Community Integration
Submission Guidelines for Continued Stay Requests

Eligibility

- **Assessment:** Please make sure date of diagnosis is updated at each Continued Stay Review (CSR). Please include all relevant diagnoses.

- **Assessment Tool:** Please make sure date of LOCUS is updated each CSR.

- **Medications:** Please list all relevant psychiatric medications

- **Clinical Indicators Justifying Service Request:** Please make sure clinical indicators are updated with each CSR.

- **Treatment and Service History:** Please make sure to updated inpatient admissions, crisis episodes, homelessness, and correction involvement.

- **Criteria for Discharge:**

    - What are the specific and measurable criteria for discharge?
    - What does the member home to accomplish from CIS services? What behaviors would member need to be able to do independently or with other supports/resources to be able to step down from CIS service? How would progress be measured so provider/member would recognize when discharge criteria have been achieved?
    - Is there a projected date of transition/discharge?
    - Please describe what the following words mean if provider uses them: reduce, maintain, decrease, and manage.
        - Example:
            - Client will be discharged when client is able to manage anxiety by client reporting less than 2 panic attacks a week.
            - Takes medication as prescribed daily for 3 months
            - When he/she can rate their anxiety less than a 5 (1-10) a minimum of 6 times in a 3 month period.

- **Treatment Plan:**
    - Are the treatment goals/objectives corresponding to discharge criteria?
        - Example:
            - If housing, coping skills, financials are identified as part of the member's discharge criteria, does the treatment plan have house, coping skills, financial goals or objectives?

  - Treatment plan contains the link between MH symptoms and MH and identified treatment goals.
  - How is CIS assisting the member in managing MH symptoms to improve member functioning?

- **Problem Statement:** Brief identification about problem to be targeted. Often may be in member words.
    - Example:
        - Member struggles with anxiety. “I can’t function in my day.”

- **Long-Term Goal:** Brief description of target. Discharge criteria targets to be supported in service plan long-term goal step area.
  - Example:
    - Member will be able to keep appointments.

- **Short-Term Goal:** Identify the steps involved with meeting the long-term goals.
  - Example:
    - Member will practice coping skills with provider at each appointment once a week.
    - Member will practice taking the bus with provider.

- **Progress Since Last Review:** Brief description of the member’s progress working on each of the Short-Term Goals.
  - Example:
    - Member has set up transportation this period with provider support and reminders.
    - Member has practiced distress tolerance skills twice this period and has reported minimal improvement with symptoms
    - Member has attended 3 out of 5 appointments on average.

- **Target Date:** Date goal is expected to be accomplished

- **Services to be Provided:** Used to list specific services
  - Example:
    - Therapy, CIS, Psychological Assessment

- **Frequency of Services:** Estimate of how regularly provider meets with member, for how long.
  - Example:
    - Weekly; monthly

- **Duration of Services:** What length are contacts with member?
  - Example:

        - 1 hour, 2 hours
- **Provider of Service:** Used to identify who the provider is for a particular service.
    - Example:
        - DLSS, CIS, PCP, Psychiatrist

- **Transition Discharge Plan:** Please include Projected Date of Transition/Discharge even if member is not expected to be discharged within this authorizations period. This date may change depending on member status or progress in treatment.

- **General Guidelines:**
    - Update all areas of CSR at each review
    - Please make sure units reflect anticipated time spent with member
    - Please include only current progress towards specific goals.
    - Please limit historical information to only include information that is directly related to current needs and activities
    - Please be aware Acentra Health communicates to provider through the download process. Please check downloads often for important information regarding your CSRs.
    - If your CSR is shortened, please read the notes from the Acentra Health daily authorization report. We are looking for specific information in the next review.
    - A vital part of all medical necessity evaluations and recovery-oriented practice is a plan to continuously prepare a person to function with the lowest intensity and least restrictive services. Constructing such a plan and testing it out does not commit a program to a specific date of discharge but having target dates allows the provider and member to understand if progress towards greater autonomy is being made.
    - If requested units are high due to issues of mobility, need for interpreter, or geography, please indicate these issues within the CSR.