

The **Acute Screening Form** is used to identify individuals under the age of 21 who are applying for admission to, were emergently admitted to, or are currently residing in a North Dakota Medicaid funded Acute Inpatient Psychiatric Unit. The Acute screen must be completed on all individuals requiring admission to an inpatient Psychiatric Unit or Psychiatric Hospital and again before the end of the certification period, should ongoing care be needed.

Screening information can be entered two ways:

- ~ Online at www.pasrr.com
- ~ Complete the Acute Screening form and fax to DDM at 1.877.431.9568 if you do not have web access.

**Advantages to completing the Acute screening form online at
www.PASRR.com:**

-Increased efficiency by providing the ability to submit all information at one time (**including** the questions historically asked by DDM reviewers when certain presenting information is present).

-Increased accessibility by offering the capacity to submit information 24-hours per day, 7 days per week, 365 days per year.

-Federal compliance and reduced exposure for facilities of all information reported to DDM so that, in the event of a state or federal audit, the basis for the decision to certify is clearly provided.

-HIPAA compliance through the web-based system which only allows *submission* of information, with users unable to gain access to DDM's database or any client data. Our web-based data is HIPAA compliant and integrates access control, authentication, and a 128-bit encryption key signed by Verisign to guarantee the security of network connections, the authenticity of local and remote users, and the privacy and integrity of data communications. As a contractor of the State of North Dakota, DDM maintains fully compliant HIPAA practices with all communications about personally identifiable client information

-‘User Friendly’ access with no IS/IT modifications or programming needs from providers to access information or submit screens. With web-based access, the provider simply accesses a specified internet address, enters a code (which will be provided to each facility prior to implementation), and begins entering information. The only changes necessary on the part of the provider may be to change settings on individual computers to print the completed screening information. Any special printing instructions will be provided on the website.

The following guidelines can be used as a reference for completing the screen:

Facility information- Please provide accurate contact information for the facility and the contact person should DDM have additional questions.

Attending physician- We require the ND MD license for Medicaid purposes.

Type of review-Please choose which type of Acute review you would like to complete:

Elective- initial review prior to admission

Emergency- review occurs within 2 days of admission to an inpatient unit

CSR- continued stay review

Retrospective- application submitted within 2 business days of notification regarding the individual's application for Medicaid

Patient demographics- All information is required or we cannot proceed with the review.

- **Medicaid ID number** should be 9 digits (please include all zeroes).
- **Medicaid Applicant** will only be “yes” if patient is currently applying for Medicaid; all patient's with a Medicaid number would be “no”.
- **Medicaid Application Date** only applies to patients that do not currently have Medicaid but are in the process of applying.
- **Admit Date** refers to the date of admission to the admitting facility.

Discharge plans

Please complete as thoroughly as possible as the information provided here will help determine the number of days for approval based on active discharge planning.

- **Tentative or Actual Discharge Date** refers to the anticipated date that patient will leave current level of care (or in the case of a retro review once the patient has left the facility, would be the actual date of discharge)
- **Tentative Discharge Plans** refers to any plans that are being considered for discharge location(s)
- **Progress** refers to any advancement towards discharge or any changes to the plan. For example: Plan to discharge home with parents; **Progress:** Mother failed drug screening, home will need further testing before child can return. PATH added as possible discharge option.
- **Approximate Date** refers to the anticipated date that this discharge plan will take place. For the above option, an example would be: **Approx date:** changed from 5/31/07 to 6/15/07 due to need for step down placement.

Responsible Party- Please ensure this information is accurate as letters are mailed to this contact person as well.

- **Living Arrangements-** Please provide the patient's living arrangement prior to inpatient admission.

Prior Inpatient Treatment- Section must be filled out completely for the initial application. Does not have to be completed for CSR's unless additional information has become available

- **Admission and discharge date-** Please be as accurate as possible, but approximate dates are acceptable. May enter in mm/dd/yyyy, mm/yyyy, or yyyy format.
- **Reason for Admission-** Please describe circumstances leading up to admission, such as suicidal statements with plan
- **Outcome-** Please describe disposition at discharge, e.g. d/c with outpatient therapy
- **Description of Treatment-** Please describe what treatment patient received while inpatient, e.g. individual therapy; chemical dependency treatment; family therapy

Prior Outpatient Treatment- Section must be filled out completely for the initial application. Does not have to be completed for CSR's unless additional information has become available

- **Admission and discharge date-** Please be as accurate as possible, but approximate dates are acceptable. May enter in mm/dd/yyyy, mm/yyyy, or yyyy format.
- **Reason for Admission-** Please describe why patient required outpatient services, e.g. individual therapy after acute inpatient admission for suicidal ideation
- **Outcome-** Please describe result of treatment, e.g. no follow up by patient after initial visit OR patient continued in treatment until admission to RTC
- **Description of Treatment-** Please describe intensity of treatment and what treatment was received, e.g. weekly individual therapy for 6 months

Alcohol and Drug Use- Please include all drugs that have been abused. Provide complete information for review to proceed. If no history of abuse, please write "none".

- **Substance-** Please include any drugs that are abused, e.g. nicotine for a 12 year old; Ritalin; Tylenol PM
- **Age of regular use-** May be the same as age first used. Approximate age is okay.
- **Date last used-** Approximate dates okay, e.g. 2 weeks ago; 6 months ago
- **Amount-** Please be specific, e.g. 2 cigarettes; 6 shots
- **Rate of Use-** Approximations are sufficient, e.g. pack of cigarettes weekly; 6 pack monthly
- **Method-** huff, drink, smoke, inject, pill

Diagnosis- Please fill this out completely. Specify "No diagnosis" or "diagnosis deferred" if applicable.

- **Axis IV-** Please mark the appropriate box. as well as specify the problem
- **Axis V-** If CAF and HAF aren't available, it is acceptable to insert the GAF score in both boxes.

Family Support System- Please complete thoroughly, placing emphasis on level of support and treatment involvement. If patient does not have any active family supports, please write “none”.

- **Person-** Specify name of family member/friend
- **Relationship-** Specify relationship to patient- parent, friend, therapist
- **Description of Support-** Please describe the support the person provides to the patient- makes weekly phone calls, visits monthly
- **Treatment Involvement-** Please describe the person’s involvement in the current treatment of the patient- participates in family therapy, helps develop treatment plan
- **Support Level-** Please describe the perceived support the patient receives from the person- highly supportive; not supportive; enabling

Prescription Medications- Please provide current medications first, and then list medications in the order of most recent being discontinued. If medication cannot be located on the drop down list, please select “other” and write the medication in the box provided.

- **Dosage-** May list all dosages taken during the day- Seroquel 25 mg Q9AM, 50 mg Q9PM.
- **Diagnosis-** Please list patient’s diagnosis that the medication is being used to treat.
- **Date started/discontinued.** Please provide dates if available. However, ranges are acceptable, e.g. started 6 months ago.

Symptoms Requiring Inpatient Care- Please mark if the admission was court ordered.

- **Symptoms-** Please describe a specific symptom that required inpatient/ongoing inpatient care, e.g. suicidal ideation with plan to cut wrists.
- **Date started/Most recent date-** Please provide the date (as close as possible) that the behavior started and the most recent date the behavior presented itself. For example, suicidal ideation with plan to cut wrists. Started: 2/21/07. Most recent: 4/30/07.
- **Intervention-** Please describe any intervention provided by the family/outpatient services to address the behavior: Outpatient therapy until 4/30/07. Increasing threats, acute inpatient admission required.
- **Effectiveness-** Please describe how the patient responded to the intervention: OP therapy ineffective. Symptoms escalated.

Precautions- Please list all precautions being used while treating the patient. Explain what behaviors warrant those precautions.

Chronic Behaviors- These are the behaviors that appear to be ongoing, with or without treatment.

- **Symptom-** Please describe a specific symptom that required ongoing care:
Aggression toward mother
- **Date started/Most recent date.** Please provide the date (as closely as possible) that the behavior started and the most recent date the behavior presented itself. For example, Aggression towards mother; Started: 2/21/07. Most recent: 4/30/07.
- **Intervention.** Please describe any intervention provided by the family/outpatient services to address the behavior: Outpatient therapy until 4/30/07. Increasing threats, so acute inpatient admission required.
- **Effectiveness.** Please describe how the patient responded to the intervention: OP therapy ineffective. Symptoms escalated.

Treatment Plan Goals-

- **Goal** should be attainable and should be based on criteria for successful discharge: Learn appropriate coping skills to deal with feelings of loss.
- **Start date** should be start date for the goal. This may be the admission date or the date of a change in the treatment plan.
- **Frequency** should be the frequency of the interventions that are being provided: daily (for individual therapy)
- **Effectiveness** refers to the improvement/regression to reach the goal: goal changed 4/30/07 due to emergence of a new behavior.

Service Intensity- Please include the total number of interventions (i.e., group therapy, family therapy) that have taken place since the previous review. For “other”, please include items such as IQ testing; chemical dependency evaluation.

If you need additional assistance with completion of the Under 21 form, please contact DDM at 877-431-1388 ext 3330 or email at help@dd-management.com.