Clinical Performance Standards:

Acute Inpatient Psychiatric (AIP)

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TABLE OF CONTENTS

1. Purpose ... 3

2. Scope of Services ... 3

3. Admission ... 3

3.1. Informed Consent ... 3

3.2. Assessment ... 4

3.2.1. Nursing ... 4

3.2.2. Psychiatric Treatment ... 5

3.2.3. History and Physical (H&P) ... 5

3.2.4. Allied Health ... 5

3.2.5. Psychosocial Assessment ... 5

3.2.6. Structured Tools ... 6

4. Course of Treatment ... 6

4.1. Treatment Modalities ... 6

4.1.1. Family Therapy ... 6

4.1.2. Individual Therapy ... 6

4.1.3. Milieu Therapy ... 7

4.1.4. Group/Allied Therapy ... 7

4.1.5. Medication Management ... 7

4.1.6. Collaboration ... 8

4.1.7. Interagency Service Planning Team (ISPT) ... 9

4.1.8. Treatment Planning ... 9

4.1.9. Psychological Testing ... 10

5. Discharge/Aftercare ... 10

5.1. Disposition ... 10

5.2. Services ... 10

5.3. Prescriptions/Prior Authorizations ... 10

5.4. Plan to Transition to School ... 11

5.5. Discharge Plan ... 11

6. Follow-Up/Outcomes ... 11

6.1. Summary of KPIs ... 11

References ... 14

1. PURPOSE

The Acute Inpatient Psychiatric (AIP) Services Performance Standards describe expectations for quality service delivery for 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 inpatient 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 AIP Performance Standards reflect the core values and principles of the **City of Philadelphia Department of Behavioral Health and Intellectual disAbility Services (DBHIDS) Practice Guidelines**, the **Mayor's Blue-Ribbon Commission on Children's Behavioral Health**, and the **Commonwealth of Pennsylvania Code Title 55 Chapter 1151 Inpatient Psychiatric Services**. The 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 Standards in collaboration with AIP 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; inpatient hospitalization is intended for individuals exhibiting acute symptoms that cannot be managed outside of a 24-hour secure setting. It provides comprehensive, intensive, short-term, resolution-focused treatment, including psychotherapeutic and psychotropic medication interventions, for individuals in a secure/locked facility. This intensive level of care (LOC) requires coordination among families and other treatment and community-based providers for the individual to return to and remain in the community successfully.

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 keeping with the CBH no ejection/rejection policy, providers must accept all individuals for acute inpatient hospitalization that CBH deems appropriate. Hospitals should be able to shift resources to best match demand and develop a strategy for managing individual member needs. Admissions processes should maximize the involvement of family members and other supports in the individual'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. Informed Consent

Psychoeducation and informed consent are critical components of inpatient hospital services. The informed consent process should be viewed as an opportunity to engage family members, provide education about the goals of inpatient treatment, and emphasize their involvement as a predictor of the individual's success in treatment. Inpatient providers should utilize partnerships with outside agencies whose staff may have contact with guardians and family members as applicable, including the Crisis Response Center (CRC) 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 individuals and guardians with reviewing and signing consent documentation. Consent forms should be culturally and linguistically appropriate, and all information releases must include names of individuals/agencies, what information will be shared, and the date the consent was signed. Signatures on consent forms for treatment and information releases should be obtained no later than 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.

Additionally, in situations with children/adolescents, once medication is recommended, medication informed consent should be pursued daily to ensure the child begins receiving necessary treatment as soon as possible (see the **Medication Management** section). Consent should be obtained per state policy for age and guardian consent. Verification of legal guardianship (e.g., court order) should be obtained for children residing in out-of-home placements, e.g., through the Philadelphia Department of Human Services/Community Umbrella Agencies (DHS/CUA).

3.2. Assessment

An integrative assessment that addresses mental health, physical health, substance use, education, family and developmental history, trauma, and the social determinants of health should be performed (required components are listed below). Assessment should emphasize wellness in addition to symptom reduction. The voice of the individual and caregiver/family and their respective perceptions of the presenting challenges must be included. Discharge planning should begin during admission; staff should identify and address any barriers to the individual 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. A structured tool to assess risk should be considered, such as the Columbia Suicide Severity Rating Scale (C-SSRS). A risk assessment can be completed by any combination of nurse, social worker, and psychiatrist. An accompanying safety plan should be completed and documented to address identified risks and guide treatment in the hospital; it should then be revised for discharge/aftercare (see the **Disposition** section).

Another critical assessment component is completing and documenting The Certificate of Need. For children and adolescents, PA regulations regarding Certification of Need for admission state, "An independent team shall certify the need for inpatient psychiatric treatment at the time of admission and document this in the medical record. The team shall (1) include a physician; (2) have competence in diagnosis and treatment of mental illness, preferably in child psychiatry; and (3) have knowledge of an individual's situation" (55 PA Code § 1151.62(b) relating to Certification of Need for Admission). The Certificate of Need allows providers to ensure that the child meets inpatient criteria and the CRC's determination.

A substance use assessment must be completed utilizing the American Society of Addiction Medicine assessment tool with recommendations for substance use treatment and presented to CBH as needed for approval for various levels of care.

3.2.1. Nursing

The nursing assessment is a face-to-face 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 (55 PA Code § 1151.66(c2) 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 individual at admission, conduct a body scan and document any injuries or bruising sustained during crisis, 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 what medications the member has been using at home and factor in this information accordingly.

3.2.2. Psychiatric Treatment

The psychiatric admission evaluation is a face-to-face evaluation with a psychiatrist completed within the first 24 hours of admission that results in a DSM diagnosis and prescription of inpatient treatment as the most appropriate, least restrictive service to meet the mental health needs of the individual. The psychiatrist should consider the need for or potential benefit of psychotropic medication interventions at this time (see the **Medication Management** section). The psychiatrist will continue to meet with the individual during the hospital admission and assess the need for continued stay by providing a mental status exam every 24 hours.

Psychiatric treatment indicates activities unique to the team psychiatrist. This section does not cover the psychiatric leadership of the treatment team/milieu and active involvement in psychosocial therapies and activities expected of the psychiatrist. Whenever possible, the treating psychiatrist should address any rule-out diagnoses and update these before the member's discharge.

3.2.3. 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.

3.2.4. Allied Health

An appropriately qualified clinician completes the Allied Health Assessment. Based on the individual'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 individual's unique needs and strengths, and reinforce patterns of healthy play in preparation for returning home.

3.2.5. Psychosocial Assessment

The psychosocial assessment should begin upon authorization and be completed within 72 hours via collateral contacts and a face-to-face interview 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. For members under 14, if the guardian is absent at admission, outreach should begin immediately, with a minimum of 24-hour follow-up for unreturned calls. Outreach to other involved parties should also start at admission, with attempts documented and letters filed (see the **Collaboration** section). The assessor should gather and synthesize all relevant information to produce a comprehensive clinical formulation that addresses functioning across domains. Efficient staffing strategies are needed, particularly for evening and weekend social work, to ensure the psychosocial assessment process can begin as soon as possible for individuals regardless of the time or day of admission.

The psychosocial assessor should obtain information about the viability of an individual's return to the previous housing arrangement. For children/adolescents with active child welfare involvement, it is necessary to identify situations where a caregiver initiates a 30-day notice for the child's removal from the home or DHS/CUA agencies closing a child's case

due to extended hospital stay as early as possible. Every effort should be made to preserve viable placements and relationships; alternate placements should concurrently be pursued when the team and family agree this is needed.

3.2.6. Structured Tools

CBH requires administering at least two evidence-supported structured tools, one trauma screening/assessment tool, one social determinant of the health screening tool, and one diagnostic tool selected by the provider.

Tools should be developmentally appropriate and relevant to the individual's symptoms. Structured tools will assist in refining the diagnostic assessment, thus reducing the incidence of the individual being discharged without confirmed, specific diagnoses (e.g., to reduce "rule-out" and "not otherwise specified" diagnoses). Structured tools can also promote individualized and trauma-informed assessment, preventing misdiagnosis 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 the **References** section.

4. COURSE OF TREATMENT

Inpatient treatment should be comprehensive, trauma-informed, individual/family-driven, and tailored to individual needs and preferences. Wellness should be emphasized in addition to symptom reduction, aiming for timely discharge to the most appropriate, least restrictive setting. 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 inpatient treatment. Family treatment sessions allow for skill practice and acquisition through real-life enactments, increasing the likelihood of a positive and sustained discharge. 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. Family sessions are conducted primarily by social workers; however, other treatment team members, including psychiatrists, are encouraged to join family sessions, particularly when families request their participation.

The frequency of family sessions should be determined based on the individual's needs. Some cases will benefit from several weekly family sessions to expedite a return home, particularly for those children who present with less acuity and only require a short stay. For members aged 17 and under, family sessions must occur at least once per week, and all outreach efforts and missed appointments must be documented.

4.1.2. Individual Therapy

Individuals will receive individual support from the inpatient team throughout their hospitalization. Individual therapy is particularly essential for individuals who may struggle with group treatment modalities or whose needs are best addressed through individual modalities; in these cases, individual therapy should occur at a higher frequency than occurs in

outpatient treatment. 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.

4.1.3. Milieu Therapy

Milieu therapy comprises many activities of a treatment environment that provide structure, predictability, consistency, and stability during inpatient stays. Examples of milieu therapy include the management and layout of the inpatient environment, efforts to maintain safety and security, and the daily program schedule. Emerging data supports moving away from non-evidence-based approaches, such as points 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 such as restraints and seclusions.

4.1.4. Group/Allied Therapy

Allied and group therapies include activities tailored to an individual's interests and strengths, including but not limited to art, dance movement, athletics, pet therapy, music, relaxation, horticulture, or occupational therapy. Providers should regularly evaluate and update programming and staff to provide individuals with various outlets for play and healing. Group therapy should include evidence-based or empirically supported programming tailored to the treatment needs of individuals on the unit. Groups may address challenges related to communication, anger/affect regulation, trauma, substance use, and social skills. Family psychoeducation and support groups are also encouraged.

4.1.5. Medication Management

Psychiatrists should assess an individual'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 medication is recommended and should be accomplished through informed consent. When indicated, medication administration should begin as soon as possible and generally within the first five days of admission.

The treating psychiatrist should document any barriers to medication initiation and titration and communicate to CBH, including a plan to address those barriers, within 3-5 days.

If an outside psychiatrist was treating an individual at the time of admission, a treatment team member must contact the outside physician. PCPs should be consulted for medically complex individuals 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.

For children, family members' participation in medication appointments helps to ensure that they understand the risks/benefits of medication options and supports adherence to the medication plan after hospitalization. Psychiatrists must meet family members in person or by phone when face-to-face meetings are impossible. Outreach efforts should be documented, and providers should request CBH support to engage family members.

When medication is being considered as part of treatment, there should be an interactive, well-documented discussion with the individual (as appropriate given age) 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 individual and caregiver/guardian as needed.

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). Any use of polypharmacy should include a well-documented rationale.

4.1.5.1. Daily Assessment and Psychiatric Notes

The hospital psychiatrist should complete daily assessments for every individual and document these in the daily psychiatric progress note with a complete MSE. The MSE should describe the clinical presentation of the individual. MSEs should reflect specificity for each individual through the elaboration of endorsed symptoms. A daily assessment with detailed MSE eases the approval process when CBH reviews the LOC recommendations.

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

4.1.5.2. Psychiatric Evaluation

A psychiatric evaluation must be completed for every individual who requires a pre-approved next LOC or a child welfare placement. The written evaluation with the following LOC recommendations must be submitted to CBH no more than five days after the recommendations are made. An essential aspect of discharge planning is that the evaluation is closely reviewed by receiving treatment providers and child welfare placement 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. 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, must be included. Recommendations for intensive levels of care, such as residential treatment facility (RTF), must be substantiated by depicting previous interventions, their impact, and the anticipated goals of residential treatment.

4.1.6. Collaboration

Strong collaboration with collateral providers/supports is essential to tailoring inpatient treatment and discharge recommendations to the individual. 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.

4.1.6.1. Current and Past Treatment Providers

Contact with other treatment providers is critical to providing effective treatment. Providers should consult current and past providers to determine previous interventions and their impact. Collaboration among providers helps the inpatient

team to continue effective interventions or introduce new ones when needed, thus increasing the likelihood of engagement from an individual 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.

4.1.6.2. Schools

As most inpatient hospitalizations are with school-aged children and school referrals prompt many, CBH expects collaboration with schools to be a significant part of assessment, treatment, and discharge planning. School staff can provide perspective on a child's needs and behaviors, thus facilitating more targeted treatment and discharge planning (see the **Plan to Transition to School** section). Additionally, schools must be consulted when planning academic portions of milieu care.

4.1.6.3. Other Involved Systems

CBH expects providers to identify other significant collaborators in an individual's life. For many children, this will include DHS/CUA case managers. Inpatient providers should maintain communication with DHS/CUA beyond the initial consent process. DHS/CUA should be consulted for perspectives on the child and family, including placement histories and settings where the child has experienced the most success. DHS/CUA collaboration is particularly critical if any changes in a placement setting will occur as part of the discharge process (group home, new foster home, etc.). System partners can better contribute to a successful and sustained discharge when inpatient providers have educated them about an individual's needs.

4.1.7. Interagency Service Planning Team (ISPT)

The ISPT is a requisite step in the inpatient course of treatment. The **Guidelines for Best Practices for Child and Adolescent Mental Health Services** should be referenced to plan and facilitate effective ISPT meetings. When IBHS or PRTF is recommended, the ISPT signature sheet should be maintained in the member's chart. The ISPT is a mechanism for child-driven, family-focused treatment and an opportunity to engage community-based treatment providers and CBH care managers in treatment planning. Providers should orient families to the purpose of ISPT meetings and encourage them to invite stakeholders and natural supports to participate. The purpose of ISPT meetings is to discuss presenting issues, current needs of the child and family, service recommendations, and review the continuum of care available, treatment interventions, child's functioning in all domains, areas of need, and barriers to success. The outcomes of structured tools should be discussed to educate attendees about the child/adolescent's diagnoses and related needs. The following participants should be involved in ISPT meetings: inpatient clinician, inpatient psychiatrist, member, legal guardian/caregiver, family members, school team, provider(s), clinical care manager (CBH), and other key parties (e.g., DHS, CUA).

The child's age and developmental capabilities should guide the decision to include the child in the ISPT meeting.

4.1.8. Treatment Planning

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

Goals should be measurable, achievable, developmentally appropriate, and related to all areas of the individual's life. Goals should include objectives and an integrated program of therapies, activities, and experiences designed to meet 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 seven days. Goals should be modified for attainability if not met after 30 days.

The plan should be designed to achieve discharge from inpatient status immediately. 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.

CBH requires that the psychiatrist, one additional member of the treatment team, and the individual or the guardian, if the person receiving treatment is under 14, sign the treatment plan.

4.1.9. Psychological Testing

Providers should ensure individuals who demonstrate such a need have access to psychological testing. Testing should be used to understand the individual's cognitive, emotional, and behavioral functioning and the impact this may have on behaviors and coping, particularly in the school or occupational setting. 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 to allow for appropriate treatment.

5. DISCHARGE/AFTERCARE

5.1. Disposition

As noted in the Psychosocial Assessment section, providers should begin investigating return home/discharge options at admission. They should engage family members, DHS/CUA, other treatment providers, schools, and CBH to facilitate an appropriate disposition plan. Providers should request assistance from CBH, schedule an inter-agency meeting before the initial review, and request an additional stay if barriers are encountered.

Safety planning to address the risk of re-traumatization should be included in the disposition plan, particularly for individuals who have experienced trauma in the setting where they are returning. Safety planning should anticipate triggers for harm to self and others that may arise following discharge, with a clear support plan for managing these triggers. Since the risk for re-hospitalization is highest during the two weeks following discharge, providers should educate families about this risk and help them identify supports to prevent the need for returning to the CRC. Providers should also guide families in considering scenarios requiring a CRC visit versus scenarios in which other supports may be successful.

5.2. Services

The full continuum of services, including evidence-based practices, should be considered when planning the subsequent services. Partial hospitalization should be considered when an individual 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 individual 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 risk period for readmission. 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.

5.3. 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 three days before the planned discharge, and families and subsequent providers should be given labs to facilitate authorizations as needed. Individuals must be discharged with 30 days 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.

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

5.4. Plan to Transition to School

Coordination with schools is an essential component of discharge planning. Providers must relay discharge recommendations to school counselors, particularly sharing interventions that should be used in the school setting to keep the child/adolescent stable and to prevent re-hospitalization. Providers should make every effort to include schools in discharge planning meetings, document outreach efforts, and contact CBH regarding communication barriers. Providers should be aware that schools cannot refuse a child's readmission, and CBH and other liaisons should be contacted in these cases.

5.5. Discharge Plan

The discharge plan should be individualized, strengths-based, and built upon supports and capacity for resilience. As previously noted, the plan will include diagnoses, outcomes of structured tools, medications, and recommendations. The plan should be reviewed with the individual and family/caregiver at discharge, along with treatment providers and other key people identified by the individual. The discharge plan should be sent to the next treatment provider, PCP, and other relevant parties as determined by the individual.

Discharge plans should be given to and reviewed with the individual, family members, and all other relevant parties, including the PCP, DHS/CUA, and the subsequent treatment provider. 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 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 individual's adjustment and remind them about initial appointments. Providers are encouraged to adopt post-discharge monitoring strategies. CBH will facilitate readmission interviews for individuals who re-present for acute inpatient admission within 30 days of discharge.

6.1. Summary of KPIs

Key performance indicators (KPIs) will be assessed quarterly by the CBH Quality Department's Performance Evaluation Unit. KPIs are well-defined performance measurements that monitor, analyze, and optimize all relevant processes to increase member satisfaction and safety. For the AIP 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 through various contacts, including quality indicator (QI) and utilization management (UM) 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 (QM) Medical Director and Senior Director to determine further appropriate actions.

Further actions can include a root cause analysis from the provider, a phone consultation with the provider, or a plan to continue monitoring the provider for another 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 refrain from engaging in quality improvement activities may be at risk for 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 AIP facility on a quarterly basis	Total number of medicine errors at the AIP 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 AIP facility on a quarterly basis	Total number of overturned complaints at the AIP LOC on a quarterly basis	CBH Performance Evaluation Team
Restraints with Injury	Incidents where an individual 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 AIP facility on a quarterly basis.	Total number of restraints with injury at the AIP 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 AIP facility on a quarterly basis	Total number of mechanical restraints at the AIP 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 his/her body by the use of any method, attached or adjacent to a person's body that he/she cannot control or remove easily	Total number of times physical restraints occurs with members at the AIP facility on a quarterly basis	Total number of physical restraints at the AIP LOC on a quarterly basis	CBH Performance Evaluation Team
Founded allegations of Abuse	Incidents of abuse where Children and Youth, or Adult protective services substantiated the allegation	Total number of times founded allegations of abuse occurs with members at the AIP facility on a quarterly basis	Total number of times founded allegations of abuse occurs with members at the AIP LOC on a quarterly basis	CBH Performance Evaluation Team

Measure	Description	Numerator	Denominator	Responsible Party
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 AIP facility on a quarterly basis	Total number of times elopement occurs with members at the AIP 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 AIP facility on an annual basis	Total number of times mortality occurs with members at the AIP 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 AIP facility on a quarterly basis	Total number of times refusals occurs with members at the AIP 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 AIP facility on a quarterly basis	Total number of times medical admissions occurs with members at the AIP 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 AIP facility on a quarterly basis	Total number of suicide attempts with medical attention at the acute inpatient LOC on a quarterly basis	CBH Performance Evaluation Team

CBH's Complaints and Grievances department will review and address member grievances as they occur in real time.

In addition, all acute inpatient 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 sent to providers quarterly 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.

REFERENCES

- CBH **Provider Manual and Clinical Practice Guidelines**
- Pennsylvania Department of Human Services **Guidelines for Best Practice in Child and Adolescent Mental Health Services**
- Substance Abuse and Mental Health Service Administration (SAMHSA) **National Guidelines for Child and Youth Behavioral Health Crisis Care**
- Trauma
  - Yale Childhood Violent Trauma Center, 2013. Trauma History Questionnaire (child and caregiver versions).
- PTSD and Other Trauma-Related Symptomatology
  - Foa, et al., 1997: Child Posttraumatic Stress Scale 5 (DSM 5).
- Depression
  - **Patient Health Questionnaire - 9** (PHQ9)
  - **PHQ9 Modified for Teens**
- Suicide Assessment
  - **Columbia Suicide Severity Rating Scale**
- Post-Natal Depression
  - **Edinburgh Postnatal Depression Scale**
- National Institute on Drug Abuse **Screening and Assessment Tools**
- The American Academy of Pediatrics **Screening Tool Finder**