CHILD Acute Psychiatric Inpatient Hospitalization

PROGRAM DESCRIPTION

Acute psychiatric inpatient hospitalization is a highly structured level of care designed to meet the needs of children and adolescents who have emotional and behavioral manifestations that put them at risk of harm to self or others, or otherwise render them unable to care for themselves. Children and adolescents in an acute setting may lack adequate impulse control and the ability to accomplish activities of daily living without significant support; needs requiring inpatient treatment should be considered in a developmental context to determine level of age-appropriateness and degree of risk of particular behaviors. Youth receiving inpatient treatment may have co-occurring substance use, medical conditions, and/or intellectual disabilities. Acute inpatient psychiatric treatment is provided in a locked, secure facility 24/7 per week by a multidisciplinary team of behavioral health professionals including psychiatrists, psychiatric nurses, and mental health technicians. The goals of psychiatric hospitalization include symptom relief and coordination of care to promote resolution of crisis and resilience. With daily assessment of risk and ongoing contact with family and relevant professionals, continuing support plans are developed in preparation for discharge.

Services include:

- Prevention of harm/ destruction of self, others, and/ or property
- Prevention of exacerbation of psychiatric symptoms
- Coaching of caregivers and other professionals to ensure appropriate supervision and support to manage risk and prevent future hospitalizations
- Management of medication with close monitoring and control of side effects
- Clinical interventions to address lack of impulse control, suicidal or homicidal ideation, psychotic state, decrease in functioning, failure to take medication resulting in symptom increase

MEDICAL NECESSITY CRITERIA (Appendix T)

Admission Criteria (must meet criteria I and II)

I. DIAGNOSTIC EVALUATION AND DOCUMENTATION

A. Presenting illness is diagnosed on DSM IV Axis I or Axis II, as part of a complete multiaxial, face-to-face diagnostic examination (MR or D&A cannot stand alone) and in accordance to ICD-9 codes, by a licensed physician contingent on confirmation by a child and adolescent psychiatrist or Board Certified psychiatrist within forty-eight (48) hours of admission.

AND

B. Psychiatric Inpatient Treatment is prescribed by the diagnosing psychiatrist, and/or as required by Pennsylvania regulation, indicating that this is the most appropriate, and least restrictive service to meet the mental health needs of the child;

AND

C. Documentation in the current psychiatric evaluation that the treatment, 24-hour supervision, and observation, provided in the Psychiatric Inpatient setting, are necessary as a result of:

- severe mental illness or emotional disorder, *and/or*
- behavioral disorder indicating a risk for safety to self/others;

AND

D. Based on the patient's current condition and current history, reasonable, documented treatment within a less restrictive setting has been provided by a mental health professional, *and/or* careful consideration of treatment within an environment less restrictive than that of a Psychiatric Inpatient Hospitalization, *and* the direct reasons for its rejection, have been documented;

AND

E. A complete strengths-based evaluation, including identifying the strengths of child's family, community, and cultural resources, must be completed prior to admission, or within 120 hours in the event of an emergency admissions.

II. SEVERITY OF SYMPTOMS

A. Significant risk of danger is assessed for any of the following

- child HARMING HIM/HERSELF
- child HARMING OTHERS
- DESTRUCTION TO PROPERTY which is:
  - life-threatening, *OR*
  - in combination with "B", "C", or "D" below;

OR

B. There is an acute occurrence or exacerbation of impaired judgement or functional capacity and capability, for the child's developmental level, that interpersonal skills, and/or self-maintenance in home/school/community is/are severely compromised;

OR

C. There are endangering complications in *either* of the following:

- complications of the child's psychiatric illness or treatment would seriously threaten the child's health safety due to a lack of capacity for self-care; OR
- due to a coexisting medical condition where the child has a medical condition or illness which, as a result of a psychiatric condition, cannot be managed in a less intensive level of care without significant risk of medical crisis or instability;

OR

D. The severity of the child's symptoms are such that continuation in a less intense level of care cannot offer either an expectation of improvement, or prevention of deterioration, as identified in the above three categories of "II."

Continued Stay Criteria (must meet criteria I and II. Complete documentation for each is required, and additional documentation as indicated in Appendix B.)

I. DIAGNOSTIC EVALUATION AND DOCUMENTATION

A. The initial evaluation and diagnosis is updated and revised as a result of a face-to diagnostic examination by the treating psychiatrist;

B. Continued Psychiatric Inpatient Treatment is prescribed by the diagnosing psychiatrist, and/or as required by Pennsylvania regulation, indicating and documenting that this is the least restrictive, appropriate service to meet the mental health needs of the child, and the discharge implementation plan;

II. SEVERITY OF SYMPTOMS

A. Severity of illness indicators and updated treatment plan support the likelihood that: *substantial benefit* is expected as a result of continued active intervention in a psychiatric inpatient setting, without which there is *great risk of a recurrence of symptoms*; *OR severity is such that treatment cannot be safely delivered at a lesser level of care, necessitating hospitalization;*

AND

B. Although child is making progress toward goals in the expected treatment process, further progress must occur before transition to a lesser level of care is advisable. The necessary changes must be identified in an updated treatment plan, and the treatment team review must recommend continued stay;

OR

C. The symptoms or behaviors that required admission, continue with sufficient acuity that a less intensive level of care would be insufficient to stabilize the child's condition;

OR

D. Appearance of new symptoms meeting admission criteria.

DISCHARGE CRITERIA (A child not meeting criteria as established in Section II, SEVERITY OF SYMPTOMS, of the CONTINUED STAY CRITERIA, must be discharged)

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 discharge from the acute inpatient setting and, if present, must have diminished to a level that can be safely managed at a less intensive level of care. A thorough documentation of the risk to self or others must be included in the medical record.

Indicators for discharge from acute inpatient care include:

- Improved impulse control
- Lessening and control of any symptom-related dangerous behaviors that posed athreat to the patient's self or others
- Willingness to take medications as prescribed
- Positive response to treatment
- More appropriate social interactions for the patient's developmental level and the ability to manage personal care appropriate to the patient's developmental and adaptive capabilities.

Linkages to the next level of care via a Comprehensive Biopsychosocial or Psychiatric Evaluation, specifically psychiatric management, psychotherapy, treatment programming, and family support must be firmly in place prior to 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. Documentation of discharge and aftercare planning should reflect the active involvement of the family as well as the child or adolescent. The family and child or adolescent agreement or disagreement with the discharge and aftercare plan should also be documented.