Mental Health Inpatient Care Requirements

Inpatient mental health treatment represents the most intensive level of psychiatric care. Multidisciplinary assessments and multimodal interventions are provided in a 24-hour secure and protected, medically staffed and psychiatrically supervised treatment environment. Twenty-four hour skilled psychiatric nursing care, daily medical evaluation and management and a structured treatment milieu are required. Inpatient services settings must provide the following:

Within 24 hours of admission:

- An initial visit with a psychiatrist, or other practitioner with prescriptive authority (e.g., Physician Assistant, Nurse Practitioner, Resident Physician) with psychiatrist consultation, for evaluation and treatment planning.
    - o A comprehensive bio-psychosocial history including at a minimum:
        - History of Presenting Illness
        - Psychiatric History
        - Past and Present use of alcohol and other drugs.
        - Medical History
        - Family History
        - Social History
        - Current Medications
        - Allergies
    - o Comprehensive Review of Systems
    - o Full mental status examination
    - o Initial Psychiatric Assessment/Formulation including current Diagnostic and Statistical Manual based diagnoses.
    - o Risk Assessment
    - o Comprehensive, individualized, treatment plan including psychopharmacologic treatment plan when appropriate
    - o Complete documentation as detailed in Section 19 of this Manual.

- An initial medical assessment
    - o History and Physical Examination with neurological emphasis
    - o Laboratory and other medical testing as appropriate
    - o Urine toxicology screen if not completed at the time of admission

- Communication with the inpatient liaison or other appropriate representative of the member's attributed Community Mental Health Center (CMHC) within 24 hours,

- Exchange of Pertinent History
- Establishing connection
- Discharge planning

- An initial visit with a psychiatrist, or other practitioner with prescriptive authority (e.g., Physician Assistant, Nurse Practitioner, Resident Physician) with psychiatrist consultation, for evaluation and treatment planning.
  - A comprehensive bio-psychosocial history including at a minimum:
    - History of Presenting Illness
    - Psychiatric History
    - Past and Present use of alcohol and other drugs.
    - Medical History
    - Family History
    - Social History
    - Current Medications
    - Allergies
  - Comprehensive Review of Systems
  - Full mental status examination
  - Initial Psychiatric Assessment/Formulation including current Diagnostic and Statistical Manual based diagnoses.
  - Risk Assessment
  - Comprehensive, individualized, treatment plan including psychopharmacologic treatment plan when appropriate
  - Complete documentation as detailed in Section 19 of this Manual.

<u>Within 48 hours of admission:</u>

- A discharge plan involving family/Member input and signed by the family/Member has been included in the patient record within forty eight (48) hours of Member's admission, or after intensive services have begun, or when the Member is clinically able to participate meaningfully in discharge planning.

- In any case where the discharge plan is delayed later than forty eight (48) hours after admission, the patient record shall include documentation of the clinical reason for the delay.

Post-admission Hospital Days

- A documented daily visit with an attending, licensed, prescribing provider.
  - Collection and review of interim history
  - Evaluation and documentation of the member's current mental status
  - Assessment of the member's progress in relation to their presenting problems
  - Justification of continued need for inpatient care
  - Update of the treatment plan, including medication strategy
  - Progress note documentation as required in Section 19 of this Manual

- Other daily interventions.
  - Individual psychotherapeutic intervention focused on presenting problems (may be part of the prescriber visit)
  - Group/milieu activity
  - Safety planning as indicated
  - Discharge planning

- Frequent coordination of care and unrestricted communication with the CMHC inpatient liaison or other appropriate representation of the CMHC, including:
  - Contact with the inpatient liaison/CMHC representative at least 3 days per week
  - Face to face meetings when requested by the liaison or other CHMC representative
  - Calls/emails from the liaison/CMHC representative returned promptly (at a minimum within 24 hours or by the next business day)

Discharge

- Communication by a practitioner involved with the member's care with the inpatient liaison/CMHC representative and/or provider(s) responsible for post discharge care regarding all pending discharges. Ideally to be completed 24 hours prior to discharge.
- Documentation of the discharge plan including follow-up appointments per Manual guidelines, discharge medications, and emergency contacts delivered to the patient in writing with a face to face review.
- Provision of a 30 day prescription for discharge medications with confirmation the member has the resources to obtain medications or documentation that a new prescription is not required.

* A dictated discharge summary faxed to the outpatient provider within 72 hours.