



Performance Standards

Diversion and Acute Stabilization

Performance Standards are intended to provide a foundation and serve as a tool to promote continuous quality improvement and progression toward best practice performances, to increase the consistency of service delivery and to improve outcomes for members

Disclaimer: These Performance Standards should not be interpreted as regulations. Entities providing services as part of the HealthChoices program must first be enrolled in the Pennsylvania Medical Assistance program as the appropriate provider type. Providers must then comply with all applicable Pennsylvania laws, including Title 55, General Provisions 1101, licensing program requirements and any contractual agreements made with Community Care Behavioral Health Organization in order to be eligible for payment for services.

PERFORMANCE STANDARDS

DIVERSION AND ACUTE STABILIZATION

Final

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Program Description

Diversion and Acute Stabilization is a voluntary, temporary therapeutic residential environment in a community setting. Utilizing CSP, CASSP, Recovery and BDAP principles, the program diverts the need for acute inpatient care by providing immediate support to individuals experiencing or at risk of an exacerbation of the symptoms of their illness. Diversion and Acute Stabilization services may also be used to help individuals succeed in their transition between levels of care, such as hospital to community residence or community residence to home. Psychiatric and/or drug and alcohol services may occur on site or be arranged with an external provider and must include linkages and coordination of services. Diversion and Acute Stabilization services are short term in nature, with length of stay based on individual need.

In Allegheny County, we have developed three levels of Diversion and Acute Stabilization services. Level 1 essentially provides room and board to enable an individual to participate in a Drug and Alcohol Partial Hospitalization Program. Level II is similar, but also includes a level of staff support, on-site case management supports, and psychoeducational opportunities. Level III is an intensive residential treatment program to be utilized as an inpatient diversion alternative or as a step-down from inpatient care. These performance standards apply to Levels II and III.

Access Standards

Level I- Admission must be scheduled in advance. Room and board only to support an individual's ability to participate in a Drug and Alcohol Partial Hospitalization Program

Level II- Admission must be scheduled in advance. Room and board, 24-hour awake staff, behavioral health training for staff, supervision of ADL's, symptom monitoring, ability to arrange for or recommend appropriate interventions.

Level III- Availability of 24-Hour access is required. Same as above with more intensive treatment services, including psychiatric services. Programs are expected to accept emergency or crisis referrals, immediate where indicated, in order to offer an alternative to an inpatient admission.

The mode of transportation for arrival to the DAS program must provide a safe environment for the consumer as agreed to by the DAS provider and the referral source.

Assessment Process

Assessing the need for Diversion and Acute Stabilization services typically begins with current service providers and referral sources, such as case managers. It is imperative that referral sources gather the necessary information for the DAS provider or CCBH to reach a decision about the appropriateness of DAS services. **Essential information from referral sources includes:**

- **Presenting symptoms, condition and stressors**
- **Current Treatment Provider/ Case Manager/Treatment Team**
- **Current Diagnosis**
- **Current Medications**
- **History/Current Chemical/Substance Abuse Assessment**
- **Current Assessment for Risk of Harm**
- **Current Functional Status**
- **Current Medical Status**
- **Disposition Plan**
- **Treatment History**
- **Physical Examination/Laboratory Work**
- **Living Situation and Support System, including primary Family Contact**
- **Specific information about past abusive behaviors toward self or others**
- **Forensic history**

DAS providers are principally responsible for educating referral sources as to their specific program design, program requirements and about the consumer-specific information needed for admission. Community Care will offer this level of care as a possible alternative for or step-down from more restrictive, inpatient care when appropriate, to potential referral sources. DAS providers are expected to work closely with referral sources to facilitate comprehensive assessment of the consumer's needs. Pre-Admission

- Precertification with Community Care Behavioral Health organization must be completed by referral source.
- The referral source must provide the DAS provider with all necessary clinical information for admission to the program. Referral sources are expected to fax executed releases of information to ensure continuity of care during the DAS stay.
- If a consumer is transitioning from an inpatient unit, the DAS unit will work closely with the inpatient unit to gather current behavioral health and physical information in a timely and efficient manner.

Immediately Following Admission:

- A face-to-face clinical assessment is initiated upon admission to DAS. This assessment will include a risk assessment, mental status, a drug and alcohol

assessment and a psychosocial history. For Level III, the individual conducting this assessment should be a master's level clinician.

- Upon admission to DAS, the member will receive an orientation to the physical plant, policies and procedures of the unit, general rules of the program regarding visitors, phone calls, meals, etc., as well as consumers' rights and responsibilities.
- Upon admission, the referral source must identify and discuss the disposition plan for transition of the consumer from DAS. The disposition plan must be developed with the consumer, and family/significant others as appropriate.

Expectations for Treatment and Treatment Linkages

The DAS provider is responsible for promoting a recovery environment for the consumer. The DAS provider should demonstrate, through policies and procedures, that their service system is compatible with recovery principles. Examples of how this may be demonstrated include the following:

- The consumer must be informed of and encouraged to exercise their rights and responsibilities.
- The DAS provider must document the consumer's participation in the development of their treatment and discharge plan.
- The consumer's right to choose service providers should be explained and guidance offered in this area.
- The provider's Quality Plan should address ways in which recovery concepts will be supported and maintained.

Medication Management:

- Referral sources are expected to get information regarding current prescriptions and other medication information to DAS providers within 24 hours of admission.
- All narcotics are kept under double-locked security as required by licensing regulations. Providers are expected to develop reasonable practice standards regarding the management of non-narcotic and physical health medications on the unit
- All consumers on DAS must be observed taking their prescribed medications. DAS providers are expected to maintain documentation of medication monitoring.
- At a minimum, daily pill counts are expected to be completed for all medications maintained on the DAS unit. This may be done more often per policy and procedure of a specific provider.

Case Management and Coordination of Care

- For all consumers who have a case manager, the case manager is expected to hold the primary responsibility for the coordination of care during the DAS stay. The case manager will hold the primary responsibility for active transition planning from this level of care, with the consumer's input and agreement. If the consumer

is engaged with a Community Treatment Team, the CTT is expected to be involved throughout the treatment episode in the DAS program.

- In the event that the consumer does not have an assigned case manager, DAS will expedite a case management referral, with consumer consent and input, and in the interim, provide necessary case management interventions. If the member is currently inpatient, the inpatient provider should be prompted to make a referral to case management with the consumer's agreement. The current primary provider or administrative case manager of the SCU should remain involved in the consumer's care during the DAS stay.
- The case manager is expected to have daily contact with the consumer in DAS unless other arrangements are made and agreed to by the DAS staff and the consumer, and the family/significant other as appropriate.

Treatment Expectations

- Level III DAS providers are expected to provide education, group and individual therapy and medication management as a core component of the program. Level II and Level III providers are expected to facilitate linkages to needed services not being provided in the program. Treatment services must meet the individual needs of the consumer. Participation in programming outside the DAS provider agency may occur when in the best interest of the consumer. Because the lengths of stay in DAS programs is expected to be brief, plans for services are expected to offer the greatest degree of continuity of care possible. DAS providers are expected to support consumers to fully participate in the development of their treatment plan.
- DAS providers are expected to provide crisis intervention as needed. DAS services are intended to prevent the need for inpatient care and promote the consumer's continued stabilization and recovery in the community.
- DAS providers are expected to facilitate communication among treatment team members and the consumer, including family/significant others as appropriate.
- DAS providers are expected to try innovative therapeutic activities in response to input from consumers.

Family Engagement

- DAS will seek appropriate releases to contact family or significant others and involve the family/significant other in planning and decision making with the consumer.
- DAS staff is expected to develop an individualized plan for contact and communication with family members/significant others with each consumer, and reflect this plan on the consumers service plan.
- DAS providers serving children and adolescents are expected to support as frequent contact with family member or caretakers as is possible, to reduce the trauma to the child/adolescent and to promote reunification and continued recovery of the child/adolescent in the home/community.

Discharge Planning

- Referral sources should identify a discharge plan at the time of admission to DAS. DAS should not be considered a permanent or long-term placement. The referral source is expected to work with the consumer, and family/significant others as appropriate, in the development of a discharge plan from DAS.
- All members of the treatment team must share responsibility for active discharge planning with the consumer, and family/significant other when appropriate, to insure a smooth transition.
- The treatment plan should identify an alternate discharge plan at all times so as to prevent a delay in discharge.
- The discharge plan should also include a crisis plan that has been developed with the consumer, and family or significant others with the consumer's permission. Crisis Plans may include advance directives.
- DAS providers are expected to notify treatment team members and CCBH of any AMA discharges to ensure effective outreach and continuity of care to the consumer. This notification should occur as soon as possible but at least within 12 hours of the discharge.

Documentation

- All DAS providers are expected to document that they have reviewed an initial packet of information with the consumer, explaining what the service is, policies and procedures, consumer rights and responsibilities.
- DAS providers are expected to maintain documentation of the individual assessments of each consumer upon admission.
- DAS providers are to complete an inventory of the consumer's belongings upon admission and review the inventory with the consumer upon discharge.
- Within 24 hours of admission, the DAS staff is expected to develop a short-term goal plan with consumers, and family/significant other as appropriate.
- Each shift is expected to document information regarding the consumer's status, progress towards goals, interventions provided during the shift.
- Medication logs will be maintained in each consumer's record.
- Documentation of consumer-specific contracts will be maintained (such as contracts for safety, behavior management contracts, contracts for voluntary drug screenings)
- Sign In/Out sheets are to be maintained by each provider.
- All DAS providers are expected to submit unusual incident reports to CCBH as well as County representatives.
- DAS providers are expected to survey consumers for satisfaction with the services. DAS providers are to consider surveying referral sources regarding their satisfaction with the services provided to consumers. Results of consumer and referral source satisfaction surveys should be utilized when developing the provider's quality improvement plan.
- DAS providers are expected to provide discharge summaries to referral sources, other involved treatment team members, and CCBH. A written after care plan should be developed with the consumer, and family/significant other as appropriate. The

written discharge plan must be given to the member, and family/significant others when appropriate, upon discharge and shared with other members of the treatment team within 12 hours of the consumer's discharge from DAS.

Length of Stay Expectations

- DAS is a short-term service. Average lengths of stays are expected to be in the range of 5-10 days.
- DAS providers should have a mechanism to review outliers to this expected length of stay to identify contributing factors to more extensive lengths of stay.

Staff Training Expectations

- DAS providers are responsible for staff training and maintaining documentation of training in the individual staff personnel charts in the following areas:
 - Orientation to DAS services
 - Consumer Rights Training
 - Confidentiality Training
 - Cultural Competency
 - Recovery Principles
 - Rehabilitation Principles
 - Crisis Intervention and Suicide Prevention Training
 - Interface with police and other external agencies
 - Dual-diagnosis
 - Forensics
 - Delirium and Dementia
 - Medication Training
 - Behavioral Health Training
 - Harm Reduction Training
 - C.P.R/First Aid Training
 - Training to work with individuals with personality disorders
- DAS providers are expected to assess the individual training needs of staff and develop and maintain individualized training plans.

Quality/Outcomes

- All DAS providers are expected to develop a quality improvement plan that routinely includes the review of outcome indicators such as goal attainment, improved level of functioning, rate of inpatient hospitalizations, and length of stay data.
- All DAS providers are expected to survey consumers for satisfaction with the service and incorporate satisfaction survey results into the quality improvement plan.
- DAS providers should consider surveying referral sources regarding their satisfaction with services provided to consumers and incorporate survey results into the quality improvement plan.