### Child and Adolescent Inpatient Performance Standards

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Child and Adolescent Inpatient Performance Standards

I. PURPOSE

The Child and Adolescent Inpatient (CAIP) Services Performance Standards describe expectations for quality in service delivery. They are intended to be used by providers to design and assess their inpatient programs and for Community Behavioral Health (CBH) to evaluate services. The Standards aim to support resilience through assessment, individualized treatment planning, mobilization of supports, and comprehensive discharge planning.

The CAIP Performance Standards provide a “blueprint” for the delivery of inpatient hospitalization for children and adolescents who are residents of Philadelphia County. They reflect the core values and principles of the City of Philadelphia Department of Behavioral Health and Intellectual disAbility Services (DBHIDS) Practice Guidelines, the Mayor’s Blue Ribbon Commission on Children’s Behavioral Health¹, and the Commonwealth of Pennsylvania Code Title 55 Chapter 1151 Inpatient Psychiatric Services. Performance Standards are intended to serve as a tool to promote continuous quality improvement and best practices, increase the consistency in service delivery, and improve outcomes for children and their families.

Community Behavioral Health (CBH) developed these Standards in collaboration with CAIP providers through a process guided by state regulations, best practice research, and consensus decision. At times, the CBH Standards exceed the minimum standards set by state regulations.

II. SCOPE OF SERVICES

Inpatient hospitalization provides intensive, short-term, resolution-focused treatment, including psychotherapeutic and psychotropic medication interventions, for children and adolescents in a secure/locked facility. Inpatient hospitalization is intended for children and adolescents exhibiting the sudden onset of acute symptoms that cannot be managed outside of a 24-hour secure setting. Such symptoms require coordinated, intensive, and comprehensive treatment, aimed at psychiatric stability so that the child/adolescent can achieve success in the home, school, and community. Close partnership with families and caregivers, educational providers, and other treatment and community-based providers is essential to achieving successful outcomes for children and adolescents who receive these services.

III. ADMISSION

DBHIDS Practice Guidelines describe the admission process as the earliest opportunity to begin identifying and emphasizing resilience capital embedded in individual, family, and community strengths. Intentional engagement practices should be applied to maximize the involvement of family members and other supports in the child’s treatment, thereby increasing capacity for successful return to home, school, and community settings.

A. Consents
Psychoeducation and informed consent are critical components of inpatient hospital services. The consent process should be viewed as an opportunity to engage family members and provide education about the goals of inpatient treatment and the importance of family involvement as a predictor of the child’s success in treatment. Inpatient providers should utilize partnerships with outside agencies, including the Crisis Response Center (CRC) and CBH, to keep guardians connected to the admission process. A staff member who is knowledgeable about the consent forms and processes should assist guardians with review and signing of consents. Efforts to obtain signatures on consents for treatment and releases of information should begin during the admission process and be completed no later than 48 hours following authorization for inpatient treatment. Additionally, once medication is recommended, medication consent should be pursued daily to ensure the child begins receiving necessary treatment as soon as possible.

Consent should be obtained in accordance with state policy for age and guardian consent. Verification of legal guardianship (e.g., court order) should be obtained, particularly for children residing in out-of-home placements, i.e. through Department of Human Services/Community Umbrella Agencies (DHS/CUA).

B. Assessment
Assessment should be holistic, shifting focus from symptom reduction to promoting wellness. A holistic assessment will integrate mental health, primary care, substance use, educational, family dynamic and trauma-related needs, as well as the mobilization of community-based supports. Discharge planning should begin during admission stages; inpatient staff should identify and begin to address any barriers to the child/adolescent returning home.

An essential part of the CAIP assessment process is the Risk Assessment. A risk assessment should be completed as early in the admission process as possible, and should address aggression/destruction of property, self-injurious behavior, suicidality, homicidality, elopement risk, and sexual acting out. A risk assessment can be completed by any combination of nurse, social worker, and/or psychiatrist.

Another critical component of the assessment is The Certificate of Need. PA regulations relating to Certification of Need for admission state that, “an independent team shall certify at the time of admission the need for inpatient psychiatric treatment and document this in the medical record. The team shall (1) include a physician (2) have competence in diagnosis and treatment of mental illness, preferably in child psychiatry and (3) have
knowledge of an individual’s situation” (55 PA Code § 1151.62(b) relating to Certification of Need for Admission). This form provides an opportunity for providers to ensure that, in addition to the CRC’s determination, the child meets inpatient criteria.

1. **Nursing**
The nursing assessment is completed within the first 12 hours of admission and is a face-to-face assessment by a Licensed Practical Nurse (LPN) or a Registered Nurse (RN), either of whom must have specialized training or one year of experience in psychiatric care (55 PA Code § 1151.66(c2) relating to Team developing plan of care). An RN must co-sign an assessment completed by a LPN. The nursing assessment may include greeting the child at admission, a body scan and documentation of injuries or bruising sustained during crisis, education / handouts about pertinent mental health topics and hospital protocol, vitals, health history, identification of complex medical needs, confirmation of medical needs as within threshold of hospital criteria, risk assessment, structured tools, substance use screening, nutrition screening, discharge planning, and a warm handoff to psychiatrist.

2. **Psychiatric**
The psychiatric admission evaluation is completed within the first 24 hours of admission and includes a face-to-face evaluation with a psychiatrist and results in DSM diagnosis and prescription of inpatient treatment as the most appropriate, least restrictive service to meet the mental health needs of the child. Consideration of need for or potential benefit of psychotropic medication interventions should be included.

3. **History and Physical (H&P)**
The H&P examination is completed by a physician within the first 24 hours of admission and should include collaboration with the primary care physician, with outreach attempts documented. This is particularly important for medically complex children and children with autism spectrum disorders who have high comorbid rates of medical and oral health concerns. The H&P is also an opportunity to order specific consults and tests. Providers are encouraged to maintain contacts and/ or ongoing relationships with local pediatricians to ensure daily access to physicians and to maintain the 24-hour standard.

4. **Allied Health**
The Allied Health Assessment is completed by a Master’s level clinician. This assessment addresses a child’s interests to determine activities to add to course of treatment, including but not limited to: art, dance movement, athletics, pet therapy, music, relaxation, horticulture, or occupational therapy. The Allied Health assessment is an opportunity to conceptualize a case, tailor a treatment plan to the unique needs and strengths of each child, and to reinforce patterns of healthy play in preparation for returning home.

5. **Psychosocial**
The psychosocial assessment should begin upon authorization and be completed within 48 hours via collateral contacts and a face-to-face interview by a Master’s level
clinician. Outreach to guardians, if not present at admission, should begin immediately, with 24-hour follow-up for unreturned calls. Outreach to other involved parties should also begin at admission, with attempts documented and letters filed (see collateral contacts). The psychosocial assessment should include all relevant input to ensure comprehensive clinical formulation, with understanding of functioning across domains. Efficient staffing strategies are needed, particularly regarding weekend social work, to ensure the psychosocial process can begin as soon as possible, including for children admitted on weekends and evenings.

The psychosocial assessor should obtain information about the viability a child’s return to previous placement and should begin to explore other placement options if needed. Providers should make every attempt to prevent late notice of a change in agency or caregiver status (e.g., in cases of caregiver submission of 30-day notice for removing a child or CHS/CUA agencies closing a child’s case due to extended stay).

6. Structured Tools
CBH requires the administering of two structured tools, one trauma screening/assessment tool and one diagnostic tool selected by the provider. Tools should be developmentally appropriate and relevant to the child’s symptoms. Structured tools will assist in accurate diagnosing, thus reducing the incidence of the child being discharged without confirmed, specific diagnoses (i.e. to reduce “rule-outs” and “not otherwise specified”). Structured tools can also promote individualized and trauma-informed assessment, preventing misdiagnosis and inappropriate interventions. Structured tools must be completed, scored, and incorporated into treatment/ shared with team within one week of admission.

The tools used should be selected by the provider. Suggested tools for trauma are:

**Trauma Screening**  
Yale Childhood Violent Trauma Center, 2013. *Trauma History Questionnaire (child and caregiver versions).* Retrieved from [http://medicine.yale.edu/childstudycenter/cvtc/redcap/THQ_Child%20revised_5-29-14_225300_22527.pdf](http://medicine.yale.edu/childstudycenter/cvtc/redcap/THQ_Child%20revised_5-29-14_225300_22527.pdf)

**PTSD and other trauma related symptomatology**  
(in the public domain for use as it is being validated by Foa’s team)

IV. COURSE OF TREATMENT
Inpatient treatment should be holistic, trauma-informed, person/family-driven, and tailored to individual needs and preferences. Wellness should be emphasized over symptom reduction, with an aim for timely discharge to the most appropriate, least restrictive setting. Evidence-informed practices should be utilized across treatment modalities.
A. Treatment Modalities

1. Psychiatric Treatment

a) Medication Management
Psychiatrists should begin to assess a child’s medication needs during the first contact to ensure necessary treatment begins as soon as possible. If a child was receiving medication management by an outside psychiatrist at the time of admission, the inpatient psychiatrist must make outreach to the outside physician. PCPs should be consulted for medically complex children and/or when medical input is required to make an appropriate and safe medication recommendation. Caregivers/legal guardians should receive education regarding the intended impact and potential side effects of the medication. Family member participation in medication appointments helps to ensure that they understand the risks/benefits of medication options and follow through on the medication plan after hospitalization. As such, psychiatrists must make outreach to family members either by meeting with them directly (preferable) or by phone when face-to-face meetings are not possible. Efforts should be documented, and CBH support sought in partnering with family members. The time between admission and the start of a medication plan will vary according to several factors, including consents and labs. Medication should generally begin within three to five days of admission. In extenuating circumstances when this is not possible, providers should contact CBH to discuss barriers.

b) Daily Mental Status Exam (MSE) and Psychiatric Notes
The hospital psychiatrist should complete daily assessments for every child/adolescent and document these in a complete MSE in the daily psychiatric progress note. The MSE should clearly describe the clinical presentation of the child. MSEs should reflect specificity for each child/adolescent through elaboration of endorsed symptoms from an exhaustive list. A detailed MSE eases the approval process when CBH reviews level of care recommendations.

The attending physician must complete the daily assessment and progress note or co-sign when residents complete. In addition to the MSE, notes should address treatment planning, progress, medication, and any changes in medication.

c) Evaluations
A psychiatric evaluation must be completed for every child or adolescent who requires a pre-approved next level of care or a child welfare placement. The written evaluation with next level of care recommendations must be submitted to CBH no more than five days after the recommendations are made. An essential aspect of discharge planning, the evaluation should be thorough, comprehensive, and strengths-based, providing reasons for hospitalization, a summary of the hospitalization/hospital course and rationale for recommendations. A narrative that encompasses and expands on predisposing, precipitating, perpetuating, and protective factors should be included, as well as DSM-5 diagnoses and recommendations. A description of the treatment history,
including past and current services and medication trials and response should be included. For recommendations to intensive levels of care, such as residential treatment facility (RTF), the evaluation should depict previous interventions and their impact and the anticipated goals of residential treatment in order to substantiate the recommendation.

2. Family Therapy
Family treatment is a critical component of inpatient treatment. By partnering with family members during treatment sessions, providers are able to incorporate individual needs, preferences, and culture in shaping treatment. Family sessions allow for skill practice and acquisition through real-life enactments, increasing the likelihood of a positive and sustained discharge. In addition, family sessions provide opportunities for family members to voice their desire for next level of care/service, and for providers and families to consider and tackle any anticipated barriers to a successful return home.

Family sessions must be prioritized in treatment planning and delivery, with any barriers to consistent meetings addressed. Providers are encouraged to accommodate the schedules of family members, including maintain weekend and evening slots, provide supportive and consistent outreach via phone calls/letters as needed, and offer transportation assistance. While face-to-face sessions are preferred, telephonic or video sessions should be offered when needed. Family sessions are conducted by social workers. Psychiatrists should join family sessions when clinically appropriate or when families request psychiatrist participation.

The frequency of family sessions should be determined based on the individual needs of each child. Some cases will benefit from several family sessions per week to expedite a return home, particularly for those children who present with less acuity and may only require a short stay. Family sessions must occur at a minimum of once per week, and all outreach efforts and missed appointments must be documented.

3. Individual Therapy
Children and adolescents will receive individual support from the inpatient team throughout their hospitalization. It is expected that providers also maintain capacity to provide specialized individual therapy (to address trauma or other challenges that surpass what can be addressed by the traditional inpatient curriculum) as clinically indicated.

4. Milieu Management
Milieu management comprises many of the activities that provide structure and an opportunity for stability during inpatient stays, including but not limited to the management and layout of the inpatient environment, efforts to maintain safety and security, and the daily schedule.

5. Group/ Allied Therapy
Allied/group therapy includes activities tailored to a child’s interests and strengths, including but not limited to art, dance movement, athletics, pet therapy, music,
relaxation, horticulture, or occupational therapy. Providers should continue to enhance programming and staff to provide children with a variety of outlets for play and healing.

B. Collateral Contacts
Collaboration with collateral contacts is essential in planning individual and tailored inpatient treatment, and in ensuring discharge recommendations are implemented. All outreach to collateral contacts should be documented, and CBH Member Services, Provider Relations, and/ or Clinical Care Management should be consulted when contacts do not respond to outreach.

1. Current and Past Treatment Providers
Contact with other treatment providers is critical to providing effective treatment. Providers should consult current and past providers to determine previous interventions and their impact. Collaboration among providers helps the inpatient team to continue effective interventions or introduce new ones when needed, thus increasing the likelihood of genuine engagement from a child/ family who may otherwise be experiencing “treatment fatigue” or discouragement. Partnering with a provider who will resume treatment following discharge helps to ensure consistency in treatment approach.

2. School
As a majority of inpatient hospitalizations are with school-aged children and many are prompted by school referrals, CBH expects that collaboration with schools will be a significant part of treatment and discharge planning. Providers are encouraged to begin outreach to schools within 24 hours of admission. School staff can provide perspective on a child’s needs and behaviors, thus facilitating more targeted treatment and discharge planning (see Plan to Transition to School). Additionally, schools must be consulted when planning academic portions of milieu care.

3. Other Involved Systems (Child Welfare, for eg.)
CBH expects providers to identify any other significant collaborators in a child’s life. For many children, this will include DHS/ CUA case managers. Inpatient providers should maintain communication with DHS/ CUA beyond the initial consent process. DHS/ CUA should be consulted for perspectives on the child and family and to obtain information regarding placement histories and settings where the child has experienced the most success. DHS/ CUA collaboration is particularly critical if any changes in setting will occur as part of the discharge process (group home, new foster home, etc.).

C. Interagency Service Planning Team (ISPT)
The ISPT is a requisite step in the inpatient course of treatment. The Guidelines for Best Practices for Children’s Mental Health² should be referenced to plan and facilitate effective ISPT meetings. In cases when BHRS or RTF is recommended, the ISPT

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signature sheet will be submitted as part of the packet to authorize those services. The ISPT is a mechanism for child-driven, family-focused treatment and an opportunity to engage community-based treatment providers and CBH care managers in treatment planning. Providers should orient families to the purpose of ISPT meetings and encourage them to invite stakeholders and natural supports to participate. The purpose of ISPT meetings is to discuss presenting issues, current needs of child and family, service recommendations, and review continuum of care available, treatment interventions, child’s functioning in all domains, areas of need, and barriers to success. The outcomes of structured tools should be discussed as a means of educating attendees about the child/adolescent’s diagnoses and related needs. The following participants should be involved in ISPT meetings:

- Inpatient clinician
- Inpatient psychiatrist
- Child*
- Legal guardian
- Caregiver
- Family members
- School team
- Provider(s)
- Clinical care manager (CBH)
- Other (i.e. DHS, CUA)

*The child’s age and developmental capabilities should be considered in the decision to include the child in the ISPT meeting.

D. Treatment Planning

PA state regulations indicate that treatment plans should be based on the diagnostic evaluation of the child/adolescent that includes the medical, psychological, social, behavioral and developmental aspects of the presenting condition and medical need for inpatient psychiatric care. The plan should be developed by an interdisciplinary team of professionals, and the child and family members must drive the treatment plan and clearly understand the goals as they are documented.

Goals should be measurable, achievable, developmentally appropriate, and related to all areas of the child’s life. Goals should include objectives and an integrated program of therapies, activities, and experiences designed to meet objectives. The treatment plan should demonstrate focus on tracking progress rather than marking time intervals. The initial treatment plan must be completed within 72 hours and updated every seven days. Goals should be modified for attainability if not met after 30 days.

The plan should be designed to achieve discharge from inpatient status at the earliest possible time. The discharge plan should be included, comprising coordination of inpatient services with partial discharge plans and/or related community services to ensure continuity of care with the child/adolescent, family, school, and community upon discharge.
CBH requires that the treatment plan is signed by the psychiatrist, one additional member of the treatment team, and the guardian or child if age 14 or over, at a minimum.

**E. Psychological Testing**

Providers should ensure access to psychological testing for children who demonstrate such a need. Testing should be used to address cognitive functioning and to rule out certain disorders, including autism spectrum disorder, psychosis, and attention deficit hyperactivity disorder. All efforts in program planning and staffing should be geared toward timely return of test results to allow for appropriate treatment.

**V. DISCHARGE/ AFTERCARE**

**A. Disposition**

As noted in the Psychosocial Assessment section, providers should begin to investigate return home options at admission. Providers should engage family members, DHS/ CUA, other treatment providers, and CBH to facilitate an appropriate disposition plan. If barriers are encountered, providers should request assistance from CBH and/or schedule an inter-agency meeting.

Safety planning to address any risk for re-traumatization should be included in the disposition plan, particularly for children who have experienced trauma in the setting where they are returning. Safety planning should also anticipate triggers for harm of self and others that may arise following discharge, with a clear support plan for managing these triggers. Since the risk for re-hospitalization is highest during the two weeks following discharge, providers should educate families about this risk and guide them in identifying supports to prevent the need for returning to the CRC. Providers should also guide families in considering scenarios that will require a CRC visit versus scenarios in which other supports may be successful.

**B. Services**

The full continuum of services, including evidence-based practices, should be considered when planning next services. Partial hospitalization should be utilized when a child needs continued intensive care. Outpatient therapy should be considered in less intense cases. Inter-agency meetings are used to facilitate consensus about recommendations. Providers must engage family members to include their voice in recommendations and to ensure they understand the rationale for services. Data indicates that two weeks following discharge is a critical risk period for recidivism, thus the first appointment with the next provider must be scheduled for a date no more than seven days after discharge. Discharge plans should be given to family members and all other relevant parties, including PCP, DHS/ CUA, and next treatment provider.

**C. Prescriptions/ Prior Authorizations**

Providers should have working knowledge of each insurer’s policies and procedures regarding prior authorizations. It is expected that providers’ internal policies and resources address external authorization challenges to prevent access issues following discharge. Efforts to obtain prior authorization should begin at a minimum of three
days prior to planned discharge, and families and/or next providers should be given labs to facilitate authorizations as needed. Children/adolescents are expected to be discharged with a prescription to cover them until their next medication appointment, which should be scheduled for a date no more than 30 days following discharge.

D. Plan to Transition to School
Coordination with schools is an essential component of discharge planning. Providers must relay discharge recommendations to school counselors, particularly sharing interventions that should be used in the school setting to keep the child/adolescent stable and to prevent re-hospitalization. Providers should make every effort to include schools in discharge planning meetings, documenting outreach efforts and contacting CBH regarding barriers to communication. Providers should be aware that schools cannot refuse a child’s readmission, and CBH and other liaisons should be contacted in these cases.

E. Discharge Plan
The discharge plan should be individualized and strengths-based, building on supports and capacity for resilience. The plan will include medication, diagnoses, outcomes of structured tools, and recommendations as previously noted. The plan should be reviewed with the individual at the time of discharge, along with family members, treatment providers, and other key people as identified by the individual. The discharge plan should be sent to the next treatment provider and any other relevant parties as determined with the individual. Recipients of the discharge plan should be documented.

IV. FOLLOW-UP/OUTCOME
The 30-day period following inpatient discharge is a critical time for successful acclimation or re-acclimation to placement and next level of care. The inpatient provider must maintain an active role in preventing re-admission. This can be accomplished through phone calls to assess the child’s adjustment and remind of initial appointments. CBH will facilitate readmission interviews.