Regional Extended Acute Care Protocol and Process

Instructions:

1. Eligibility Criteria must be met before any person can be considered for referral to the Regional EAC level of care.

I. Eligibility Criteria:

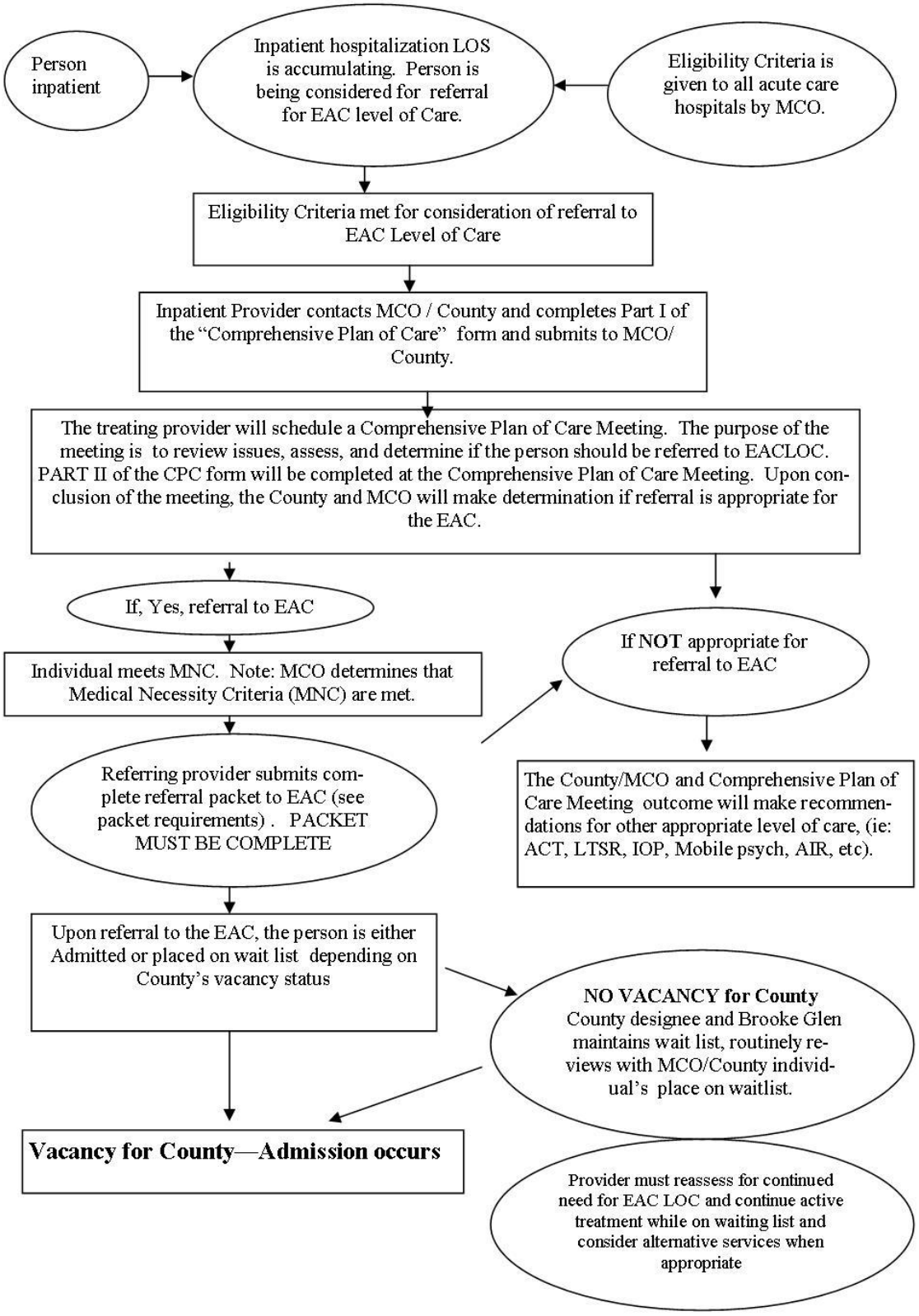
A. General criteria
   1. Individual is at least 18 years of age or older
   2. Resident of Bucks, Chester, Montgomery or Delaware Counties.
   3. Currently inpatient hospitalization under MH commitment (either voluntary or involuntary)
   4. HealthChoices eligible
   5. If not HealthChoices, then County Administration pre-authorization of funding could potentially be considered
   6. Meets medical necessity criteria (refer to DPW website & MCO)

B. Treatment/Service History
   i. 45 days of accumulated inpatient psychiatric hospitalization during the last 12 months **AND/OR**
   ii. including current commitment, at least two 303 commitments within the past 12 months **AND/OR**
   iii. The client must have a primary diagnosis that meets criteria for treatable serious mental illness as defined by Bulletin OMH 94-04 for persons diagnosed **AND/OR**
   iv. Documentation that client poses a significant risk of harm to self or others or is unable to take care of self; **AND/OR**
   v. the client has psychiatric symptoms that are insufficiently resolved despite acute inpatient hospitalization and treatment; **AND** which cannot be provided in a less intensive level of care

2. Part I of the attached Comprehensive Plan of Care Form must be completed for any individual who is being considered for potential referral to the Regional EAC.

3. Comprehensive Plan of Care Process – This process will include documentation, a Comprehensive Plan of Care Form (CPC Form) and a Comprehensive Plan of Care Meeting (CPC Meeting) to determine if the referral to the EAC is appropriate or if the individual's needs can be met at a less restrictive level of care
   a. Contact will be made by the treating provider to either the County or MCO to discuss consideration for EAC level of care and/or alternative service options. **NOTE: No direct contact should be made with the EAC unless a referral has been approved by the COUNTY and the MCO.**
   b. If appropriate, Part I of a Comprehensive Plan of Care Form (see attached) will be initiated by the treating provider containing the individual's demographic information, service and historical information, as well as information which identifies current challenges and service needs. Part II of the CPC Form will be completed in collaboration with all present during the CPC Meeting.
   c. After submission and review of the CPC Form, the treating provider will convene a "Comprehensive Plan of Care Meeting" with all stakeholders including but not limited to: the individual being considered for potential referral to EAC, family/other support persons, the current treating provider, other ancillary and service support staff, County and MCO representatives, etc.
   d. Upon conclusion of the Comprehensive Plan of Care Meeting, the County and MCO will make the determination if the referral is appropriate for the EAC level of care.
   e. If referral is deemed appropriate for EAC level of care and the MCO has determined that Medical Necessity Criteria has been met, the referring provider should then complete referral and submit to the EAC. (See Referral Packet requirements listed in Attachment B).
   f. If the referral is not appropriate for the EAC level of care, the County and MCO will provide assistance in accessing appropriate services/supports based on the individual's identified needs.

Regional Extended Acute Care Referral and Admission Process



EAC Admission Flowchart effective: 8/2013

Regional Extended Acute Care
Comprehensive Plan of Care (CPC) Form Part I

Instructions: Provider / Inpatient Facility will complete the information on the Comprehensive Plan of Care (CPC) Form and submit with request for Comprehensive Plan of Care Meeting to MCO and/or County. Part II of the CPC Form will be completed at the Comprehensive Plan of Care Meeting which is designed to discuss strengths and concerns, assess need for services/supports, and develop a comprehensive plan with the individual to best meet his/her needs.

Individual's name: _____ Date of Birth: _____
Last name, First Name, MI dd/mm/YYYY

Social Security #:_____ County(circle): **BUCKS CHESTER DELAWARE MONTGOMERY**

Referral source: Hospital / Individual completing form:_____

_____ Individual contact #:_____

Current Hospital Admission Date: _____

Current Commitment & Effective Date:_____

Previous Commitments within last 12 months _____
List dates and commitment type

Insurance (circle all appropriate): Magellan Community Care Behavioral Health MA (FFS)
MA Pending None Medicare Private/Commercial (list)_____ Other_____
Insurance Policy Number: _____

Income Amount: _____ Source: _____
Individual's Housing Status: Homeless: Y _ N __ if none: Previous Housing type:_____

Current Address: _____

Does individual have a case manager/Recovery Coach? Y / N Name/agency/contact #:_____
_____

Previous Hospitalizations & Substance Abuse Treatment in last 12 months:		
Hospitalization	Dates of Admission/Discharge	Disposition

Does individual have history of Substance Abuse: If so, list type, frequency and last use:

Type	Frequency	Last use

Current Legal status Y/N (i.e.: Probation, Parole, pending charges, etc): _____

Incarcerations / Legal encounters within last year: _____

_____

_____

List Formal and Informal Supports within last year: Include all professional supports and other self help supports IE: treatment services such as outpatient, case management, housing, peer supports, faith-based groups, family, etc.)

Service/Support: (Agency/support Contact name)	Frequency of Contact

Clinical Presentation:

Description of history of suicide attempts: _____

_____

Behavioral Challenges:

_____

_____

_____

_____

Presenting Problem: Clinical Impression of current crisis, (based on current and past information about the individual), & why is it happening now: _____

_____

_____

_____

Current Treatment Interventions/Plan: _____

_____

_____

_____

Current Medications:

Medication	Dose	Frequency	Reason

Previous medications (if known) and outcome:_____

_____

_____

_____

Diagnosis:

Axis I: _____

Axis II: _____

Axis III: _____

Axis IV: _____

_____

Axis V: Current GAF:_____ Past Year (if known):_____

Comprehensive Plan of Care Form Part II

To be completed by provider during the Comprehensive Plan of Care Meeting in collaboration with all present at the meeting.

Date of Comprehensive Plan of Care Meeting: _____

Persons Attending:

Name	Agency/Role	Contact information (phone/email)

Presenting Problem/ Successes/Challenges:

How to best support this individual:

Barriers to continued support in the community:

Why does this person need to be referred to the EAC:

Plan of Care Determined: