540 ELECTRONIC VISIT VERIFICATION ~~OTHER CARE COORDINATION ISSUES~~

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PURPOSE

This Policy outlines the Division's requirements regarding the mandated use of an Electronic Visit Verification (EVV) system for personal care and home health services pursuant to 42 U.S.C. §1396b(l).

DEFINITIONS

1. "Aggregator" means a function of the AHCCCS EVV Vendor System that allows the state to compile all data and present it in a standardized format for review and analysis.
2. "AHCCCS Electronic Visit Verification (EVV) Vendor" means the AHCCCS selected State-Wide EVV vendor to comply with the 21st Century Cures Act (Cures Act).

3. "Alternate Electronic Visit Verification System" or "Alternate EVV System" means any EVV system(s) chosen by a Provider as an alternate to the AHCCCS selected State-Wide EVV vendor.

4. "Direct Care Worker" or "DCW" means for the purpose of this Policy, an individual providing one or more of the services subject to EVV.

5. "Designee" means for the purposes of this Policy, an individual who is 12 years of age or older and who is delegated by the Member or Health Care Decision Maker the responsibility of verifying service delivery on behalf of the Member.

6. "Electronic Visit Verification" or "EVV" means a computer-based system that electronically verifies the occurrence of authorized service visits by electronically documenting the precise time a service delivery visit begins and ends, the individuals receiving and providing a service, and type of service performed.

7. "Manual Edit" means any change to the original visit data. All edits shall include an appropriate audit trail.

8. "Member" means the same as "Client" as defined in A.R.S. § 36-

551.

9. "Planning Document'' means a written plan developed through an assessment of functional needs that reflects the services and supports, paid and unpaid, that are important for and important to the Member in meeting the identified needs and preferences for the delivery of such services and supports.

10. "Prior Authorization" means for purposes of this Policy, a process by which it is determined in advance whether a service that requires prior approval will be covered, based on the initial information received. Prior Authorization may be granted provisionally (as a temporary authorization) pending receipt of required documentation to substantiate compliance with AHCCCS criteria. Prior Authorization is not a guarantee of payment.

11. "Provider" means any individual or entity contracted with the Division that is engaged in the delivery of services, or ordering or referring for those services, and is legally authorized to do so by the State.

12. "Responsible Person" means the parent or guardian of a minor with a developmental disability, the guardian of an adult with a

developmental disability or an adult with a developmental disability who is a Member or an applicant for whom no guardian has been appointed.

13. "Service Confirmation" means a notification to AHCCCS through an online portal by a Provider a service that does not require Prior Authorization will be provided to a Member that is medically necessary.

POLICY

A. ELECTRONIC VISIT VERIFICATION

1. The Division shall use EVV to ensure, track, and monitor timely service delivery and access to care for Members.

2. The Division shall ensure Providers utilize AHCCCS' single statewide EVV System for data collection or choose an AHCCCS approved Alternate EVV System capable of sharing data with the Aggregator.

B. SERVICE VERIFICATION

1. The Division shall ensure that all Providers who are subject to EVV utilize the AHCCCS procured system or an AHCCCS

approved Alternate EVV System to electronically track the defined data specifications available on the AHCCCS website.

2. The Division shall require the Responsible Person to verify hours worked by the Direct Care Worker (DCW) at the point of care or within 14 calendar days of the visit.

3. The Division shall require the Responsible Person to verify Manual Edits to visits.

4. The Division shall require the Responsible Person to arrange for a Designee to have the verification responsibility and complete the Division's Electronic Visit Verification (EVV) Designee Attestation (Form DDD-2102A) when the Responsible Person is unable or is not in a position to verify service delivery on an ongoing basis.

5. The Division shall require the Electronic Visit Verification (EVV) Designee Attestation (Form DDD-2102A) to be completed, at a minimum, on an annual basis to attest that the Responsible Person has communicated the requirements of the verification responsibility to the Designee to whom they are delegating the verification responsibility.

6. The Division shall require Providers to assist the Responsible Person in making an informed decision about verification delegation.

7. The Division shall permit the Responsible Person to make a change to their verification delegation at any time by completing an Electronic Visit Verification (EVV) Designee Attestation (Form DDD-2102A).

8. The Division shall require exceptions to the Designee age requirement to be discussed with the Planning Team and documented on the Electronic Visit Verification (EVV) Designee Attestation (Form DDD-2102A) prior to the delegation of service delivery verification responsibility.

9. The Division shall not allow the Responsible Person or the Designee to verify service delivery for the services that they have personally rendered.

10. The Division shall require documentation on the Electronic Visit Verification (EVV) Designee Attestation (Form DDD-2102A) when there are barriers to verification.

C. PAPER TIMESHEETS

1. The Division shall allow the use of paper timesheets when the actual date and the start and end time of the service provision are independently verified.

2. The Division shall permit the use of Paper Timesheets under the following circumstances:

   a. The DCW and the Member live in geographic areas with limited, intermittent, or no access to landline, cell, or internet service;

   b. Individuals for whom the use of electronic devices would cause adverse physical or behavioral health side effects or symptoms;

   c. Individuals electing not to use other visit verification modalities on the basis of moral or religious grounds;

   d. Individuals with a live-in caregiver or caregiver accessible on-site 24 hours and for whom the use of other visit verification modalities would be burdensome;

   e. Individuals who need to have their address and location

information protected for a documented safety concern.

3. The Division shall require a signed Electronic Visit Verification (EVV) Paper Timesheet Attestation (Form DDD-2101A) and utilize the standardized paper timesheet specified in the DDD Electronic Visit Verification Paper Timesheet (Form DDD-2100A).

4. The Division shall review annually and monitor the use of the Electronic Visit Verification (EVV) Paper Timesheet Attestation (Form DDD-2101A) to ensure they are utilized for permitted circumstances only.

5. The Division shall allow Providers to utilize their own paper timesheet when their timesheets capture the minimum data elements specified in the DDD Electronic Visit Verification Paper Timesheet (Form DDD-2100A).

6. The Division shall ensure the Provider enters the paper timesheets into their EVV System no more than 21 days past the date of service rendered as long as timeliness filing standards are met as outlined in Division Operations Policy 203 and Provider Manual Chapter 12.

D. EVV MODALITIES

1. The Division shall ensure the Responsible Person can choose, at a minimum on an annual basis, the device that best fits their lifestyle and how they manage their care.

2. The Division shall ensure the Provider has at least two different types of visit verification modalities to accommodate Member preferences and service delivery areas with limited, intermittent, or no access to a landline, cell, or internet service.

3. The Division shall require the Provider to assist the Responsible Person in making an informed decision about the choice of data collection modality.

4. The Division shall permit the Responsible Person to change the EVV modality at any time.

5. The Division shall permit Provider agencies to allow DCWs to utilize personal devices.

6. The Division shall ensure the Provider has a backup plan for EVV if the personal device becomes inoperable.

7. The Division shall permit the Provider to choose to allow GPS

tracking while the DCW is on the clock and disclose this to the Responsible Person how and why the DCW is being tracked and ensure the disclosure is documented and on file.

8. The Division shall permit the Responsible Person, as applicable, the opportunity to change their preference for the visit verification device the DCW will use.

F. CONTINGENCY/BACK-UP PLAN

1. The Division shall require the Provider to use the standardized Contingency/Back-Up Plan forms to plan for missed or late service visits and discuss the Responsible Person's preference on what to do should a visit be late or missed and be noted for each service the Provider is providing.

2. The Division shall require Independent Providers to use DDD-EVV Member Contingency/IP Model Back-Up Plan (Form DDD-2113A).

3. The Divisions shall require Qualified Vendors to use Electronic Visit Verification (EVV) Member Contingency/Back Up Plan (Form DDD-2099A).

4. The Division shall require the Provider to review the Contingency/Back-Up Plan with the Responsible Person annually.

5. The Division shall require the Provider to follow up with the Responsible Person when a visit is late or missed, to discuss what action needs to be taken to meet the service need.

6. The Division shall require the Provider to permit the Responsible Person to change decisions about their preference levels regarding missed or late service visits and the Contingency/Back-Up Plan at any time.

7. The Division shall require the Provider to assign a default preference based on the service when the Responsible Person does not choose a preference.

H. REPORTING

1. The Division shall utilize EVV data to monitor and analyze the following to support Provider compliance with EVV as well as inform network adequacy and workforce development planning:

   a. Member access to care:

      i. Late and missed visits and adherence to contingency

planning preferences; and

ii. Timeliness of new services from the date it was determined medically necessary to the date the service was provided for newly enrolled and existing Members.

b. Provider Performance:

i. Unscheduled visits;

ii. Manual Edits;

iii. Device utilization;

iv. EVV modality types in use;

v. Visits that follow the Member's Contingency/Back-Up Plan; and

vi. Monitoring of service hours authorized compared to service hours actually provided.

2. The Division shall require the Provider to self-monitor and analyze the following:

a. Performance, including location discrepancies, and visit

exceptions;

b. Devices by monitoring and maintaining a list of AHCCCS EVV Vendor devices assigned to the Provider; and

c. Service delivery by monitoring service hours authorized compared to service hours actually provided.

I. PROVIDER REQUIREMENTS AND DIVISION OVERSIGHT

1. The Division shall monitor all Provider responsibilities specified in this policy as part of annual monitoring to ensure compliance with the following roles and responsibilities of the Provider required to utilize EVV:

a. Notifying the AHCCCS EVV Vendor of all new users and user terminations and all data security incidents;

b. Collecting and maintaining records for the audit period of at least six years from the date of payment, applicable attestations regarding verification delegation, paper timesheet allowances, and contingency/back-up plans as outlined in Section (F) of this Policy;

c. Counseling the Responsible Person, as applicable, on the

scheduling flexibility based on the Member's service plan or Provider plan of care and what tasks can be scheduled and modified depending on the DCWs scheduling availability at least every 90 days;

d. Developing a general weekly schedule for each service;

e. Ensure the EVV System records the schedule for each service;

i. The system is prohibited from canceling a scheduled visit;

ii. Visits may be rescheduled; and

iii. The EVV System denotes what scheduled visits are rescheduled visits;

iv. Scheduling is not required for Members who have live-in or onsite caregivers.

f. Ensuring that all associated EVV System users have access to training on the EVV System;

g. Providers using an Alternate EVV System, submitting data

timely to AHCCCS as a condition of reimbursement as specified in technical requirement documents available on the AHCCCS website;

h. Comply with Member responsiveness including requirements that Qualified Vendors answer the phone 24/7 or return a phone call within 15 minutes for Members who are reporting a missed or late visit;

i. For Providers using the AHCCCS procured EVV System, developing and implementing policies to account for and ensure the return of devices issued by Providers to DCWs;

j. Ensuring the Provider has at least two different types of visit verification devices available to accommodate Member preferences and service delivery areas with limited, intermittent, or no access to landline, cell, or internet service;

k. Ensuring any device used to independently verify start and end times without the use of GPS is physically fixed to the Member's home to ensure location verification;

l. Ensuring any Providers that permit DCWs to utilize personal devices have an alternate verification method or option if the device becomes inoperable;

m. Ensuring that Member devices are not used for data collection unless the Member has chosen a verification modality that requires the use of their device;

n. Contacting the Member to validate any visit exceptions including instances when the Member indicates the service or duration does not accurately reflect the activity performed during the visit;

i. The documentation of exceptions need to be consistent with CMS's Medicare signature and documentation requirements for addendums to records; and

ii. Changes as a result of the exceptions process are considered an addendum to the record and do not change the original records.

o. Documenting Manual Edits to visits within the system and

maintaining hard copy documentation.

J. SUPPLEMENTAL INFORMATION

1. The choice of a modality may be limited for Members who receive service(s) on an intermittent basis, such as respite care or home health services.

2. EVV Prior Authorization and Service Confirmation Portal:

   a. Some EVV services require Prior Authorization and some do not. To ensure all EVV services have an authorization record in the EVV System, AHCCCS has instituted and will require the use of Service Confirmations for EVV services that currently do not require Prior Authorization;

   b. Service Confirmations are a notification to AHCCCS for any EVV services not Prior Authorized by a Provider that a service will be provided to a Member that is medically necessary. AHCCCS has created an online web-based Service Confirmation portal for Providers to enter the required data for the service;

      i. Service code;

ii. Units; and

iii. Dates of service.

c. The Service Confirmation Portal is available on the AHCCCS website;

d. The medical necessity determination date is an additional element required for EVV Services on the Prior Authorization or Service Confirmation;

e. The medical necessity determination date is the date the need for a new service was determined as specified in guidance documents available on the AHCCCS website.

3. Electronic Visit Verification (EVV) Paper Timesheet Attestation (Form DDD-2101A) is utilized to justify the allowance of the use of paper timesheets.

4. Electronic Visit Verification (EVV) Paper Timesheet Attestation (Form DDD-2101A) is specific to the Member and the services they receive from a single Provider.

5. The signature does not have to be recorded in the EVV System, but Providers shall have the original, wet copy of the signature

on file for audit purposes.

6. A faxed copy of the signature is permissible for billing purposes.

7. It is allowable for Members to choose different preference options based upon the service.

~~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 andpotentially 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 Manager 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).~~

~~D. 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.~~

~~T~~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.~~