1. Please complete either the Continued Stay or Discharge portion of form as needed.
2. Please complete a separate form for each member request.
3. To avoid lapse in coverage, please submit 1 week prior to end of member's current authorization period.
4. Please update all sections each review. Please put "N/A" if area is not applicable.
5. Please keep in contact with your assigned clinical care manager with regard to planned discharge or any significant concerns regarding member's participation in treatment.
6. PerformCare will review and complete authorization within 2 business days.
7. Authorization can be verified in NaviNet. For instructions, please contact your assigned Account Executive.
8. FAX all paper submissions to **888-296-4002**.
9. Any questions or concerns please call 888-700-7370 and ask for assigned CCM or supervisor.

PerformCARE®

ADULT LONG TERM PARTIAL HOSPITALIZATION PROGRAM TX REQUEST SUBMISSION FORM

Member Name:

DOB: **MAID:**

FOR DISCHARGES, PLEASE SKIP TO DISCHARGE PORTION AND COMPLETE ALL SECTIONS.

CONTINUED STAY REVIEW:

ALL EXAMPLES IN ITALICS

Date: Provider Site:

Person submitting form/Credentials:

Contact Number/Extension:

Dates Requested for Authorization: (to) Please ensure dates are on weekdays.

Number of Days Requested (Ex. 30, 60, 90, Other)

Scheduled Days and Hours/Week: Hrs/Day: Days/Week:

DIAGNOSIS: (Requesting ICD 10 code, Written Psychiatric Diagnosis, and Medical Diagnosis)

F33.3 MDD Severe Recurrent with Psychotic Features, F10.20 Alcohol Use D/O Severe, F71 Intellectual Disability Moderate

GERD, HTN, Diabetes Type 2 Please list active medical diagnoses.

MEDICATIONS: Adherence: (Y/N) *No* Barriers: *transportation, poor memory*

Rationale for Med Changes:

PSYCHOTROPIC – NAME/DOSE/FREQ/DATE OF LAST CHANGE/RECENT LEVEL/DATE:
Include Rationale for Med Changes:

Paxil 20 mg QD – prior to admission

Seroquel 200 mg BID increased 3/1/2016

Depakote 750mg BID decreased 3/2/16 (level=120 on 3/1/16)

Please list medications on separate lines.

Prescribing Physician: Full name and credentials is requested.

MEDICAL – NAME/DOSE/FREQ/DATE OF CHANGE/RECENT LEVEL/DATE: Include Rationale for Med Changes:

HCTZ 50 mg QD – prior to admission

Prilosec 20 mg QD – prior to admission

Please list medications on separate lines.

Prescribing Physician: Full name and credentials is requested.

Adherence: (Y/N) *No* Barriers: *transportation, poor memory*

Plan to address barriers: *identify delivery pharmacy, blister pack medications, referral to Mobile Psych Nursing for in home medication education and management*

Rationale for Med Changes: *Seroquel increased due to hearing voices at night. Depakote decreased due to elevated level.*

SUBSTANCE ABUSE:

Current/Recent use of substances: (Y/N) *Yes* History of Use: (Y/N) *Yes. Alcohol heavy use in his 20's, recent relapse and increased consumption over past month*

SUBSTANCE/ROUTE: (Oral/IV/Nasal/Smoking/Sublingual): AMT/FREQ: FIRST USE: LAST USE:

Alcohol: oral, 2- 3 x month, amount unclear, FU – 14 yo, LU – 4/7/2016

Cannabis: smoking, intermittent 1 – 3x month, FU – 20 yo, LU- 4/7/2016

Current SA TX*: attends monthly AA groups, current sponsor*

Planned SA Tx: *referral to SA Outpatient or IOP if member agreeable*

Barriers: *transportation, member's denial about severity of problem*

Plan to address barriers: *MATP referral, AA peers can assist with transportation to meetings, PHP staff to complete additional screening, Outreach to VA for outpatient SA treatment resources or refer to local SA provider, Attempt to engage sponsor in treatment meetings, Referral will be made by PHP staff to obtain RASE Recovery Specialist*

TRAUMA/ABUSE/GRIEF AND LOSS:

History: *WW II Veteran, Involved in combat, Hx Childhood Trauma, Resides in domestic violent situation, Grandson taking member's money and as result member's financial means overextended*

Was Abuse Reported: (Please elaborate) *Physical, sexual abuse as a child not reported.*

Any New Disclosure: (If Yes, please elaborate) *Grandson has been borrowing money without repayment. Member verbalizing fear of not being able to pay bills and fear of saying no to future requests*.

Was Abuse Reported: (Y/N) *Yes - Reported to Area Agency on Aging* Date Reported:*2/25/2016*

Current TX: *None at this time, will continue to monitor for needs*.

Planned Trauma Tx: *PHP discussing with member plan to refer to a specialized outpatient provider in community*

Barriers: *homelessness, too overwhelmed with stressors, member not ready to discuss*

Plan to address barriers: *Psychoeducation provided to member/family/supports, Motivational Interviewing to increase insight, Revised safety planning, Work on sleep hygiene schedule*

CURRENT MENTAL/FUNCTIONAL STATUS/LIVING ENVIRONMENT: *Attendance good. Short term memory issues – forgetful at times but long term memory intact. Complains of slight increase in auditory hallucinations at times, which seem to be improving with change of medications. Has some transportation issues getting to AA meetings. Worried about the future and his finances. Depressed and lonely on weekends. No SI/HI/SIB. Affect blunted. Participating in groups with encouragement. Living alone in his own apartment and daughter, son-in-law, grandson live nearby.*

MEMBER DRIVEN GOALS (Limit to 3 – Please Update)

1) Goal: *Improve medication compliance*

Action Steps: *Identified delivery pharmacy with blister med packing. Recommending Mobile Psych Nursing (MPN) for education and safety assessment.*

Progress: *Completed recommendation for MPN in discussion with TCM. TCM plans to follow up with pharmacy in one week and will coordinate MPN visits with PCP.*

Barriers: *Time* Plan to address: *N/A*

2) Goal: *Minimize auditory hallucinations*.

Action Steps: *Medication adjustment. Psychoeducation. Identify coping skills to manage symptoms.*

Progress: *Improvement in nighttime auditory hallucinations.*

Barriers: *None identified.* Plan to address: *N/A*

3) Goal: *Decrease signs/symptoms of depression.*

Action Steps: *Psychoeducation in groups. Develop healthy coping skills*.

Progress: *Member identifies need to develop social weekend supports*.

Barriers: *Transportation*. Plan to address: *Member to consider inviting family/friends to his home*.

CULTURAL/LANGUAGE/SPECIAL NEEDS IMPACTING TX: *Veteran, Primary language other than English, Physical Disability, Sexual orientation, Cultural Identity, Cultural Beliefs related to medication or MH treatment, Religious Preferences*

Measures to address: *Use translator, address member with preferred pronoun and name, validate member's cultural beliefs regarding medication in care planning*

FAMILY PSYCHIATRIC HISTORY: *Maternal: family hx Depression and Anxiety, Paternal: Father hx of Alcoholism, Paternal Grandparents history of Alcoholism*

FAMILY AND NATURAL SUPPORTS INVOLVEMENT/CONTACT:

Involved Family/Natural Supports: (Please list) Daughter, *Son-In-Law*

Participants/Summary of Session/Last Contact: *On 3/3/16, daughter and member participated in phone session with PHP therapist; Discussed member's financial concerns; Developed plan where daughter will assist with monitoring member's finances; Discussed plan to address concerns about grandson's behavior as a family and may consider taking legal action if problem persists.*

Barriers: *hostile family environment, estranged from family, paranoid thoughts, family transportation barriers, family members in poor health, family work schedules*

Plan to address: *Phone family session to be scheduled, continue with mental health stabilization and re-offer family session*

PREVENTION PLAN

Relapse Triggers: *Family conflict, homelessness, medication non-adherence, isolation, increased anxiety, paranoia*

Warning Signs: *Not taking meds, increase in paranoia, increase in voices, increased conflict with others*

Coping Skills: *Cognitive Restructuring, Self soothing, Thought stopping, Distraction, Reframing, use of supports, reading, journaling, knitting, physical exercise/activity, call sponsor, attend 12 step meetings, call my daughter on the phone. If a child: have parents been advised of child's coping skills and encouraged to transfer skills to home.*

Member Identifies Strengths As: *Independent, sense of humor, belief in God*

Measures to Utilize Strengths: *Creating a daily schedule of activities, use humor to decrease anger, memorize a bible verse to say when stressed*

If member cannot identify strengths, what steps are being taken to assist member to identify? *Use of assessment tool to identify strengths*

Natural Supports: *Daughter, Son-In-Law, AA Sponsor, Neighbor, Family Friend, Work Colleagues/Employer, Pastor, Church Members*

Community Supports: *12 Step Meetings, Community Support Groups, Volunteering, Church*

Does member have a WRAP Plan? (Y/N)

If no, was WRAP explained to member and referral made for Peer Support per member agreement?

Does Member's WRAP Plan match Prevention Plan? (Y/N)

(Elaborate)

Member Crisis Plan: (Please Update) *Pick 1 -2 coping strategies from my WRAP plan, If coping skills not helping go to my Phone list of supports and make phone calls, If talking with my Supports is not helpful make call to County Crisis Intervention and speak with Crisis Staff, If at any time I feel I am unsafe I will call 911 or ask a support to assist me in getting to Emergency Room*

CURRENT TREATMENT ADHERENCE:

Barriers: *Transportation, illness, social isolation, physical location, non-adherence to medications, difficulty getting to pharmacy, impaired sleep schedule, frequent family crisis, memory issues, difficulty adhering to schedule, physical location, formulary concerns impacting medication, unstable housing*

Plans to Address: *Developing an attendance contract, hold team meeting/family session to engage supports, MATP referral, bubble pack medications*

COORDINATION OF CARE: Please list Provider, Contact, Phone/Ext, and Last Contact for any professional involvement outside of PHP including PCP, Specialist

VA Center Lebanon: Jim Jones, LSW 888-888-8888 x. 000 3/31/16

Recovery Insights: Joe Smith 000-000-0000 x. 000 4/1/16

CASE MANAGEMENT: Please identify Level of Case Management (Admin, RC, ICM/BCM), (Include Name, Agency, Phone/Ext.) (Include Name/Phone/Ext.)

Type of contact: phone/visits to PHP, participation in team meetings

Date of last contact and plan: *(Elaborate)*

DISCHARGE PLAN (Aftercare Planning starts at Admission – asking for PHP's evolving recommendations for aftercare services prior to member's anticipated discharge.)

MEMBER'S CURRENT ADDRESS/PHONE NUMBER:

PROFESSIONAL SUPPORTS: (Level of Care, Provider Name/Site, Contact Number, Appt. Date/Time)

RECOVERY FOCUSED SUPPORTS: (Indicate Type, Provider, Contact)

INFORMAL SUPPORTS: (Type, Name, Contact Number)

ANTICIPATED D/C DATE:

SIGNATURE OF PERSON COMPLETING FORM: DATE:

DISCHARGE REVIEWS

Member Name:

DOB: **MAID:**

Date: Provider Site:

Person Submitting Form/Credentials:

Contact Number/Extension:

DISCHARGE DATE: *date of d/c from program*

DISCHARGE TYPE: (Completion of Treatment, AMA, Withdraw From T, Other)

If treatment was not completed, please identify rationale: *Member no showed for program, no response from phone calls or outreach by mail, member went to jail, or other reason member was d/c from tx*

PHP Staff Follow-up/Outreach*: Attempted 3 phone calls, sent formal letter with aftercare resources, contacted ICM requesting follow-up*

DIAGNOSIS: (Include ICD 10 code, Written Psychiatric Diagnosis, and Medical Diagnosis)

MEDICATIONS: Adherence: (Y/N) *No* Barriers: *transportation, poor memory*

PSYCHOTROPIC – NAME/DOSE/FREQ/ DATE OF CHANGE/ RECENT LEVEL/DATE: Include Rationale for Med Changes:

Abilify 5 mg q HS

Depakote ER 500 mg am and 1000 mg HS VPA Level 88 3/2/2016

MEDICAL – NAME/DOSE/FREQ/DATE OF CHANGE/RECENT LEVEL/DATE: Include Rationale for Med Changes:

Lisinopril 10 mg AM

AFTERCARE

PROFESSIONAL SUPPORTS: (Level of Care, Provider Name/Site, Contact Number, Appt. Date/Time)

MH OP: John Doe, LSW Somerset MH/ID 000-000-0000 x000 3/12/16 4pm

Med Mgmt: Jane Doe, MD Philhaven Mt Gretna 000-000-0000 x. 000 3/13/16 8am

PCP: Gary Doe, MD Family Medicine Group 000-000-0000 x. 000 5/1/16 9am

Peer Support: Julie Doe 000-000-0000 4/1/16 2pm

RASE Recovery Specialist: Tammy Doe 000-000-0000 x. 000 4/5/16 1pm

RECOVERY FOCUSED SUPPORTS: *Certified Peer Support, Mt Gretna 000-000-0000, Mark Doe*

INFORMAL SUPPORTS: (Type, Name, Contact Number)

12 step meetings 4x week, Family to transport to appointments, Friends assist with transportation to 12 step meetings, Church, Tempo Clubhouse (as often as needed), Community Grief Support Group 1x month Wednesdays 7:00pm

PREVENTION PLAN: (Triggers, Warning Signs, Crisis Plan)

Relapse Triggers: Family conflict, homelessness, medication non-adherence, isolation, increased anxiety, paranoia

Warning Signs: Racing thoughts, Difficulty sleeping, Nightmares, Isolation

Coping Skills: Calling my sponsor, Attending a 12 step meeting, Calling my daughter to talk on phone, Cognitive Restructuring, Self soothing, Thought stopping, Distraction, Reframing, use of supports, reading, journaling, knitting, physical exercise/activity. Parents are aware of member coping skills, and will encourage use when they identify warning signs.

Member Crisis Plan: Pick 1 – 2 coping strategies from my WRAP Plan, If coping skills not helping go to my Phone list of Supports and make phone calls, If talking with my Supports is not helpful make call to County Crisis Intervention and speak with Crisis Staff, If at any time I feel like I am unsafe I will call 911 or will ask support person to assist me in getting to Emergency Room

MEMBER'S CURRENT ADDRESS/PHONE NUMBER:

SIGNATURE OF PERSON COMPLETING FORM: DATE: