SALISH BHO

INPATIENT POLICIES AND PROCEDURES

Policy Name: INTRA-BHO WSH TRANSFERS (within the Region) **Policy Number:** 12.10

Reference: State Contract, Inter-BHO Transfer Agreement

Effective Date: 10/2013

Revision Date(s): 7/2014; 5/2016

Reviewed Date: 5/2016; 6/2017; 5/2018

Approved by: SBHO Executive Board

PURPOSE

Behavioral Health Organizations (BHOs) follow specific guidelines when an individual in the state hospital is discharged to a different BHO. A BHO receiving an individual from the state hospital assumes financial responsibility for multiple costly services, including residential care, inpatient treatment, state hospital penalties, and Medicaid Personal Care (MPC). The purpose of inter-BHO guidelines is to share the financial risk associated with such transfers.

Salish BHO is unique in that risk for inpatient and MPC services are passed along to providers, as well as the funds to cover the associated risk. Unlike other BHOs, where the risk related to a transfer from one agency to another would be covered by the BHO, in SBHO the provider assumes the risk.

In order to create the same level of fairness found in the statewide inter-BHO transfer agreement, SBHO requires providers to share risk when transferring to another provider in SBHO when the individual is being discharged from a state hospital.

PROCEDURE

The BHO will apply the same criteria for Intra-BHO transfers as that developed for transfers to other BHOs. The length of time the referring agency is financially responsible for the individual is based upon a four-factor analysis.

The factors are as follows:

1. Transfer is being requested due to availability of specialized non-Medicaid resource.
2. High inpatient utilization – 2 or more inpatient admissions in the previous 12 months, an inpatient stay in a community hospital for 90 days or more in the previous 12 months, or discharge from a state hospital in the previous 12 months.

3. History of felony assaults, ORCSP eligibility, or multiple assaultive incidents during inpatient care (that may not have resulted in criminal charges but resulted in injuries).
4. Significant placement barriers - behavioral issues resulting in multiple placement failures, level 3 sex offender, arson history, dementia (the BHO would need to be involved even though HCS might be arranging placement), and co-morbid serious medical issues.

Responsibility for outpatient and crisis services is assumed by the receiving agency upon transfer, regardless of risk factors. Responsibility for specialized non-Medicaid services is held by the referring agency as below. Specialized non-Medicaid services includes, for purposes of this protocol, IMD admissions, residential placement, and state hospital census.

- One risk factor: 6 months
- Two risk factors: 9 months
- Three or more risk factors: 12 months

The referring agency will retain the individual on their state hospital census until the individual is discharged. Regardless of risk factors, the referring agency will accept on their census any individual placed in the receiving agency who returns to the state hospital within 60 days of their discharge.

Referral Process

1. For all individuals in a state hospital (regardless of risk factors) who intend to discharge to another agency within SBHO, an Intra-BHO transfer request will be initiated by the agency of responsibility (hereinafter referred to as the referring agency).
2. The transfer is to be facilitated through the joint efforts of the state hospital social work staff and the BHO liaisons of both the referring agency and the receiving agency.
3. A request for intra-BHO Transfer form and relevant treatment and discharge information is to be supplied by the referring agency to the receiving agency via the liaisons.
4. The referring agency will remain the primary contact for the hospital social worker and the individual until the transfer is completed.
5. The BHO and other responsible agencies must be involved and approve the transfer plan and placement in the receiving agency when that agency's resources are obligated as part of the plan (e.g., Home and Community Services, Developmental Disabilities Administration).
6. Should there be disagreement about the discharge and outpatient treatment plan, a conference will occur. Participants will include the individual, hospital social worker or representative of the hospital treatment team, liaisons from both providers, the BHO, and other responsible agencies.
7. Once the discharge plan has been agreed upon, the request for intra-BHO transfer will be completed within two weeks (or sooner if discharge will be affected by a delay). The SBHO will notify both agencies regarding approval of the plan.

MONITORING

This policy is mandated by state contract.

1. This policy will be monitored through use of SBHO:
   - Grievance Tracking Reports
   - Targeted provider clinical chart review of each transfer to ensure program coordination

2. If a provider performs below expected standards during any of the reviews listed above a Corrective Action will be required for SBHO approval.