

Comprehensive Behavioral Health Management/College Health IPA Policy and Procedure Manual	
Policy Name: Clinical Indicators: Inpatient Hospitalization	Utilization Management
Date: 8-93 Reviewed by QI Committee: 12-06, 11-07, 9-08, 9-09, 01-10 Revised by QI Committee: 12-06, 9-08, 01-10	Page: 1 of 3 Policy Number: UM-3.1

Purpose: The purpose of this guideline is to ensure that Comprehensive Behavioral Health Management/College Health IPA (CBHM/CHIPA) manages all cases according to current clinical guidelines. It is important that each patient receive the appropriate level and intensity of care in relation to available resources and the biopsychosocial needs of the patient.

Policy:

1.0 Description

Emphasis of utilization management is on providing the least restrictive level of care along with the most intensive level of services necessary to achieve rapid stabilization and/or restoration of function for the patient. This guideline is used for determining if the clinical needs of the patient require inpatient hospitalization.

2.0 Determine Appropriate Level of Care

The patient is considered appropriate for inpatient admission if one or more of the following conditions exist:

- 2.1 The patient is on a legal hold initiated by an approved mental health provider or a law enforcement officer.
- 2.2 The patient requires suicidal precautions (minimum of every 30 minutes observation) based on one or more of the following:
 - 2.2.1 A suicide attempt has been made which is serious by degree of lethal intent, hopelessness, impulsivity, or concurrent intoxication.
 - 2.2.2 The patient expresses current suicidal ideation and is assumed to be in “real and present danger” (e.g. has a plan, means for suicide)
 - 2.2.3 There is a recent history of self-mutilation, significant risk-taking, or other self-endangering behavior.
 - 2.2.4 The patient has a recent of history of drug ingestion with a strong suspicion of intentional overdose. Such a patient would not require intensive medical monitoring but could require treatment of psychiatric and/or substance abuse disorder.
- 2.3 The patient requires homicidal/danger to other precautions (minimum of every 30 minutes observation) when assaultive threats or behavior have occurred and there is a clear risk of escalation or repetition of this behavior in the near future.
- 2.4 The patient has a chronic and/or serious mental illness, which is currently presenting with disordered/bizarre behavior or psychomotor agitation or retardation, which interferes with the activities of daily living to such a degree that the patient cannot function at a lower level of care.
- 2.5 Patient is intoxicated and requires inpatient detoxification based on at least one of the following:
 - 2.5.1 Current medical or psychiatric conditions that require hospitalization or in conjunction with withdrawal symptoms, expected to cause problems

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requiring hospitalization. The CIWA (Clinical Institute Withdrawal Assessment) is used as an evaluation tool.

- 2.5.2 A history of complicated withdrawal (e.g. seizures or delirium) with a comparable quantity and duration of alcohol/drug use.
- 2.5.3 Anticipated complicated withdrawal based on a history of alcohol/drug use, physical findings, and blood alcohol level or drug level determinations. (E.g. BAC \geq .35, Narcotic withdrawal scale grade 3 or 4).

3.0 Determine Appropriate Intensity of Care.

Guidelines for determining the appropriate intensity of care along with the need for specific interventions are:

- 3.1 Patient is to be housed on a secure unit with 24-hour nursing and medical services. Level of security (locked versus open) is determined by severity of risk and legal status of patient.
- 3.2 The patient is to be seen within 24 hours after admission and then daily thereafter by the psychiatrist or addictionologist.
- 3.3 For child and adolescent patients
 - 3.31 A family session should be held within 48 hours after admission when feasible.
 - 3.32 If a family crisis is a primary factor in the set of conditions precipitating the admission, family therapy of one to two hour sessions should be initiated for up to three days. If the crisis is not resolved and has become the primary reason for continued hospitalization, out of home placement (relative, friend, CPS, etc.) should be encouraged. Outpatient treatment would then be continued to resolve the crisis and reunite the family.
- 3.4 The possible need for placement should be determined within 48 hours of admission. If placement will be necessary, the UM Coordinator should be NOTIFIED IMMEDIATELY. The UM Coordinator will work with the hospital social worker, treatment team, family, and community agencies as necessary to facilitate appropriate placement.

4.0 Determine the Need to Continue at Present Level of Care

While hospital admissions may be authorized for several days, the need to remain at this level of care should be evaluated every two to three days. As soon as ALL of the criteria for discharge have been met, the patient should be discharged and admitted to the next appropriate level of care (e.g. PH, IOP or OP).

- 4.1 No longer requires close observation, physical restraint, seclusion or precautions. Type/dosage of psychotropics unchanged in last two days.
- 4.2 Appropriate follow-up care plan completed with which patient is able to comply.
- 4.3 Patient and significant others informed of and understand warning symptoms.

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- 4.4 For detoxification patients, vital signs and laboratory values are within normal limits or at least at premorbid levels.
- 4.5 If one or more of the other conditions below are present, the need for continued stay should be evaluated by the CBHM/CHIPA Medical Director or Physician Advisor:
 - 4.5.1 Failure to comply with treatment program within three days.
 - 4.5.2 Failure to improve within five days.

5.0 Special Considerations for Patients with Dementia

- 5.1 In attempting to triage patients with dementia, when “grave disability” is the primary referring problem, assessors should consider three issues:
 - 5.1.1 Will the requested intervention (hospitalization) result in the individual being able to return to their previous level of functioning i.e., the resolution of the acute psychiatric symptoms will allow the patient to return home?
 - 5.1.2 Is the hospitalization being used as a transition plan for a patient that should otherwise be referred directly to a supervised living situation?
 - 5.1.3 Is the “danger to self” predominantly the result of inadequate supervision?
- 5.2 If treatment is unlikely to restore functioning, and the individual will require placement; then in the absence of an imminent danger to self or others, based on an exacerbation of an acute psychiatric condition, the provider should collaborate with the patient’s Primary Care Physician and family to coordinate appropriate placement.
- 5.3 It is important that the need for admission to an acute care psychiatric facility be evaluated with consideration of other alternatives such as emergency outpatient psychiatric evaluation, partial hospitalization, placement, environmental intervention (family supervision), locked SNF or other community resource.