



Acute Inpatient Treatment

Acute treatment represents a level of care designed to meet the needs of patients who have psychopathology resulting in emotional and behavioral manifestations that require an inpatient setting, and represent an imminent threat to themselves or others. The level of clinical intervention that distinguishes acute inpatient treatment is 24 hours per day/seven days per week psychiatric nursing supervision and ongoing assessment. Twenty-four hour monitoring by a multidisciplinary team of behavioral health professionals is required for the patients to remain safe, to be effectively treated and to progress to a less restrictive level of care. The primary consideration for the selection of acute care is the type and acuity of symptoms in the patient's clinical presentation. The safety of patients is of paramount importance; a thorough evaluation of suicidal ideation, homicidal ideation and ability to care for self must be conducted. Patients whose symptoms place them at acute risk of harm to self or others must be admitted to the acute setting. Patients in the acute setting may lack adequate impulse control, the ability to cooperate with the staff of the inpatient unit, the ability to communicate effectively with the inpatient staff, and to accomplish activities of daily living without significant support. Diagnosis, per se, should not be the primary consideration in the selection of this level of care.

Typical care in the acute setting involves:

- ▶ daily psychiatric nursing evaluations
- ▶ direct services by a Board Certified psychiatrist seven days a week
- ▶ medication management in a highly structured therapeutic setting
- ▶ psychotherapeutic interventions as indicated.

The therapeutic setting is capable of managing patients who require substantial support to deal with their symptoms and situation. The staff in the acute setting must be of sufficient number and skill to manage violence that results from the patient's psychopathology. Psychiatric and medical physician services are available 24 hours per day, seven days a week for emergencies.

Consults appropriate to the patient's condition are conducted and non-acute medical problems are managed. Patients and their families receive psychoeducation relevant to their particular situation.

Indicators for discharge from an acute setting

Patients are discharged from the acute setting when their symptoms have decreased to a level that no longer requires 24-hour a day monitoring and support. Indicators for discharge include improved impulse control, medication compliance, positive response to medications, effective communication and accomplishment of activities of daily living with minimal support. Significant symptoms may remain at the conclusion of a stay in the acute setting, but can be effectively treated and managed in a less restrictive level of care. Suicidal and homicidal ideation and intent must be carefully evaluated prior to release from the acute setting and, if present, must have diminished to a level that can be safely managed at a lower level of care. Thorough documentation of the risk to self or others must be included in the medical record. Linkages to the next level of care, specifically psychiatric management, psychotherapy, and family support must be firmly in place prior to discharge. Arrangements for having support and/or vocational counseling or rehabilitation should be in place, as well. Patients and their families are centrally involved in the therapeutic process, treatment planning and discharge planning.

Indications for admission to acute inpatient treatment for children and adolescents

The clinical indications for acute inpatient admission and treatment of children and adolescents are the same as adults. However, the typical clinical presentations requiring acute inpatient care are determined by the youngsters' developmental levels. Acute inpatient treatment is designed to address their clinical problems and their emotional, intellectual, social, and educational needs as children and adolescents. The need for acute inpatient treatment for children and adolescents includes:

- ▶ imminent threat to themselves or others due to psychopathology
- ▶ marked emotional distress that is otherwise intolerable to the child
- ▶ marked lack of self-care otherwise appropriate for the child's age and developmental level
- ▶ the onset of disturbed behavior or emotional states that has not been already fully assessed
- ▶ serious medical conditions that are complicated by severe behavioral disturbance, or
- ▶ lack of treatment response for severe psychopathology in less restrictive settings.

The child's threat to self or others may be unique to her/his age, such as the repeated running away of a young adolescent who subsequently lives on the streets, homeless without adult supervision or protection for days or weeks on end. The core clinical needs of a child or adolescent who requires acute inpatient care are the same as adults, including: 24 hours a day/seven days a week psychiatric nursing care, and an intensive multidisciplinary treatment team headed by an attending child and adolescent psychiatrist, daily child psychiatric intervention, and 24 hours per day/seven days per week availability of psychiatric and medical physician services for emergencies. The child or adolescent acute inpatient clinical service should provide a highly structured therapeutic setting with psychotherapeutic and psychotropic medication interventions. The setting should be capable of managing children and adolescents who require substantial therapeutic support to deal with their emotional and behavioral disturbances, including the need to manage agitation and violence that results from the youngster's psychopathology.

Because of the importance of the family and parents in every child's life, the involvement of parents and close family members in the ongoing assessment, stabilization, treatment planning, treatment and aftercare planning is centrally important to acute inpatient care for these young patients. Aftercare planning for a child or adolescent receiving acute inpatient treatment should be actively pursued by the inpatient treatment team from the time of admission. The inpatient team needs to coordinate aftercare planning through the use of timely interagency planning meetings with the child's parents/guardians, but also with other agencies involved with the child, especially the child's school and aftercare treatment provider. Other agency representatives assigned to assist a given child who has been treated with psychiatric hospitalization should be included in the interagency aftercare planning meetings when appropriate, such as DHS workers, child advocate attorneys and caseworkers, SCOH workers, probation officers and targeted case managers.

Indicators for discharge from acute inpatient care

Indicators for discharge from acute inpatient care for patients of all ages include:

- ▶ improved impulse control
- ▶ lessening and control of any symptom-related dangerousness to patient's self or others
- ▶ willingness to take medications as prescribed
- ▶ positive response to treatment

- ▶ more appropriate social interactions for the patient's given developmental level and
- ▶ the ability to manage personal care appropriate to the patient's developmental and adaptive capabilities.

Significant symptoms may remain at the conclusion of a stay in the acute setting, but can be effectively treated and managed in a less restrictive level of care. Suicidal and homicidal ideation and intent, and other high-risk behaviors, such as fire setting, must be carefully evaluated prior to release from the acute inpatient setting and, if present, must have diminished to a level that can be safely managed at a lower level of care. Thorough documentation of the risk to self or others must be included in the medical record. Linkages to the next level of care, specifically psychiatric management, psychotherapy, treatment programming, and family support must be firmly in place prior to discharge. Arrangements for having support and/or vocational counseling or rehabilitation for adult patients should be in place at the time of discharge. Child and adolescent patients should have comprehensive planning and recommendations completed for appropriate educational services after discharge, including the possible need for special education services.



Subacute Inpatient Treatment

Subacute treatment represents a level of care designed to meet the needs of patients who have psychopathology resulting in emotional and behavioral manifestations that require an inpatient setting, but do not represent an imminent threat to themselves or others. Twenty-four hour monitoring by a multidisciplinary team of behavioral health professionals is required for the patients to remain safe, to be effectively treated, and to progress to a less restrictive level of care. The primary consideration for the selection of subacute care is the type and acuity of symptoms. The safety of the patients is of paramount importance. A thorough evaluation of suicidal ideation, homicidal ideation and ability to care for self must be conducted. Patients whose symptoms place them at acute risk of harm to self or others must not be admitted to the subacute setting. Patients in the subacute setting should have adequate impulse control, as well as the ability to cooperate with the staff of the inpatient unit, to communicate effectively with the inpatient staff and to accomplish activities of daily living with minimal support. Diagnosis, per se, should not be the primary consideration in the selection of this level of care.

Typical care in the subacute setting involves: daily psychiatric nursing evaluations, direct services by a Board Certified psychiatrist at least three times weekly, and medication management in a structured, therapeutic setting, psychotherapeutic and social interventions. For children and adolescents, maintenance of academic studies and focus on social skills building are essential. The therapeutic setting is capable of managing patients who require substantial support to deal with their symptoms and situation. Psychiatric and medical physician services are available 24 hours per day, seven days a week for emergencies.

Patients and their families are centrally involved in the therapeutic process, treatment planning and discharge planning. Consults appropriate to the patient's condition are conducted and non-acute medical problems are managed. The patients and their families receive psychoeducation relevant to their particular situation. Patients are discharged from the subacute setting when their symptoms have decreased to a level that no longer requires twenty four-hour a day monitoring and support. Indicators for discharge include good impulse control, medication compliance, effective communication and the accomplishment of activities of daily living consistent with the developmental capabilities of the patient. Significant symptoms may remain at the conclusion of a stay in the subacute setting, but these symptoms can be effectively treated and managed in a less restrictive level of care.



Medical Necessity Criteria for Acute and Subacute Inpatient Hospitalization

Acute Inpatient Admission Criteria

- I. Has the patient had an evaluation by a psychiatrist that establishes a psychiatric diagnosis or a provisional psychiatric diagnosis?
(Answer must be yes for admission)
 - A. Is this diagnosis solely due to substance abuse, mental retardation, or a cognitive disorder? **(Answer must be no for admission)**
- II. **The answers to all the following questions are yes.**
 - A. Does the patient require 24-hour availability of services for diagnosis, monitoring, and assessment?
 - B. Does the patient require the availability of a physician 24 hours a day to make timely and necessary changes in the treatment plan?
 - C. Does the patient require the involvement of a psychiatrist in the development and management of the treatment plan?
 - D. Does the patient require 24-hour availability of psychiatric nursing to implement the treatment plan and monitor the patient's condition and response to treatment?
 - E. Does the patient require 24-hour clinical management and supervision?
- III. **The answer to one or more of these questions is yes.**
 - A. Does the patient represent a significant risk of harm to self, others, or to the destruction of property?
 - B. Does the patient have a psychiatric medical condition and physical illness that may compound one another and may result in a medical crisis or medical instability?
 - C. Is the patient so impaired by the psychiatric condition that the patient's judgement, self-care, social and/or occupational functioning are severely threatened?
 - D. Does the patient require psychiatric care that would be medically unsafe if administered at a lower level of care?

- E. Have the patient's symptoms increased to a degree of severity that this level of care is required to prevent deterioration to a level that may result in danger to self, others or property?

Subacute Inpatient Admission Criteria

Does the patient have a behavioral disturbance that requires an inpatient setting?

Does the patient meet the following criteria? **(All must be answered yes.)**

- ▶ The patient is not an immediate threat to self or others.
- ▶ The patient has adequate impulse control.
- ▶ The patient is able to cooperate with the ward staff.
- ▶ The patient can accomplish activities of daily living [ADLs] with minimal or no assistance.
- ▶ The patient can communicate effectively with staff.
- ▶ The patient requires a 24-hour per day nursing supervision to maintain safety.

FOR CHILDREN AND ADOLESCENTS

- ◆ An appropriately executed 201 voluntary commitment, or a court ordered 303 involuntary commitment is in place.
- ◆ A comprehensive typewritten psychiatric evaluation has been completed within 10 days of admission. A new evaluation is unnecessary, because the clinical needs of the patient have not changed and aftercare recommendations have not been revised.
- ◆ Physical health conditions must be stabilized and in a routine maintenance phase of management.

Narrative Requirements for Acute and Subacute Admission

Focus on current symptoms

- ◆ Describe current behavior
- ◆ Describe current Mental Status
- ◆ Focus on suicidal ideation (SI), homicidal ideation (HI), psychotic, neurovegetative, affective and other symptoms of sufficient severity that the patient is unable to meet basic needs.

Medications

- ◆ Names, doses and frequency of dosing, compliance
- ◆ Side effects

Other

- ◆ Living situation
- ◆ Medical problems
- ◆ Substance abuse
- ◆ Initial diagnosis
- ◆ Initial treatment plan

Past History of risk indicators

- ◆ Significant suicide attempt
- ◆ Successful homicide or serious injury to others
- ◆ Forensic history and status
- ◆ For children and adolescents, history of physical/sexual abuse

Continued Stay Criteria for Acute and Subacute Treatment

Must meet criteria in I and II.

- I. The answer to one or more of the following is yes.
 - A. Does the patient have a persistence of symptoms that meet admission criteria?
 - B. Have new symptoms developed that meet admission criteria?

- C. Has the patient had an adverse reaction to medication; procedures or therapies that require continued hospitalization?
- D. Will the withdrawal of inpatient services likely result in decompensation that can not be managed at a lower level of in care?

II. The answers to all of the following are yes.

- A. Has a physical exam been completed within 24 hours of admission?
- B. Has a psychiatrist conducted a psychiatric examination within 24 hours of admission?
- C. Is the patient participating in treatment and discharge planning?
- D. Does the treatment plan reflect appropriate care for the patient's needs?

Narrative Requirements for Acute and Subacute Continued Stay

Focus on treatment and resolution of symptoms

- ◆ Mental Status Changes
- ◆ Medications:
 - ▶ Names
 - ▶ Doses
 - ▶ Frequency of doses
 - ▶ Response to medications
 - ▶ Side effects
 - ▶ Compliance

Discharge Criteria for Acute Inpatient Treatment

1. All of the following must be answered yes for discharge:
- A. Have the patient's symptoms been reduced to a level that the patient's treatment can be managed at a lower level of care?
 - B. Have any psychiatric medical conditions diminished in severity such that they can be managed at a lower level of care?
 - C. Can the improvements in the mental and physical status be maintained at a lower level of care?
 - D. Does the patient no longer represent a danger to self, others or property?
 - E. Has an effective discharge plan been developed?

OR

If the reason for admission was a diagnostic evaluation and/or a medical treatment, has this been completed?

OR

Has the patient left against medical advice and does not meet criteria for involuntary commitment?

OR

Has the patient been transferred to another facility for continued care?

Discharge Criteria for Specific to Subacute Inpatient Treatment

All of the following must be answered yes.

- ◆ Have the patient's symptoms resolved to a sufficient degree that 24-hour/day monitoring is not required?
- ◆ Is the patient compliant with medication?
- ◆ Are ADLs accomplished with problems?
- ◆ Does the patient have good impulse control?
- ◆ Is the patient communicating effectively with staff?

FOR CHILDREN AND ADOLESCENTS

- ◆ Are ADLs appropriate to the patient's developmental capabilities maintained by the patient?
- ◆ Does the patient have improved impulse control to allow for clinical management at a lower level of care?
- ◆ Is the patient effectively communicating with staff appropriate to the patient's developmental capabilities?

Narrative Requirements for Subacute Discharge

- ◆ Discharge Criteria in RFP are met [see above Psychiatric Inpatient Services]



Partial Hospitalization

Partial hospitalization is a treatment program that combines elements of the inpatient and outpatient setting in a structured, therapeutically intensive treatment program that coordinates clinical services to achieve a stable therapeutic milieu. Partial hospitalization offers an alternative to hospitalization for individuals who represent no imminent danger to themselves or others.

The treatment program in partial hospital settings must have a specified structure and be offered within a specific time framework. Clear guidelines for admission, evaluation, effectiveness of treatment and discharge are necessary for a partial hospitalization program. Signs and symptoms of behavioral disorders are carefully and continuously monitored in this setting to document progress or regression. Prompt and effective intervention with the individual who is exhibiting increased symptomatology is a hallmark of a partial hospitalization program and often averts hospitalization. Crisis intervention may also be a focus of treatment.

Partial hospitalization programs exist for all age groups and a variety of diagnostic categories. Addictive disorders may be treated in partial programs and specialized programs for patients with co-morbid psychiatric disorders and addictive disorders.

Admission to a partial program often follows an inpatient stay. The individual exiting the hospital may have significant residual symptomatology and disability and require the intensive treatment of a partial hospital program to remain stable and/or progress in the resolution of symptoms. Other individuals may be admitted from lower levels of care as an alternative to admission to the hospital. Once the individual has made sufficient progress, discharge from the partial hospital setting to a lower level of care may be possible.

Medical Necessity Criteria for Partial Hospitalization

Admission Criteria

- I. The answer to one of the following must be yes
 - A. Does the patient have an established history of a psychiatric disorder with current symptoms that require this level of care?
 - B. If the patient lacks a history of a psychiatric disorder, has a psychiatrist, or a licensed clinical psychologist confirmed a psychiatric diagnosis that requires this level of care?
 - C. Has the patient had an evaluation by a psychiatrist, or a licensed clinical psychologist at another mental health facility who is recommending direct referral to this level of care?
 - D. Does the patient need a diagnostic evaluation that cannot be performed at a lesser level of care?
 - II. One of the following must be answered yes for admission to partial hospital:
 - A. Does the patient have the ability to participate in the partial hospitalization level of care? Specific considerations include:
 - ▶ Does the patient require intensive biopsychosocial interventions?
 - ▶ Can the patient be safely maintained at home or in a structured residence?
 - ▶ Does the severity of the patient's condition prohibit maintenance at a lower level of care?
- OR**
- B. Has the patient had an adverse reaction to medication, procedures, or therapies that requires frequent monitoring that cannot be managed at a lower level of care?

- III. All of the answers to the following must be yes:
- A. Is the patient receiving active treatment within the framework of a multidisciplinary individualized treatment plan?
 - B. Is a psychiatrist involved in the development and management of the treatment plan and program?
 - C. Is the treatment plan for discharge modified in keeping with the changing clinical picture of the patient?
 - D. Is the patient an active participant in discharge planning?
 - E. When appropriate, are members of the patient's family and community supports involved with treatment and discharge planning?

Narrative Information Required

SYMPTOMS

Describe the nature and severity of the patient's symptoms in detail.

MEDICATIONS

Names
Doses
Frequency of Doses
Blood levels if applicable
Response
Side effects
Compliance

TREATMENT PLAN

Plans developed for discharge and/or lower level of care.

Discharge Criteria

I. All of the following must be answered yes:

- A.** Have the symptoms, functional impairments and/or medical problems that warranted admission diminished in severity sufficiently that the patient can be managed at a lower level of care?
- B.** Will treating the patient at a lower level of care sustain and support the improvement attained at the partial hospital level of care?
- C.** Has an effective discharge plan been developed and have the treatment providers at a lower level of care agreed to provide care for the patient?

OR

II. One of the following must be answered yes.

- A.** If the sole reason for admission was to perform a diagnostic evaluation, has it been completed?
- B.** Has the patient withdrawn from treatment against advice and does not meet criteria for involuntary treatment?
- C.** Has the patient been transferred to another facility for care?



Psychiatric Outpatient Care

Psychiatric outpatient care encompasses a wide range of therapeutic modalities that are usually based in an office setting. Psychiatric evaluations, psychotherapy, psychoeducation, treatment of addictive disorders, family therapy, behavioral therapy, psychopharmacology and many other modalities are conducted in the psychiatric outpatient setting. Individuals engaged in treatments in this setting are no imminent danger to themselves or others and are generally functional in their social and occupational/school roles. The issues addressed may be of a focal nature in a time-limited framework, be addressed in long-term psychotherapy or psychopharmacological maintenance. Often, outpatient care is used to maintain the gains made at a higher level of care or to continue the work initiated at a higher level of care.

Admission Criteria

- I. Has a mental health professional determined that this level of care is appropriate for this patient? If so, what are the identified symptoms, degree of impairment, and diagnosis?
- II. **One of the following must be answered yes:**
 - A. Does the patient have a psychiatric illness evidenced by a reduced level of functioning and/or subjective distress in response to an acute event?
 - B. Does the patient have signs and symptoms of a psychiatric illness that are causing reduced function and/or subjective distress?
 - C. If the patient has a history of psychiatric illness and is in remission, will the patient regress without this level of care?
 - D. Has a comprehensive evaluation been conducted that includes the following elements: psychiatric diagnosis, medical diagnosis; psychological, educational, social and vocational factors?

Continued Care Criteria

- I. Does the patient have a current psychiatric diagnosis or a provisional diagnosis?
- II. **One of the following must be answered yes:**
 - A. Does the patient exhibit one or more of the symptoms that prompted admission?
 - B. Can the patient be expected to benefit from this level of care?
 - C. Has the patient developed new symptoms that can be managed effectively at this level of care?
 - D. Given the patient's history, will withdrawal of treatment result in decompensation or regression?
- III. **All of the following must be answered yes:**
 - A. Is the patient an active participant in treatment and discharge planning?
 - B. Has a psychiatrist reviewed and approved the treatment plan?
 - C. Does the treatment plan include a discharge plan? (Are the goals and objectives defined and measurable?)
 - D. Has the treatment plan been changed to meet the changing needs of the patient?
 - E. Is the care the patient is receiving based on a multidisciplinary, individualized treatment team approach?

Discharge Criteria

- I. Has the patient completed treatment as evidenced by a reduction or absence of the symptoms that originally indicated this level of treatment?
- OR**
- II. Has the patient withdrawn from treatment against advice and does not meet criteria for involuntary treatment?

Specific Clinical Information - Narrative

- ◆ Diagnosis
- ◆ Medications
 - ▶ Names
 - ▶ Amounts
 - ▶ Response
 - ▶ Side effects
- ◆ Treatment Plan
 - ▶ Biological interventions
 - ▶ Psychological interventions
 - Individual therapy
 - Family therapy
 - Psychoeducational treatment
 - ▶ Social interventions
 - Vocational advocacy training/counseling
 - Housing
 - Community and social involvement
- ◆ Plans developed for discharge