

**Arizona Department of Health Services
Division of Behavioral Health Services
PROVIDER MANUAL
Community Partnership of Southern Arizona (CPSA Edition)**

Section 10.22

Network Inpatient Treatment

I. Purpose

- A. To ensure that the members in out-of-home services are served in the least restrictive and most appropriate placement, are returned to their home or community as soon as is clinically reasonable, and that all suitable alternatives to hospitalization are considered.
- B. To ensure that Comprehensive Service Networks are monitoring services being provided to the member while hospitalized and that gaps or delays in service provision do not impede timely discharge to less intensive services.
- C. To ensure that members receiving services in a Level I psychiatric hospital have an active Child/Family Team/Adult Recovery Team (CFT/ART) that diligently works to develop an appropriate plan for returning the member to his/her home and community.

II. Objectives

This protocol represents the “minimum expectations” of Network performance and serves as a basic guide for Network behavioral health staff that is responsible for the care of hospitalized members. The intensity of contact and monitoring for persons during hospitalization and those identified in the discharge plan must be individualized and based on clinical need.

III. Introduction

Although the behavioral health system strives to provide services to members in their home and community, there are times when the most appropriate setting for intervention is Level I acute or sub-acute unit. Inpatient care allows a member’s behavioral health condition to be stabilized while giving the member, the member’s family, clinical team and community representatives an opportunity to develop an appropriate discharge plan through the CFT/ART process for meeting the member’s needs in his/her home and community.

IV. References

- A. [CPSA Provider Manual Section 3.16, Out-of-Home Protocol](#)
- B. [CPSA Provider Manual Section 3.14](#)
- C. [CPSA Provider Manual Section 5.1 Notice Requirements and Appeal Process for Title XIX and Title XXI Eligible Persons](#)
- D. [CPSA Provider Manual Section 5.5 Notice and Appeal Requirements \(SMI and General\)](#)
- E. [ADHS/DBHS Practice Improvement Protocol 8:THE ADULT CLINICAL TEAM](#)
- F. [ADHS/DBHS Practice Improvement Protocol 9: The Child and Family Team](#)
- G. [ADHS/DBHS Practice Improvement Protocol 14: Out-of-home Care Services](#)
- H. [CPSA Protocol Manual Section 3.8 Crisis Planning and Risk Assessment Protocol](#)

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V. Scope

This protocol applies to members being served by CPSA Comprehensive Service Networks (Networks) and who receive treatment services in a Level I acute hospital, or Level I sub-acute facility inclusive of psychiatric health facility (PHF) or extended care unit (ECU). It does not apply to members who are placed in a Level I residential treatment center (RTC). Coordination of care for these members is guided by the Out-of-Home Protocol.

VI. Procedure

A. Diversions and Admissions

1. All less restrictive placements must be formally considered prior to any emergency admissions. The Network on call staff must be notified and clinically appropriate and safe alternatives to hospitalization discussed. Network on-call staff is required to respond to diversion calls as soon as possible but no later than one hour after they have been paged or called.

Members presenting to an Emergency Department (ED) will require verification of eligibility and enrollment.

2. Networks must ensure that on-call staff have knowledge of and immediate access to alternative placements or service options.
3. Requests for hospital services should consider:
 - a. imminent risk of danger to self or others as a result of a behavioral health condition;
 - b. disturbance of mood, thought or behavior which renders the member acutely incapable of developmentally appropriate self-care or self-regulation;
 - c. the need for an assessment or medication trial that cannot be safely or adequately implemented in a less restrictive setting;
 - d. the presence or absence of a less restrictive level of care suitable to the behavioral health needs of the member; and,
 - e. the likelihood of imminent behavioral decompensation.
4. Considerations for diversion should include as appropriate:
 - a. SAMHC crisis beds
 - b. Level II settings with additional wrap-around services
 - c. Temporary respite placements
 - d. Intensive in-home service provision
 - e. Sendero Level II services
 - f. Compass Detox
 - g. 23 hour Drop In Centers with additional service provision
 - h. Other community-based services that meet the individual's or child's and family's immediate behavioral health needs.
5. Lack of agreement about the need for hospital admissions through an ED must be resolved through Medical Behavioral Health Professional (MBHP-to-MBHP) consultation, and must be initiated within one hour by the Network. If consensus cannot be reached, the ED physician may admit and the Network can request review by CPSA UR the next business day.

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6. Diversion options from an ED must be implemented, and the member transported by the Network, within 2 hours (or 4 hours if the provider is greater than 60 miles from the ED). If the transfer is not accomplished within the allowed time frame the hospital may admit the person to the hospital's psychiatric unit without prior authorization from CPSA.
7. Once stabilized, members must not remain in the ED overnight for convenience of the Network unless the ED physician so requires for further stabilization and documents the need in the member's chart.
8. The Network on-call staff is responsible for providing the ED or psychiatric unit the most current medication information. (Currently CPSA can provide paid prescription information through the CPSA prior authorization phone number or through CPSA Provider Services after regular business hours. The member's pharmacy may be helpful as well).
9. The Network on-call staff must inform the site supervisor or designee of the admission or diversion outcome as soon as possible but no later than 9:00 am the following business day.
10. The Network case manager or designee will fax or deliver outpatient records including but not limited to medication sheets, due date of next intra muscular injection (IM), if applicable, psychiatric evaluation, last physician note, and Individual Service Plan (ISP) to the inpatient team by 10:00 a.m. of the first business day following the admission.
11. The Network Hospital Liaison or designee will arrange for the outpatient MBHP to contact the inpatient MBHP within one working day for a brief discussion of the case and treatment.

B. Hospital Clinical Rounds and Communication

1. It is the expectation of CPSA that there be communication between the outpatient and inpatient MBHPs on the front end of every admission, prior to discharge, and whenever there is lack of clinical progress or disagreement between the inpatient and outpatient team. Network Hospital Liaisons, hospital social workers or discharge planners, and any other members of the team should be trained and expected to promptly arrange MBHP-to-MBHP dialogue as clinical situations dictate.
2. The Network Hospital Liaison or designee will attend hospital clinical rounds in person or by telephone at least twice per work week and review the discharge plan with the inpatient MBHP so that there is ample opportunity to collaborate on a viable discharge plan upon which all agree. If the Network Hospital Liaison or designee cannot attend clinical rounds, the inpatient social worker, discharge planner, or MBHP will be contacted by the Network Hospital Liaison or designee that day to discuss the discharge plans.
3. The Network Hospital Liaison or designee ensures that a detailed and up-to-date Network Discharge Plan Form is available for the inpatient team to review at each staffing. The Network Hospital Liaison or designee will obtain and document written or verbal agreement with the plan from the attending inpatient MBHP. The Network

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Discharge Plan Form will include the specific services to be provided by the Network, and the anticipated frequency of those services.

4. If the inpatient treating MBHP does not agree with the plan, the Network Hospital Liaison or designee will facilitate a MBHP-to-MBHP review. If this review does not resolve the disagreement or if the MBHP-to-MBHP call does not occur within 48 business hours of request, the Network Hospital Liaison will contact the Network Clinical Director and the CPSA UR Supervisor to facilitate the process.

C. Service and Discharge Planning

1. All reasonable attempts must be made by the Network to ensure that the CFT/ART process begins within 24 hours of admission and that a CFT/ART Behavioral Health Representative has face-to-face contact (or telephone contact if provider is further than 60 miles from the Level I facility) with the member within 2 business days of admission.
2. The frequency of subsequent visits by the CFT/ART Behavioral Health Representative should be determined by clinical status, member need, and service planning needs and should be documented on the Network Discharge Planning Form. Visits should occur at a minimum of every third day unless otherwise justified and documented on the Network Discharge Plan Form. Members in the Carondelet Extended Care Unit (ECU) and rural provider SEABHS Psychiatric Health Facility (PHF) are visited weekly at a minimum by an ART representative.
3. A CFT/ART meeting should occur within 48 hours of admission. CFT/ART members must include the member whenever clinically appropriate and may also include:
 - a. Outpatient MBHP
 - b. Case manager
 - c. Network Hospital Liaisons
 - d. Parent/guardian
 - e. Family members
 - f. Hospital social worker or discharge planner.
4. The Network Hospital Liaison or case manager will coordinate the time of the CFT/ART meetings with the facility staff to ensure that a room and staff members are available.
5. If the parent or guardian is unavailable in person, they are included in the CFT/ART by telephone conference call. Unless clinically contraindicated, the member must be present, if able and willing to participate.
6. By defining behavioral health service requirements rather than desired placements or level of care, a broader array of outpatient options can be considered. Thus, CFT/ART discussions should define the behavioral health needs of the member in as detailed a manner as is possible at the time and should be carefully documented in the ISP and on the Network Discharge Plan Form. Success is dependent on how thoroughly the history, needs, priorities, and goals of the member and the team are articulated up front.

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7. Discharge planning must start as soon after admission as possible, and efforts to secure discharge services and placements considered appropriate at that time must be clearly documented.
8. Within 48 business hours of admission the initial discharge plan is documented by the Hospital Liaison or designee on the Network Discharge Plan Form including the specific services to be provided upon discharge detailing frequency and intensity.
9. The Networks will have an identified staff who is ultimately responsible to supervise the hospital liaisons and oversee their discharge planning (Network Supervisor). This individual will ensure that the discharge plans submitted are clinically sound and obtainable in a time frame that does not result in delays in discharge.
10. As most inpatient interventions will lead to revisions of outpatient service needs or service intensity, the ISP should be revised accordingly and shared with the inpatient team. The ISP should be addressed in the context of CFT/ART protocol with input facilitated from all members of the team whether or not they are available to physically attend inpatient CFT/ART meetings.
11. The Network Discharge Plan Form must be filled out in its entirety and include specificity of actions, responsible parties and dates of the steps to be taken. If a required service is not currently available, then the plan will clearly identify the steps to be taken, when and by whom, to get the service in place as quickly as possible in order to prevent avoidable delays in discharge. References such as “to be determined” or “deferred until patient stabilizes” or “placement pending” are not specific enough to be helpful.
12. Any barriers to service provision will be reported to the Network Supervisor in order to assist with the timely resolution of those barriers.
13. Updates to the discharge plan will be documented by the case manager or designee as a late dated entry on the Network Discharge Plan Form or on an Updated Network Discharge Plan Form for placement in the facility record including specific dates of referrals, interviews and other decision steps necessary to finalize the discharge plan.
14. All Network Discharge Plan Forms and updates to the form will be signed by the member/guardian (if able), an inpatient team member and the Network hospital liaison or designee, and the yellow copy will be left for filing in the inpatient chart.
15. The Network will ensure that all members who potentially qualify for SMI status are referred to the Network site supervisor for SMI evaluation (7 business day time frame to complete evaluation) and will document the referral on the Network Discharge Form.
16. The Network will ensure that a prior authorization request for any medication requiring a prior authorization is submitted to CPSA prior to the member’s discharge.
17. For children up to 21 years, the Network case manager ensures completion of the CON by the Network MBHP and faxes it to CPSA UM at 520-618-6720 ASAP. The Network will track timely completion of the CON and any subsequent RONS that are required.

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18. For petitioned members, the Network tracks the court hearing date and schedules a CFT/ART to prepare the COT Outpatient Plan with the member before the hearing date. The COT plan must be accepted by the in-patient team and provided to both the Network Supervisor and the T36 Coordinator 2 days prior to the hearing date.
19. If a referral to the Arizona State Hospital or ECU is made by the CFT/ART, the case manager or designee ensures records are available for the CPSA Prior Authorization (PA) Referral packet within 48 hours after the CFT/ART meeting. The Network Supervisor screens the CPSA Request for Prior Authorization packet for completeness prior to faxing to CPSA. If necessary to ensure proper placement, the Medical Director or designee will provide AzSH or ECU with a written justification for admission.
20. Any plans considered transitional (e.g. temporary step down to Level II Group Home) must include a timeframe agreed upon by the inpatient team and the ART, which must include the agreement of the inpatient and outpatient MBHP, and specific details of the anticipated services that will follow.
21. Before discharge, the case manager or CFT/ART behavioral health representative completes an ISP to address the outpatient service needs and the services required, including the referrals that need to be made and the timeframes for completion.
22. If the member is nearing readiness for discharge and the plan is not finalized within 48 hours prior to discharge for any reason, the Hospital Liaison or designee contacts CPSA UR, the Network treating MBHP, site supervisor/administrator and Network Supervisor immediately.
23. The Hospital Liaison or designee is responsible for ensuring that all required notices are offered to the member consistent with the [CPSA Provider Manual 5.0](#) and are faxed to CPSA UM for the CPSA record.

D. Follow-up services after discharge

1. The case manager or designee schedules a follow-up face-to-face appointment for the member and a CFT/ART team member within 72 hours of discharge for the purpose of a welfare check upon the member's discharge to the community and availability of medication. Progress towards the treatment goals defined in the ISP and delivery of services are reviewed.
2. The case manager schedules a post-discharge follow-up appointment with the Network treating MBHP to occur within 15 days of discharge.
3. If the member fails to keep the initial scheduled appointment, the case manager or CFT/ART behavioral health representative must initiate a home visit (if member is under COT) or a telephone contact immediately.

E. Minimum staffing requirements

The Network will ensure the following staffing to implement the protocol:

1. A supervisor dedicated to overseeing the training of Network Hospital Liaisons in Level I processes and ensuring processes are implemented in a timely and complete manner.

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- a. Sufficient number of Network Hospital Liaisons to coordinate admissions and discharges from Level I facilities with Network case managers and members, and to attend local hospital rounds or staffings and/or exchange clinical and discharge planning information by phone as follows:
 - b. UPH, St. Mary's, UMC, Palo Verde, St. Joseph's Hospital, Sonora and SAMHC at least two times per work week.
 - c. SEABHS PHF and LFC PHF must be a minimum two times per work week attendance by phone or in person.
 - d. ECU a minimum of weekly attendance by phone or in person.
2. MBHP staff 24/7 availability to Network Hospital Liaisons and case managers (including diversion on-call staff)
3. On-call 24/7 diversion staff prepared to respond to calls from Level I ED and the means to authorize transport from the ED.