcare providers, coaches, and community resource providers, representatives from churches, synagogues, or mosques, agents from other service systems like the Department of Child Safety. The size, scope, and intensity of involvement of the team members are determined by the objectives established for the child, the needs of the family in providing for the child, and by who is needed to develop an effective service plan, and can therefore expand and Contract as necessary to be successful on behalf of the child.

**Co-occurring** - Coexistence of both a behavioral health and a substance use disorder.

**Medication Assisted Treatment (MAT)** - Use of medications in combination with counseling and behavioral therapies for the treatment of substance use disorders.

**Peer/Recovery Support Service** - Intentional partnerships, based on shared lived experiences, to provide social and personal support. This support is coupled with specific, skill-based training, coaching, or assistance to bring about social or personal change at the

individual, family or community level. These services can include a variety of individualized and personal goals, including living preferences, employment or educational goals, and development of social networks and interests.

**Peer/Recovery Support Specialist** - Individual trained, credentialed, and qualified to provide peer/recovery support services within the AHCCCS Program.

**Service Plan** - A complete written description, of all covered health services and other informal supports, which includes individualized goals, family support services, care coordination activities and strategies to assist the member in achieving an improved quality of life.

**Treatment Plan** - A complete written description of all services to be provided by Behavioral Health Residential Facility. The Treatment Plan is based on the intake assessments, outpatient Service Plan, and includes input from the CFT/ART. The Treatment Plan is reviewed and updated with the member and CFT/ART at least once a month.

## **POLICY**

Care and services provided in a BHRF are based on a per diem rate (24-hour day), require prior and continued authorization, and do not include room and board. All authorization requests for Behavioral Health Residential Facility services shall be treated as expedited requests (within 72 hours of receipt of authorization). The Division of Developmental Disabilities will conduct a second level review on members who were denied BHRF admission.

The Administrative Services Subcontractors (AdSS) shall ensure appropriate notification is sent to the Primary Care Physician and Behavioral Health Provider/Agency/TRBHA upon intake to and discharge from the BHRF.

### **A. Criteria for Admission**

AdSS must have admission criteria for medical necessity that, at a minimum, include the below elements. AdSS must publish the criteria, subject to Division approval as specified in the Contract.

If a member has a diagnosed Behavioral Health Condition that reflects the symptoms and behaviors necessary for a request for residential treatment, the Behavioral Health Condition causing the significant functional and/or psychosocial impairment must be evidenced in the assessment by the following:

1. At least one area of significant risk of harm within the past three months as a result of:
  - a. Suicidal/aggressive/self-harm/homicidal thoughts or behaviors without current plan or intent.
  - b. Impulsivity with poor judgment/insight.
  - c. Maladaptive physical or sexual behavior.

- d. Member's inability to remain safe within his or her environment despite environmental supports (i.e. informal supports).
- e. Medication side effects due to toxicity or contraindications.

**AND**

- 2. At least one area of serious functional impairment as evidenced by:
  - a. Inability to complete developmentally appropriate self-care or self-regulation due to member's Behavioral Health Condition(s);
  - b. Neglect or disruption of ability to attend to majority of basic needs, such as personal safety, hygiene, nutrition or medical care;
  - c. Frequent inpatient psychiatric admissions or legal involvement due to lack of insight or judgment associated with psychotic or affective/mood symptoms or major psychiatric disorders;
  - d. Frequent withdrawal management services, which can include but are not limited to, detox facilities, MAT and ambulatory detox;
  - e. Inability to independently self-administer medically necessary psychotropic medications despite interventions such as education, regimen simplification, daily outpatient dispensing, and long-acting injectable medications; or
  - f. Impairments persisting in the absence of situational stressors that delay recovery from the presenting problem.
- 3. A need for 24-hour behavioral health care and supervision to develop adequate and effective coping skills that will allow the member to live safely in the community.
- 4. Anticipated stabilization cannot be achieved in a less restrictive setting.
- 5. Evidence that appropriate treatment in a less restrictive environment has not been successful or is not available, therefore warranting a higher level of care.
- 6. Member agrees to, and participates in, treatment. In the case of minors, family/guardian/designated representative also agrees to and participates as part of the treatment team.

**B. Expected Treatment Outcomes**

- 1. Treatment outcomes must align with the following:
  - a. The Arizona Vision-12 Principles for Children's Behavioral Health Service Delivery as directed in AMPM Policy 430;

- b. The 9 Guiding Principles for Recovery-Oriented Adult Behavioral Health Services and Systems as outlined in Contract; and
    - c. The member's individualized basic physical, behavioral, and developmentally appropriate needs.
  2. Treatment goals must be:
    - a. Specific to the member's behavioral health condition(s);
    - b. Measurable and achievable;
    - c. Unable to be met in a less restrictive environment;
    - d. Based on the member's unique needs and tailored to the member and family/guardian/designated representative choices where possible;
    - e. Supportive of the member's improved or sustained functioning and integration into the community.

**C. Exclusionary Criteria**

Admission to a BHRF shall not be used as a substitute for the following:

1. An alternative to detention or incarceration;
2. A means to ensure community safety in circumstances where a member is exhibiting primarily conduct disordered behavior without the presence of risk or functional impairment;
3. A means of providing safe housing, shelter, supervision, or permanency placement;
4. A behavioral health intervention when other less restrictive alternatives are available and meet the member's treatment needs, including situations when the member/guardian/designated representative are unwilling to participate in the less restrictive alternative; or
5. An intervention for runaway behaviors unrelated to a behavioral health condition.

**D. Criteria for Continued Stay**

AdSS must have medical necessity criteria for continued stay that, at a minimum, include the below elements. AdSS must publish those criteria, subject to Division approval as specified in Contract. BHRF providers providing services to FFS members must adhere to the below elements.

During Treatment Plan review BHRF staff, and as applicable the CFT/ART, shall

assess continued stay and update the Treatment Plan. Progress towards the treatment goals and continued display of risk and functional impairment shall also be assessed. Treatment interventions, frequency, crisis/safety planning, and targeted discharge must be adjusted accordingly to support the need for continued stay. The following criteria must be considered when determining continued stay:

1. The member continues to demonstrate significant risk of harm and/or functional impairment as a result of a behavioral health condition.
2. Providers and supports are not available to meet current behavioral and physical health needs at a less restrictive lower level of care.

#### **E. Discharge Readiness**

AdSS must have medical necessity criteria for discharge that, at a minimum, include the below elements. AdSS must publish that criteria, subject to Division approval as specified in Contract. BHRF providers providing services to FFS members must adhere to the minimum discharge elements below.

Discharge readiness must be assessed by the BHRF staff and as applicable by the CFT/ART during each Treatment Plan review and update. The following criteria must be considered when determining discharge readiness:

1. Symptom or behavior relief is reduced as evidenced by completion of Treatment Plan goals.
2. Functional capacity is improved; essential functions such as eating or hydrating necessary to sustain life has significantly improved or is able to be cared for in a less restrictive level of care.
3. Member can participate in needed monitoring or a caregiver is available to provide monitoring in a less restrictive level of care.
4. Providers and supports are available to meet current behavioral and physical health needs at a less restrictive level of care.

#### **F. Admission, Assessment and Treatment Plan**

AdSS shall have a policy to ensure the admission, assessment, and treatment planning process is completed consistently among all providers in accordance with A.A.C. R9-10-707 and 708 and Contract requirements. BHRF Providers rendering services to Fee-For-Service members must follow the below outlined admission, assessment, and treatment planning requirements.

1. Except as provided in subsection R9-10-707(A)(9), a behavioral health assessment for a member is completed before treatment is initiated and within 48 hours of admission.
2. The CFT/ART/TRBHA, as applicable, is included in the development of the Treatment Plan within 48 hours of admission for members enrolled with the AdSS.

3. All BHRFs serving TRBHA members must coordinate care with the TRBHAs throughout the admission, assessment, treatment, and discharge process.
4. The Treatment Plan connects back to the member's comprehensive Service Plan for members enrolled with the AdSS.
5. A comprehensive discharge plan is created during the development of the initial Treatment Plan and is reviewed and/or updated at each review thereafter. The discharge plan must document the following:
  - a. Clinical status for discharge
  - b. Member/guardian/designated representative and, CFT/ART/TRBHA as applicable, understands follow-up treatment, crisis and safety plan, and
  - c. Coordination of care and transition planning are in process (e.g. reconciliation of medications, applications for lower level of care submitted, follow-up appointments made).
6. The BHRF staff and the CFT/ART as applicable meet to review and modify the Treatment Plan at least once a month.
7. A Treatment Plan may be completed by a BHP, or by a BHT with oversight and signature by a BHP within 24 hours.
8. The provider has a system to document and report on timeliness of the BHP of BHP signature/review when the Treatment Plan is completed by a BHT.
9. The provider has a process to actively engage family/guardians or designated representative in the treatment planning process as appropriate.
10. The provider's clinical practices, as applicable to services offered and population served, must demonstrate adherence to best practices for treating the following specialized service needs, which include but are not limited to:
  - a. Cognitive/intellectual disability
  - b. Cognitive disability with comorbid Behavioral Health Condition(s)
  - c. Older adults, and co-occurring disorders (substance use and Behavioral Health Condition(s), or
  - d. Comorbid physical and Behavioral Health Condition(s).
11. Services deemed medically necessary through the assessment and/or CFT/ART/TRBHA, as applicable, which are not offered at the BHRF, shall be documented in the Service Plan and documentation shall include a description of the need, identified goals and identification of provider who will be meeting the need. The following services shall be made available

and provided by the BHRF and cannot be billed separately unless otherwise noted below:

a. Counseling and Therapy (group or individual):

**Note:** Group Behavioral Health Counseling and Therapy may not be billed on the same day as BHRF services unless specialized group behavioral health counseling and therapy have been identified in the Service Plan as a specific member need that cannot otherwise be met as required within the BHRF setting.

b. Skills Training and Development:

- i. Independent Living Skills (e.g., self-care, household management, budgeting, avoidance of exploitation/safety education and awareness).
- ii. Community Reintegration Skill building (e.g., use of public transportation system, understanding community resources and how to use them).
- iii. Social Communication Skills (e.g., conflict and anger management, same/opposite-sex friendships, development of social support networks, recreation).

c. Behavioral Health Prevention/Promotion Education and Medication Training and Support Services including but not limited to:

- i. Symptom management (e.g., including identification of early warning signs and crisis planning/use of crisis plan);
- ii. Health and wellness education (e.g., benefits of routine medical check-ups, preventive care, communication with the PCP and other health practitioners);
- iii. Medication education and self-administration skills;
- iv. Relapse prevention;
- v. Psychoeducation Services and Ongoing support to maintain employment work/vocational skills, educational needs assessment and skill building;
- vi. Treatment for Substance Use Disorder (e.g., substance use counseling, groups); and
- vii. Personal Care Services (see additional licensing requirements in A.A.C. R9-10-702, 715 and 814).

## **G. BHRF and Medication Assisted Treatment**

AdSS and BHRF providers must have policies and procedures to ensure members on Medication Assisted Treatment (MAT) are not excluded from admission and are able to receive MAT to ensure compliance with Arizona Opioid Epidemic Act SB 1001, Laws 2018. First Special Session.

## **H. BHRF with Personal Care Services**

BHRFs licensed to provide Personal Care Services must offer services in accordance with A.A.C R9-10-702 and A.A.C R9-10-715. AdSS and BHRF providers must ensure that all identified needs can be met in accordance with R9-10-814 (A)(C)(D) and (E).

The following are examples of services that may be provided:

1. Blood sugar monitoring, Accu-Check diabetic care
2. Administration of oxygen
3. Application and care of orthotic devices
4. Application and care of prosthetic devices
5. Application of bandages and medical supports, including high elastic stockings
6. ACE wraps, arm and leg braces, etc.
7. Application of topical medications
8. Assistance with ambulation
9. Assistance with correct use of cane/crutches
10. Bed baths
11. Care of hearing aids
12. Radial pulse monitoring
13. Respiration monitoring
14. Denture care and brushing teeth
15. Dressing member
16. Supervising self-feeding of members with swallowing deficiencies
17. Hair care, including shampooing
18. Incontinence support, including assistance with bed pans/bedside commodes/ bathroom

supports

19. Measuring and recording blood pressure
20. Non-sterile dressing change and wound care
21. Passive range of motion exercise
22. Use of pad lifts
23. Shaving
24. Shower assistance using shower chair
25. Skin maintenance to prevent and treat bruises, injuries, pressure sores. Members with stage 3 or 4 pressure sore is not to be admitted to BHRF (A.A.C.R9-10-715(3)), and infections
26. Use of chair lifts
27. Skin and foot care
28. Measuring and giving insulin, glucagon injection
29. G-tube care
30. Ostomy and surrounding skin care
31. Catheter care