<table>
<tr><td colspan="2"></td><td colspan="2">#802</td><td colspan="5">Service Referral Process
☒ Policy ☐ Standard Operating Procedure</td></tr>
<tr><td colspan="2">Date of Inception:</td><td colspan="2">08-07-2023</td><td colspan="2">CEO Approval:</td><td colspan="3"></td></tr>
<tr><td colspan="2">Current Approval Date:</td><td colspan="2">08-07-2023</td><td colspan="2">CMO Approval (If Required):</td><td colspan="3"></td></tr>
<tr><td>Operational Scope:</td><td>Board Directors ☐</td><td>Admin ☐</td><td>PF ☐</td><td>CC / QM ☐</td><td>Rights ☐</td><td>RCM ☐</td><td>ERS ☐</td></tr>
<tr><td>H/S ☐</td><td>IHS ☐</td><td>IT/IDS ☐</td><td>Sec / Safety ☐</td><td>Environmental ☐</td><td>Facilities ☐</td><td>☐</td><td>Agency ☒</td></tr>
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802 Purpose

To provide procedural steps and guidelines for completing referrals and transport for community provider services including On-Site Provider Health (Provider) staff, co-located providers, In-Network and Out-of-Network service referrals. This procedure encompasses:

- Processing a service referral request;
- Communication and coordination with service participants and receiving provider agencies;
- Requesting and gaining approval of outpatient single case agreements (SCA) in the Provider Sites;
- Steps for processing Provider Referral Packets and disclosure of protected health information.

A single case agreement (SCA) should only be considered after there has been an exhaustive search of RBHA In-Network providers. These procedures do not apply to the delivery of emergency treatment, those involving treatment in a Residential facility, Electroconvulsive therapy (ECT) requests, or psychological testing.

802.1 Scope:

All Provider employees

802.2 Definitions

Co-Located Providers are staff from provider agencies that are co-located at the Provider Site.

In-Network Service Referrals are referrals to community service providers that are contracted with the Health Plan. This includes both in-community and co-located agencies and staff.

Out-of-Network Service Referrals are referrals to agencies and practitioners that require a Single Case Agreement to access the service.

Provider Delivered Services - Services delivered by Provider employees and personnel members. Warm Handoff is defined as:

a) Within the same Site to Provider staff or co-located providers: A warm handoff is a handoff conducted in person, between two members of the health care team, in front of the person

{and family if present). The referring staff member documents all efforts in the referral process in a Contact Note.

b) To an outside Provider: When the referral is made to an outside provider agency the Case Manager (CM) and/or other assigned staff will describe to the person {and family if present} the reason that the other provider can better address a specific issue with the person and emphasize the other providers experience and competence in the specific issue. Whenever possible several alternative providers should be identified. The staff member will ask the individual if they need assistance in contacting the provider to schedule an appointment and if so, assist the person in contacting the provider. When possible, a call is made to the provider in the presence of the person to notify them of the impending referral. The staff member will follow up with the person regarding their engagement with the referred provider and will assist the person to connect or if necessary, change providers. The CM should document all efforts in the referral process in a Contact Note.

802.3 Procedure

I. Eligibility

A. AHCCCS TXIX Service Participants are eligible to receive service referrals for Provider Site staff, co-located, in-network and out-of-network (Single Case Agreement) services, and primary healthcare services.

B. Provider has developed Communication and Care Management Protocols that identify specific individualized referral, warm handoff, consent, information sharing, crisis/urgent issues, and provider-to-provider consultations. These protocols are located in the P Drive Referral and Preferred Providers and should be followed when referring to these specific providers. The list will be expanded as additional protocols are developed with providers.

C. In addition, Provider has prioritized appointments and referrals for individuals who have been placed on the High-Risk Registry or who have been identified as having Gaps in Care.

D. Non-TXIX Service Participants may be eligible for Medicare or commercial insurance service referrals to Provider Site staff, co-located providers, and in-network or out-of-network providers. In some cases, the service referral will require a prior authorization from the Third-Party Payer. Non-TXIX participants are eligible to participate in behavioral health support and rehabilitation services delivered by Provider and other community agencies based on available funding and consistent with the Provider policy ADM .08 Co-Pays, Refunds and Third-Party Coordination of Benefits.

II. General Procedures

A. The Clinical Care Team's is responsible for assessing a service participant's acute, behavioral, and health-related social needs and assigning he person to the appropriate level of care. assisting the participant in developing goals, objectives, and interventions for care through the development of the Integrated Service Plan (ISP). The risks and benefits of service referrals are explained to service participants, guardians and/or designated representatives.

It is important, in consultation with the service provider, to identify the appropriate level of care and the frequency and expected length of the service being requested and clearly describe this in the ISP. This ISP will be utilized as part of the service referral process. The individuals Level of Care is adjusted as necessary to ensure the individual receives the services and supports necessary to meet their presenting needs.

B. Documentation of all service referrals/transports is maintained in the medical record and includes: 1.2 B

1. Service referral packet consistent with this policy;
2. Communication with staff at the receiving provider agency using the warm handoff procedure described above;
3. Consents;
4. Date, time, and frequency of the referral service and;
5. The mode of transportation as applicable, including Provider staff members who may be accompanying the service participant.

III. Referral Type

A. Provider Site Staff:

Type of services being requested includes, but is not limited to:

1. Primary Care Services,
2. Substance Abuse Counseling,
3. Health and Wellness Services,
4. Nutrition Services,
5. Peer Support Services,
6. Family Support Services
7. Rehabilitation and Employment Services

B. Co-Located Supported Employment Staff:

1. When the assessment and ISP are completed the care team can proceed to identifying a service referral through the following steps:
2. Contact the Coordinator for openings with the co-located program.
3. Complete Part I of the Provider Referral Request, Attachment A, with the participants' information and a signed Consent to Release Protected Health Information (PHI).
4. SE Providers are responsible for obtaining General Consent to Treat for their services.

C. In-Network Provider Agency Referrals (Not Co-Located)

Type of services being requested includes, but is not limited to:

a) Individual counseling,
b) Group counseling,
c) DBT counseling,
d) Substance Abuse counseling,
e) In-home support services,
f) Day treatment,
g) Rehabilitation providers and recovery center

5. The Provider clinical team faxes and/or scans the Provider Referral Request, Attachment A (and Attachment 8 if applicable), SMI referral packet checklist, Attachment C, and the signed Consent to Release Protected Health Information to the selected provider agency.
6. The provider agency reviews the request and determines if the referral request will be accepted or declined.
7. If the request is declined, the provider agency takes the following actions:
    a) On the Provider Referral Request, Attachment A, mark the "Decline check box, record the date declined, and indicate reason for declining the referral;
    b) Fax the Provider Referral Request, Attachment A, to the clinical team within one business day of the request.
    c) It is the responsibility of the declining agency to issue a Notice of Action for Title 19 participants.
8. If assessing the need for Dialectal Behavioral Therapy (DBT), a systematic cognitive- behavioral approach for those participants struggling with Borderline Personality Disorder, it is recommended that the DBT Referral Guide for Clinical Teams be utilized during clinical team staffing and ISP development. This will assist in the assessment and identified needs for DBT.
9. If the request is approved, the provider agency takes the following actions:
    a) Mark the 11Accept11 check box on the Provider Referral Request, Attachment A;
    b) Complete the SMI Packet Checklist, Attachment C, in order to identify the medical record documentation that is needed for the referral packet;
    c) Fax the Provider Referral Request, Attachment A and SMI Referral Packet Checklist, Attachment C to the care team within one business day of the request.
10. The Clinical Care Team reviews the response from the provider to determine if the request has been decline or approved, and takes the following actions:
    a) If the request is declined, the team will submit a referral to another provider agency, as outlined above.
    b) If the referral is accepted, the team forwards the SMI Referral Packet Checklist, Attachment C to the Site Medical Record Office Assistant. Referral packet requests will be processed within 72 hours of the date that clinical team receives notification the referral has been accepted.
11. The designated Office Assistant will complete the referral packet and notifies the Care Team the referral packet is ready. If the packet is to be hand-delivered, the Office Assistant will include the Drop off Receipt with the packet. If the packet is to be mailed to the provider agency, the Office Assistant will prepare the mailing envelope and place into the Inter-office mail for USPS mail. The Office Assistant then files the Provider Referral Request, Attachment A in the medical record.

IV. Single Case Agreements

A. When all attempts to secure a service referral through the person's Medicare, private insurance or all In-Network provider referrals have been exhausted, the Clinical Care Team can submit a Single Case Agreement (SCA}. Acceptable reasons for pursuing a SCA are:

1. Isolated Area: The participant resides in a rural area of Maricopa County and travel to a contracted provider is impractical
2. Lack of Clinical Expertise: Contracted providers do not have the ability/clinical expertise required to treat the participant's behavioral health condition.
3. Population Specific Sub-Specialization Necessary: The participant requires a covered services provider who specializes in population specific delivery.
4. Refusal to Accept: Contracted providers have the ability/clinical expertise required to treat the participant health condition, but refuses to do so AND there is no alternative contracted provider (document refusal on request}.
5. Timeliness of Service: Contracted providers have the ability/clinical expertise required to treat the participant's behavioral health condition, but the first available appointment will not be sufficient to meet the immediate, urgent, or routine needs of the person.

V. Referrals for Primary Care Services

A. Provider Co-Located Primary Care Referrals and Integrated Clinics

The Care Team follows procedures for accessing the on-site primary care provider as established by the Site. All PCP referrals should be warm hand-offs.

B. Community Based Primary Care Referrals

1. The Care Team identifies the assigned AHCCCS acute care plan and primary care provider and offers these as resources to the service participant.
2. The Care Team follows procedures for coordination of care with identified primary care providers as detailed in PRG .04 PCP Coordination and Information Sharing, including any needed release of information.
3. Provider Sites provide referrals to any known community healthcare provider accepting referrals for Non-TXIX adults, particularly FQHC facilities.

VI. Consumer and Family Experience Surveys

A. The Provider Quality Management (QM) Department conducts Consumer and Family Experience Surveys in order to identify satisfaction with agencies and community-based organization to which Provider sends referrals.

B. Based on a sampling methodology the Provider QM Department will notify the CM of the need to obtain consumer and family input.

C. Survey results are used to monitor and improve the quality of referral relationships f or agencies used by the Provider Clinical Care Teams.