STATEWIDE CONTINUITY OF CARE POLICY

I. Purpose

This policy is intended to establish a level of accountability for consumer care within the publicly funded mental health system in Colorado and for consumers in the private sector, who receive or may be entitled to receive some aspect of care from the publicly funded mental health system. In all cases, the quality of consumer care is expected to be a high priority and must be considered in the application of these policies. All state-funded agencies (Behavioral Health Organizations [BHOs], Community Mental Health Centers [CMHCs], Clinics, and Colorado Mental Health Institutes [CMHIs]) are to follow the procedures outlined and to abide by the conflict resolution mechanisms outlined within this agreement, as are public or private providers and 27-10 facilities when interfacing with the Colorado publicly funded mental health system. It is the intent of this policy that where there are references to responsibility or expectations of BHOs or CMHCs, it extends to all individuals or parties who by contractual obligation are providing the regulated duties of the BHOs/CMHCs.

II. Courtesy Evaluations/Emergency Services

A. Per Division of Mental Health Rules and Regulations and the Department of Health Care Policy and Financing's (Department's) contracts with BHOs, crisis and emergency services shall be available 24 hours a day including Saturdays, Sundays and holidays to any person in need of such services without regard to residence or payer source. (See Attachment A – BHO Authorization of Services Provided by Out of Area Mental Health Centers and Consumer Access to Out of Area Mental Health Center Services)

B. A courtesy assessment (i.e., face-to-face contact) may be requested of another CMHC by the CMHC responsible for the provision of services, upon notification that a consumer has presented in another CMHC's service area. The CMHC responsible for the provision of services will be contacted prior to initiating the courtesy assessment, for the purpose of case consultation. The CMHC responsible for the provision of services shall respond within one hour to requests for available information from the CMHC completing the courtesy assessment. For Medicaid recipients, emergency services shall be available by phone within 15 minutes of the initial contact in person within one hour of contact in urban and suburban areas, in person within two hours of contact in rural and frontier areas. Courtesy evaluations must be conducted within the above timeframes, regardless of the county of origin of the Medicaid recipient's Medicaid benefits.

C. Upon completion of the courtesy assessment, the CMHC providing the courtesy assessment shall provide the responsible CMHC and the facility accepting placement, the findings, conclusions, and recommendations of the courtesy assessment. If there is agreement, the CMHC responsible for the provision of services will arrange for the transfer of care. This will include obtaining/providing authorizations for care and transportation when required. The

CMHC responsible for the provision of services shall follow the recommendation(s), or, if they disagree with the recommendation (s), provide an alternative plan that ensures that clinically appropriate treatment is initiated immediately. The CMHC responsible for the provision of services will assume responsibility for the transfer of care to include obtaining/providing authorizations for care and transportation.

III. Determining Responsibility for Consumer Care

The BHO from which the consumer is receiving Medicaid benefits is responsible for the coverage and payment of emergency services. All medically necessary services for Medicaid eligible consumers, except emergency services, require prior authorization.

If the consumer moves to another BHO service area, the old BHO remains responsible for authorizing and paying for medically necessary services until such time as the enrollment is changed to the new BHO. The new BHO should work with the client and the old BHO to minimize disruptions to care, to minimize provider changes for the client and to otherwise promote good continuity of care. The consumer shall be encouraged to transfer the benefits. The receiving BHO shall inform the consumer of the appropriate location for changing their Medicaid to their new county of residence. The receiving BHO should initiate services as soon as possible but within 30 days of the first contact.

When a consumer's Medicaid benefits are transferred, both the original BHO and the new BHO are expected to fully cooperate in the clinical care coordination involved in the transfer. (See Attachment A – BHO Authorization of Services Provided by Out of Area Mental Health Centers and Consumer Access to Out of Area Mental Health Center Services)

For Medicaid recipients, the BHO is only responsible for authorizing and paying for medically necessary court-ordered services.

Along with the aforementioned guidelines for consumers receiving Medicaid benefits, the following guidelines are to be used **sequentially** to determine the CMHC responsible for the provision of consumer care for non-Medicaid consumers.

A. If a consumer has an open treatment record at a CMHC, that CMHC is responsible for care.

B. If the consumer has been hospitalized in either of the CMHIs or in another hospital under the responsibility of a CMHC in the last thirty days, that CMHC is responsible for the consumer care.

C. If it is determined that a consumer has an open treatment record in more than one CMHC, responsibility for the hospitalization will revert to the place of the consumer's current residence.

D. The CMHC that admitted the consumer to a hospital is responsible for coordinating case management services, including aftercare and discharge planning with the hospital treatment team unless it is determined to be the responsibility of another CMHC.

E. Prior to a consumer being placed in a long term residential facility (all Board and Care Facilities) that results in a change of established residency, the responsible CMHC shall negotiate a continuity of care agreement with the CMHC responsible for the provision of services in the service area where the consumer is placed. This agreement shall specify which CMHC is responsible for providing/authorizing services. The maximum time frame for this agreement is twelve months or until eligibility is transferred to the new County of residence, whichever is sooner. Unless otherwise specified, the receiving CMHC is responsible for mental health services after the Continuity of Care Agreement expires. (See Attachment B – Sample Continuity of Care Letter)

F. If the consumer is in an inpatient treatment or residential facility, but that placement will not result in change in permanent address (e.g. Therapeutic Residential Child Care Facility, Psychiatric Residential Treatment Facility, Group Home, Foster Home, and Institute For Forensic Psychiatry), the CMHC that is responsible for the service area of the consumer's established residency retains responsibility.

G. If the consumer has established residency in Colorado, the CMHC that covers the service area that includes this address is responsible for the provision of services.

H. Indigent, unenrolled individuals who present in crisis or emergency at hospital emergency rooms without referral from the CMHC are expected to be treated by a hospital emergency department.

I. If a CMHC initiates placement into a CMHI bed, then the CMHC that initiated placement will be responsible for the disposition planning and provision of services.

J. If none of the above apply, the CMHC that is responsible for the service area where the consumer presents is responsible for the arrangement/provision of services.

IV. Transportation

A. The CMHC, which is responsible for the provision of services (according to the procedures outlined above) is also responsible for arranging for transportation of the consumer both to and from the CMHI.

B. In many instances, law enforcement agencies provide transportation to the appropriate treatment agency by virtue of statutory authority, court order, or agreement with the CMHC where the consumer initially presents for care. Private

psychiatric hospitals, residential child care facilities and other private residential facilities may be expected to provide transportation from such facilities to the appropriate CMHI or hospital in the event a consumer requires that level of care.

V. Case Management Between State Institutes and Community Providers

A. Change of residence/service access

1. If an enrolled consumer verbalizes concrete and workable plans to live in a different service area than he/she has in the past, the consumer shall provide an address to the receiving CMHC or BHO in order to receive an assessment for services from the CMHC or BHO in that service area. The referring agency will notify the receiving CMHC or BHO in the new area to make a referral for the consumer. A Medicaid recipient has the right to choose their mental health provider, regardless of residence. The BHO in the county of eligibility is responsible for service authorization and payment.

B. Utilization review/management

1. The hospital and designated BHO or CMHC staff person shall coordinate all aspects of the consumer's care and treatment including other relevant bed utilization issues for the consumer, beginning at a minimum within five days of a new admission and continuing at least monthly thereafter. Disagreements regarding bed utilization shall be referred to clinical administration of the hospital and CMHCs/BHOs at the lowest level possible.

2. If there are disagreements regarding specific consumer bed allocation issues, the designated CMHC/BHO personnel shall attempt to resolve the issues with the hospital admissions director or his/her designee. If questions or problems are not resolved, the designated CMHC/BHO personnel shall contact the hospital admissions director or his/her designee for that treatment unit for resolution. Beyond this effort, the executive director or designee of the agency shall be involved.

3. A Medicaid recipient has the right to receive mental health services from more than one provider. For example, a Medicaid recipient has the right to receive medication services from their PCP or a private psychiatrist and receive other outpatient mental health services from a CMHC or private provider. The BHO or the CMHC will provide coordination services to ensure appropriate linkages and communication between providers.

D. Discharge planning

1. Designated BHO or CMHC personnel shall work with the identified hospital personnel to facilitate and create an appropriate individualized discharge and aftercare plan for and with every consumer and authorized family members from the date of admission. All CMHCs should have coordinators assigned to the CMHIs.

2. The CMHIs have responsibility to ensure the consumer is informed of appropriate mental health aftercare when BHO/CMHC staff is not involved. This also applies to consumers that are discharged "Against Medical Advice."

3. When a consumer is discharged from the hospital , the receiving CMHC or BHO shall offer a date for an initial appointment time to provide or arrange for the provision of services within seven calendar days of the discharge from the hospital.

E. Waiting lists (Admissions and Discharges)

1. It is the responsibility of each CMHC to manage the waiting list for their allocated adult beds. Each CMHC in the State of Colorado is allocated by State Division of Mental Health (DMH) a specific number of inpatient adult (ages 18-59) beds at one of the CMHIs. Each CMHC may admit only this number of adult consumers to the CMHIs.

2. The CMHCs shall work collaboratively with one another and the CMHIs for priority utilization of beds.

3. The CMHIs shall keep waiting lists for those beds that are not allocated to the CMHC, such as children and adolescents, older adult consumers and children and adolescents involved with Psychiatric Residential Treatment Facilities (PRTFs) and/or Therapeutic Residential Child Care Facilities TRCCFs).

F. Private hospital/private provider referrals

1. If a private hospital requests admission to the CMHIs, a face-to-face evaluation by the CMHC or designee is required. If clinically appropriate as determined by the CMHC/BHO or designee, the consumer may be admitted or the consumer's name added to the waiting list, if applicable.

2. Private psychiatric hospitals, PRTFs, TRCCF's, private practitioners and other providers of psychiatric services are expected to provide emergency services for the consumers they serve. This includes the responsibility for arranging off-hour coverage, as well as emergency hospitalization and medication. However, if private consumers contact CMHC emergency services, they should not be refused service if it is found that services are

not available to them elsewhere. When consumers receiving services from a private practitioner or entity contact the CMHC emergency services, the responsible private entity should be notified for the purposes of coordinating care. Any external provider involved in the treatment process must follow the Division of Mental Health Statewide Continuity of Care Policy.

3. Some consumers receiving services in private psychiatric hospitals, PRTFs/TRCCFs or other residential facilities may be appropriately referred to the responsible CMHC or BHO for admission to one of the CMHIs. This transfer of responsibility shall be done in a manner that maximizes good consumer care and continuity of care. When a consumer is accepted from a CMHC, the following conditions shall be met:

   a. Result of assessment/evaluation meets DMH target definition (See Attachment C – Target Status Algorithm).

   b. There is clinical justification for consumer's transfer/admission to the CMHI.

   c. The consumer's condition shall be safe for transfer.

   d. Advance notice consistent with C.R.S. 27-10-101 *et seq*. – Care and Treatment of the Mentally Ill – shall be provided to both the consumer and the CMHC or BHO, in order to ensure good continuity of care (in some cases, consumers referred to inpatient care may need to be placed on a CMHC waiting list for admission to one of the CMHIs).

   e. All appropriate clinical information shall be shared with the CMHC/BHO or CMHIs in a timely manner. This also applies to individuals transferring between the CMHIs.

VI. Transfer of Certification/Legal Issues

A. Court-ordered

1. Consumers may be court-ordered to the CMHIs for mental health evaluations and/or treatment without the coordination of the appropriate CMHC. On those occasions, the designated CMHI personnel shall notify the appropriate CMHC of the admission, assess for clinical appropriateness, and report back to the court.

2. Within 8 hours, the CMHIs shall inform the CMHC designated personnel in the county where the court order has been initiated or where the residence has been established, if different from county where court order has been issued.

B. Transfer of certifications

1. A transfer of certification is a process that should include discussion between both the sending and receiving agencies prior to discharge.

2. A 27-10 designated facility proposing to transfer certification to another designated facility shall notify the potential receiving facility as soon as possible as to the reasons for seeking the transfer. Appropriate clinical information should be shared. The receiving facility must agree to the transfer of certification before the transfer occurs.

3. Upon denial of a certification transfer request, the receiving (denying) CMHC must provide a written response to the sending CMHC. This response must include justified clinical rationale for the denial.

4. The BHO in which a consumer is enrolled is responsible for providing or arranging for all medically necessary services that could include outpatient certification in a nursing home.

5. The BHO in which a consumer is enrolled is responsible for discharge planning from the institutes, providing or arranging for all medically necessary services.

6. Any clinical disagreements emerging between 27-10 facilities shall be resolved before the certification is transferred.

7. Transfer of certified consumers from private facilities to the CMHIs or CMHCs will be subject to the same legal rules and regulations as CMHCs and CMHI before the certification is completed. Any clinical disagreement between the transferring and receiving 27-10 facilities should be resolved before transfer of certification is completed.

7. 7. It is up to the court with jurisdiction where a certification is held as to whether or not they want to change venue. A petition has to be made to the court of jurisdiction to change venue to another court (via the county, CMHC, or CMHI).

C. Transfer of consumers with medical clearance issues

1. When a consumer being considered for transfer and/or admission to a CMHI comes from an acute care facility, a medical unit, or an emergency department, the referral/admission paper work must include:

   a. The results of a recent medical exam. This may result in a request for a physician-to-physician phone contact to discuss the details of actions taken to evaluate, medically treat, and stabilize the

consumer. The CMHIs may request or require that this information be faxed before approval of admission.

b. The transfer to CMHI should be completed following the Emergency Medical Treatment and Labor Act (EMTALA) transfer rules. Most hospitals have an existing form that they use when transferring a consumer to another medical facility.

c. The referring medical physician's approval for medical clearance does not automatically mean that a CMHI admission has been approved. The standard operating procedure for psychiatric admissions to the various CMHIs' divisions continues to be in effect. For example, the routine of calling for bed allocation status and approval is necessary even before the implementation of the EMTALA transfer rules. Staff in the CMHI Admissions Office may be of assistance in facilitating the physician-to-physician contact if the consumer to be admitted meets the above-mentioned criteria. The intent is to work cooperatively to ensure completion of this process in a timely manner with as little inconvenience as possible to the consumer.

D. Legal paperwork issues

1. Upon admission or transfer of consumers to 27-10 designated facilities, all required legal paperwork (e.g., copy of recent certification, court order for certification, medication affidavit letter, court-ordered medication order) shall be forwarded or sent with the consumer at the time of transfer or admission. For after hour admissions, all required paperwork should be sent with the consumer or at the earliest possible time, but no later than the next business day. It is the responsibility of the treating CMHC to complete all required 27-10 paperwork in a timely manner. The sending CMHC shall inform the receiving facility of any impending paperwork (e.g., extension of certification status, which is due to the court 14 days before extension of certification, deadlines for submission of paperwork to renew certification, pending legal charges).

E. Pre-screens for non-committed youth in detention with mental health problems

1. Each CMHC is responsible for pre-screening of non-committed youth in detention from their service areas. If a CMHC performs a courtesy pre-screen for a youth that does not live in their service area, they shall inform the CMHC where the youth resides that they have done the pre-screen and forward results to the responsible CMHC.

F. Institutional transfers

1. The Division of Youth Corrections (DYC) shall facilitate institutional transfers for their consumers with mental health emergencies when they are admitted to the CMHIs. After the CMHI approves the admission, institutional transfer forms shall be completed by the sending agency and sent with the consumer upon admission.

2. Youth placed in the community under the authority of DYC shall remain the responsibility of DYC under state regulation and/or Medicaid funding requirements.

3. If the transfer from DYC is 18 years of age or older, the client shall be placed in an allocated adult bed based on the address of their legal residence.

4. It is important to note that the parameters of such services and their associated delivery systems change when consumers reach age 18. This can be at variance with the age range of covered services available to consumers through DYC and the Department of Human Services. Every effort shall be made in collaboration between systems to satisfy treatment needs in the best interest of the consumer. In this regard, determination of responsibility for consumer care shall follow the guidelines previously cited.

5. Institutional transfers of committed youth between the DYC and the CMHIs shall be carried out in accordance with the existing interdivisional agreement. (See Attachment D – CMHIFL/DYC Memorandum of Agreement and Attachment E – CMHIP/DYC Memorandum of Agreement)

G. Transfers in and out of Colorado under the Interstate Compact

1. All efforts related to Interstate Transfers must be coordinated through the Division of Mental Health.

2. Under CRS 24-60-1001 et seq., Interstate Compact on Mental Health, consumers with mental illness can be transferred in or out of Colorado when transfer in the best interest of the consumers, their families and the community.

3. Residence or family support of the person to be transferred is the prerequisite for transfers made under provisions of the Interstate Compact on Mental Health. All interstate transfers must be from state hospital to state hospital (with involvement of the identified CMHC for use of an allocated bed).

4. Consumers must consent to being transferred from one state to another, and a statement must be signed by the individual indicating that the transfer is voluntary. Transportation costs are the responsibility of the sending state. Unless a consumer is returning to his /her state of residence, families must be involved in requests for interstate transfers.

5. Transfers must be coordinated between the sending and receiving states' Interstate Compact Coordinators. Questions regarding Interstate Compact issues should be directed to Division of Mental Health.

VII. Conflict Resolution

A. Conflicts regarding Continuity of Care between any agencies or entities should be resolved as quickly as possible and at the lowest clinical and administrative level possible within the involved organizations in order to ensure that consumer care is not disrupted. However, if attempts to resolve these conflicts are unsuccessful between the involved organizations, the following steps are to be followed in order to resolve the conflict.

1. The parties are first expected to contact the Continuity of Care Coordinator for the CMHI that provides the age-specific inpatient beds for the CMHC/BHO.

2. The CMHI Continuity of Care Coordinator may provide further clarification and suggestions for resolution.

3. If the conflict remains unresolved at this level, the CMHC/BHO may then request a meeting (telephonic conferencing is an acceptable alternative) involving the Chair (his/her designees) of either statewide Continuity of Care Committee.

4. Individuals and/or agencies outside the publicly funded mental health system (for example, Kaiser, Alcohol and Drug Abuse Division) may be added to this meeting, as required or appropriate.

5. This meeting shall be set up as soon as possible, but no later than two working days from the conflict resolution request. If this does not occur, the Division of Mental Health will establish the time and place for this meeting.

6. Within three working days of this conflict resolution meeting, the Chair of the responsible CMHI's Statewide Continuity of Care Committee will render a decision.

7. If the conflict is still not resolved, the CMHC/BHO executive director or designee with the authority to act on his/her behalf will meet to try to resolve the issue.

8. If the conflict remains unresolved at this level, the CMHC/BHO may appeal the decision to the Director (or his/her designee) of DMH. DMH shall have three working days to render a decision that will be binding on all parties.

B. The Continuity of Care Coordinator is an individual designated at each CMHC/BHO/CMHI who is a focal point for continuity of care issues and questions and represents the CMHC/BHO/CMHI on statewide Continuity of Care Committees and in conflict resolution matters. Attendance of Continuity of Care Coordinators is expected at the CMHIP and/or CMHIFL Statewide Continuity of Care committee meetings.

VIII. Children/Adolescents

A. Responsibility for children and adolescents is often a complex issue involving a number of systems, including families, mental health, child welfare, courts and schools. Interagency collaboration between these systems, especially mental health and child welfare, is essential. Children/adolescents in the care of the child welfare system should be referred to the responsible CMHC/BHO for needed mental health services.

B. In the event that it is determined that a child is in need of inpatient placement, disposition planning should begin at the earliest possible point. The families and surrogate families should be full participants in this disposition planning. Such planning and collaboration permits the exploration of community based services as a clinically appropriate alternative to hospitalization, development of discharge planning that will shorten the length of stay through the provision of transitional community based services, and coordination of on-going case management responsibility. Upon discharge, all educational information, including assessments, are sent to the student's next placement and to the school district so the student's transition runs as smoothly as possible.

C. In cases where an out of home placement is required in order for a child or adolescent to leave the hospital, communication between the CMHC/BHO and child welfare as appropriate shall take place at the earliest opportunity. When possible, this should begin prior to the admission to the hospital of the child or adolescent. It is the responsibility of the CMHC/BHO to ensure that such collaborative planning and case management is in place for each child/adolescent requiring an alternative living situation in the community. In situations where children/adolescents will be returning to their own home following hospitalization, collaborative disposition planning is essential. The responsible CMHC/BHO will ensure that case management services involving the other key community systems in the youngster's life will be in place. In either situation, joint planning on the part of the hospital, including CMHIs and the responsible CMHC/BHO is required. The responsible CMHC/BHO should have the lead in disposition planning when it involves outreach to, and linkage with, community based agencies on behalf of the child/adolescent.

IX. Special Populations

A. Primary responsibility for the treatment of consumers with co-occurring disorders of mental illness and substance abuse is delineated in the Division of Mental Health/Alcohol and Drug Abuse Division Interagency Agreement Update dated September 1, 1998 (See Attachment F). This agreement defines the respective responsibilities of the mental health system and the alcohol and drug abuse system in treating consumers with co-occurring disorders. Mental health and substance abuse agencies will coordinate service delivery whenever indicated. This coordination is particularly important during assessment and disposition. In emergency or crisis situations, responsibility lies with the agency of first contact.

B. Responsibility for Department of Corrections (DOC) offenders who meet DMH clinical criteria for services are delineated in the Interagency Agreement between DOC and DMH dated May 2006 (See Attachment G). These offenders include individuals who have been accepted for parole, a community correction placement, or have discharged his/her sentence.

C. After the responsibility for consumer care is determined per the continuity of care guidelines, the responsible CMHC shall assist in securing or providing services for the hearing impaired individual. CMHI-FL is the statewide facility for hearing impaired treatment of individuals with mental disorders needing inpatient care.

D. The CMHC shall be responsible for coordinating with the DD service system for the arrangement or provision of services to consumers who have dual mental health and developmental diagnoses. The BHO/CMHC is responsible for services necessary to treat the psychiatric diagnosis, whether the diagnosis is primary or secondary. Admission of a dually-diagnosed individual to a CMHI in a CMHC allocated bed shall require the DD placement facility agreeing in advance to keep a placement available for the consumer upon discharge. (See Attachment H – Memorandum of Understanding among Developmental Disability Services and Mental Health Services and Attachment I – BHO Practice Standards: Evaluation and Treatment of Covered Mental Illness in Children, Youth, and Adults with Developmental Disability)

E. Prior to nursing home admission, an agreement must be in place between the responsible and receiving CMHCs identifying the specific services to be provided by each CMHC both before and after Medicaid transfer. The responsible CMHC shall inform the receiving nursing facility of the plan for services as well as the name and phone number of the CMHC staff member responsible for ensuring that the services are provided. Prior to finalizing a nursing home admission and before the consumer is moved to the admitting nursing home, the transfer of any certification must be agreed to by the receiving CMHC. The CMHC holding the certification must have a current Placement Facility Agreement with the receiving nursing facility.

X. Documentation Requirements

A. To ensure quality in continuous care between treatment entities, to include CMHCs and BHOs the following is required: The treatment provider referring a consumer for care and treatment elsewhere shall provide a documented record of treatment. The purpose of such information shall be the continuation of services in a positive and proactive manner. All regulations and statutory requirements governing confidentiality, standards of quality, and consumer involvement shall be observed. The CMHC shall provide all necessary pre-admission documentation identified by the CMHIs. The CMHC and CMHI are expected to exchange information that will foster improved continuity of care planning from point of admission through discharge. This may include but is not limited to the following: specific disposition planning, interagency conferences, liaison meetings, case management documentation, monthly treatment plan reviews, notations regarding special consumer considerations or needs, and discharge/termination summary packets. Additional documentation requirements are also noted elsewhere in this document related to specific topics.