



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.

INPATIENT HOSPITALIZATION

PERFORMANCE STANDARDS

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 the child and/or adult 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 member’s immediate status and needs and fulfilling the following purposes toward continued recovery for the member:

- 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 member with participation by appropriate inpatient staff, the member, family/significant others (if member 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 member is currently being served by a community based service, such as case management, community treatment team (CTT) or in-home family based services. When the member or family/significant other indicates their involvement, these programs must be notified as soon as possible that the member has presented at the emergency department for inpatient admission, be available to give pertinent clinical information and to assess the member 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 should be completed upon admission to the unit:

- Nursing assessment within one hour of the admission.
- MD evaluation within 24 hours of the admission.
- MISA assessment within 24 hours of admission.
- Social worker assessment within 48 hours of admission which includes the following:
 - Identification and contact with the member’s outpatient treatment team to obtain clinical information.

- Treatment history.
- Current treatment modalities being delivered.
- Beginning the process of transition planning from the inpatient level of care.
- Initial contact with the family/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 member's return to community living, as appropriate and agreed to by the member.
- For children and adolescents, the school should be contacted the next school day. Children, Youth, and Family Services (CYS) and Juvenile Probation and Parole must also be notified with 24 hours of admission if a child has a current relationship with those agencies.
- An explanation of the member's rights and responsibilities including information on how to contact the patient advocate if he/she is dissatisfied with any aspect of care.

Providers are expected to provide this information to the member 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 the member and family/significant other as appropriate and agreed to by the member, in the development and implementation of the inpatient treatment plan and all aftercare planning is crucial to the success of the member 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 member to the unit previously used for inpatient hospitalization whenever possible, to insure continuity of care, with the exception of member dissatisfaction with previous treatment and a request to be treated by another provider.
- Availability of social work staff seven days a week to meet the needs of the family/significant other and to ensure appropriate aftercare and supports are available to the member and family/significant other once the member is discharged from inpatient care. Given appropriate member agreement to contact the 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 member 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 member, ancillary assessments, and treatment plan seven days a week with documentation in progress notes.
- Medication treatment plan clearly documented in member record to ensure an integrated treatment plan which ensures continuity by MD coverage.
- Transition plan clearly documented to prevent any delay in the member's discharge.
- Linkages to next level of care clearly documented, including provider, address, date, time, and contact person.

RECOVERY

Inpatient providers are responsible for promoting a recovery environment for the member 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 member must be informed of his/her rights and responsibilities at the time of admission. The member 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 member at the time of admission, in addition to being posted in a clearly visible location on the unit.
- Provide opportunities for the member to participate in the development of his/her treatment plan. Providers must demonstrate methods by which they will engage the member in the development of his/her treatment plan. Whenever possible and with the member's consent, family/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 member in his/her continued recovery in the community.
- The member's right to choose his/her service provider should be explained and guidance offered in this area. The member should be encouraged to request assistance in making informed choices by using their assigned SCU administrative case manager, intensive case manager/resource coordinator (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 member's cultural needs whenever possible. The member should be encouraged to exercise his/her right to choose based on his/her specific cultural needs.
- The member, and/or family/significant other, 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

Inpatient providers are responsible for ensuring that efforts are made to provide these linkages for the member, 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 member record and must include the following:

- Contact with the member's current behavioral health provider to obtain current treatment information including medication regime.
- Identification of the member's primary care physician (PCP) and notification of the member'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 member's current housing arrangement within 24 hours of admission to determine the appropriateness for the member's return to that location, e.g., Personal Care Boarding Home (PCBH), specialized mental health housing, Bridge Housing, family, etc.
- Contact with the member'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 member 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 member 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 member.
- 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 member.
- Contact with the county community hospital liaison whenever indicated for members without ICM/RC or CTT involvement.
- Identification of spiritual and religious needs or issues.

DISPOSITION PLANNING

Inpatient providers are 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 member record:

- A transition plan must be initiated within 24 hours of admission in collaboration with the outpatient treatment team, member and family/significant other.
- An estimated length of stay must be identified for the first utilization management review.
- The member's support system must be identified and included in transition planning with the agreement of the member.
- 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 RC, a referral should be made. If the member 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 member 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 using the discharge date as first day of service. Consider engagement with this service while member 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, the inpatient provider should coordinate the completion of the Best Practice evaluation recommending RTF including pertinent clinical information and recommendations for treatment.

DISCHARGE

At the time of both planned or against medical advice (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 AMA discharges, 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 member, family/significant other, and Community Care with an individualized updated crisis plan for the member.
- Every member should be given an appropriate crisis line telephone number.
- The member should have a follow up appointment within seven days of discharge in hand at discharge that includes the name and phone number of this aftercare provider.

- The member 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 member or family/significant other in writing at the time of discharge.
- The member who has an active Axis III diagnosis must be given an appointment with the PCP.
- Authorization for the next service should be obtained by the receiving provider and coordinated with Community Care.
- Discharge and follow up information should be given to the Community Care care manager via telephone or fax on the day of discharge.
- A release of information 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. The following are crucial elements of this reporting:

- The inpatient provider is responsible for making contact with Community Care 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 Axes I-V must be provided to Community Care upon admission and discharge.

COMPREHENSIVE PROVIDER EVALUATION PROCESS (CPEP)

Community Care provides an annual CPEP report that includes several indicators related to inpatient services such as length of stay, readmission rate, significant member incidents, and member 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. This plan must be submitted to Community Care 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.