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Partners in Recovery ... [1]

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## Partners in Recovery

### Civil Admission To and Discharge From the Arizona State Hospital

#### Procedure Document

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<b>CMC or Department Name:</b> Partners in Recovery Direct Care Clinics							
<b>CMC or Department Procedure Name and Number:</b> Civil Admission To and Discharge From the Arizona State Hospital							
<b>Date of Inception:</b>							
<b>Previous Approval Date:</b>	N/A						
<b>Current Approval Date:</b>							
<b>Operational Scope:</b>	<input checked="" type="checkbox"/> Clinical	<input type="checkbox"/> QI	<input type="checkbox"/> Network	<input type="checkbox"/> Customer Service	<input type="checkbox"/> Claims	<input type="checkbox"/> Other:	<input type="checkbox"/> Other: Other

## PROCEDURES

### ***Purpose:***

To supplement Partners in Recovery **Arizona State Hospital** policy with a detailed procedural guide. This desk top procedure identifies the Arizona State Hospital admission standards, procedures for requesting hospital transfer, patient staffing and submitting the admission application; the process for a collaborative case conference, peer review and level I and II reconsideration; the hospital admission process, waiting list and the CMO or designee approval/denial of the application; the admission assessment timeline, patient staffing requirements and establishment of treatment goals/discharge criteria; establishing discharge readiness, placement on the discharge ready list and referral to community placement or community services; and the development and implementation of a consumer transition plan.

### **I. Arizona State Hospital Admission Standards:**

Requesting Inpatient Provider evaluates the Patient as requiring admission to the Arizona State Hospital (Hospital) using the Hospital admission criteria as follows:

- A. Patient displays psychiatric conditions that render him or her persistently and acutely disabled (PAD), gravely disabled (GD), or a danger to self or others (DTS / DTO);
- B. The behavioral conditions require 24-hour skilled nursing supervision and medical care;
- C. The Patient has had three or more acute Level 1 psychiatric hospitalizations in the past year in spite of good discharge/ aftercare implementation;

- D. The Patient is unable to maintain in a community level of care due to chronic behavioral health problems in spite of multiple treatment attempts and medication trials;
- E. The Patient is currently not functioning at or near baseline for the last 6 months;
- F. The estimated length of inpatient stay is greater than 45 days; and
- G. No other appropriate level of care to meet the Patient's behavioral health needs exists or has been successful.

## **II. Request for Hospital Transfer, Patient Staffing and Admission Application:**

- A. Requesting Inpatient Provider contacts the Partners in Recovery Outpatient Clinical Team (OCT) to schedule a staffing. At the staffing, Inpatient provider and OCT reviews admission criteria and all treatment options. Both organizations must have senior clinicians that are familiar with the patient and have available all relevant records at the staffing.
- B. If OCT and Inpatient Provider are not in consensus for a referral to the Arizona State Hospital, the Partners in Recovery OCT Clinical Coordinator or Clinical Director will contact the Magellan Arizona State Hospital Liaison (AzSH Liaison) to schedule a collaborative case conference. At this meeting the OCT will provide an overview of the Behavioral Health Recipient's ("recipient") current mental status, current interventions, recommendations for discharge and available treatment options. If determined the Hospital is an appropriate referral, and a less restrictive placement is not available, the OCT will have five business days to complete the application for admission to the Hospital.
- C. If the recommendation is a referral to the Hospital, the OCT completes the application (<http://www.azdhs.gov/bhs/guidance/ash.pdf>) and faxes it to the Magellan AzSH Liaison at (314) 292-1314. The AzSH Liaison will begin tracking Application Timelines. The Inpatient provider will adjust the ITDP as necessary.
- D. The application and attachments are reviewed for completeness. The application will not be considered complete without the target symptoms and skills being fully addressed and all requested outpatient and inpatient information. If additional clinical information is needed, the AzSH Liaison will coordinate with the OCT to obtain needed information. If the packet is incomplete, the AzSH Liaison notifies the OCT to obtain necessary documentation. The 5-day clock will stop until the AzSH Liaison receives requested information. Upon receipt of complete clinical information, the AzSH Liaison forwards the application to the Magellan Physician Advisor for review. If all information is obtained and reviewed, the Magellan Physician Advisor will make a determination within five business days.

## **III. Collaborative Case Conference; Guidelines for Peer Review and Level I and II Reconsideration:**

- A. If the application for referral to the Hospital is not approved by the Physician Advisor, the reason for denial is indicated (See Attachment B1) and notice is given to the OCT,

current inpatient team, and any other involved parties. If the attending Physician (“attending”) is not in agreement, they have 3 business days to request a peer review to provide any additional information for consideration in the original determination. The peer review is conducted between the Physician Advisor and the attending. If the approval is further denied during the phone call, and the attending is not in agreement he/she may request a Reconsideration. At this time, notification of intended action is sent to the consumer and the OCT, including the attending. The Reconsideration occurs within 3 business days with a different Physician Advisor. During the phone call, determination of authorization is stated.

#### **IV Hospital Admission Process, Waiting List, and CMO Approval/Denial:**

- A. If the admission to the Hospital is approved and there is no current waitlist, the AzSH Liaison forwards the Application for Admission and attachments to the Hospital Admissions office, and notifies OCT, inpatient provider, and any other involved parties.
- B. If a waitlist exists, the recipient will be placed on the waitlist by approval date and monitored by the AzSH Liaison.
- C. When the Hospital Admissions Coordinator receives documentation from the Inpatient Provider and Magellan, a Patient Profile Summary is completed. This summary, along with the records is then forwarded to the Hospital Chief Medical Officer (CMO) for review and determination within two business days. The Hospital CMO will supply a statement of the decision (generated by the Hospital) and forward to the AzSH Liaison.
- D. If the Hospital CMO denies the recipient for admission to the Hospital, the denial statement (generated by the Hospital) will explain why the recipient is not accepted for admission. The AzSH Liaison forwards the reason for denial to the OCT and involved parties and the Hospital will send notice of intended action to the recipient and attending. At this time, the OCT can request reconsideration by submitting additional information as requested on the denial, and/or completing a Physician to Physician review between the Magellan CMO and the Hospital CMO to further discuss the reason for denial and current reason for referral.
- E. If the Hospital CMO accepts the recipient for admission, the admissions office will send the AzSH Liaison notice of acceptance and scheduled date of admission (generated by the Hospital). If there are no current beds available at the time of approval, the recipient will be placed on the waitlist based on the date of notification. Twenty- four hours prior to admission, the current Inpatient Social Worker will fax a copy of the Certification of Need (CON) to the AzSH admissions office at (602) 220-6355 and the Magellan Health Services AzSH Liaison. The AzSH Liaison will then forward the CON then to a Care Manager to generate the Letter of Authorization (LOA).

#### **V. Admission Assessment Timeline, Patient Staffing Requirements and Establishment of Treatment Goals/Discharge Criteria:**

- A. Within 24 hours of admission to the Hospital, the Hospital treatment team will complete all applicable assessments and the 10-day staffing is scheduled. Within five

business days, the Hospital Social Worker notifies the Magellan AzSH Liaison of the staffing date and time. Upon notification of the 10-day staffing, the AzSH Liaison notifies the Magellan OCT and the Magellan Arizona State Hospital Transition team of the staffing date and time.

- B. Participants in the 10-day staffing include the recipient, Magellan AzSH Liaison, Hospital treatment team, Partners in Recovery OCT from originating site, Magellan AzSH Transition Psychiatrist, and Clinical Coordinator. The Partners in Recovery originating OCT reviews the target skills and symptoms as well as recommended interventions as stated in the Application for Admission. This determines the treatment goals to be addressed, as well as discharge criteria as indicated in the application that must be addressed prior to discharge readiness. At this time transfer to the Arizona State Hospital Transition inpatient clinical team is discussed and scheduled.
- C. If the recipient is identified as appropriate for Dialectical Behavioral Therapy (DBT) skills training, the Hospital team will work with the outpatient team to complete a referral through the Hospital DBT Program Manger. Once the recipient begins Inpatient DBT skills training through the Hospital, the Magellan team will notify the Magellan Manager of Counselors of the start date. As the recipient makes progress in treatment and during subsequent treatment plan reviews, the team will evaluate for outpatient DBT Skills training and transition for continued DBT Skills Training with involvement of the Hospital DBT Program Manger and Magellan Manager of Counselors as required.
- D. A staffing will occur every 30 days with the Magellan Outpatient clinical team, Hospital team, and other involved parties until discharge ready. Discharge readiness is discussed in each staffing. For those recipients who are younger than 22 or older than 64, a RON will be generated for continued stay based on clinical team discussion. Continued stay will be conducted and reviewed by Magellan Care Managers. If continued stay criteria is not met after review, a denial will be issued and the care manger will send the Notice of Intended Action. The recipient's clinical team and/ or Hospital may ask for reconsideration (follow section 3B of this document). The Magellan Outpatient AzSH Transition Psychiatrist must attend the first staffing and each subsequent staffing a minimum of every 90 days thereafter. As Discharge readiness approaches, Partners in Recovery Case Manager and Psychiatrist complete Partners in Recovery Discharge Assessment Tool and coordinate additional evaluations as needed. The Partners in Recovery Rehab Specialist will become involved as community services become appropriate.

## **VI. Discharge Readiness, Placement on the Discharge Ready List and Referral to Community Placement or Community Services:**

- A. The recipient is deemed appropriate for Discharge at a 30-day staffing, as indicated by all target symptoms and skills being addressed by the discharge criteria determined in the 10-day staffing and per the application, and the recipient is demonstrating consistent discharge criteria behavior. The Hospital Social Worker will provide a packet to the Hospital Social Work Administration who will forward the packet to the Magellan AzSH Liaison. Within five business days, the Partners in Recovery Outpatient

Psychiatrist will complete a face- to- face Psychiatric Evaluation with the recipient to determine discharge readiness.

- B. Once discharge readiness has been assessed by the OCT, notice of approval or denial is sent by the Partners in Recovery Outpatient Psychiatrist to the Hospital Social Work department. The Hospital Social Work department will confirm that entitlements have been applied for by the Hospital Social Worker and are in process. Once the benefit process has been confirmed, along with approval of discharge readiness, the recipient's name will be placed on the Discharge Ready List and the Hospital Social Work department will forward notice to the AzSH Liaison (generated by the Hospital). If the discharge ready Consumer is under forensic commitment (NGRI or GEI), the date the recipient is placed on the list is the date of Court or PSRB approval and not the date the packet is completed. The Hospital will send Notice of Intended Action to the recipient and/ or guardian when placed on the discharge ready list.
- C. When the recipient is placed on the Discharge Ready List, the AzSH Liaison documents the date of approval and 30-day discharge window. The Magellan AzSH Transition OCT will coordinate a discharge staffing and invites the Magellan benefit specialist, housing specialist, rehab specialist, and other supports. At this staffing, the following will be discussed and confirmed: discharge level of care, approved community housing or residential placement, rehabilitation supports, need for pre-authorization of medications, and any pending applications for benefits. The Partners in Recovery Clinical Team will update the ITDP/ISP, and will forward the discharge information to the AzSH Liaison.
- D. If the decision is a referral to Residential Treatment or the Community Living program, the Partners in Recovery Case Manager completes the Residential Request or the Community Placement Request Form and forwards the request to the Housing Department.
- E. Once the Placement has been determined and a referral sent, the Case Manager arranges a staffing with the recipient, community service provider and clinical team to discuss treatment needs and review the ISP. At this time the Clinical Team will update the recipient's ISP to reflect changes in services as discussed and approved during the staffing. If at the staffing the Clinical Team recommends a Community Placement and the recipient is in agreement, the Case Manager and Housing Administrator will schedule an opportunity to visit the proposed location of interest. Please note the staffing can occur at the time of the visit to the proposed location in the interest of time.
- F. If a new service is needed, the request for services will be forwarded to the Program Development Department in coordination with the Contracts and Network Department for submission of a Request for Letter of Interest (RFLOI) at the time required services are documented. The Program Development Department will then coordinate with other involved departments and agencies to facilitate service delivery.
- G. Monthly Hospital staffings continue as discharge progresses and the transition is discussed. If during the transition time the recipient decompensates or requires additional clinical intervention, the Partners in Recovery OCT and the Hospital team will discuss status on the discharge ready list and determine whether the recipient requires a hold or removal from the list. The recipient can then be placed on a 30- day

hold for re-evaluation, and if still not clinically ready for discharge, removed from the list. The Hospital Social Worker will inform the Hospital Social Work Administration of the determination and the recipient's status on the discharge ready list will be updated.

## **VII. Transition Plan:**

- A. During the consideration for discharge process, the OCT, Hospital team, other involved parties such as family or guardian, and community service provider (if applicable) discuss and create a transition plan whereby the recipient spends various amounts of time in the community, such as day and overnight passes, until the date of discharge. The OCT has 30 days to discharge the recipient into the community.
- B. On the day of discharge, the recipient sees the Magellan Outpatient Psychiatrist and then weekly thereafter for one month post discharge. During this time, the OCT discusses the recipient's progress in weekly meetings held at the AzSH Transition team site. On the day of discharge, the Hospital staff notifies AHCCCS of the discharge, and documents the Primary Care Provider's name, address, and phone number for medical coordination. The OCT contacts the assigned PCP to coordinate medical appointment and medical medication prescriptions.

