Article 28 Hospital Intermediate-Stay Units

Two inpatient mental health units have been authorized by the NYS Office of Mental Health to provide intermediate inpatient care in the Article 28 hospital setting:

- Second Chance Program at New York Presbyterian – Westchester (White Plains)
- Extended Treatment Unit at St. Joseph's Medical Center (Yonkers)

These intermediate stay units are specialized units designed to provide care for patients with serious mental illness with a history of poor community tenure who would benefit from incisive somatic treatment coupled with social learning and behavioral paradigms, with special focus on comprehensive discharge planning. Care is person-centered, with the individual's goals informing treatment. Aftercare planning is responsive to the particular needs of the patient and aims to maximize opportunities for the patient to use new skills to support meaningful community re-integration. The length of stay is approximately 90-120 days, with variation based on response to treatment and appropriate disposition.

I. Admission and Access

1. Clinical Admission Criteria (all criteria must be met)
   - Patients may be referred from Westchester County, NYC and the Hudson River Region.
   - Patients must be 18 years of age and older and meet medical health clearance criteria applicable to acute stay units.
   - Diagnosis of a serious mental illness (such as schizophrenia, schizoaffective disorder, bipolar disorder, depressive disorder).
   - Symptoms and/or problematic behaviors are severe enough such that the individual cannot be safely managed in a less restrictive setting and consistent with generally acceptable medical necessity standards for acute inpatient stay.
   - Self-maintenance skills and/or community living skills are significantly impaired such that the individual cannot be safely managed in a less restrictive setting.
   - Candidates are treatment refractory with residual symptomatology despite multiple pharmacological trials of adequate dosage and duration.
   - Candidates have demonstrated poor community tenure in the recent past, and risk of re-hospitalization is high.
   - Specific goals for behavioral improvement can be delineated.
   - A minimum of cognitive reserve (to allow skill acquisition) and motivation (to address functional deficits) is present (even if insight and capacity to cooperate is limited).
   - Improvement in adaptive functioning is a reasonable expectation.

2. Clinical Exclusion Criteria
   - Antisocial personality disorder as the primary driver of maladaptive behaviors or presenting a significant barrier to therapeutic benefit despite engagement and motivation.
   - Severely aggressive or predatory or sexually inappropriate behaviors that would threaten disruption of the milieu.

- Neurodevelopmental Disorders (such as Intellectual Disability and Autism Spectrum Disorder).

3. Access
   - Referrals: Patients are referred by inpatient acute stay psychiatric units, or by Medicaid Managed Care Organization (MCO) plan care managers to:
     - NYP-WD: Andrew Bloch at 914-997-5738
     - Saint Joseph's: Samiyrah Bennett at 914-378-7966
   - A Referral Packet is forwarded to the referring clinical entity, which includes: Psychiatric assessment, psychosocial assessment, physical exam, lab work (CBC, Chemistry Panel), PPD and progress notes. In addition, Second Chance has a program referral form.
   - Patients participate in a screening interview, either in-person or telephonically. The purposes of the interview are to confirm that the individual meets the admission criteria and to begin to orient the patient to the program. Patients must voluntarily consent to admission to the unit.
   - The referring facility contacts the MCO for pre-authorization of admission to the intermediate stay unit as per MCO protocol and documents authorization number, contact name and phone number. Prior authorization is required for all admissions regardless of referral source (e.g., admitted directly to the intermediate stay unit from the community; transferred from an acute unit in the same hospital; or transferred from another facility.)
   - In the event a patient is deemed appropriate for admission by the intermediate stay unit team, but admission/transfer is not authorized by the MCO, there will be an opportunity for the intermediate stay unit and MCO to review the case. In such instances, the referring clinical team may request that the intermediate stay unit representative discuss the case with the MCO.
   - Transportation is arranged by the sending facility on a mutually agreed upon date and time.

II. Treatment Planning/Utilization Management

Treatment planning is a person-centered process involving the collaboration of the patient, the treatment team, the patient's family/significant others, community supports (such as the patient's care coordinator), and the MCO. The treatment plan is seen as the first phase of a recovery plan that will be continued after discharge.

1. Overarching goals and objectives of treatment planning:
   - The intermediate stay units focus on achievement of satisfaction and success in the community after discharge. The treatment plan identifies the patient's needs, strengths (including natural supports) and challenges (including medical health, chronic or episodic substance use), including barriers to a successful discharge and community tenure.

- Treatment plan objectives are measurable steps toward recovery. The first steps include symptom resolution and improvements in functioning within the unit milieu. The treatment plan methods include the behavioral program on the unit, group and individual therapy, and the use of evidence-based guidelines for psychopharmacological treatment. Specific skill development as tied to specific barriers to community tenure may serve as an objective of an intervention.
- Treatment plan reviews (updates) track patients' progress toward achieving their goals and assess their readiness for discharge. Goals and objectives are modified to address identified barriers to discharge. The discharge plan is updated and modified as indicated. Available metrics, e.g., Clinical Global Impression Scale may be utilized in assessing progress.

2. Treatment is guided by the following general timeline:
   - Week 1: The treatment team completes all elements of the unit's assessment process. The treatment team, patient and the patient's support system then formulate the Comprehensive Treatment Plan. The elements of the assessment include:
     - Psychiatric assessment and complete psychopharmacological assessment to clarify diagnosis and treat acute symptoms
     - Psychosocial assessment and behavioral/functional assessment to identify skill deficits and problematic behaviors
     - Psychological assessment and determination of need for psychological testing to aid diagnostic and cognitive assessments
     - Total health assessment including medical as may impact discharge planning and community tenure
     - Planned early engagement of existing natural support in shared planning and decision making as appropriate
     - Initiation of discharge planning (see below)

     The specific elements of the treatment plan are discussed with the MCO and agreed upon. A senior clinician level review/collaboration phone call with the MCO takes place on or around Day 7. These senior clinician reviews, which may be "MD to MD" at the discretion of the unit leadership and MCOs, should include discussion of specific resourses that may be available "in network" with the MCO and would be facilitated by the MCO whenever possible (to be negotiated by the MCO on behalf of the provider/patient).
   - Weeks 2-4: Treatment plan reviews are conducted as needed to ensure that, by the end of week 4, the patient, treatment team, and MCO arrive at a consensus regarding treatment goals, obstacles, barriers, and planned interventions to be included in the Comprehensive Treatment Plan.
   - Weeks 5-12: Treatment plan reviews continue. These reviews identify whether the timeline for achievement of goals and objectives is being met. Barriers to goal achievement and to implementation of the discharge plan are identified, as are strategies for mitigating them.

3. Utilization Management:

Utilization Management focuses on achieving treatment plan goals that will lead to a fuller recovery, including a discharge plan that will build on skills acquired and goals achieved on the unit with expectation of improved tenure in the community. Skill sustainment through specific community supports needs to be considered and integrated. The reviews are a collaborative effort between the units and MCOs to identify barriers that have been encountered both to meeting the timeline on the unit and to implementing the optimal discharge plan.

- The first review with the MCO takes place one week after admission to the unit. The Comprehensive Treatment Plan is reviewed and it is revised based on the discussion with the MCO. An approximate timeline for achieving objectives toward the goals is established.
- It is recommended that, if treatment is progressing as expected according to the initial review and treatment plan, continued stay reviews with the MCO should occur every two weeks. In the unusual circumstance that it seems likely that the patient will not be ready for discharge within the model framework, consideration is given to initiating a State PC application. Note: Application to State PC does NOT indicate that State PC is the preferred and/or final disposition.
- Decisions regarding the treatment plan are reached by consensus, with an opportunity to escalate disagreements to the medical directors of the units and the MCOs.

III. Discharge Planning

- The intermediate units and MCOs will partner to optimize the patient's discharge plan.
- Discharge Planning is a critical element of the treatment on the unit, so as to ensure improved tenure in the community. At the time of admission, an assessment of previous discharge plans and reasons for readmissions is performed. Risk factors for future readmissions are assessed.
- Family/significant others, community support and outpatient treatment providers are contacted within 24 hours of admission for their input in formulating a successful discharge plan.
- Patients, families/significant others and community supports are actively engaged in residential planning, including the housing application process, which is initiated as soon as clinically possible. The Local Government Unit (LGU) and regional OMH offices will be involved as needed.
- Status of entitlements is reviewed within the first week.
- If the patient is a Health and Recovery Plan (HARP) member, the patient will be enrolled in a Health Home as part of the discharge plan. If the patient is already enrolled in a Health Home, a Health Home care manager is included in the discharge planning process.
- Discharge criteria are individualized and include achievement of specific skills in addition to symptom resolution, e.g., demonstrate skills/ability to obtain and maintain independent housing.

- In evaluating possible aftercare and residential arrangements, the team assesses the readiness of the providers to continue the interventions and the social learning model used on the unit, so as to build on the gains achieved.
- Skill transfer plans are provided to aftercare providers/systems. The plans will include:
  - Written plans and verbal handoff for all discharged patients.
  - Case/care manager, home health case manager, ACT, etc., visits on the units for patients at very high risk of rapid readmission.
  - Staff-accompanied visits to aftercare facilities/providers for patients at highest risk of rapid readmission.
- Assessments for other support services, e.g., care coordination, ACT and AOT are completed.
- Support system meetings (family, care coordinator, natural supports etc.) are conducted in order to assist the patient in the transition to outpatient status.
- Community exposure outings are arranged to assess discharge readiness and to assist the patient in making the transition.
- After discharge, patients and providers are called by the unit staff to ensure that all elements of the discharge plan were achieved and that any support required by the patient is provided.

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Memorandum

To: Managed Care Plan Liaisons to NYS

From: Thomas Smith, MD, Medical Director, NYSOMH Division of Managed Care

Date: September 30, 2015

Re: MCO Behavioral Health Guidance memo
Utilization management for Article 28 hospital long-stay units:
Second Chance Program at New York Presbyterian – Westchester (White Plains)
Intermediate Care Unit at St. Joseph's Medical Center (Yonkers)

NYS requests that HARPs and Mainstream Managed Care Organizations (MMCOs) adopt a modified approach to utilization management for the two hospital inpatient units referenced above. Both units have been in operation for many years and are authorized by OMH to provide intermediate care for individuals with serious mental illness and complex needs, many of whom have been hospitalized at State Psychiatric Centers and are re-entering the community. Both inpatient programs are located in Westchester County but treat a significant number of NYC residents. The NYP Second Chance program operates 30 beds and the St. Joseph's Intermediate Care Unit operates 14 beds. Nearly all admissions are Medicaid (non-duals) who have not had their benefits managed by plans to date.

Following are descriptive statistics for the two hospital inpatient programs:

		2010	2011	2012	2013	2014
Discharges	NYP	50	66	64	62	67
	St. Joe's	22	17	25	32	23
Admitted from State PC	NYP	N/A	20 (30%)	10 (16%)	10 (16%)	10 (15%)
	St. Joe's	0	0	0	0	0
County of Origin= NYC	NYP	N/A	N/A	45 (70%)	43 (53%)	49 (73%)
	St. Joe's	4 (18%)	4 (24%)	9 (36%)	9 (28%)	3 (13%)
Mean Length of Stay (days)	NYP	N/A	174	170	151	177
	St. Joe's	217	281	194	162	218
Discharged to Community	NYP	46 (92%)	53 (80%)	49 (77%)	51 (82%)	59 (88%)
	St. Joe's	12 (55%)	13 (76%)	15 (60%)	25 (78%)	19 (83%)
Discharged to State PC	NYP	4 (8%)	13 (20%)	13 (20%)	9 (15%)	7 (10%)
	St. Joe's	8 (36%)	2 (12%)	6 (24%)	7 (22%)	4 (17%)

These inpatient units are in a position to play an important role in the overall continuum of care given the ongoing pressures to lower the census at State Psychiatric Centers and improve community tenure for individuals with serious mental illness and complex needs. However, because of the long lengths of stay, plans may be more likely to issue medical necessity denials for these cases due to failure to show timely response to treatment. Because of this, NYS requests that HARPs and MMCOs refrain from issuing medical necessity denials for the initial 120 days of inpatient care for any new admission to these units on or after October 1, 2015, until further notice. Plans should conduct concurrent reviews and advise and support discharge planning activities.

The costs for these long hospitalizations are included in the 2016 capitation rate and stop-loss provisions will also help limit plan financial liability for these extended inpatient stays. OMH will shortly convene a workgroup including representatives from plans and the two hospitals to develop recommendations for program modifications to ensure these units play an important role in the transforming mental health system of care.

Please let us know if you have further questions.

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Memorandum

To: Managed Care Behavioral Health Medical Directors

From: Thomas Smith, MD, Associate Medical Director, NYSOMH

Date: September 1, 2016

Re: Utilization management for Article 28 hospital long-stay units:
Second Chance Program at New York Presbyterian – Westchester (White Plains)
Extended Treatment Unit at St. Joseph's Medical Center (Yonkers)

Enclosed is guidance for Medicaid Mainstream Managed Care Organizations (MMCOs) and Health and Recovery Plans (HARPs) regarding admission and utilization management guidelines for the two hospital inpatient units referenced above.

Background
NYS issued guidance in September 2015 advising plans to work closely with the intermediate units on these long-stay cases but to refrain from issuing medical necessity denials until at least day 120 of inpatient care. In December 2015, NYSOMH convened a workgroup including representatives from plans and the two hospitals to review these intermediate care inpatient mental health units and develop recommendations for program modifications. Over the last several months the group has collaborated on the enclosed guidance document outlining admission and continuing stay criteria as well as collaborative discharge planning activities.

Next steps
The workgroup will reconvene in Fall 2016 to further review experiences. Additionally, the hospital clinical leadership teams will organize on-site visits to further engage Managed Care colleagues. Both the MMCOs and the hospital clinical leaders are challenged to identify the value added in their work with each other. The future roles of these units will be clear when all involved identify the unique elements of these programs that add value and define their place in the state's integrated system of care.

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