



Performance Standards

Inpatient

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

INPATIENT

Final

Updated 05/22/03

These Performance Standards are intended to be “best practice” standards that inpatient providers will use to design and assess their programs and that Community Care can use to assist with assessment of the quality of services. Community Care is aware that program design may vary at times due to the clinical needs of the members. Providers are expected to continue to comply with all existing licensing regulations and requirements. Community Care expects providers to incorporate the principals of recovery into all aspects of care and treatment.

Program Description- Inpatient hospitalization provides a secure/locked setting for the delivery of acute care services for children and/or adults with a serious mental illness, substance abuse problem or co-occurring disorders (MISA) Such acute care requires coordinated, intensive and comprehensive treatment, tailored to the individual consumer’s immediate status and needs and fulfilling the following purposes toward continued recovery for the consumer:

- increasing psychiatric and medical stability, including medication management
- improving the level of functioning and self-maintenance ability, as a means to prevent recidivism
- ameliorating symptoms
- coordinating a discharge and transition plan for the consumer with participation by appropriate inpatient staff, the consumer, family/significant others (if consumer agrees), and representation from the necessary community-based supports.

Initial Assessment - Prior to admission to the inpatient unit, the emergency department staff are required to determine if the consumer is currently being served by a community-based service, such as Intensive Case Management (ICM), Community Treatment Team (CTT) or In-home Family Based Services. When the consumer, family or significant other indicates their involvement, these programs must be notified as soon as possible that the consumer has presented at the emergency department for inpatient admission, be available to give pertinent clinical information and to assess the consumer for a recommendation of a diversion to a less restrictive level of care. The emergency department staff should also obtain signatures for releases of information prior to admission to the unit. The following upon admission to the unit:

- Nursing assessment within 1 hour of the admission
- MD evaluation within 24 hours of the admission
- MISA assessment within 24 hours of admission
 1. Social Worker assessment within 48 hours of admission which includes the following: Identification and contact with the consumer's outpatient treatment team to obtain clinical information, treatment history, current treatment modalities being delivered and to begin the process of transition planning from the inpatient level of care
 2. Initial contact with the family or significant other to obtain pertinent historical information, to schedule the first family/significant other meeting, and assist the family/significant other with planning for the consumer's return to community living, as appropriate and agreed to by the consumer.
 3. For children and adolescents, the school should be contacted the next school day. Children, Youth and Family (CY&F) and Juvenile Probation and Parole must also be notified with 24 hours of admission if a child has a current relationship with those agencies.
 4. An explanation of the consumer's rights and responsibilities, including information on how to contact the patient advocate if they are dissatisfied with any aspect of care. Providers are expected to provide this information to consumers in writing at the time of admission.

Continuity of Treatment – All treatment modalities at the inpatient level of care must be delivered to provide an effective, consistent and therapeutic environment designed to maximize the potential benefits of the hospitalization with a smooth transition to the next level of care and continued recovery in the community. The active participation of consumers, and families/significant others as appropriate and agreed to by the consumer, in the development and implementation of the inpatient treatment plan and all aftercare planning is crucial to the success of consumer following discharge from inpatient care to

community-based care and supports. The following elements are required components for service delivery on an inpatient unit:

- If readmission is required, efforts should be made to send the consumer to the unit previously used for inpatient hospitalization whenever possible, to insure continuity of care, with the exception of consumer dissatisfaction with previous treatment and a request to be treated by another provider.
- Availability of Social Work staff seven days per week to meet the needs of the family/significant other and to ensure appropriate aftercare and supports are available to the consumer and family/significant other once the consumer is discharged from inpatient care. Given appropriate consumer agreement to contact family/significant other, Providers are required to provide education to the family including information on the current diagnosis, prognosis, current best practices in the treatment of specific diagnoses including information on prescribed medications and continued therapies/treatment, availability of community-based services and general information regarding family and consumer peer support services/support groups. Providers are expected to answer family questions and provide written educational materials to the family specific to their family's needs.
- Milieu therapy/program schedules demonstrating active, recovery focused, culturally competent treatment and/or psychoeducation occurs on a daily basis.
- MD assessment of the status of the consumer, ancillary assessments, and treatment plan 7/days week with documentation in progress notes
- Medication treatment plan clearly documented in consumer record to ensure an integrated treatment plan which ensures continuity by MD coverage
- Transition plan clearly documented to prevent any delay in the consumer discharge
- Linkages to next level of care clearly documented, including provider, address, date, time and contact person

Recovery – The inpatient provider is responsible for promoting a recovery environment for consumers receiving behavioral health services and recovery principles should be an integral part of all aspects of care. The inpatient provider must demonstrate in the policy and procedure manual how recovery principles are incorporated into all aspects of inpatient care. Examples of how this may be demonstrated include the following:

- The consumers must be informed of their rights and responsibilities at the time of admission. Consumers must be instructed in how to access the hospital's patient advocate and how and to whom to report dissatisfaction with care. Patient rights and responsibilities and contact information for the patient advocate should be provided in writing to the consumer at the time of admission, in addition to being posted in a clearly visible location on the unit.
- Provide opportunities for consumers to participate in the development of their treatment plan. Providers must demonstrate methods by which they will engage the consumer in the development of their treatment plan. Whenever possible and with the consumer's consent, family and/or significant others should be included in the development of the treatment plan, particularly related to the need for family and/or

other natural supports to support the consumer in their continued recovery in their community.

- The consumer's right to choose their service provider should be explained and guidance offered in this area. Consumers should be encouraged to request assistance in making informed choices by using their assigned SCU Administrative Case Manager, ICM, RC or Independent Supports Coordinator as appropriate.
- The provider's Quality Plan should address ways in which recovery concepts will be supported and maintained
- Services should meet the consumer's cultural needs whenever possible. Consumers should be encouraged to exercise their right to choose based on their specific cultural needs.
- Consumers, and/or families/significant others, should be given contact information for advocacy services, peer and family support services and educational materials related to mental illness and substance abuse.

Transition Notification and Collaboration

Linkages with Other Services/Supports - The inpatient provider is responsible for ensuring that efforts are made to provide these linkages for the consumer, with the appropriate Releases of Information signed, in a timely and efficient manner to promote continuity of care and effective transition planning. These linkages, must be documented in the consumer record and must include the following:

- Contact with the consumer's current Behavioral Health (BH) provider to obtain current treatment information including medication regime
- Identification of the consumer's Primary Care Physician (PCP) and notification of the consumer's inpatient admission to this physician within 24 hours
- Contact with the Special Needs Unit of the Physical Health Managed Care Organization (MCO), Laboratory Studies, X-rays and other testing must be completed in a timely and efficient manner. These standards should be addressed and monitored in the provider's Quality Plan.
- Contact with the consumer's current housing arrangement within 24 hours of admission to determine the appropriateness for the consumer's return to that location (i.e. Personal Care Boarding Home (PCBH), Specialized Mental Health housing, Bridge Housing, family, etc)
- Contact with the consumer's insurance plan or CAO regarding coverage or eligibility issues for specific services
- Contact with Medical Assistance Transportation Program (MATP) prior to discharge to facilitate compliance with follow-up appointment if the consumer identifies transportation problems
- Contact with the transition plan to the next level of care service provider(s) to facilitate the referral process, unless otherwise agreed upon by the treatment team

- If the consumer has an active AXIS III diagnosis upon discharge, the inpatient provider is responsible for ensuring that the transition plan includes a scheduled appointment with the PCP prior to discharge to address any specialized medical needs of the consumer
- If a substance abuse issue has been identified through the MISA assessment, follow-up care must be arranged with a provider who can appropriately meet the substance abuse and/or mental health treatment needs of the consumer.
- Contact with the county community hospital liaison whenever indicated for consumers without ICM/RC or CTT involvement
- Identification of spiritual and religious needs or issues

Disposition Planning- The inpatient provider is responsible for coordinating and completing the plan for transition from the inpatient level of care to the next level of care. Other treatment team members may be responsible for specific components of the plan but the inpatient provider holds the primary responsibility. This planning must begin within 24 hours of admission. The following elements must be documented in the consumer record:

- A Transition Plan must be initiated within 24 hours of admission in collaboration with the outpatient treatment team, consumer and family/significant other
- An estimated Length Of Stay must be identified for the first Utilization Management review
- The consumer's support system must be identified and included in transition planning with the agreement of the consumer
- The outpatient treatment team and case manager must be part of transition planning
- If long-term care is being considered, a Diversion Meeting must be arranged with the county. The county should be contacted as soon as this consideration exists. It is the responsibility of the inpatient provider to notify all members of the treatment team including outpatient providers of the meeting date and time
- If a case manager is not assigned, an ICM or Resource Coordination, a referral should be made. If the consumer refuses the referral, the Administrative Case Manager of the Service Coordination Unit should be notified.
- Community Care must be notified by the inpatient provider whenever a consumer is being considered for a referral to CTT. For members already working with a CTT, the inpatient provider is expected to coordinate all aftercare plans with the CTT.
- Determine the next Level Of Care (LOC) using the discharge date as first day of service. Consider engagement with this LOC while consumer is still inpatient
- If CTT is being considered as a referral, an interagency team meeting should be scheduled. When appropriate, a referral for CTT may be initiated by the inpatient provider to Community Care. .
- If a Residential Treatment Facility (RTF) is being considered, an interagency meeting with the appropriate county involvement should be facilitated. If the inpatient psychiatrist is recommending RTF LOC, the inpatient provider should coordinate the

completion of the Best Practice Psychiatric Evaluation recommending RTF including pertinent clinical information and recommendations for treatment.

Discharge- At the time of both planned or AMA discharges, the following components must be in place to ensure a seamless, successful transition to the next level of care.

- With the exception of discharges against medical advice (AMA), 24-hour notification of a pending discharge should be given to outpatient providers with information about discharge medications.
- At the time of discharge from the inpatient unit, the inpatient provider will have provided the consumer, family/significant other and Community Care with an individualized updated crisis plan for the consumer.
- All consumers should be given the Allegheny County Emergency Services crisis line telephone number
- The consumer should have a follow-up appointment within 7 days of discharge in hand at discharge that includes the name and phone number of this provider
- The consumer should have prescriptions for current medication regime for at least two weeks with a two-week refill. Educational materials, including possible side effects and counter indications, about these medications should be provided to the consumer/family/significant other in writing at the time of discharge.
- Consumers who have an active AXIS III diagnosis must be given an appointment with the PCP.
- Authorization for the next LOC should be obtained by the receiving provider and coordinated with Community Care.
- Discharge and follow-up information should be given to the CCBH Care Manager via telephone or fax on the day of discharge.
- A ROI should be obtained to send discharge information to outpatient providers, RTF and schools.

Quality Assessment and Accountability Measures

Reporting – Inpatient providers are responsible for adhering to the procedural agreements with Community Care Behavioral Health. The following are crucial elements of this reporting:

- The inpatient provider is responsible for making contact with Community Care Behavioral Health for all Precertification, Continued Stay Reviews and Discharge Reviews within the designated time frames.
- Significant Member Incidents must be completed and sent to Community Care within 24 hours of the incident.
- The diagnosis on 5 Axes must be provided to Community care Behavioral Health upon admission and discharge.

Provider Benchmarking

Community Care provides an annual benchmarking report that includes several indicators related to inpatient services such as length of stay, readmission rate, significant member incidents and consumer complaints. Providers will be asked to comment on these indicators if their measurement varies significantly from the network average and to provide corrective action plans when indicated.

Quality issues

Each inpatient provider is required to have a written Quality Management plan document that is reviewed and updated annually to reflect patient needs, address patient satisfaction with care and outline the provider's quality assessment tools. The Quality Management plan must be submitted to Community Care Behavioral Health as part of the credentialing process. Providers are expected to gather data on member and family satisfaction with care at least annually and demonstrate quality improvement initiatives in response to satisfaction survey results.