

**Procedure for Long Term Psychiatric Care Determinations for
Members Requiring Geropsychiatric Treatment**

Actor	Action
<p>Contractor</p>	<ol style="list-style-type: none"> <li data-bbox="553 268 1513 737"> <p>1. Determines whether the situation of the Member meets both of the following criteria:</p> <ol style="list-style-type: none"> <li data-bbox="651 380 1505 558"> <p>a. There is a need for either Intensive Psychiatric Rehabilitation or other tertiary treatment in a State hospital (or for adults extended care program), or extended and specialized medication adjustment (psychotropic) in a secure or otherwise highly supervised environment; and</p> <li data-bbox="651 600 1409 737"> <p>b. The Member has received all usual and customary treatment including, if Medically Appropriate, establishment of a medication program and use of a Medication Override Procedure.</p> <li data-bbox="553 779 1513 1146"> <p>2. If the situation of the Member meets both of the criteria listed in step 1, determines whether the Member is eligible for State hospital-GTS. To be eligible for these services, the DMAP Member must be:</p> <ol style="list-style-type: none"> <li data-bbox="651 957 987 999"> <p>a. Age 65 or over, or</p> <li data-bbox="651 1031 1495 1146"> <p>b. Ages 18 to 64 and have significant nursing care needs (e.g., must be bathed, dressed, groomed, fed, and toileted by staff) due to an Axis III disorder of an enduring nature.</p> <li data-bbox="553 1178 1513 1871"> <p>3. With the assistance of Acute Inpatient Hospital Psychiatric Care or subacute psychiatric care or other inpatient services staff, does the following:</p> <ol style="list-style-type: none"> <li data-bbox="651 1325 1471 1440"> <p>a. Contacts the OSH Geropsychiatric Outreach and Consultation Service (OCS) at (503) 945-7136, Monday through Friday, 8:00 a.m. to 5:00 p.m.;</p> <li data-bbox="651 1472 1495 1587"> <p>b. Obtains the Request for Long-Term Care Determination for Persons Requiring Geropsychiatric Treatment (request form) from the State hospital GTS staff;</p> <li data-bbox="651 1619 1513 1766"> <p>c. Assess Member's capacity to provide informed consent. If Member is determined unable to provide informed consent, take appropriate action towards Civil Commitment for Members not already protected by guardianship.</p> <li data-bbox="651 1797 1446 1871"> <p>d. Obtains all supporting documents listed on the request form.</p> <li data-bbox="553 1902 1487 1976"> <p>4. Sends, by facsimile, the request form and documents to the OSH Geropsychiatric OCS Screener at (503) 945-2807.</p>

Actor	Action
OCS Screener	<p>5. Within three working days of receiving a completed request form, does the following:</p> <ul style="list-style-type: none"> a. Reviews the request form and documentation for compliance with criteria for LTPC for persons requiring State hospital-GTS. b. If necessary, visits the Acute Inpatient Hospital Psychiatric Care or subacute psychiatric care or other inpatient services facility to interview staff and the Member. c. Discusses findings, determination, and placement alternatives with Contractor or Contractor representative (i.e., the person who sent the request form or other person designated on the request form). d. Indicates findings, determination, and effective date of LTPC as specified in Exhibit B, Part II, Section 1, Subsection c, Paragraph (10) (c) (iii) of this Contract on the request form. <p>6. If the Member is found appropriate for LTPC at State hospital-GTS, works with State hospital-GTS, Contractor, and the Acute Inpatient Hospital Psychiatric Care or subacute psychiatric care or other inpatient services facility to set the State hospital-GTS admission date and to coordinate such admission.</p> <p>7. Sends, by facsimile, the completed request form to Contractor and requester. Also, forwards a copy of the request form to the Institutional Revenue Section of OHA.</p>
Contractor	<p>8. If the Member is not found appropriate for LTPC at State hospital-GTS, or is found appropriate on a date other than the date specified in step 5.d., does one of the following:</p> <ul style="list-style-type: none"> a. Accepts the decision of the OCS Screener and provides appropriate treatment. Works with Acute Inpatient Hospital Psychiatric Care or subacute psychiatric care or other inpatient services staff, DHS SPD staff, OHA staff, and in some cases, emergency response system staff to develop a plan for continued care and treatment. b. If the decision is not accepted, requests a clinical review within three working days of receiving notice of the LTPC determination. Sends a written request and documentation specified in Step 3.d. of this Exhibit to the Adult Mental Health Services Unit via facsimile at (503) 378-8467.
Adult Mental Health Services Unit	<p>9. If Contractor requests a clinical review, sends, by facsimile, the request form and documentation submitted by Contractor in accordance with Step 3.d. of this Exhibit to the Clinical Reviewer.</p>

Actor	Action
Clinical Reviewer	<p>10. Does the following within three working days of receiving the clinical review packet:</p> <ul style="list-style-type: none"> a. Reviews all documentation submitted by Contractor in accordance with Step 3.d. of this Exhibit. b. Decides whether the Member is appropriate for LTPC. c. Determines the effective date of LTPC as specified in Exhibit B, Part II, Section 1, Subsection c, Paragraph (13) (c) of this Contract, if applicable. d. Updates the request form. e. Notifies by phone: the Contractor, Adult Mental Health Services Unit and the OCS Screener of the determination. f. Sends, by facsimile, the completed request form to the Contractor, Adult Mental Health Services Unit and the OCS Screener.
OCS Screener	<p>11. If the Member is found appropriate for LTPC, coordinates with the physician and admission staff the transfer to the setting recommended as of the date specified.</p>
Adult Mental Health Services Unit	<p>12. If transfer to the LTPC setting will not occur on the effective date of LTPC, OHA assumes payment responsibility for charges related to the Acute Inpatient Hospital Psychiatric or other inpatient services stay from the effective date of LTPC until the Member is discharged from such setting</p>

Request for Long-Term Psychiatric Care Determination for Persons Requiring Geropsychiatric Treatment

REQUEST				
Contractor:		Referral Date:		
Member Name:			DOB:	
Referral Agent:		DSM Axis I	DSM Axis II	DSM Axis III
Admission Date:	Prime Number:			
BASIS FOR REQUEST (NOTE: All criteria must be met.)				
<input type="checkbox"/> Member is 65 or older or Member is 64 or younger AND has significant nursing care needs (e.g., must be fed, dressed, groomed, bathed, and toileted by staff) AND these needs arise from an Axis III disorder of an enduring nature (e.g., Alzheimer's, Huntington's, TBI, CVA) (Note: A person 64 or under whose nursing care needs arise from acute decompensation of an Axis I disorder or are the result of behavioral noncompliance would not be admitted to State hospital - GTS and should be referred to the Adult Mental Health Services Unit.)				
<input type="checkbox"/> There is a need for either: <ul style="list-style-type: none"> <input type="checkbox"/> Intensive Psychiatric Rehabilitation or other tertiary treatment in an State hospital or extended care program, or <input type="checkbox"/> Extended and specialized medication adjustment (psychotropic) in a secure or otherwise highly supervised environment; and <input type="checkbox"/> The Member has received all usual and customary treatment, including if Medically Appropriate, establishment of a medication program and use of a Medication Override Procedure. 				
DOCUMENTATION SUPPORTING REQUEST				
(NOTE: All documents must be attached and must document the basis for request criteria.)				
<input type="checkbox"/> Physician's history and physical <input type="checkbox"/> Diagnostic Test results and Lab reports <input type="checkbox"/> List of current medications, dosages and length of time on medication <input type="checkbox"/> Guardianship or Civil Commitment documents (if applicable) <input type="checkbox"/> Reports of other consultations <input type="checkbox"/> Civil Commitment investigation report (if available) <input type="checkbox"/> Social histories <input type="checkbox"/> ADL Assessment (if available) <input type="checkbox"/> Current week's progress notes <input type="checkbox"/> Advance Directive (if available)				

Please summarize the reason why the patient needs LTPC.

ANALYSIS OF DOCUMENTATION SUPPORTING REQUEST
(Remainder of form to be completed by Gero Outreach staff.)

DETERMINATION

Patient's Name:

Prime No.:

Approved

Date of
Determination:

Name of Clinical Decision Maker:

Denied

Date Patient Admitted to State hospital-GTS:

CRITERIA FOR LONG TERM GEROPSYCHIATRIC INPATIENT CARE

- Person is 65 or older or person is 64 or under and meets nursing care criteria.
- Person has a psychiatric/neurological disorder causing severe behavioral disturbances with need for 24 hour hospital level medical supervision.
- At least one of the following conditions is met:
 - Need for extended (more than 21 days) regulation of medications due to significant complications arising from severe side effects of medications.
 - Need for continued treatment with electroconvulsive therapy where an extended (more than 21 days) inpatient environment is indicated and the inappropriateness of a short-term or less restrictive treatment program is documented in the Health Record.

- Continued actual danger to self, others or property that is manifested by at least one of the following:
 - The Member has continued to make suicide attempts or substantial life-threatening behavior or has expressed continuous and substantial suicidal planning or substantial ongoing threats.
 - The Member has continued to show evidence of danger to others as demonstrated by continued destructive acts to person or imminent plans to harm another person.
 - For Members 65 and over ONLY: The Member has continued to show evidence of severe inability to care for basic needs due to significant decompensation of an Axis I diagnosis.
- Failure of intensive emergency response system evidenced by documentation in the Health Record of:
 - An intensification of symptoms and/or behavior management problems beyond the capacity of the enhanced care service to manage within its programs; and
 - A minimum of one attempt to manage symptom intensification or behavior management problems within the local Acute Inpatient Hospital Psychiatric Care unit.
 - Has received all usual and customary treatment including, if Medically Appropriate, establishment of a medication program and use of a Medication Override Procedure. Has received medical evaluation and stabilization of acute medical problems.

OUTCOME OF CLINICAL REVIEW

<input type="checkbox"/> Upheld <input type="checkbox"/> Reversed	Transfer Date:	Name of Clinical Reviewer:
		Date of Decision: