

CLINICAL PERFORMANCE STANDARDS
Extended Acute Care (EAC)
Services

Updated March 2026



**Community
Behavioral
Health**

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1. PURPOSE

The Extended Acute Care (EAC) Services Clinical Performance Standards (CPS) outline expectations for high-quality service delivery to members whose services are funded through Community Behavioral Health (CBH) or Philadelphia County. They are intended as a guide for providers to design and monitor their EAC programs and for CBH to evaluate these services. The Standards support recovery and resilience through comprehensive assessment, individualized treatment planning, mobilization of supports, and comprehensive discharge planning. CBH expects quality care for all members, with no cited refusals for providing care and treatment to members, regardless of any previous treatment experiences.

The EAC CPS reflect the core values and principles of the City of Philadelphia Department of Behavioral Health and Intellectual Disability Services (DBHIDS) [Practice Guidelines for Resilience and Recovery Oriented Treatment](#), [55 Pa. Code § 1151: Inpatient Psychiatric Services](#), and [55 Pa. Code § 5100: Mental Health Procedures](#). These standards aim to describe foundational standards, promote continuous quality improvement and best practices, increase consistency in service delivery, and improve outcomes for members and their families.

CBH developed these CPS in collaboration with EAC providers through a process guided by best-practice research, consensus, and state regulation.

2. SCOPE OF SERVICES

The DBHIDS practice guidelines emphasize resilience through community-based, least restrictive care whenever possible; EAC is intended for members exhibiting ongoing acute symptoms that cannot be managed outside of an acute inpatient (AIP) hospitalization setting, who pose a risk to themselves or others, or who are otherwise unable to maintain safety in a less restrictive setting. It provides comprehensive, intensive, short-term, resolution-focused treatment, including psychotherapeutic and psychotropic medication interventions, for members in a secure facility. This intensive level of care (LOC) requires coordination among families and other treatment and community-based providers for the member to successfully return to and remain in the community.

3. ADMISSION

The DBHIDS practice guidelines describe the admission process as the earliest opportunity to identify resilience capital embedded in the individual, family, and community. In accordance with the [CBH Provider Refusal Policy](#), providers must accept members for EAC that CBH deems appropriate, as evidenced by ongoing physician advisor consultations and the use of CBH's [medical necessity criteria \(MNC\) for EAC](#). Consideration for admission occurs if the member has not attained stability despite treatment interventions and is not able to step down to less intensive LOCs. CBH is open to review uniquely challenged member cases on case-by-case with

the EAC clinical leadership team when a level of recommendation is made by the treating team and approved by the CBH physician but denied by EAC. The denial must be clinically justified and reviewed through a case conference with the provider and the Senior Director of Complex Care and Special Populations.

The AIP unit must provide a clear, step-by-step clinical pathway that outlines the member's course of care, including all interventions, supports, and treatment strategies implemented before the referral to the EAC unit. This pathway should identify the specific interventions attempted, the member's response to these interventions, and the clinical indicators that prompted the need for referral to EAC. As EAC units provide treatment services that cannot be delivered in standard AIP units, a referral to EAC must therefore reflect that all appropriate acute-level interventions have been attempted, documented, and the member's continued needs exceed the scope of the AIP unit. Specifically, Adult Inpatient Units are hospital-licensed, medically intensive, and short-term psychiatric services for individuals who meet inpatient criteria, whereas EAC is a non-hospital, longer-term residential stabilization program for individuals who no longer require hospital-level care but still need 24-hour structured treatment. EACs have a focus on continued symptom reduction, function improvement and transition planning to a lower level of care while reducing readmission to acute inpatient and long lengths of stay.

It is expected that a physician-to-physician review be conducted between the EAC and the acute hospital before admission to the EAC. For members approved for EAC who have support coordination, the EAC will work collaboratively to obtain a copy of the individual service plan (ISP) and partner with CBH, Intellectual Disability Services, and the respective supports coordinator organization (SCO) to ensure coordinated, person-centered care.

The admission process should include a consultation with the Admission, Discharge, and Planning Team (ADAPT), a component within DBHIDS that conducts all evaluations for members authorized by CBH for admission into the EAC LOC.

The ADAPT unit's primary function is to ensure that the comprehensive evaluation is integrated into the initial treatment plan. It should include interviewing the member, compiling all relevant medical records, consulting with the referring AIP provider and the CBH physician, and implementing clinical management. ADAPT is also responsible for managing the referrals and admissions to EAC. Additionally, ADAPT provides support to the EAC by connecting consumers to community resources during discharge planning. It is expected that the comprehensive evaluation completed by the ADAPT unit will be integrated into the treatment plan and monitored as part of the CBH utilization review (UR) process.

To promote seamless, person-centered care, the ADAPT team will be invited to collaborate with the CBH UR and EAC treatment teams at least two weeks before admission. Together, and in partnership with CBH clinical management, the teams will align treatment goals and coordinate services to ensure the members' needs are fully supported.

EAC should include family, case managers, guardians, and other support systems in the member's treatment, both formally through team meetings and informally through case updates. Upon admission and throughout the episode of care, ongoing clinical assessments are conducted to ensure the member continues to meet MNC for this LOC. If a member is actively engaged with case management (CM) services, the CM team collaborates closely with both the AIP and EAC treatment teams to facilitate a coordinated transition and warm handoff. CM remains involved for the first 30 days following admission to EAC to support stabilization and continuity and may be reactivated 60 days before discharge if the member continues to meet the MNC for CM services. As a part of comprehensive discharge and transition planning, an application for transitional independent placement (TIP) housing is initiated during the AIP phase and reviewed during the EAC transition meeting. If not completed, and if appropriate, the EAC should complete the TIP application as soon as possible. If the member is not appropriate for TIP placement, options such as domiciliary care, personal care, home placement, and other housing resources should be explored. Please note that an assessment should be completed with the [Philadelphia Corporation for Aging \(PCA\)](#) to determine eligibility for personal care or domiciliary care placement. If a member is eligible for but not receiving Supplemental Security Income (SSI), an application should be initiated with assistance from the family and other system partners who may be involved in the case. At the EAC transition meeting, entitlement documentation, benefit status, and other supportive housing eligibility materials are also reviewed collaboratively to ensure a seamless transition into community-based living when clinically appropriate. Admissions processes should maximize the involvement of family members and other supports in the member's treatment, thereby increasing the capacity for successful return to home, school, and community settings. Discharge planning activities begin during the admission process.

3.1. EAC Transition Meeting

The purpose of the EAC transition meeting is to ensure a seamless handoff that supports continuity of care, mitigates risk, and facilitates long-term treatment planning. The required attendees include the CBH clinical EAC team, AIP behavioral health team (i.e., SW, Psych, RN, etc.), EAC team, CM/community team, ADAPT team, and additional supports identified when clinically appropriate and with consent. A CBH EAC clinical care manager (CCM) is the primary facilitator who schedules the meeting, ensures all behavioral health disciplines are notified, develops a meeting agenda in collaboration with the treating providers, documents meeting outcomes, and assigns tasks and timelines to the members' charts. CCMs will also distribute written minutes to all participating teams following the conclusion of the EAC transition meeting. The AIP will identify unresolved needs requiring EAC transition, including present barriers to stabilization in acute care. AIP will also provide all completed legal documents and entitlement materials, as well as the status of the process of acquiring any outstanding documents. The EAC team outlines initial transition goals and anticipated treatment focus and requests any additional documentation needed before admission. The CM team reviews entitlement and benefit status, ensures that supportive housing eligibility documents are up to date, and identifies any applications that must be initiated or renewed before CM services are suspended following the transition to EAC. The ADAPT team

provides recommendations for behavioral interventions and treatment planning during transition and continued stay within EAC.

3.2. Informed Consent

Psychoeducation and informed consent are critical components of EAC. The informed consent process should be viewed as an opportunity to engage the member and family members, provide education about the goals of EAC treatment, and emphasize their involvement as a predictor of the member's success in treatment. EAC providers should utilize partnerships with outside agencies whose staff may have contact with guardians and family members, as applicable, including outpatient providers, case managers, and CBH, to keep guardians and family members involved in the admission process.

A staff member knowledgeable about the consent forms and processes should assist members and their guardians in reviewing and signing the consent documentation. Consent forms should be culturally and linguistically appropriate. Release of information forms must include the names of the members/agencies, the type of information to be shared, and the date the consent was signed. Signatures on consent forms for treatment and information releases should be obtained within 48 hours following authorization for inpatient treatment. If a member is too disorganized or refuses to participate in the consent process within the first 48 hours of admission, documentation of the member's refusal would satisfy this standard.

3.2.1. Assessment

Assessments provide the foundation for individualized treatment planning, ensuring that interventions are targeted to the member's current clinical presentation, recovery goals, and psychosocial needs. The ADAPT assessment will be used as part of the admission process, in conjunction with assessments completed by the EAC. Both provide the foundation for an individualized and integrative assessment to be performed (required components are listed below) that addresses mental health, physical health, substance use, education, family and developmental history, trauma, and health-related social needs (HRSN). An assessment should emphasize wellness and symptom reduction. The voices of the member and their caregiver/family, along with their respective perceptions of the presenting challenges, must be included. Monthly reassessments throughout the member's time in EAC are equally vital, as they ensure that the member continues to meet MNC for this LOC and that treatment remains clinically appropriate and goal-directed. Assessments should also be utilized as a guide for discharge and transition planning, helping to identify when a member can safely move to a less restrictive environment while maintaining continuity of care. Discharge planning should begin during admission; staff should identify and address any barriers that may prevent the member from successfully returning home and participating in community-based treatment.

An essential part of the assessment process is risk assessment. A risk assessment should be completed and documented as early in the admission process as possible. It should address

aggression/destruction of property, self-injurious behavior, bullying (whether victim or perpetrator), suicidality, homicidality, elopement risk, and sexual acting out. CBH requires a structured tool to assess risk of self-harm or suicide, such as the [Columbia Suicide Severity Rating Scale \(C-SSRS\)](#). For members who are determined to be moderate or high risk for suicide or self-harm, EAC providers should initiate appropriate monitoring and treatment plan interventions to address the risk, including safety planning. A risk assessment can be completed by any combination of nurses, social workers, and psychiatrists. An accompanying individualized safety plan should be completed and documented to address identified risks and guide treatment in the EAC unit; it should then be revised for discharge/aftercare (see [Section 5.1: Disposition](#)). Trauma assessment tools should also be included in the assessment process. Many EAC members have long histories of abuse and neglect and aged out of the [PA Department of Human Services](#). Assessments should include adaptive assessment scales to understand the member's capacity to understand and participate in treatment. The EAC should have physician and nursing capacity to treat chronic and complex medical needs onsite. Appropriate physical examination and monitoring will occur in accordance with best practices. EAC should be able to obtain necessary laboratory work at admission, for ongoing monitoring, and when more in-depth testing is needed.

For members with co-occurring disorders who may be able to remain in EAC, the EAC must implement an integrated approach to care, including screening and symptom monitoring, treatment integration, evidence-based practice therapies, and utilization of a collaborative team of professionals (i.e., therapists, doctors, social workers) with expertise in both mental health and substance use disorder.

A substance use assessment must be completed using the [American Society of Addiction Medicine \(ASAM\) Criteria \(3rd Edition\)](#) assessment tool when clinically indicated with recommendations for substance use treatment must also be presented to CBH as needed for various LOC approvals.

3.2.2. Nursing

The nursing assessment is an in-person assessment completed within the first 12 hours by a licensed practical nurse (LPN) or a registered nurse (RN), either of whom must have specialized training or one year of experience in psychiatric care (per [55 Pa. Code § 1151.66\(c\)\(2\)](#) relating to team developing plan of care). An RN must co-sign an assessment completed by an LPN. During this assessment, the nurse should greet the member, conduct a body scan and document any injuries or bruising, provide any pertinent education/handouts about mental health topics and hospital protocol, check vital signs, obtain health history, identify complex medical needs and determine whether they are within the threshold of hospital criteria, conduct a risk assessment (unless conducted by another qualified staff person), screen for substance use, complete nutrition inventory, begin discharge planning, and ensure continuity of care with psychiatry.

The nurse or other delegated clinical staff should obtain and review the list of discharge medications from the AIP psychiatry unit and may assist with medication reconciliation (as directed by the EAC admitting physician).

3.2.3. Psychiatric Evaluation

The psychiatric admission evaluation is an in-person evaluation with a psychiatrist completed within the first 24 hours of admission that results in a [DSM](#) diagnosis and prescription of extended AIP treatment as the most appropriate, least restrictive service to meet the mental health needs of the member. The psychiatrist should review the discharge medication list from the AIP psychiatry unit and, based on the psychiatric evaluation, resume or modify these medications according to their professional clinical judgment and the member's current presentation and treatment needs. (see [Section 4.1.5: Medication Management](#)). The psychiatrist will continue to meet with the member daily during the hospital admission to assess the need for any treatment modifications and to determine if the member requires a continued stay. The psychiatrist should document these assessments in daily progress notes.

Whenever possible, the treating psychiatrist should address and update any ruled-out diagnoses throughout the course of EAC treatment and before the member's discharge.

3.2.4. History and Physical (H&P)

A physician completes the H&P examination within the first 24 hours of admission. This should include collaboration with the primary care physician. The H&P is an opportunity to order consultations and tests as indicated. Providers are encouraged to maintain contacts and ongoing relationships with local primary care physicians to ensure daily physician access and maintain the 24-hour standard of care.

3.2.5. Allied Health Assessment

A mental health professional conducts the Allied Health Assessment. The mental health professional must have a bachelor's degree in social work or a related field such as psychology, human services, sociology, behavioral health or other social service-related field. Based on the member's interests, this assessment determines developmentally appropriate therapeutic activities to add to the course of treatment, including, but not limited to, art, dance movement, athletics, pet therapy, music, relaxation, horticulture, or occupational therapy. The allied health assessment is an opportunity to conceptualize a case, tailor a treatment plan to each member's unique needs and strengths and reinforce patterns of healthy play in preparation for returning home.

3.2.6. Psychosocial Assessment

The psychosocial assessment should begin upon authorization and be completed within 72 hours via collateral contacts and an in-person interview at the EAC unit with a master's-level clinician. If a member is too disorganized or refuses to participate in the assessment process within the first 72 hours of admission, documentation of the member's refusal would satisfy this standard.

Outreach to other involved parties should also start at admission, with attempts documented and letters filed (see [Section 4.1.6: Collaboration](#)). The assessor should gather and synthesize all relevant information to produce a comprehensive clinical formulation that addresses functioning across domains. Efficient staffing strategies are necessary, particularly for evening and weekend social work, to ensure that the psychosocial assessment process can begin as soon as possible for members, regardless of the time or day of admission. Part of the psychosocial assessment should include an adaptive assessment of life skills, and key components should include:

- ➔ **Personal and social history:** Includes background information, family history, education, employment, and relationships
- ➔ **Mental and physical health:** Covers psychiatric history, current symptoms, coping mechanisms, and medical history
- ➔ **Current functioning:** Assesses how the member functions in their daily life, including self-perception and ability to function in the community
- ➔ **Social and environmental factors:** Explores social support systems, living situation, and external influences like work or school environments
- ➔ **Risk assessment:** Includes questions about thoughts of self-harm or harming others
- ➔ **Strengths and abilities:** Identifies a member's positive attributes and coping mechanisms
- ➔ **Goals:** Assesses what the member hopes to achieve through treatment

The psychosocial assessor should obtain information about the viability of a member's return to the previous housing arrangement.

Every effort should be made to preserve viable placements and relationships; alternate placements should be pursued concurrently when the team and family agree that this is necessary, with the incorporation and prioritization of the member's input and preferences.

3.2.7. Structured Tools

CBH requires administering at least

- ➔ (2) Evidence-supported structured tools
- ➔ (1) Trauma screening/assessment tool
- ➔ (1) HRSN screening tool
- ➔ (1) Diagnostic tool selected by the provider

- ➔ (1) Depression Screening Tool (Use the [Patient Health Questionnaire-9, or PHQ-9](#))

Assessing trauma responses should be part of the comprehensive evaluation, which includes a person’s history of trauma and current symptoms, such as flashbacks, nightmares, irritability, and sleep disturbances. This process typically includes screening for traumatic experiences and symptoms, a clinical interview, and potentially a formal assessment using standardized tools. Provider should screen all members for depression using the PHQ-9.

Tools should be developmentally appropriate and relevant to the member’s symptoms. Structured tools will assist in refining the diagnostic assessment, thereby reducing the incidence of members being discharged without confirmed, specific diagnoses (e.g., to reduce “provisional” and “not otherwise specified” diagnoses). Structured tools can also promote individualized and trauma-informed assessment, preventing misdiagnoses and inappropriate interventions. Structured tools must be completed, scored, shared with the team, and incorporated into treatment within one week of admission.

The provider should select the tools used. Suggested tools are provided in [Section 7: References](#).

4. COURSE OF TREATMENT

EAC treatment should be comprehensive, trauma-informed, individual/family-driven, and tailored to individual needs and preferences. The course of treatment should incorporate a whole-person approach, providing comprehensive assessment, treatment, and discharge planning for all members. Psychiatric nursing and clinical staff should be available 24/7 to implement treatment and closely monitor responses to EAC interventions. EAC providers must maintain continuous 24-hour nursing services, with an RN supervising care, and an RN or LPN must be on duty at all times. Staff must be able to address myriad presenting challenges stemming from mental health needs, substance use, cognitive limitations, medical complexities, psychosocial barriers, legal involvement, or a combination of these. Well-established referral pathways and connections to community supports should be mobilized to ensure successful discharges. Services should be culturally competent, trauma-informed, and able to meet the special needs of members. Wellness should be emphasized in addition to symptom reduction, with the goal of achieving timely discharge to the most appropriate, least restrictive setting. Incorporating a strong recovery focus, including life skills training and preparation for community reintegration, is another essential principle of EAC. Evidence-based practices should be utilized across treatment modalities.

4.1. Treatment Modalities

4.1.1. Family Therapy

Family treatment is a critical component of extended AIP treatment. Family treatment sessions enable skill practice and acquisition through real-life enactments, thereby increasing the likelihood of a positive and sustained outcome. In addition, family treatment sessions provide opportunities

for family members to voice their desire for the next LOC/service and for providers and families to consider and tackle any anticipated barriers to a successful return home.

Family sessions must be prioritized in treatment planning and delivery, and any barriers to consistent meetings must be addressed. Providers are encouraged to accommodate family members' schedules, including maintaining weekend and evening slots, providing supportive and consistent outreach via phone calls/letters, and offering transportation assistance. Face-to-face sessions are preferred family treatment modalities. However, telephonic or video sessions should be provided when needed. Social workers typically conduct family sessions; however, other treatment team members, such as psychiatrists, are also encouraged to participate in family sessions, particularly when families request their involvement.

The frequency of family sessions should be determined based on the member's needs, but at a minimum, should include family sessions at the onset of treatment and at least monthly. A master's-level clinician must render family therapy to ensure adherence to clinical standards and alignment with evidence-based practice.

4.1.2. Individual Therapy

Members will receive individual support from the inpatient team throughout their hospitalization. Individual therapy is particularly essential for members who may struggle with group treatment modalities or whose needs are best addressed through individual modalities; in these cases, individual therapy should occur at least once weekly.

Providers should also maintain the capacity to provide specialized individual therapy to address trauma, risk behaviors, substance use issues, or other challenges that surpass what can be addressed by the traditional inpatient milieu approaches. Evidence-based treatments are particularly encouraged during individual treatment. Therapists should frequently and transparently document, discuss, and coordinate the therapeutic techniques and modalities being used with other members of the treatment team. Individual therapy sessions will be conducted by a master's level mental health clinician to ensure adherence to best practices and quality of care. Bachelor's level staff may support the therapeutic process through milieu support, facilitation of psychoeducational groups, structured interventions, and individual skill building. Bachelor's level staff should possess a bachelor's degree in social work or a related field such as psychology, human services, sociology, behavioral health or other social service-related field. Weekly therapy at the EAC level is essential for reinforcing treatment goals and coping strategies between team interventions. This also enhances member engagement, empowerment, and self-efficacy.

4.1.3. Milieu Therapy

Milieu therapy encompasses various activities within a treatment environment that provide structure, predictability, consistency, and stability during extended acute stays. Examples of milieu therapy include the management and layout of the environment, efforts to maintain safety and security, and the daily program schedule. Emerging data support moving away from non-evidence-

based approaches, such as point and level systems, toward patient-centered, trauma-informed approaches based on collaborative problem-solving. Evidence demonstrates that such strategies improve individual self-efficacy and reduce adverse outcomes, including restraints and seclusions.

4.1.4. Group/Allied Therapy

Allied and group therapies include activities tailored to a member's interests and strengths, including, but not limited to, art, dance movement, athletics, pet therapy, music, relaxation, horticulture, and occupational therapy. Providers should regularly evaluate and update programming and staff to provide members with various outlets for play and healing. Group therapy should include evidence-based or empirically supported programming tailored to the treatment needs of no more than 12 members in the unit per group. While carefully selected videos and other media can serve as tools to enhance group therapy, the content should have a clear therapeutic purpose. A facilitated discussion must accompany it. Groups may address challenges related to communication, anger/affect regulation, trauma, substance use, and social skills. Family psychoeducation and support groups are also encouraged. Creative expressive arts, as part of allied therapy in an extended AIP unit, offer benefits such as stress reduction, improved mood, and enhanced self-expression and can be implemented through various activities, including drawing, painting, music, and movement. These therapies are designed to provide a non-verbal outlet for members, helping them process difficult emotions, connect with themselves and others, and develop coping skills during their length of stay.

4.1.5. Medication Management

Psychiatrists should assess a member's medication needs during the first contact to ensure necessary treatment begins as soon as possible. As noted above, medication consent should be sought daily as required, once a medication is recommended, and should be obtained through informed consent. EAC providers must complete medication reconciliation during the admission process and initial assessment. This should include a detailed review of the discharge medication list from the AIP unit, as well as contact with pharmacies or other prescribers if needed for clarification. The admitting prescriber should promptly place orders for all medications that are to be continued to prevent missed doses. Modifications can be made once the initial EAC psychiatric assessment has been completed. The treating psychiatrist should document any barriers to medication initiation and titration and communicate to CBH, including a plan to address those barriers, within 14 days.

If the member has an established outpatient psychiatrist, a treatment team member must contact the outside psychiatrist. Established primary care or medical specialty providers should also be consulted for medically complex members and when medical input is required to make an appropriate and safe medication recommendation (psychiatrists can review physical health documents for this information, if sufficient). Outreach attempts and collaboration should be documented. General physical health providers and other specialty care physicians should be available for face-to-face consultation throughout the member's EAC stay, if needed to address new or complex medical concerns and treatments.

Psychiatrists must meet with family members in person or via a HIPAA-compliant video platform, or by phone when face-to-face meetings are not possible. Outreach efforts should be documented, and providers should request support from the CBH Clinical Team to engage family members.

When medication is being considered as part of treatment, there should be an interactive, well-documented discussion, utilizing principles of [Shared Decision-Making](#) with the member and caregiver/guardian as needed regarding:

- ➔ The rationale for an initial prescription of medication, including the condition or targeted symptoms
- ➔ The risks associated explicitly with the proposed use
- ➔ If the selected medication is off-label, the nature of off-label use and the reasons for choosing the non-FDA-approved medication
- ➔ As applicable, the nature of any black box warnings, as well as the regulatory requirements and monitoring schedules set forth by the FDA for these uses
- ➔ Proposed strategy for tapering and discontinuing the prescribed medication

Documentation should clearly describe the details and rationale from the above list and indicate that they were discussed with the member and caregiver/guardian as needed.

It is expected that members who are prescribed antipsychotic medications and mood stabilizers that require routine laboratory monitoring will continue to have laboratory monitoring ordered at intervals that reflect best practices and the standard of care. (see [CBH pharmacy resources for providers](#)). When a member refuses to undergo recommended medical assessment and bloodwork, this should be documented, along with efforts made by the treatment team to engage the member in participation and a discussion of the risks and benefits of refusal.

Given the unique nature of the EAC treatment setting, there are opportunities to make substantial changes to the medication regimen that may require more gradual titration or taper than can be accomplished in a relatively brief AIP setting, or more careful monitoring than can be done in an outpatient setting. Consideration should be given to optimizing psychiatric medications to a regimen that will enhance functioning and the member's sense of well-being, while minimizing side effects. Medication changes should be made promptly to avoid unnecessarily prolonging the member's stay.

Throughout the EAC treatment stay, whenever a member's progress has plateaued, symptoms have increased, side effects or medical complications have emerged, or the member has needed frequent "as needed" or "PRN" medication administration, changes to the medication regimen should be considered. The psychiatric progress notes should include the plan related to medication titration, the rationale for changes/adjustments (or lack thereof), and the options discussed with the member.

Once the member has begun to experience relative stability and particularly leading up to planned discharge, the medication regimen should be consolidated to the fewest number of pills and doses, and polypharmacy should be reduced to the greatest extent possible. Consideration should be given to converting medications to extended-release formulations, as well as [long-acting injectable \(LAI\) medications](#), to improve the manageability of and adherence to the medication regimen.

Literature and guidelines regarding pharmacotherapy best practices must be consulted and documented. CBH has developed [clinical practice guidelines \(CPGs\)](#) to outline best practices for treating specific disorders or particular populations. The CPGs reflect evidence-based guidelines from leading expert groups, such as the [Substance Abuse and Mental Health Services Administration \(SAMHSA\)](#), the [American Academy of Child and Adolescent Psychiatry \(AACAP\)](#), and the [American Psychiatric Association \(APA\)](#). A well-documented rationale should accompany any use of polypharmacy. Additionally, CBH maintains robust [pharmacy resources](#) that are updated frequently on [cbhphilly.org](#).

4.1.5.1. Daily Assessment and Psychiatric Notes

The EAC psychiatrist should conduct in-person daily assessments for every member and document these in the daily psychiatric progress note, including a complete mental status examination (MSE). The MSE should describe the clinical presentation of the member. MSEs should be individualized and specific for each member. A daily assessment, including a detailed MSE, along with the psychiatrist's assessment of the treatment trajectory and plan, helps facilitate efficient utilization review and clarify the need for continued stay. This expectation ensures daily assessment from a psychiatrist occurs to reduce length of stay.

The attending physician must complete the daily in-person assessment and progress notes. Notes should address treatment planning, progress, medication, and any changes in medication with a clear rationale in addition to the MSE. EAC staff must provide psychoeducation to the member on treatment planning, progress, and medication, and ensure the member's participation in decision-making.

4.1.6. Collaboration

Strong collaboration with collateral providers/supports is essential to tailoring inpatient treatment and discharge recommendations to the member. All outreach to collateral contacts should begin at admission and be documented; when contacts do not respond, CBH Member Services, Provider Relations, and Clinical Care Management should be consulted.

4.1.7. Current and Past Treatment Providers

Collaboration with other treatment providers is crucial to delivering effective treatment. Providers should consult current and past providers to determine previous interventions and their impact. Collaboration among providers helps the extended acute treatment team to continue effective interventions or introduce new ones when needed, thus increasing the likelihood of engagement

from a member who may otherwise be experiencing “treatment fatigue” or discouragement. Partnering with a provider who will resume treatment after discharge helps to ensure consistency in treatment approaches.

4.1.8. Treatment Planning

PA regulations indicate that treatment plans should be based on the member’s diagnostic evaluation, including the presenting condition’s medical, psychological, psychosocial, behavioral, and developmental aspects, as well as the medical need for inpatient psychiatric care. An interdisciplinary team of professionals should develop the plan, and the individual and their family members must drive it, clearly understanding the goals as they are documented.

Goals should be measurable, achievable, developmentally appropriate, and related to all areas of the member’s life. Goals should include specific objectives and an integrated program of therapies, activities, and experiences designed to achieve these objectives. The treatment plan should evolve and change as it tracks progress rather than marking time intervals. The initial treatment plan must be completed within 72 hours and updated every 14 days. Goals should be modified for attainability if not met after 30 days.

The plan should be designed to achieve immediate discharge from inpatient status. The discharge plan should include coordination of inpatient services with partial discharge plans and related community services to ensure continuity of care with the individual, family, school, and community upon discharge.

4.1.9. Psychological Testing

Providers should ensure members who demonstrate such a need have access to psychological testing. Testing should be used to understand the member’s cognitive, emotional, and behavioral functioning and the impact this may have on their behaviors and coping mechanisms. Psychological testing can facilitate diagnostic clarity and individualized recommendations. All program planning and staffing efforts should be geared toward the timely return of test results, allowing for appropriate treatment.

4.1.10. Enhanced Staffing Requests

All initial requests for enhanced staffing (1:1) or private rooms within the EAC must be submitted to the assigned CCM before 3:00 p.m. Requests made after this time will be processed through the PES line (215-413-7171). If a provider wishes to request enhanced staffing or a private room during a member’s continued stay, the request should be made to the assigned CCM within one business day of the beginning of the enhanced staffing or private room. In this instance, the CCM may retroactively authorize up to one business day. If a provider has been delivering enhanced staffing or providing a private room to a member and wishes to request retrospective approval, only a physician advisor may retroactively approve enhanced staffing or a private room of more than one business day. If a member receiving enhanced staffing or a private room leaves a provider to receive

outside treatment (e.g., transfer to a medical unit) and then returns to the same LOC at the same provider, the agency should contact their assigned CCM via email or voicemail to confirm the readmission date, and the CCM will document it. Concurrent requests must be submitted to the assigned CCM must include the following: A clinical rationale and risk factors, complete mental status exam (MSE), description of safety concerns or triggers, dates and hours of need, titration plan indicating how staffing will be reduced as clinically appropriate, safety interventions utilized and an explanation of how enhanced staffing will support the member therapeutically. All requests will be reviewed with the physician advisor to determine medical necessity, with the review frequency determined by the approving physician based on clinical indication. Failure to follow these procedures may result in delays or denial of enhanced staffing authorizations.

4.1.11. Activities of Hospital Grounds

Any activities outside of the unit must have a clearly therapeutic or medically necessary purpose, which should be documented in the treatment plan. EAC units should have a written policy for assessing the elopement risk and overall safety risk of the member, based on their current clinical presentation, when making determinations for members participating in any activity off hospital grounds. The individualized assessment should take into account the member's current mental status, recent behaviors, risk factors such as history of aggression, psychosis, medication, and treatment compliance, level of insight, commitment status, etc. The attending psychiatrist should be involved in the determination process and must provide approval for members to participate in off-site therapeutic activities.

CBH advises that only members who are psychiatrically stable, nearing the end of their stay on the EAC unit, and are not at imminent risk of harm to themselves or others should be considered for attendance at elective activities off the unit (this does not include medical appointments). CBH will approve 1:1's for higher risk members for necessary appointments. These appointments can refer to obtaining vital documents, medical appointments, or other activities that support disposition planning.

5. DISCHARGE/AFTERCARE

5.1. Disposition

As noted in the [Psychosocial Assessment section](#), providers should initiate investigations into return home/discharge options at admission. They should engage family members, guardians, other treatment providers, and CBH to facilitate an appropriate disposition plan. CBH will participate in care coordination meetings with the EAC providers as part of the UR process, including attending interagency meetings and addressing any barriers that may impact disposition.

Safety planning must occur as a part of the discharge process. Safety planning should include triggers and warning signs for harm to self and others that may arise following discharge. The safety

plan should include individualized strategies and coping skills, as well as supportive and clinical contacts, and crisis resources. Safety planning should also address the risk of re-traumatization for members who have experienced trauma in the setting where they are returning. The safety plan should be reviewed with the member and their identified supports before discharge.

Since the risk of re-hospitalization is highest during the two weeks following discharge, providers should educate families about this risk and help them anticipate challenges, identify strategies, and access supports to aid in addressing the member's continued needs in the community setting. Providers should also guide families in considering scenarios that require a visit to a crisis response center (CRC) versus those in which other supports may be more effective.

5.1.1. Psychiatric Evaluation

A psychiatric evaluation must be completed for every member who requires a pre-approved next LOC. The written evaluation, along with the following LOC recommendations, must be submitted to CBH within five business days after the recommendations are made. An essential aspect of discharge planning is that the evaluation is closely reviewed by receiving treatment providers. It should be thorough, comprehensive, and strengths-based, providing reasons for hospitalization, a summary of the hospitalization/hospital course, a solid biopsychosocial formulation, diagnoses, and rationale for recommendations completed by a licensed psychiatrist or psychologist. A formulation is a narrative that encompasses and expands on predisposing, precipitating, perpetuating, and protective factors. Treatment history, including past and current services, medication trials, and responses to these trials, must be included. Recommendations for intensive LOCs, such as Residential Treatment Facilities for Adults (RTFAs), must be substantiated by demonstrating previous interventions, their impact, and the anticipated goals of residential treatment. Several LOCs, including RTFA, Adult Mental Health Residential (AMHR), and Community Treatment Team – Community Supported Living (CTT-CSL), Non-Hospital EAC (C-EAC), and the Philadelphia Model (IBHLTC), require completion of a comprehensive biopsychosocial evaluation (CBE). See [CBH Provider Manual](#) Section 3.9: Service-Specific Guidelines and the Comprehensive Biopsychosocial Evaluation (CBE) Required Elements Appendix for more information.

5.2. Case Management (CM)

Discharge planning begins upon admission, with initial identification of potential community supports and housing considerations. Within 30 days of anticipated discharge, CM services for members who have been identified as meeting MNC shall be actively reengaged or engaged with the provider to secure community resources, support outpatient appointments, and ensure continuity of care when transitioning into the community. EAC ensures warm handoffs to community providers and confirms connections to outpatient services. All discharge and transition planning activities must be clearly documented, including dates, as well as communication outcomes with receiving providers and member/family participation.

5.3. Services

The full continuum of services, including evidence-based practices, should be considered when planning the subsequent services. Partial hospitalization should be considered when a member requires continued intensive care. Outpatient therapy should be considered in less intense cases or when specialized evidence-based treatment is indicated. Inter-agency meetings are used to facilitate consensus about recommendations. Providers must engage the member receiving treatment and their caregivers/guardians, where applicable, to include their voice in recommendations and to ensure they understand the rationale for services. National and CBH data highlight the two weeks following discharge as a critical period for readmission risk. Thus, the first appointment with the subsequent provider must be scheduled for a date no more than seven days after discharge, with appropriate documentation of explanation in those situations when that cannot occur.

5.4. Prescriptions/Prior Authorizations

Providers should have a working knowledge of each insurer's policies and procedures regarding prior authorizations. Providers' internal policies and resources must address external authorization challenges to prevent access issues following discharge. Efforts to obtain prior authorization should begin at least five days prior to providers being given the results of laboratory studies to facilitate authorizations as needed. Members must be discharged with a 30-day supply of medication (or a prescription) and a refill prescription until their next medication appointment, which should be scheduled for no more than 30 days following discharge. For members who are prescribed an LAI medication, consideration should be given to coordinating with a pharmacy local to the member's discharge address for administration of the LAI in the event the member does not establish care with the next provider before the next injection is due.

The nurse or other delegated clinical staff should reconcile any medications the member has been using at home with those prescribed upon discharge.

5.5. Discharge Plan

The Discharge planning process should be based on a thorough assessment of the member's needs. Family should be actively involved in the planning process. Necessary steps should be taken to refer patients to other services, especially those within the community. The process begins at the time of admission to any treatment LOC and includes a team, including but not limited to case managers, family, social workers, nursing staff, and others involved in a case, to come together and identify a pathway to discharge. Effective and appropriate discharge planning can lead to successful and longer community tenure, especially when HRSN are resolved, which ultimately can reduce readmissions and improve the quality of interventions due to careful planning. Discharge planning is a necessary element of the assessment and treatment plan for every member admitted to any LOC. For the discharge planning to be effective, an assessment of the specific needs of that member should be done, which includes:

1. Capacity for Self-Care

Assess the patient's capacity, insight, and perception toward the psychiatric illness. This will help us understand their current levels of functioning and the potential need for support and assistance. The UR process will help those developing the plan to better understand how one responds to treatment and opportunities post-discharge for potential decompensation. This includes assessing social determinants, determining whether the patient has the necessary resources and ability to access the prescribed medications, and traveling for follow-up appointments. Furthermore, assessing strengths is essential in determining how one will handle the various aspects of their behavioral health disorders and treatment.

2. Clinical Needs

Identify the potential predisposing factors that can lead to distress or relapse. Information related to sleep patterns, nutrition, lived experience, and adverse effects of medications, among others, are factors that should be evaluated in partnership with those who know the member. Understanding past treatment episodes, precipitating factors, and early warning signs can help teach the member coping strategies before discharge. Furthermore, assess the family's understanding of the illness and its treatment, as well as their needs related to the illness. Having a crisis plan as part of the discharge planning process is essential.

3. Other Needs

Assess socioeconomic, cultural, and spiritual domains. Reviewing eligibility for other supports—particularly entitlements, waivers, and other community resources—will be important in the process to support members post-discharge.

The assessment in these areas will help to define the services and supports needed to transition from one LOC to another.

As previously noted, the plan will include diagnoses, outcomes of structured tools, a complete medication list, and recommendations for follow-up at the next recommended LOC. The discharge plan should consist of scheduling behavioral health appointments for the member (ideally with follow-up within seven days) and any recommended medical follow-up appointments. The plan should be reviewed with the individual and family/caregiver at discharge, along with treatment providers and other key people identified by the member. The discharge plan should be sent to the next treatment provider, primary care providers (PCP), and other relevant parties as determined by the member. The discharge plan should also include a review of the member's safety plan and provide an updated copy of the safety plan to the member and all identified supports (with consent).

For members with dual diagnoses, discharge plans must sufficiently address both mental health and substance use disorders, including appropriate follow-up care for mental health and substance use treatment. Providers should ensure that all parties understand the discharge plan. Recipients of the

discharge plan should be documented, and CBH CCM should receive the discharge plan within 24 hours of discharge.

6. FOLLOW-UP/OUTCOMES

The 30-day period following inpatient discharge is critical for successful acclimation or re-acclimation to the placement and the next LOC. The inpatient provider must maintain an active role in preventing re-admission. This can be accomplished through phone calls to assess the member’s adjustment and remind them about initial appointments. Providers are encouraged to adopt post-discharge monitoring strategies. CBH will facilitate readmission interviews for members who re-present for AIP admission within 30 days of discharge.

6.1. Summary of KPIs

Key performance indicators (KPIs) are well-defined performance measurements that monitor, analyze, and optimize all relevant processes to increase member satisfaction and safety. For the EAC Program LOC, the indicators assessed are as follows: Medicine Errors, Overturned Complaints, Elopement, Mortality, Refusals to Admit, Medical Admission, Suicide Attempts with Medical Attention, Restraints with Injury, Mechanical Restraints, and Physical Restraints. CBH will monitor these metrics quarterly through various contacts, including quality incidents (QI) and complaint data. For additional information, please refer to the Documentation and Significant Incident Reporting section of the [CBH Provider Manual](#).

Providers identified as outliers are reviewed with the CBH Quality Management Medical Director and Senior Director to determine further appropriate actions.

Further actions may include a root cause analysis by the provider, a phone consultation with the provider, or a plan to continue monitoring the provider for an additional quarter. Providers can expect to be notified during a regularly scheduled meeting with CBH or via email when identified as outliers within their LOC. Providers who continue to be recognized as outliers and fail to engage in quality improvement activities may be at risk of termination from the network.

Measure	Description	Numerator	Denominator	Responsible Party
Medicine Errors	Errors related to dispensing medication (The provider may have failed to follow a particular policy or procedure.)	Total number of medicine errors at the EAC facility on a quarterly basis	Total number of medicine errors at the EAC LOC on a quarterly basis	CBH Performance Evaluation Team
Overturned Complaints	Complaints supported in favor of the member (The provider may have failed to follow a particular policy or procedure.)	Total number of overturned complaints at the EAC facility on a quarterly basis	Total number of overturned complaints at the EAC LOC on a quarterly basis	CBH Performance Evaluation Team

Measure	Description	Numerator	Denominator	Responsible Party
Restraints with Injury	Incidents where a member who has been subjected to physical or mechanical restraints experiences physical harm or injury as a result of being restrained	Total number of times restraints with injury occur with members at the EAC facility on a quarterly basis	Total number of restraints with injury at the EAC LOC on a quarterly basis	CBH Performance Evaluation Team
Mechanical Restraints	Any device or instrument used to restrict a person's movement or limit their physical mobility	Total number of times mechanical restraints occurs with members at the EAC facility on a quarterly basis	Total number of mechanical restraints at the EAC LOC on a quarterly basis	CBH Performance Evaluation Team
Physical Restraints	Any action or procedure that prevents a person's free body movement to a position of choice and/or normal access to their body by the use of any method, attached or adjacent to a person's body that they cannot control or remove easily	Total number of times physical restraints occurs with members at the EAC facility on a quarterly basis	Total number of physical restraints at the EAC LOC on a quarterly basis	CBH Performance Evaluation Team
Founded Allegations of Abuse	Incidents of abuse where adult protective services substantiated the allegation	Total number of times founded allegations of abuse occurs with members at the EAC facility on a quarterly basis	Total number of times founded allegations of abuse occurs with members at the EAC LOC on a quarterly basis	CBH Performance Evaluation Team
Elopement	Incidents where a member has escaped or ran away from a secured bed-based facility	Total number of times elopement occurs with members at the EAC facility on a quarterly basis	Total number of times elopement occurs with members at the EAC LOC on a quarterly basis	CBH Performance Evaluation Team
Mortality	Incidents of member death resulting from suicide, overdose, or other phenomena	Total number of times mortality occurs with members at the EAC facility on an annual basis	Total number of times mortality occurs with members at the EAC LOC on an annual basis	CBH Performance Evaluation Team
Refusal to Admit	Incidents where there is bed availability but the provider refuses to accept the member	Total number of times refusals occurs with members at the EAC facility on a quarterly basis	Total number of times refusals occurs with members at the EAC LOC on a quarterly basis	CBH Performance Evaluation Team
Medical Admission	Incidents where members are admitted to a medical facility	Total number of times medical admissions occurs with members at the EAC facility on a quarterly basis	Total number of times medical admissions occurs with members at the EAC LOC on a quarterly basis	CBH Performance Evaluation Team
Suicide Attempts with Medical Attention	Suicide attempt of a member that requires medical attention	Total number of times suicide attempts with medical attention occurs with members at the EAC facility on a quarterly basis	Total number of suicide attempts with medical attention at the AIP LOC on a quarterly basis	CBH Performance Evaluation Team

In addition, all AIP providers will be reviewed quarterly using 7- and 30-day follow-up after discharge and readmission within 30 days of discharge as proxy measures for treatment outcomes. Performance reports for these measures will be shared with providers on a quarterly basis and discussed at CBH clinical provider meetings. Providers performing poorly on these measures may be asked to submit a root cause analysis and action plan to CBH. Conversely, providers that meet performance goals on these measures may be eligible to receive an annual performance award through the CBH Pay-For-Performance (P4P) program.

7. REFERENCES

- ➔ [CBH Provider Manual](#)
- ➔ [CBH MNC](#)
- ➔ [CBH Clinical Practice Guidelines](#)
- ➔ [CBH Pharmacy Resources for Providers](#)
- ➔ [P4P Operational Definitions](#) (Under the *Quality* tab)
- ➔ [55 Pa. Code § 1151: Inpatient Psychiatric Services](#)
- ➔ [55 Pa. Code § 5100: Mental Health Procedures](#)
- ➔ Depression: [Patient Health Questionnaire 9 \(PHQ-9\)](#)
- ➔ Suicide Assessment: [Columbia Suicide Severity Rating Scale \(C-SSRS\)](#)
- ➔ Post-Natal Depression: [Edinburgh Postnatal Depression Scale \(EPDS\)](#)
- ➔ National Institute on Drug Abuse: [Screening and Assessment Tools Chart](#)