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SERVICES

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Psychiatric Intensive Care (PIC) Case Studies

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CASE STUDIES

Introduction

The following is a packet of information to assist all parties (Iowa Hospitals and their medical staff, MCOs, State of Iowa) in learning about, thinking through and implementing the new Acute Psychiatric Intensive Care Services legislation. Case examples are fictitious amalgamations of real Iowans.

Training Instructions:

1. Read Case Study
2. Review Psychiatric Intensive Care Services Criteria (not attached)
3. Decide if patient qualifies for PIC services/payment (initially and on-going)
4. Discuss cases with your provider team, administrative and utilization management (UM) team members

Start by considering if a patient potentially qualifies for this additional payment, consider these 4 factors.

- The patient must be an active Iowa Medicaid Member.
    - If presumptive eligibility, prior authorization is required through Iowa Medicaid Fee-for-Service.
- The patient must be between 18 and 64 years old
- The patient must have a serious mental illness (a) diagnosed with a DSM mental illness (2) that illness must be causing serious functional impairment.
- The patient must have a current, severe, imminent risk of serious harm to self or others

Other points:

- The patient must be admitted to your hospital. Patients being served in clinics or hospital outpatient departments (HODs) – including the Emergency Department – do not qualify
- While the patient is likely being cared for on an inpatient behavioral health/psychiatric floor, the PIC rules do not require it. Patients in med/surg or ICU hospital beds are eligible (if they meet the other criteria).

Case #1

Part 1

Sara L. was a 42 year old Caucasian female brought into the ED at 12:30 AM by Polk County sheriff's deputies. Law enforcement had been called to Sara's home by her boyfriend. Sara was initially calm while deputies remained on site. Staff in the ED were able to contact the boyfriend who indicated that Sara was "going crazy, talking nonsense, and tearing up the house." She had been talking to people who weren't there, and told her boyfriend that voices were telling her that there were people living in the attic who were going to kill her. She told her boyfriend that she intended to kill them first. After deputies left the hospital, Sara began to become more agitated, and attempted to elope by charging past staff and running for a nearby exit. She was actively resisted when staff attempted to redirect her. Public safety officers executed a physical hold based upon the acute risk Sara represented. Sara continued to struggle, kicking and scratching staff who were attempting to provide assistance. Ultimately, Sara required IM medication, ordered by the ED provider, and she was placed in a room in the main ED with a 1:1 safety assistant (ie sitter). Medications were effective and the patient slept for several hours. At that point, labs were obtained and were unremarkable. Blood alcohol level was 0. A urine drug screen was ordered but a specimen had not yet been obtained. All inpatient psych beds were full in the hospital and staff shortages didn't allow for an extensive search for psych beds at other facilities. In the morning, once she had awakened, Sara was restless, irritable, and very argumentative. Sara tossed her food tray on the floor and yelled profanity and threats of harm at the staff. The psychiatrist (Dr. Good) rounded on the patient in the ED. They reviewed the medical record and determined that the patient had a history of mental health treatment at a sister facility. Sara carried a primary diagnosis of schizophrenia. The social worker in the ED obtained further collateral information from the boyfriend. He shared that Sara had stopped taking her medications at least six weeks earlier, and had been decompensating, but refused treatment and would not go see her outpatient provider. Although she remained easily agitated, Sara voiced concern that she might be pregnant, so cooperated with providing a urine specimen which was negative for substances and negative for pregnancy. Dr. Good recommended inpatient hospitalization. In the afternoon, the inpatient psychiatry unit had a discharge, and a bed became available. Sara was unwilling to sign consent paperwork to be admitted voluntarily and ED staff sought a court order to facilitate admission. Patient was then moved to the inpatient psychiatry unit and the 1:1 safety assistant was discontinued. An H&P was completed, and the primary diagnosis remained schizophrenia with a differential including schizoaffective disorder, bipolar type.

Does Patient qualify for PIC services on Day 1? If so, how many days should the MCO authorize?

Part 2

Dr. Good restarted the patient's previously prescribed outpatient psychiatric medications in the ED, and these were continued upon admission on Day 1. Sara was placed in the most secure room on the behavioral health floor. On Day 2, Sara remained highly symptomatic, responding to auditory hallucinations, and nearly getting into a physical altercation with a peer. She was not redirectable and a physical hold, IM meds, and seclusion were required due to her aggressive behavior. On Day 3, dosages of scheduled meds were increased. Behavior remained poorly controlled with ongoing aggression. Sara kicked a patient care tech who was assisting with meals. Later in the evening she attempted to bite the environmental services staff worker who was present on the unit. Patient continued to actively respond to internal stimuli. She reported hearing voices commanding her to "get out. Get free." She talked about delusions including her belief that the same people that were trying to harm her at her house were present in the hospital. She was highly anxious, frightened that these people would kill her. On Day 4 medications were adjusted further. Patient remained psychotic and at times agitated, shouting,

and making verbal threats, but did not act to harm herself or others. Utilization Management staff asked Dr. Good if the hospital should pursue additional PIC day authorization

Does Patient qualify for additional PIC services during her inpatient stay?

Part 3

Day 5 the commitment hearing was held. Although the patient was showing some signs of improvement, she remained symptomatic with impaired insight and judgment. Dr. Good recommended ongoing inpatient care. Sara is court ordered to remain in the hospital. She is disappointed, but she tolerates the hearing and outcome without becoming agitated. Discharge plan is for patient to return to home and continue outpatient care. However, Sara's boyfriend is reluctant to have her back in the home until he can meet with her in person and he's out of town for two days on a roofing job. On Day 6 Utilization Management staff ask Dr. Good if hospital should pursue additional PIC day authorization. Patient has not moved rooms and remains on the unit with the highest staffing ratio. Sara has not been physically aggressive since Day 3. On the evening of Day 7 Sara's boyfriend visits on the unit. Sara was calm and advised him that her hallucinations were improved. She made no delusional statements and indicated willingness to continue treatment after discharge, including IOP. He agreed to her returning home the following day. Staff asked boyfriend to remove any weapons from the home, and he agreed to do so. Appointment is scheduled with outpatient provider, but not for 4 weeks – due to outpatient provider's schedule. Day 8 Sara is discharged home.

Does Patient qualify for additional PIC services on any of the final days of her inpatient stay?

Case #2

Part 1

Larry D. was a 56 year old male brought to the ED by his 80 year old mother on a Saturday morning at 6:00 AM. Larry's mother states that her son "has been drinking again. He smashed up the living room after talking with his ex-wife. He's been in a bad place for two weeks or so." Larry was a veteran and gun rights advocate (according to the "God, Guns, Family" t-shirt he was wearing). ED staff asked the patient to change into safety scrubs, per protocol, but he declined. Staff asked to search his possessions/person and he vehemently declined. He began to loudly recite the Constitution of the United States. He was noted to have slurred speech and was repeating the same lines over and over. Staff called a public safety officer to assist as the patient continued to be disruptive and uncooperative. Staff insisted patient change out of his clothes and into scrubs for safety reasons. Larry became belligerent towards staff, shouting profanity and verbal threats to harm them. He then lunged and attempted to grab at staff. He scratched a nurse's eye. Staff then had to place the patient in a physical hold to avoid further harm. Larry was escorted to one of the special ED safe rooms to detox. He cooperated with taking oral medication and fell asleep a short time later. Dr. Right rounded in the ED just before noon. He reviewed the medical record and met with the patient. Lab results showed a high blood alcohol level of 347. Dr. Right noted that Larry had been seen at this hospital prior for knee surgery a year ago. According to notes by his Primary Care Provider, patient's problem list included alcohol use disorder, diabetes, depression, and hypertension. During interview with the patient, Larry was very quiet, somber, disinterested, and difficult to engage to the point of ignoring Dr. Right. Screening tools for anxiety show low risk, but Columbia suicide screening tool is high risk/red, including thoughts, plan, and ability to carry out suicide. A 1:1 safety assistant was assigned to Larry at the time of the initial screening. Dr. Right recommended admission to an acute adult behavioral health unit. Another patient's discharge was planned for 6:00 PM that evening and Larry would be able to move to

the unit at that time, about seven hours in the future. Larry was his own decision maker and signed paperwork without reading it or listening to the staff attempting to talk with him about what it said. Patient was admitted to the inpatient unit that evening and the safety assistant was discontinued. The attending provider completed an H&P the following morning. Larry was diagnosed with Adjustment disorder with mixed disturbance of emotions and conduct; Alcohol use disorder; suicidal ideation.

Does Patient qualify for PIC services?

Part 2

Without continued alcohol intake Larry would be at high risk for alcohol withdrawal. To avoid this and the possible need for transfer to a medical floor for detox, Dr. Right ordered scheduled lorazepam and implemented a detox protocol from the behavioral health floor using CIWA. Dr. Right also called for a medicine consult to address co-morbid health conditions. On the unit, Larry slept the entire day in his room and didn't interact much with his roommate or staff. On Day 2 Larry's behavior was similar. He was isolative with an irritable edge. His vital signs were mostly stable, and he did not require additional medications for detox. Larry ate 2 of the 3 meals provided. A Family Medicine doctor rounded with Larry and put in orders for Larry's home antihypertensives, and metformin twice daily. In the evening at med passing time, Larry refused all medications and told the nurse to "F#ck off," indicating that it was pointless to take medication related to ongoing thoughts to end his life. On Day 3, Larry reluctantly agreed to leave his room and join programming scheduled for patients for the first time. However, it didn't go well. He was noted to be argumentative with the therapist, interrupted peers frequently, and made inappropriate references to a popular Call of Duty video game, suggesting that violence might solve his problems in life.

Does Patient qualify for continued PIC services/funding?

Part 3

On Day 4, Larry was boisterous and cantankerous, but participated in group, and he also cooperated with a substance abuse evaluation. The recommendation from the CADC was for residential level of treatment. The discharge planner knew (based on recent calls to treatment facilities for another patient) that Larry would likely not get a bed for at least two weeks. By then he might no longer need that level of care. The care team discussed options including discharging Larry to home immediately with a recommendation for outpatient mental health and substance abuse treatment. However, intakes for each were both scheduled for several weeks out due to lack of access. On Day 5, the attending provider who was covering for Dr. Right for two days did not feel comfortable with this plan, primarily because the patient continued to make believable threats about hurting himself and ex-wife, in addition to vague threats about "society going to hell." On Day 6, Larry completed his course of scheduled lorazepam and continued to require no additional medication for detox. Larry remained irritable and difficult to engage, but he made no overt threats to harm himself or others. On Day 7, Dr. Right returned as Larry's attending. Larry stated that he wanted to go home. He had made a phone call to his ex-wife and indicated that she was encouraging to him. The provider was reluctant to discharge Larry, but the provider asked him specifically about thoughts to harm himself and others and the patient denied having any intent or plans. Larry was unwilling to remove any weapons from his home, citing his staunchly held beliefs about gun rights. Larry was strongly encouraged to remain in the hospital for further assessment and safety planning. He refused. Although patient had ongoing risk factors for violence, the treatment team felt that the risk was unlikely to be modified by involuntary treatment on an acute psychiatric unit. Larry's mother was contacted, with the patient's consent, to discuss discharge

planning. She was counseled about the process to request a court order for substance abuse treatment if Larry further decompensated or did not follow through with the recommendation for outpatient treatment. She voiced understanding and indicated she would continue to do her best to provide Larry with emotional support. The patient was discharged per his request just before 5:00 PM with his mother providing transportation.

Does Patient qualify for additional PIC services on any of the final days of his inpatient stay?