Monterey County Behavioral Health
Policy and Procedure

Policy Number	480
Policy Title	Natividad Medical Center Mental Health Unit Health Record Documentation
References	Monterey County Health Department policies California Code of Regulations, Title 9, chapter 11 California Code of Regulations, Title 22 Short-Doyle and Short-Doyle/MediCal regulations Code of Federal Regulations, Title 42, Chapter IV, subchapter C, subpart D; Natividad Medical Center Mental Health Unit Utilization Review Plan
Form	
Effective	August 10, 2017

1 **Policy**
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3 PURPOSE
4 Monterey County Behavioral Health (MCBH) in conjunction with Natividad Medical Center (NMC)
5 Mental Health Unit (MHU) to provide acute inpatient treatment as part of a continuum of mental
6 health services. The aim is to provide acute inpatient services to stabilize patients to support their
7 transition and to their community. For patients requiring a more restrictive level of care, the MHU
8 staff shall refer patients to the MCBH outpatient programs to support their transition to a more
9 appropriate level of care.
10
11 NMC MHU is an acute psychiatric inpatient unit within the general NMC hospital setting. Inpatient
12 treatment services include the following
13
14 A. Psychiatric and Medical assessment, (including history and physical examinations within
15 24 hours after admission) sufficient to establish a psychiatric diagnosis, a treatment plan
16 and initiate appropriate inpatient care
17 B. Individual, group, family and milieu therapy
18 C. Occupational/recreational therapy
19 D. Psychological or psychometric assessment
20 E. The prescription and provision of medication and ancillary laboratory testing as deemed
21 necessary by the physician of record
22 F. Formulation of treatment plans and discharge plans in conjunction with:
23 a. the patient
24 b. the family whenever a first degree relative can legally be involved
25 c. the MCHD-BHD Adult Service staff.
26 G. Discharge planning

a. Discharge summaries must be provided to the MCBH continuing care staff within seven (7) working days of the date of discharge and pursuant to Welfare and Institutions Code Section 5622, and contains the following information:
    i. Assessment of present level of functioning, including capacity to provide for food, clothing, and shelter
    ii. Diagnoses, including treatment initiated, medications, and dosage schedules
    iii. Six-month and twelve-month prognosis
    iv. The specific program and services required so the person can minimize future confinement and receive the treatment in the least restrictive setting, including:
        1. Treatment objectives and goals stated in terms which allow for measurement of progress and identification of the mental health personnel responsible for the implementation of the goals and objectives
        2. Referral to providers of Medi-Cal and mental health services
        3. Identification of public social services, legal aid, educational, and vocational services.
b. If the person is homeless, arrangements, if possible, for the voluntary placement of the person in a living environment suitable to his or her needs
c. Other pertinent information in addition to requirements by Welfare and Institutions Code Section 5622, will be provided at the request of a designated MCBH staff member.

H. Discharge criteria
a. The NMC MHU staff will provide the MCBH social worker with relevant information to secure placement. The information will include but not be limited to the following:
    i. Diagnosis, including treatment initiated
    ii. Medications and dosage schedules
    iii. Laboratory test results
    iv. Psychiatric evaluations
    v. Nursing notes

Definitions

An Admission- patient is transferred from NMC emergency department or directly from another hospital to NMC to address acute psychiatric mental health needs and address acute psychiatric issues of danger to self, danger to others, and/or gravely disabled to support the restoration of functioning and safety. Medical necessity criteria must be met for admission.

Acute Day- patient’s condition continues to (1) meet medical necessity for diagnosis or treatment of a mental disorder, (2) acute interventions have not been exhausted, and (3) no other less intensive level of care would be adequate.

Administrative Day- patient no longer meets medical necessity criteria for inpatient hospitalization; however, patient's stay at the hospital must be continued beyond the patient’s need for acute psychiatric inpatient hospital services due to a temporary lack of residential placement options at non-acute residential treatment facilities.

Restoration of Competency 1370.01 (“1370”)- patient is admitted from Monterey County jail for restoration of competency to stand trial. This is an excluded admission criteria that is not billed for Medi-Cal reimbursement.

Readmission- occurs when a patient is readmitted to Natividad Medical Center Mental Health Unit within 30 days of discharge. If the patient is readmitted within 24 hours of discharge, this is considered a Sentinel Event and may be reviewed by Natividad Medical Center Quality Improvement team.

Procedures

1. Evaluation
    a. Emergency Department
        - Crisis clinician consults with on-call Psychiatrist, who makes decision on admission to MHU
            - Document admission orders in Meditech
    b. Referred from other psychiatric facilities or hospitals
        - The on-call Psychiatrist will have a doctor-to-doctor consultation to make the decision to admit the patient to NMC MHU.
            - Document admission orders in Meditech
    c. Referred from another NMC medical department, ie. Intensive Care Unit or Medical-Surgical
        - The on-call Psychiatrist and MHU Social Worker will evaluate the patient for a 5150 hold and/or 5250 hold
        - When the patient is ready for discharge from the medical department, and the patient continues to meet medical necessity for inpatient psychiatric hospitalization, the medical doctor consults with the on-call Psychiatrist to determine if transfer to the MHU is appropriate.
            - Document admission orders in Meditech

2. Medical Necessity for Medi-Cal reimbursement:
    a. Diagnostic Criteria: The focus of services should be directed to functional impairment related to an mental disorder contained in CCR, Title 9, Chapter 11, Section 1820.205 (a)(1)(A-R). This is known as an “included diagnosis”.
    b. Impairment Criteria: The patient must meet both (a) and (b) below:
        - Cannot be safely treated at a lower level of care, except that a beneficiary who can be safely treated with crisis residential treatment services or psychiatric health facility services for an acute psychiatric episode must be considered to have met this criterion
        - Required psychiatric inpatient hospital services, as the result of a mental disorder, due to indications in either:
            - Had symptoms or behaviors due to a mental disorder that (one of the following):
                - Represented a current danger to self or others, or significant property destruction.
                - Prevented the patient from providing for, or utilizing food, clothing or shelter.

121 - Presented a severe risk to the patient's physical health.
123 - Represented a recent, significant deterioration in ability to function
125 - Required admission for one of the following:
126 - Further psychiatric evaluation.
127 - Medication treatment.
128 - Other treatment which could reasonably be provided only if the beneficiary were hospitalized

130 a. Treatment shall not be provided for patients with the following conditions:

131 - No patient shall be billed to Short/Doyle if their admission to the MHU is for a primary Medical condition.
133 - Diseases or physical conditions which preclude participation in or benefiting from a mental health treatment program
135 - Acute ingestion of substance or individual with primary diagnosis of substance abuse without a primary diagnosis of severe mental illness
137 - Acute ingestion of alcohol or individuals with primary diagnosis of alcoholism or alcohol abuse without a primary functional diagnosis of severe mental illness
140 - Individuals with a diagnosis of organic brain syndrome without a primary functional diagnosis of severe mental illness

142 3. Admission to MHU

143 a. Psychiatric Evaluation (for admission after business hours, Psychiatrist must be completed within 24 hours of admission)

145 - presenting complaint;
146 - history of present illness;
147 - past/current providers;
148 - past psychiatric history;
149 - substance abuse history;
150 - medical history;
151 - family psychiatric history;
152 - psychosocial history;
153 - mental status exam;
154 - vital signs;
155 - labs;
156 - DSM-5 and ICD10 diagnosis, including mental health, substance abuse, medical, environmental;
158 - prognosis;
159 - estimated length of stay;
160 - strengths;
161 - safety risk;
162 - safety plan;
163 - level of safety;
164 - Psychiatric treatment;

165 - Medical treatment;
166 - disposition;
167 - medical necessity
168

169 b. Psychosocial History (for admission after business, Social Worker must complete
170 within 72 hours of admission)
171 - Client's goals for hospitalization;
172 - current significant relationships;
173 - family/significant other name/phone number;
174 - spouse name/phone number;
175 - children name/phone number;
176 - other names and contact information;
177 - treatment staff may discuss diagnosis, meds, prognosis with;
178 - Significant Childhood History;
179 - Family Constellation;
180 - Developmental History;
181 - Family Psychiatric History;
182 - Vocational History;
183 - Level of education;
184 - Legal history (DUI, Convictions, etc.);
185 - Hx military service;
186 - Current living situation;
187 - Family/Significant Other involved in treatment/DC Plan;
188 - Dependent Care Needs;
189 - Community Agency Involvement;
190 - Community Agency Contact Person;
191 - Community Agency Phone #;
192 - Alcohol/Substance Abuse;
193 - Emotional History;
194 - Sexual Abuse;
195 - Physical Abuse;
196 - Financial Exploitation;
197 - Current Financial Status/Income;
198 - After Care Referral
199 - Patient unwilling/unable to participate in the assessment
200 - Complete Psychosocial History using ED crisis team assessment
201 and previous medical records
202 - Document source of information in "Client's Goals for
203 Hospitalization" section of Psychosocial History
204 - Document efforts and challenges via progress note (Meditech)

c. History and Physical (if after business hours, Physician Assistant to be complete within 72 hours of admission)

4. Lanterman-Petris-Short (LPS)
    a. A patient may be admitted to the MHU for restoration of competency to stand trial. A patient on LPS Conservatorship may have been evicted from an Institution of Mental Diseases (IMD) or augmented board and care and be placed at the MHU to help the patient secure a placement at an appropriate level of care.

5. Diagnosis

a. In order to obtain reimbursement, the primary diagnosis must be an “included diagnosis” and ICD10 code set from the list provided by Department of Health Care Services (DHCS).

b. If the diagnosis changes at any time during treatment, the Psychiatrist will document the change in a Mental Health Progress Note and document the reason for the change.

6. Plan of Care (due within 72 hours of admission)

a. Diagnoses (DSM 5), symptoms, complaints, and complications indicating the need for admission;
b. Description of the functional level of the beneficiary and strengths
c. Specific observable and/or specific quantifiable goals/treatment objectives related to the patient’s mental health needs and functional impairments resulting from the qualifying mental health diagnosis/diagnoses
d. Descriptions of the types of interventions/modalities, including a detailed description of the interventions to be provided
e. A proposed frequency and duration for each of the interventions
f. Interventions which are consistent with the qualifying diagnoses
g. Orders for Medications; Treatments; Restorative and rehabilitative services; Activities; Therapies; Social Services; Diet; Special procedures recommended for health and safety of patient.
h. Plans for continuing care, including review and modification to the plan of care
i. Plans for discharge
j. Documentation of the patient’s degree of participation in and agreement with the plan
k. All disciplines required signature, initials and date on plan
l. Documented evidence plan is established, directed, and approved by physician
m. Patient’s signature and date
    - If patient is unwilling/unable to participate, document efforts on plan
n. If patient remains hospitalized longer than 90 days
    - New plan of care is required

7. Mental Health Progress Notes (Psychiatrist)

a. Daily
b. Electronically signed and dated
1. Itemized Status Exam Subjective;
2. Mental Status Exam;
3. Vital signs;
4. Current Medication;

5. Vitals;
6. Labs;
7. DSM-5 and ICD 10 diagnosis including Mental Health, Substance Abuse, Medical, and Environmental;
8. Impression;
9. Prognosis;
10. Estimated Length of stay (days);
11. Strengths;
12. Safety Risk;
13. Safety plan;
14. Level of safety;
15. Psychiatric treatment;
16. Medical treatment;
17. Disposition;
18. Medical Necessity

8. Social Services Progress Note (Social Worker)

a. Daily
b. Electronically signed and dated
c. Acute Day status:
    - staff present during session;
    - location of session;
    - patient's legal and mental status exam;
    - Social Worker interventions used to help patient reach treatment goals listed in Multidisciplinary Treatment Plan;
    - patient responses to Social Worker interventions;
    - collateral information gathered and provided;
    - Social Worker plan to continue to assist with discharge planning, assisting patient with achieving treatment goals, referrals provided, and collaboration with lower level of care staff and outpatient mental health and/or substance recovery providers to coordinate services

d. Administrative Day status (at least 1 non-acute residential facility contact is required on same day physician order of Administrative Day status is made)
    - Staff present during session;
    - Location of session;
    - Patient's legal status and mental status exam;
    - Discharge, aftercare, and placement plan;
    - Contacts made to non-acute residential treatment facilities;
    - Obstacles that impede plan implementation;
    - Any other relevant information about Social Worker services provided.

e. 1370.01 status must include:
    - Staff present during session;

297 - Location of session;
298 - Patient's legal status and mental status exam;
299 - Social Worker interventions used to help restore patient to competency to
300 stand trial;
301 - Patient's ability to state the charges, fines and penalties, role of public
302 defender, role of district attorney, and role of judge;
303 - Social Worker plan to continue to assist patient with restoration of
304 competency, collaboration with court liaison to schedule court hearing,
305 and any referrals for outpatient mental health and/or substance recovery
306 services
307
308 9. Acute Day
309 a. At least one acute day status must be present in order to claim administrative day
310 status
311 b. Documentation must establish the patient:
312 - Continues to have an "included diagnosis"
313 - Could not be safely treated at a lower level of care
314 - As a result of the included diagnosis, requires continued services for one
315 of the following:
316 - Symptoms or behaviors for danger to self or others, significant
317 property destruction;
318 - Symptoms preventing patient from providing for, or utilizing food,
319 clothing, or shelter; symptoms presenting a severe risk to
320 patient's physical health;
321 - Symptoms that represent a recent, significant deterioration in
322 ability to function;
323 - Symptoms or behaviors that require further psychiatric evaluation,
324 medication treatment, or other treatment that can only be
325 provided if patient is hospitalized;
326 - Presence of new symptoms that meet medical necessity;
327 - Symptoms or behaviors that require continued medical evaluation
328 or treatment that can only be provided if the patient remains in the
329 hospital.
330
331 10. Administrative Day
332 a. At least one (1) non-acute residential facility contact is required on the same day
333 physician orders Administrative Day status
334 b. Psychiatrist:
335 - Document via Nursing Communication Order:
336 - Date Administrative Day status begins
337 - Include the level of placement
338 - Acute Psychiatric Hospital (AP);
339 - Institutions for Mental Diseases (IMD);

- Augmented Board and Care;
- Mental Health Rehabilitation Center (MHRC);
- Special Treatment Program (STP)/Skilled Nursing Facility/(SNF);
- Community Residential Treatment Center (CRTS)

- Only one level of care written in Nursing Communication Order may be present at any given time
- If there is a change to the level of care to any of the above listed facilities
  a. Psychiatrist will write new Nursing Communication Order stating: "Administrative Day status beginning today for placement at (type of lower level of care placement)"
- If patient meets medical necessity criteria for Acute Day status
  a. Document the reason for change in status in a Mental Health Progress Note and complete a Nursing Communication order stating: "Acute Day status as of (date)".

c. Social Worker
- Document attempt to contact five (5) placement contacts per week (7-day period).
  - Date of contact
  - Facility name;
  - Facility type;
  - Status of placement option (accepted or rejected);
  - Relevant comments;
  - Signature of person making contact (electronic signature in Meditech)
    a. When there are fewer than five (5) appropriate, non-acute residential treatment facilities available, thus, fewer than five (5) placement contacts made
    b. Administrative Day Waiver Request for Medi-Cal or Medi-Cal Eligible Patients form must be completed. In no case, shall there be less than one (1) contact per week.

11. Discharge
  a. Patient does not meet criteria for Acute Day status
  b. Appropriate lower level of placement was found for patient on administrative days
  c. Patient was restored to competency to stand trial
  d. Psychiatrist
  - Discharge Order (Psychiatrist)
  - Discharge Instructions (Psychiatrist completes prior to discharge)
    - Discharge Instructions;
    - Discharge Activity;
    - Discharge diet;

- New medications;
- Continued medications;
- Discontinued medications;
- Follow up;
- Safety plan;
- Core measures;
- Discharged on multiple antipsychotic medication;
- Does patient have one of these diagnosis

- Discharge Summary (Psychiatrist completes within 24 hours of discharge)
  - Admission Date;
  - Discharge Date;
  - Brief HPI;
  - Mental Status Exam;
  - Discharge Diagnosis;
  - Hospital course;
  - Results
    a. Last vitals
    b. Labs
  - Discharge Instructions

e. Social Worker
- MHU Social Worker DC and After Care Instructions
  - Date of admission;
  - Discharge date;
  - Diagnosis;
  - Symptoms that may be experienced as result of diagnosis;
  - Treatment During Hospitalization;
  - Recommended Treatment to minimize future hospitalization;
  - Additional referrals;
  - Prognosis at 6 months;
  - Prognosis at 12 months;
  - Alcohol and Drug Treatment Needs;
  - Other Alcohol/Drug Treatment Needs;
  - Follow up Appointment;
  - Public Social Services;
  - Legal Aid;
  - Medical Aid;
  - Vocational;
  - Education;
  - Housing;
  - Other DC Planning/After Care Instructions

f. Registered Nurse
- MHU Social Worker DC and After Care Instructions
  - Take all medications as prescribed;
  - Notify Doctor if your symptoms become worse;
  - Med Education Complete.

430
431
432 12. Concurrent Utilization Review (completed in Interqual)
433 a. Utilization Review Nurse reviews chart to ensure criteria met for admission, acute
434 day services, and administrative day services
435 - Criteria met
436 - Submit billing grid for reimbursement
437 - Criteria not met
438 - Send to Monterey County Quality Improvement reviewer
439 b. Quality Improvement reviewer reviews chart
440 c. Quality Improvement reviewer notifies staff that documentation was sent for
441 secondary review and offers staff to correct documentation
442 d. Quality Improvement reviewer sends to Physician Advisor for Secondary Medical
443 review
444 e. Physician Advisor approves or denies services
445
446 13. Documentation in Avatar (Social Worker)
447 a. MHU Admission Bundle (within 72 hours of admission)
448 - Admission form
449 - CSI Admission form
450 - Diagnosis form
451
452 b. Discharge bundle (within 24 hours of discharge)
453 - Diagnosis form
454 - Discharge form
455
456