

Acute Inpatient Hospitalization- Child and Adolescent MH

Definition

An Acute Inpatient program is designed to provide medically necessary, intensive assessment, psychiatric treatment and support to youths with a DSM (current version) diagnosis and/or co-occurring disorder experiencing an acute exacerbation of a psychiatric condition. The Acute Inpatient setting is equipped to serve patients at high risk of harm to self or others and in need of a safe, secure, lockable setting. The purpose of the services provided within an Acute Inpatient setting is to assess and stabilize the youth's acute psychiatric conditions.

Policy

Acute Inpatient mental health services are available to Medicaid Managed Care eligible youth, age 20 and younger.

Program Requirements

Refer to the program standards common to all levels of care for general requirements.

Licensing

The hospital must be licensed or formally approved as a hospital by the Nebraska Department of Health and Human Services (DHHS), Division of Public Health, or appropriately licensed in the state where the hospital is located. Acute Inpatient services must be accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), enrolled with the NE DHHS Division of Medicaid and Long-Term Care, and be contracted with the Nebraska Managed Care entity.

The hospital must have written policies and procedures related to:

Refer to "Standards Common to all Levels of Care" for a potential list of policies generally related to the provision of mental health and substance abuse treatment. Hospitals must develop policies to guide the provision of any service in which they engage clients, and to guide their overall administrative function and to meet the approval of their accrediting body.

Features/Hours

The program has the ability to accept admissions at any time and operates 24 hours a day, 7 days per week. Staff must be available to schedule meetings and sessions at a variety of times including weekends and evenings in order to support family involvement for the youth.

Service Expectations

- Before admission to the inpatient psychiatric facility or prior to authorization for payment, the attending physician or staff physician must make a medical evaluation of each youth's and certify in writing (**42 CFR 441.154**) the need for care in the hospital (**42 CFR 456.170**) (**See Definition of Evaluation Below**)
- Before admission or prior to authorization for payment, a multidisciplinary/bio-psychosocial, trauma-informed assessment must be conducted for the youth by licensed professionals as per **42 CFR 441.156** (**See Definition of Evaluation Below**)

- Screening for substance use/abuse conducted as needed. A complete substance abuse evaluation conducted by a Nebraska fully licensed clinician working within their scope of practice if the screening indicates the need.
- Before admission to the inpatient psychiatric facility or prior to authorization for payment, the attending physician or staff physician must establish a written plan of care involving active treatment for the youth (**42 CFR 456.180**) which includes discharge plan components (consider family, community and other supports) (**See Definition of Plan of Care Below**)
- Plan of care reviews under the direction of the physician should be conducted at least daily, or more frequently as medically necessary, by the essential treatment team members, including the physician/APRN, RN, and youth served as appropriate; and complete interdisciplinary team meetings under the direction of the physician during the episode of care and as often as medically necessary, to include the essential treatment team, youth, their family/parent/guardian/future caregiver, and other team members and supports as appropriate. Updates to the written plan of care should be made as often as medically indicated.
- Multimodal treatments available/provided to each youth daily, seven days per week beginning at admission
- Medication management
- Individual, group, and family therapy available and offered as tolerated and/or appropriate
- Face-to-face service with the physician (child psychiatrist preferred), or APRN, 6 of 7 days. Three of the face-to-face visits are required to take place with the physician.
- Psychological services as needed
- Consultation services for general medical, dental, pharmacology, dietary, pastoral, emergency medical, therapeutic activities
- Laboratory and other diagnostic services as needed
- Hospital Social Services to engage in discharge planning and help the youth/parent/family/future caregiver develop community supports and resources and consult with community agencies on behalf of the youth and their family/caretaker.
- A written Utilization Review Plan for medical care evaluation studies as outlined in (**42 CFR 456.142**)

Definitions:

Medical Evaluation

According to **42 CFR 456.160**, (1) A physician must certify for each applicant or recipient that inpatient services in a mental hospital are or were needed. (2) The certification must be made at the time of admission or ... before the Medicaid agency authorizes payment. 42 CFR 456.170 states that:

- “(a) Before admission to a mental hospital or before authorization for payment, the attending physician or staff physician must make a medical evaluation of each applicant’s or recipient’s need for care in the hospital; and appropriate professional personnel must make a psychiatric and social evaluation.

- (b) Each medical evaluation must include -
- (1) Diagnoses;
 - (2) Summary of present medical findings;
 - (3) Medical history;
 - (4) Mental and physical functional capacity;
 - (5) Prognoses; and
 - (6) A recommendation by a physician concerning -
 - (i) Admission to the mental hospital; or
 - (ii) Continued care in the mental hospital for individuals who apply for Medicaid while in the mental hospital.”

Additional Requirement for Patients Under 21 Years of Age (42 CFR 441.156)

- (1) Assess the recipient’s immediate and long-range therapeutic needs, developmental priorities, and personal strengths and liabilities
- (2) Assess the potential resources of the recipient’s family
- (3) Setting treatment objectives; and
- (4) Prescribing therapeutic modalities to achieve the plan’s objectives

Plan of Care

“(a) Before admission to a mental hospital or before authorization for payment, the attending physician or staff physician must establish a written plan of care for each applicant or recipient.

- (b) The plan of care must include -
- (1) Diagnosis, symptoms, complaints, and complications indicating the need for admission;
 - (2) A description of the functional level of the individual;
 - (3) Objectives;
 - (4) Any orders for -
 - (i) Medications;
 - (ii) Treatments;
 - (iii) Restorative and rehabilitative services;
 - (iv) Activities;
 - (v) Therapies;
 - (vi) Social services;
 - (vii) Diet; and
 - (viii) Special procedures recommended for the health and safety of the patient;
 - (5) Plans for continuing care, including review and modification to the plan of care; and
 - (6) Plans for discharge.
- (c) The attending or staff physician and other personnel involved in the recipient’s care must review each plan of care at least every 90 days”.

Additional Requirement for Patients Under 21 Years of Age (42 CFR 441.155) See CFR Guidelines for Full Description

- The Plan of Care must be based on an appropriate evaluation by a team of professionals as specified in **42 CFR 441.156**
- Be developed by the evaluating team of professionals
- State treatment objectives

- Prescribe an integrated program of therapies, activities, and experiences designed to meet the treatment objectives
- Include and post-discharge plan designed to ensure continuity of care with the youth's family, school, and community upon discharge

Social Worker:

Social work services in the Acute Inpatient program are carried out under the direction of a Social Work Services Director preferably possessing a MSW degree from an accredited school of social work, licensed in the State of Nebraska, and working within his/her scope of practice. The Social Worker(s) fulfills responsibilities relating to the specific needs of the individual patient and their families in regard to discharge planning, community resources, consulting with other staff and community agencies as needed. This position may also assist in obtaining psychosocial information for use in planning by the treatment team.

Technicians:

Technicians, HS with JCAHO approved training and competency evaluation. (2 years experience in mental health service preferred)

Staffing Ratio (42 CFR 482.62)

- Availability of medical personnel must be sufficient to meet psychiatrically/medically necessary treatment needs for individuals served.
- RN availability must be assured 24 hours each day.
- The number of qualified therapists, support personnel, and consultants must be adequate to provide comprehensive therapeutic activities consistent with each patient's active treatment program.

Training

Refer to "Standards Common to all Treatment Services" for a list of potential training topics related to the provision of mental health and substance abuse treatment. Agencies should provide adequate pre-service and ongoing training to enhance the capability of all staff to treat the individuals they serve and provide the maximum levels of safety for themselves and others. All staff must be educated and trained in rehabilitation and recovery principles.

Clinical Documentation

The program shall follow the agency's written policy and procedures regarding clinical records. The agency's policies must include specifics about timely record entry by all professionals and paraprofessionals providing services in the program.

The clinical record must provide information that fully discloses the extent and outcome of treatment services provided to the client. The clinical record must contain sufficient documentation to justify Medicaid Managed Care participation.

The record must be organized with complete legible documents. When reviewing a clinical record, a clinician not familiar with the client or the program must be able to review, understand and evaluate the mental health and substance abuse treatment for the client. The clinical record must record the date, time, and complete name and title of the facilitator of any treatment service provided to the client. All progress notes should contain the name and title of the author of the note.

In order to maintain one complete, organized clinical record for each client served, the agency must have continuous oversight of the condition of the clinical record. The provider shall make the clinical record available upon Medicaid and/or the managed care entity's request to review or receive a copy of the complete record. All clinical records must be maintained for seven years following the provision of services.

Length of Stay: A number of days driven by the medical necessity for a patient to remain at this level of care.

Special Procedures

The Acute Inpatient treatment program is responsible to follow all Federal, State, and accrediting body guidelines in the use of restraint and seclusion.

Clinical Guidelines: Acute Inpatient Child and Adolescent – MH

Admission Guidelines

The following guideline is necessary for admission:

1. The child/adolescent has been evaluated by a licensed clinician and demonstrates symptomatology consistent with a DSM (current edition) diagnosis which requires and can reasonably be expected to respond to therapeutic intervention.
2. There is evidence of actual or potential danger to self or others or severe psychosocial dysfunction as evidenced by at least one of the following:
 - A suicide attempt which is serious by degree of lethality and intentionality or suicidal ideation with a plan and means. Impulsive behavior and/or concurrent intoxication increase the need for consideration of this level of care. Assessment should include an evaluation of:
 - the circumstances of the suicide attempt or ideation;
 - the method used or contemplated;
 - statements made by the individual; and
 - the presence of continued feelings of helplessness and/or hopelessness, severely depressed mood, and/or recent significant losses.
 - Current assaultive threats or behavior, resulting from an Axis I disorder, with a clear risk of escalation or future repetition (i.e., has a plan and means).
 - Recent history of significant self-mutilation (non-chronic), significant risk-taking, or loss of impulse control resulting in danger to self or others.
 - Recent history of violence, resulting from an Axis I disorder.
 - Command hallucinations directing harm to self or others.
 - Disordered/bizarre behavior or psychomotor agitation or retardation that interferes with the activities of daily living to such a degree that the child/adolescent cannot function at a less intensive level of care.
 - Disorientation or memory impairment which is due to an Axis I disorder and endangers the welfare of the child/adolescent or others.
 - The child/adolescent manifests severe, sustained, and pervasive inability to attend to age-appropriate responsibilities and/or severe deterioration of family and work/school functioning and no other level of care would be intensive enough to evaluate and treat the disorder. (Note: This does not imply that most evaluations require inpatient admission or that a hospital is the appropriate setting for ongoing

treatment. Admissions under this guideline are primarily for the purpose of containing, evaluating, and engaging the individual receiving services, (e.g., a child/adolescent who is a chronic runaway, has multiple diagnoses, and family stressors.)

- Inability to maintain adequate nutrition or self-care due to a psychiatric disorder and family/community support cannot be relied upon to provide essential care.
- The child/adolescent has experienced severe or life-threatening side effects of atypical complexity from using therapeutic psychotropic drugs.

Exclusion Guidelines

Any of the following Guidelines is sufficient for exclusion from this level of care:

1. The child/adolescent can be safely maintained and effectively treated at a less intensive level of care.
2. Symptoms result from a medical condition that warrants a medical/surgical setting for treatment.
3. The child/adolescent exhibits serious and persistent mental illness consistent through time and is not in an acute exacerbation of the illness.
4. The primary problem is social, economic (e.g., housing, family conflict etc.), one of physical health without a concurrent major psychiatric episode meeting Guidelines for this level of care, or admission is being used as an alternative to incarceration.
5. Treatment for Pervasive Developmental Disorders and/or adaptive limitations from Pervasive Development Disorders is ineligible for Medicaid reimbursement.

Continued Stay Guidelines

All of the following Guidelines are necessary for continuing treatment at this level of care:

1. The child/adolescent's condition continues to meet admission Guidelines for inpatient care, acute treatment interventions (including psychopharmacological) have not been exhausted, and no other less intensive level of care would be adequate.
2. Treatment planning is individualized and appropriate to the child/adolescent's changing condition with realistic and specific goals and objectives stated, and include active family and/or agency involvement.
3. All services and treatment are carefully structured to achieve optimum results in the most time-efficient manner possible consistent with sound clinical practice.
4. Progress in relation to specific symptoms or impairments is clearly evident and can be described in objective terms but goals of treatment have not yet been achieved, or adjustments in the treatment plan to address lack of progress and/or psychiatric/medical complications are evident.
5. Care is rendered in a clinically appropriate manner and focused on the child/adolescent's behavioral and functional outcomes as described in the discharge plan.
6. When medically necessary, appropriate psychopharmacological intervention has been prescribed and/or evaluated.
7. There is documented active discharge planning,

Discharge Guidelines

Any one of the following Guidelines is sufficient for discharge from this level of care:

1. Treatment plan goals and objectives have been substantially met.
2. The child/adolescent no longer meets Continued Stay Guidelines or meets Guidelines for a less intensive level of care.
3. The child/adolescents physical condition necessitates transfer to a medical facility.

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