

**REFERRAL, ADMISSION, AND  
DISCHARGE PROCEDURES FOR  
INPATIENT PSYCHIATRIC SERVICES**

Effective December 1, 1998

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## I. INTRODUCTION

### A. PURPOSE

This policy provides DHR staff with procedures to follow when assessing a child's need for inpatient psychiatric services (diagnosis, evaluation, and treatment), and when appropriate, the subsequent admission to and discharge from the hospital setting. The individualized service planning (ISP) process shall be utilized in conjunction with these procedures when assessing need and planning the delivery of services to children for whom the Department has custody or planning responsibility.

**NOTE:** Diagnostic and evaluative services provided at Bryce Hospital require the concurrence of, and commitment to, the State Department of Mental Health prior to admission. This policy is not intended to provide guidance in these situations even though the assessment process noted in II., A. should be similar. Contact your SDHR consultant for guidance when these services are being considered.

### B. GUIDELINES

This policy has been developed to comply with the following operating principles or standards of the R.C. Consent Decree:

Section VIII. 48(c). The "system of care" shall not initiate or consent to the placement of a class member in an institution or other facility operated by DMH/MR or by DYS unless the placement is the least restrictive, most normalized placement appropriate to the strengths and needs of the class member.

Section VIII. 51(d). The "system of care" shall forbid summary discharges from placements. DHR shall promulgate a policy acceptable to both parties, that describes steps that must be taken prior to a class member's discharge from a placement. The policy may permit in exceptional circumstances the placement of a class member in a temporary, emergency setting without prior notice to DHR.

This policy was also developed to comply with the R.C. Consent Decree Implementation Plan, "System Processes and Services" chapter, page 16, which states ". . . DHR will adopt -- through policy and/or licensure standards -- specific criteria, mutually acceptable to the parties, for referral and admission to, as well as discharge from, foster homes, therapeutic foster homes, group facilities, psychiatric hospitals, and institutions operated by DMH/MR or DYS." All other principles of the R. C. Consent Decree (e.g., least restrictive environment, close proximity, and those related to maintaining contact with family) apply during hospitalization unless otherwise specified in the ISP.

## C. GLOSSARY

**Institution** - (see R.C. Consent Decree, Section V. Definitions, # 21)

A psychiatric hospital, a psychiatric ward of a general hospital, any facility operated by DMH/MR or DYS, or a detention facility. It does not include a child care institution, group home, group foster home, or foster family home (including a therapeutic foster home) or other similar placement.

**Qualified Professional** - (see Provider Manual for Rehabilitative Services)

- a. A physician licensed under Alabama law to practice medicine;
- b. A master's level psychologist or a psychological technician licensed under Alabama law;
- c. A master's level professional counselor licensed under Alabama law;
- d. A master's level social worker (non-DHR employee) licensed under Alabama law who has specialized training in psychiatric care; or
- e. A registered nurse who has completed a master's degree in psychiatric nursing.

## II. REFERRAL AND ADMISSION

The ISP process is utilized to identify strengths and needs of children and their families, identify steps and services to address the needs, and determine the least restrictive environment in which the children's needs can be met. The ISP team shall be fully involved when assessing the need for, and appropriateness of, inpatient services even though the child welfare worker, supervisor, and / or program supervisor have primary responsibility for completing the referral and admission process.

The referral and admission process includes:

- (1) assessing a child's need for inpatient services;
- (2) confirming the need with a qualified professional; and
- (3) obtaining SDHR consultation and approval for service delivery.

### A. ASSESSING THE NEED FOR INPATIENT SERVICES

Inpatient services shall only be considered when a child cannot be safely evaluated and/or treated on an outpatient basis or in a less restrictive setting. There are situations where supportive services will enable a child to be served on an outpatient basis or in a less restrictive setting, and the provision of these services shall always be considered prior to inpatient referral. An example could be authorizing basic living skills for behavioral aides to assist children to manage their behaviors.

ISP team members shall assess information gathered from the following areas when considering the need for inpatient services:

### 1. Behavioral Indicators

A description of the current behaviors exhibited by the child shall be obtained with attention given to the following:

(a) Child is a danger to self or others

Describe any threats, attempts or specific plans the child has made to inflict harm on self or others, and if there are any lethal means at the child's disposal to inflict such harm. Any prior history of harm to self or others needs to be included.

(b) Child displays out of control behavior(s)

List the behavior(s) that cannot be controlled (e.g., fire setting, violent temper tantrums, sexual acting out) and describe them specifically. Include information about the frequency, duration, level of intensity, and possible events precipitating the behavior(s)

(c) Child takes prescription medication to control behavior(s)

List any medication(s) prescribed to control the child's behavior or affect including dosage, how administered, benefits, and any side effects on the child. Determine if there is a responsible parent/caregiver administering the medication, and if there is an indication of any use of non-prescription or illegal drugs. If the child appears to need a medication evaluation, determine if the evaluation can be accessed on an outpatient basis with or without the benefit of supportive services.

(d) Child experiences delusions or hallucinations

If the child describes visual, tactile, or auditory hallucinations or is frightened by fantasies, the situation is considered urgent. An outpatient evaluation by a qualified professional should be arranged immediately since it is sometimes difficult to differentiate between children's fantasies and true hallucinations.

### 2. Prior Services and Treatment Interventions

The following information shall be obtained on prior inpatient **and** outpatient services when assessing the current need for inpatient services:

- (a) hospital, facility, or service provider's name;
- (b) treating physician or service provider's qualification (e.g., psychiatrist, psychologist);
- (c) referral reason;
- (d) service(s) provided including length, frequency, and outcome;
- (e) medication(s) prescribed;

- (f) recommendations upon hospital discharge or termination of service(s); and
- (g) the extent to which the recommendations have been followed, modified, or strengthened to address the child's current needs.

## B. CONFIRMING THE NEED FOR INPATIENT SERVICES

Once the ISP team has determined that the child is unable to be served in a less restrictive setting and that inpatient services appear to be needed, that need must be confirmed by a qualified professional (refer to definition in glossary) **prior to contact** with SDHR for placement approval. The qualified professional shall not be on staff at the hospital setting where inpatient services will be sought.

The qualified professional shall personally assess the child, and as appropriate, the family members and other caregivers. The professional shall provide information regarding:

- specific needs related to exhibited behaviors;
- risk of harm to self or others;
- diagnosis;
- clear evidence that the child's needs can not be met on an outpatient basis or in a less restrictive setting with supportive services being provided; and
- determination that services require an inpatient setting, and the anticipated length of the hospital stay.

Confirmation by the qualified professional may be provided in an ISP meeting, a case staffing with the professional and other appropriate child and family planning team members in attendance, or it may be provided to the child and family planning team in writing. **The child welfare worker is responsible for informing the qualified professional of the available service array and the Department's responsibility to develop needed services. The worker shall also explore with the qualified professional whether a less restrictive environment exists in which the child's needs may be met.** When ISP meetings are held and the qualified professional is unable to attend, the professional's input must be included and may be provided by conference call or through a written report of the findings.

When a child is receiving outpatient services or services in a less restrictive setting, continuity of care is an important factor for achieving desired outcomes. If a service provider recommends inpatient services and the ISP team is not in agreement, a second opinion may be sought. If deemed necessary, the second opinion shall be provided by a qualified professional not on staff at the hospital where services will be sought. The worker is responsible for contacting that professional to obtain confirmation that inpatient services are necessary.

## C. SDHR CONSULTATION AND APPROVAL

Inpatient psychiatric services require SDHR approval prior to the child's admission. The SDHR consultant having responsibility for providing consultation and approval for child welfare services shall be contacted during the assessment process to assist the ISP team in determining both the need for, and appropriateness of, inpatient services, and shall be contacted once the qualified professional has confirmed the need for inpatient services.

The DHR-FSD-1829, Referral and Approval for Inpatient Psychiatric Services, and the following procedure shall be utilized for obtaining approval from the SDHR consultant:

1. Section I of the DHR-FSD-1829 is to be completed by the child's worker and signed by the appropriate supervisor.
2. The supervisor will contact the SDHR consultant to provide notification that inpatient services appear to be needed and that a qualified professional has confirmed that need. Copies of the completed 1829, current ISP and/or social summary, and the qualified professional's assessment findings are then faxed to the consultant for review. The consultant and county staff will discuss the information gathered during the assessment and confirmation phases. Although verbal approval may be granted for a maximum of fourteen (14) days when inpatient services are deemed appropriate, crisis stabilization may occur more quickly (e.g., during a 24 to 48 hour or one (1) week hospital stay), and appropriate discharge planning shall facilitate the child's move to a less restrictive setting upon stabilization.
3. Once placement approval has been received, county staff will locate a hospital where the child can receive and be admitted for the needed inpatient services. Initial efforts must be made with hospitals which accept Medicaid.
4. When a hospital is located and placement arranged, county staff shall notify the SDHR consultant of the hospital name and admission date.
5. The consultant will send the county written confirmation of the approval (see sample letter in forms section).
6. The county supervisor will complete Section II of the 1829, and within three (3) days of the child's admission, mail the second copy to the consultant.

**EXCEPTION:** Children frequently provide verbal and/or non-verbal cues which indicate increased behavioral/emotional needs. When these needs are appropriately addressed on a timely basis, the frequency of situations reaching a crisis level and requiring after hours or weekend hospitalizations can be decreased.

County management staff shall monitor the number of after hours and weekend hospitalizations which occur and shall assess the precipitating factors to determine if children's needs are being appropriately addressed.

When it is necessary to hospitalize a child for inpatient psychiatric services on the weekend or after office hours, the supervisor must notify the SDHR consultant of the child's hospitalization on the next working day. DHR-FSD-1829 will be completed per instructions.

### Extensions:

When inpatient services are needed beyond 14 days, extensions are considered on a case-by-case basis. Information required for extensions includes:

- child's current status;
- a description of the progress made during hospitalization;
- barriers which are impeding progress toward discharge;
- supportive services offered and delivered to address the barriers;
- a description of efforts made to develop supportive services which will facilitate the child's safe placement in a less restrictive setting; and
- documentation supporting the need for an extension (i.e., treating physician or therapist's statement), estimated length of the extension, and if a second (2nd) opinion is considered necessary.

It is the county supervisor's responsibility to telephone the SDHR consultant granting prior approval, provide the necessary information to request an extension, and document the approval in Section III of the 1829.

### **III. DISCHARGE**

Discharge planning shall begin immediately upon a child's admission to the hospital and continue throughout inpatient service delivery. The ISP team shall partner with hospital staff responsible for the planning and delivery of services and make every effort to hold an ISP meeting at the time of the child's admission in order to be involved in the development of the hospital's treatment plan.

The child's family, out-of-home caregiver (if applicable), the child welfare worker, and other appropriate ISP team members shall participate in hospital staffings and partner to:

1. advocate for and monitor service delivery to determine that the child is receiving the needed services;
2. remain aware of the medication(s) prescribed and administered, their benefits, and any side effects upon the child;
3. be involved in planning the child's move to a less restrictive environment as soon as services can be safely provided on an outpatient basis; and
4. secure copies of the medical records and discharge summary to facilitate coordination of aftercare services.

The ISP team must consider the type and extent of services being delivered, the child's progress (or lack thereof), and the qualified professional's recommendations for stepping the child down to



a less restrictive environment where needs can be met. The ISP shall address the inpatient services provided to meet the child's needs, identify the most appropriate and least restrictive placement setting to meet those needs, and the steps to be taken by the ISP team members prior to and at the time of the child's discharge.

Section IV of the DHR-FSD-1829 is completed and submitted with a copy of the discharge summary to the SDHR consultant no later than three (3) working days after a child's discharge from the hospital. If the discharge summary is not available within this time frame, it must be submitted to the consultant upon receipt.

#### IV. FINANCIAL RESPONSIBILITY

Financial resources must be explored to determine the appropriate payment method for inpatient services. Inpatient psychiatric services are costly and the following payment methods shall be considered in the order listed.

##### 1. PRIVATE PAY / INSURANCE

Private payment/insurance is to be considered as **the first method of payment** if the child and/or the child's family have financial resources or private medical insurance to cover the cost of inpatient psychiatric services. The worker shall promptly obtain and provide the necessary information to the hospital for billing and claiming purposes.

##### 2. MEDICAID

**Medicaid eligibility determinations must be made for all children in DHR custody who reside in out-of-home placements.** When a child is Medicaid eligible and the hospital accepts Medicaid, the worker is responsible for providing the child's Medicaid eligibility information (e.g., copy of current Medicaid card) to the hospital's billing department.

**NOTE:** The worker must also make certain the child will be eligible for extended hospital days by having the Medicaid caps lifted. Procedures for lifting caps are found in the MaxPak manual.

##### 3. COUNTY FLEX FUNDS

Flex funds shall be utilized prior to requesting SDHR payment for inpatient services.

##### 4. SDHR PAYMENT

Requests for SDHR payment of hospital bills for inpatient psychiatric services shall only be sought after all other financial resources have been considered and utilized. Refer to Family and Children's Services Manual, Payment of Exceptional Needs or Medical Care, for additional information and procedures.

## **V. CASE RECORD AND FACTS DOCUMENTATION**

All information gathered to support the need for hospitalization must be scanned in the FACTS file cabinet in the Medical folder under the client's name.

The Psychiatric Hospital placements must be documented in FACTS in the placement module on the non-paid placement screen. On the non-paid placement screen select service for Level 1 "Placement/Psychiatric Hospital –CW," select the appropriate Level 2 option.

An accurate control system of all children placed in hospitals for psychiatric services must be maintained locally. This system must include, at a minimum, the child's name, the hospital name, admission date, discharge date, and the placement type into which the child was discharged. A sample psychiatric hospitalization log utilizing an Excel spreadsheet is located in the Forms section of this policy.

## **VI. FORMS**

A sample of all forms and instructions are included in this section.