



Seattle Children's Hospital

# Parent Initiated Treatment from an Inpatient Psychiatric Hospital Perspective

Presented by:

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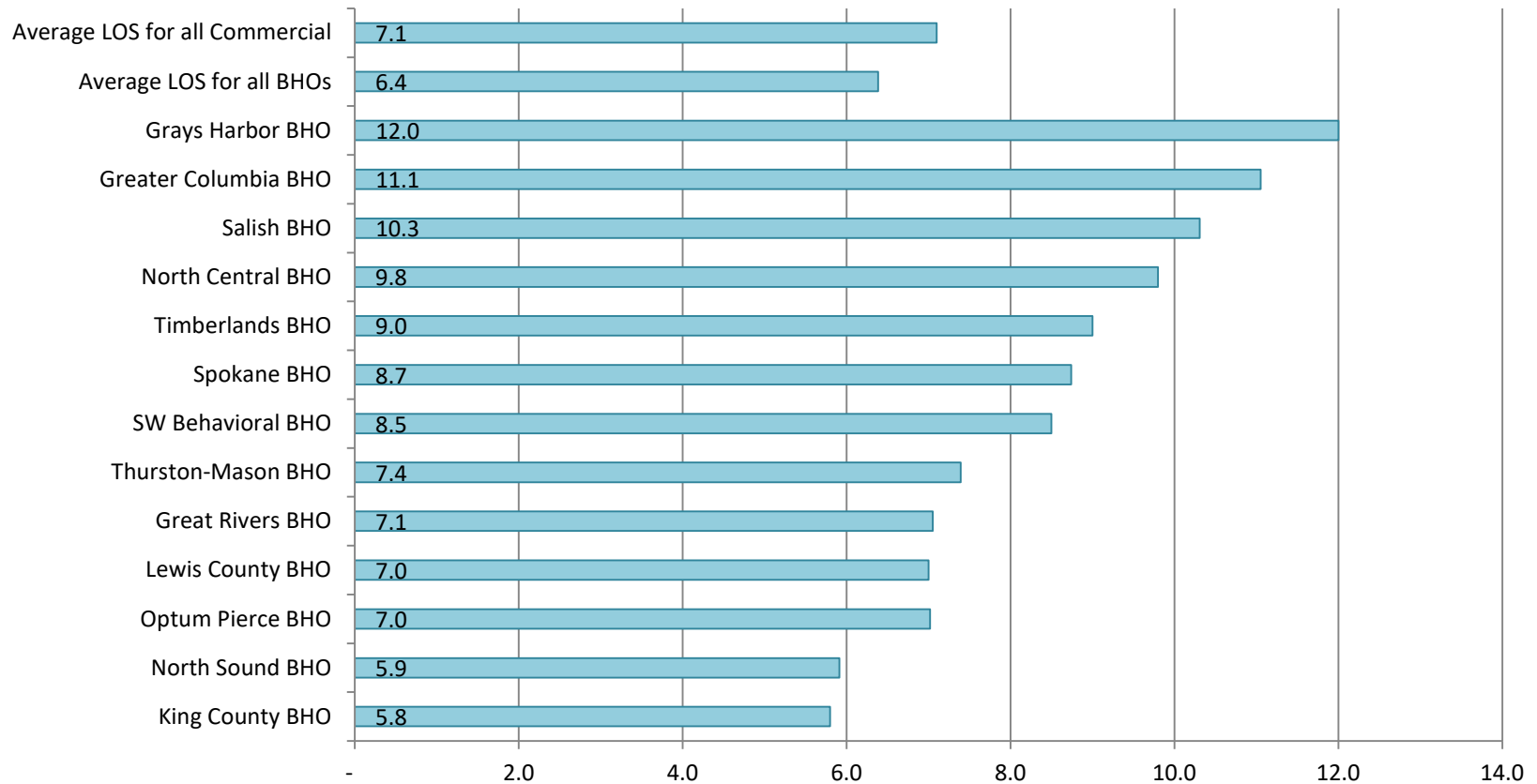
# Readmissions:

- Our inpatient unit has an overall 10% rate of readmission within 30 days of discharge (data from September 2017).

| ● Payer class    | Readmission < 30 days | Total Admissions | Readmission Rate |
|------------------|-----------------------|------------------|------------------|
| Commercial       | 129                   | 1347             | 10%              |
| Financial Aid    | 0                     | 2                | 0%               |
| Medicaid         | 1                     | 16               | 6%               |
| Other            | 0                     | 1                | 0%               |
| Tricare          | 13                    | 90               | 14%              |
| Medicaid-BHO-ITA | 12                    | 44               | 27%              |
| Medicaid-BHO     | 83                    | 935              | 9%               |
| Grand Total      | 238                   | 2435             | 10%              |

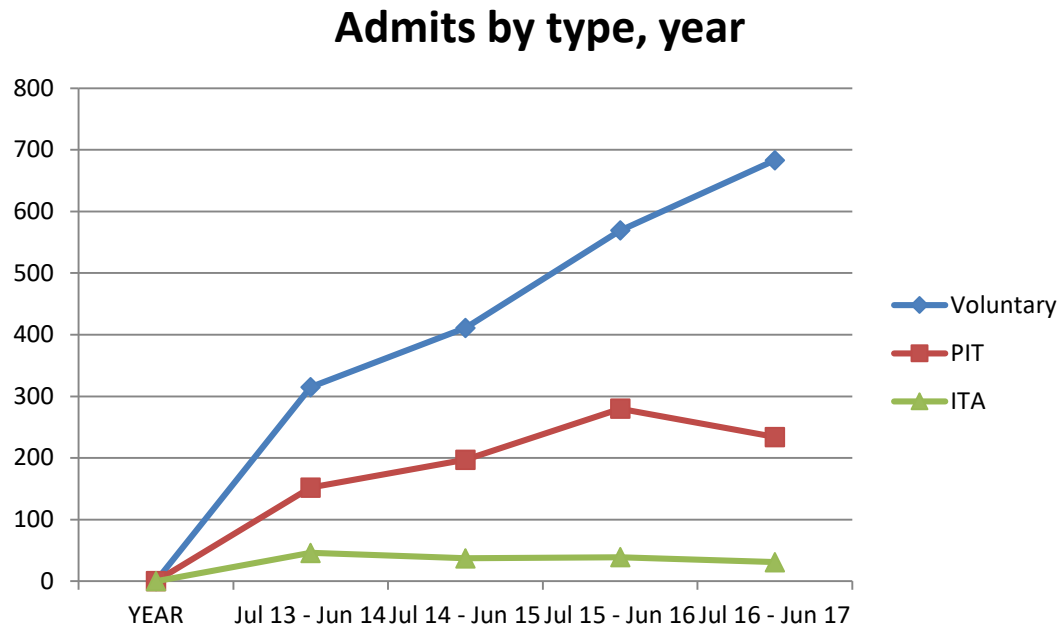
# Payer Based Variation:

## Average of # of days admission – data from September 2017



# PIT Volume:

- From 7/13 to 6/17, 66% of admissions were voluntary, 29% were PIT, and 5% were ITA.



# PIT Notification Process:

- All parents/guardians of patients ages 13-17 are provided a copy of the “Mental Health Treatment Options for Minors” in the emergency department, whether or not their child is admitted.
- Patients admitted under PIT are provided a copy of “When Your Parent Admits You to the Inpatient Psychiatry and Behavioral Medicine Unit” which describes their rights.

# PIT Advantages:

- Patients are motivated to stabilize in order to discharge.
- Parents feel empowered to help their child obtain necessary treatment.
- PIT admissions are less traumatic for teens compared to having to go to ITA court (strapped to a gurney).
- PIT admissions allow providers to spend their time delivering needed care in the hospital instead of testifying in court and waiting

# PIT Barriers:

- PIT is not an option if there is no parent or legal guardian available to give consent
  - must have legal guardian or Children's Administration case worker consent if patient is in dependency
  - Other caregiving relatives and foster parents are not allowed to give consent for PIT admission.
- PIT less effective if parents disagree with the treatment plan or worry about teen anger directed at them re: admission

# PIT Barriers:

- PIT does not allow providers to compel medications; patients must consent
  - If compelling antipsychotic medications is necessary, this is a reason to convert to ITA
- There is no “less restrictive order” (LRO) for PIT
  - The LRO can serve as a “safety net” which allows a patient to be readmitted for evaluation by DMHP if the patient is not following the agreement that led to discharge and/or becoming unsafe again.
  - Without ITA’s LRO, only outpatient option to compel treatment is parent submitting an At-Risk-Youth petition to juvenile court



# PIT Barriers:

- Community providers prefer ITA if concerned patient may need CLIP facility
  - patients on 180 day orders are eligible for CLIP
- Voluntary CLIP process burdensome - very time consuming in some counties
- PIT expires 30 days after review, regardless of patient stability. If a patient cannot be safely discharge, an ITA evaluation will be need to be pursued to keep the patient in the hospital.

# PIT Barriers:

- Authorization from payer is required for PIT admission and continued stay.
  - Challenge to help families ready to take their child home when safe, but still symptomatic
  - Length of authorizations has been decreasing
- Youth with developmental disabilities stabilizing on unit at time of PIT review but still not safe to return home
  - We have had several patients denied for continued stay under PIT and had to request ITA to continue a stay due to safety concerns

# PIT Dynamics: Inpatient

- Significant regional differences in PIT referrals
- King and other urban counties often refer patients under PIT
- Many rural counties seem to avoid PIT
  - Our clinical teams will then drop the rural ITA and convert to PIT soon after admission after talking with parents/legal guardians
  - ITA request means Designated Crisis Responder (DCR) does an ER evaluation, which a rural hospital might rely on for getting a psychiatric assessment

# PIT Dynamics: Outpatient

- We have a large outpatient program.
- We have not used outpatient PIT primarily because “evaluation only” is not particularly helpful to families.
- Treatment is the most helpful mental health intervention, and the outpatient PIT law only includes evaluation.
- There is general lack of awareness about outpatient PIT options – and not the same notification requirements for providers.

# Recommendations:

- Funding to increase consistent education about PIT across Washington State for:
  - BHO contracted agencies
  - DCR
  - Emergency department personnel
  - Hospitals
- Medicaid funds for intermediate levels of care such as partial hospitalization, intensive outpatient, residential treatment (e.g. severe eating disorders – not well served by CLIP).

# Recommendations:

- Consider changing the law to allow for PIT stays longer than 30 days to remove need to convert some to ITA – OR – consider revision to change ITA law for juveniles to count time already under PIT for PIT to ITA conversions
- Clarify areas in the law regarding consent to release information for patients admitted under PIT (i.e. who has authority to release records)
- Considering changing the law regarding outpatient PIT to include treatment (*maybe with time limits?*) and expectations to notify parents about outpatient PIT as an option