Inpatient Psychiatric Performance Specifications

These performance specifications apply to the following Tufts Health Plan products:

- ☐ Tufts Health Plan Commercial (including Tufts Health Freedom Plan)[1]
- ☐ Tufts Medicare Preferred HMO (a Medicare Advantage product)[2]
- ☒ Tufts Health Plan Senior Care Options (SCO) (a dual-eligible product)[2]

These performance specifications apply to the following Tufts Health Public Plans products:

- ☐ Tufts Health Direct (a Massachusetts Qualified Health Plan (QHP) (a commercial product)
- ☒ Tufts Health Together (a MassHealth MCO Plan and Accountable Care Partnership Plan)
- ☐ Tufts Health RITogether (a Rhode Island Medicaid Plan)
- ☒ Tufts Health Unify (OneCare Plan; a dual-eligible product)

Providers contracted for this level of care or service will be expected to comply with applicable regulations set forth in the Code of Massachusetts Regulations and all requirements of these service-specific performance specifications, in addition to the General Behavioral Health Performance Specifications. All Performance Specifications are located online at tuftshealthplan.com in the Provider Resource Center.

DEFINITION

Inpatient psychiatric treatment is the most intensive level of psychiatric care and should be used to stabilize Members who have an acute psychiatric condition or an acute exacerbation of a chronic condition with a sudden onset or worsening of symptoms. It is expected that treatment at this level of care will result in significant improvement of symptoms during the course of a brief hospital stay.

Providers of inpatient psychiatric treatment services are required to admit and treat all Members for whom it has been determined that this level of care is medically necessary, regardless of clinical presentation, as long as a bed is available and, in an age-appropriate unit. Tufts Health Plan uses inpatient level of care for Members only when less intense or restrictive levels of care cannot safely or effectively treat the Member.

Facilities providing this level of care are expected to accept and treat Members to the unit 24 hours per day, 365 days per year.

COMPONENTS OF SERVICE

1. All hospitals licensed by the Department of Public Health (DPH) that admit mentally ill persons on any admission status other than, or in addition to, voluntary status shall also be licensed by the Department of Mental Health (DMH).
2. All Behavioral Health Inpatient Providers must accept for admission or treatment all Members for whom Tufts Health Plan has determined admission or treatment is Medically Necessary, regardless of clinical presentation, as long as a bed is available in an age-appropriate unit.
3. Full therapeutic programming is provided with a sufficient professional-staff-to-patient ratio to manage a therapeutic milieu of services seven days per week, including weekends and holidays. The scope of available services includes, but is not limited to, the following:
   - Psychiatric and medical evaluation
   - Pharmacological services
   - Individual therapy
   - Group therapy
   - Family evaluation and therapy

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[1] Commercial products include HMO, POS, PPO, Tufts Health Freedom Plan, and CareLink℠ when Tufts Health Plan is the primary administrator.

[2] Tufts Medicare Preferred and Tufts Health Plan SCO are collectively referred to in this payment policy as Senior Products.

- Psychological testing
- Vocational assessment
- Rehab and recovery resources and counseling
- Substance use evaluation and counseling
- Education
- Behavioral plans

4. For minor children and for adults who give consent, the facility, at a minimum, makes documented attempts to contact guardian, family members, and/or significant others within 24 hours of admission, unless clinically contraindicated. If contact is not made, the rationale shall be documented in the Member's record.
5. A comprehensive psychiatric evaluation must be conducted within 24 hours of admission to assess the medical, psychiatric, pharmacological, and treatment needs of the Member.
6. Following the initial evaluation, the psychiatrist must meet with the Member at least once a day.
7. A Behavioral Health Multidisciplinary Team is assigned to each Member within 24 hours of admission.
8. The Behavioral Health Multidisciplinary Team meets, completes, and to the maximum extent practicable reviews the Member's treatment plan within 24 hours of admission, modifies the treatment plans as needed and, during the Member's Behavioral Health Inpatient Services stay, periodically meets to review and modify the treatment plan.
9. The provider ensures that each Member has daily individual contact with unit staff, and that individual therapy with an assigned master's-level clinician, group therapy, and family therapy are provided at a frequency determined in each Member's individualized treatment plan as clinically indicated. For members under the age of 21 living with family members, family therapy should occur at least once per week unless contraindicated.
10. Psychiatric/medication evaluation is provided within 24 hours of admission and at least daily for follow-up.
11. All urgent consultation services, laboratory tests, and radiological exams resulting from the psychiatric evaluation, medical history, and physical examination/medical assessment, or as subsequently identified during the admission, are provided within 24 hours of the order for these services.
12. The facility has access to translators and translator services appropriate to the needs of the population served.
13. The facility must promote continuity of care for Members who are readmitted to Behavioral Health Inpatient and 24-Hour Diversionary Services by offering them readmission to the same Provider when there is a bed available in that facility.
14. The facility must coordinate with contracted ESPs in the Service Area(s), including procedures to credential and grant admitting privileges to ESP psychiatrists.
15. The facility must convene regular meetings and conduct ad hoc communication on clinical and administrative issues with ESPs to enhance the continuity of care for Members.

STAFFING REQUIREMENTS

1. The inpatient facility will maintain appropriate staffing-to-patient ratio to safely care for Members 24/7/365.
2. The facility has a written plan that clearly delineates (by shift) the number and qualifications of its professional staff, including nurses, social workers, and other mental health professional and psychology staff in relation to its average number of occupied beds.
3. The facility must have a governing body and an organized professional staff whose primary function is to diagnose, treat, or rehabilitate Members with psychiatric problems. The staff will include a credentialed, supervising psychiatrist, offer 24-hour nursing coverage, and individualized treatment plans.
4. The director of a licensed facility shall hold an advanced degree from an accredited college or university in a discipline appropriate to the care and treatment of the mentally ill.
5. If the director of a licensed facility is not a fully licensed physician, there shall be a director of psychiatric or medical services for such facility who is a physician fully licensed to practice medicine under Massachusetts law, and who is certified or eligible to be certified by the American Board of Psychiatry and Neurology in psychiatry, provided that in the discretion of the Department of Mental Health, experience and expertise may be considered in lieu of board certification or eligibility.

6. The program shall maintain adequate staffing to carry out the program's functions in the treatment of behavioral health needs, representing at a minimum the following disciplines: psychiatry, nursing, social work, psychology, and OT/RT.
7. Staff, organization, positions and qualifications shall be documented in writing through:
   - An organization outline detailing the working relationships and responsibilities of staff
   - Individual resumes of staff stating training, education, and experience
   - Individual job descriptions
   - Individual work schedules
8. The attending physician must meet with the Member daily, document daily in the medical record, and serve as the Member's primary physician. On days when the attending physician is unavailable, a medically trained physician designee of the attending physician carries out these functions for the Member in his or her stead. The attending physician, as much as possible, designates a consistent substitute to ensure that the Member receives as much continuity in psychiatric care as possible.
9. Substance use treatment experience and training is present among the treatment team composition for Members whose diagnoses include those related to substance use. In these cases, substance use treatment is directed by a staff member qualified (e.g. certified, licensed, experienced) in the provision of substance use treatment and who also possesses a master's-level degree, at a minimum.
10. The facility ensures that all clinical work is subject to regularly scheduled supervision by an independently licensed clinician and written supervision notes are kept.
11. The facility is responsible for providing staffing and supervision in accordance with THPP Behavioral Health General Performance Specifications, DPH and BSAS Licensing requirements.
12. All staff receive periodic training, including training by consumer/survivors and parents of children and adolescents regarding what is and is not helpful/therapeutic.
13. Staffing should reflect the cultural, gender, and linguistic needs of the community it serves.
14. The facility must have human rights and restraint and seclusion protocols that are consistent with the DMH regulations and include training of the provider's staff and education for Members regarding human rights.
15. The facility must have a human rights officer who shall be overseen by a human rights committee, and who shall provide written materials to Members regarding their human rights, in accordance with applicable DMH regulations and requirements.

SERVICE, COMMUNITY AND COLLATERAL LINKAGES

1. The facility staff coordinates treatment planning and aftercare with the Member's primary care clinician, outpatient, and other community-based providers, involved state agencies, educational system, community supports and family, guardian, and/or significant others when applicable. If consent for such coordination is withheld or refused by the parent or guardian of a minor, then this is documented in the Member's record.
2. The facility must coordinate treatment and discharge planning with the state agencies (e.g., DCF, DMH, DYS, DDS) with which the Member has an affiliation. The facility notifies the appropriate DMH regional office of every Member followed by that office who is admitted to the unit.
3. The facility ensures that a written aftercare plan is available to the Member at the day of discharge. When consent is given, a copy of the written aftercare plan is forwarded at the time of discharge to the referral source, family/guardian/significant other, DMH, (if DMH member), outpatient or community-based provider, PCP, school, and other entities and agencies that are significant to the Member's aftercare.
4. In the case of children or youth involved with CBHI services, the facility social worker or other clinician will collaborate with those providers including, but not limited to, Community Service Agencies (CSA). The facility will accommodate requests from a CSA to facilitate or attend a team meeting while the Member is at the facility.

QUALITY MANAGEMENT (QM)

1. The facility will develop and maintain a quality management plan that is consistent with that of Tufts Health Public Plans and which utilizes appropriate measures to monitor, measure, and improve the activities and services it provides.
2. A continuous quality improvement process is utilized, and will include outcome measures and satisfaction surveys, to measure and improve the quality of care and service delivered to Members, including youth and their families.

3. Clinical outcomes data must be made available to Tufts Health Public Plans upon request and must be consistent with Tufts Health Public Plans' performance standard for acute inpatient services.
4. All Reportable Adverse Incidents will be reported to Tufts Health Public Plans within one business day of their occurrence per Tufts Health Public Plans policy and DMH licensing requirements. A Reportable Adverse Incident is an occurrence that represents actual or potential harm to the well-being of a Member, or to others by action of a Member, who is receiving services managed by Tufts Health Public Plans or has recently been discharged from services managed by Tufts Health Public Plans.
5. The facility/program will adhere to all reporting requirements of DPH and/or DMH regarding Reportable Adverse Incidents and all related matters.

TREATMENT PLANNING AND DOCUMENTATION

1. The facility's treatment team establishes a provisional treatment and discharge plan within 24 hours of the Member's admission. The Member is expected to participate in treatment planning, or documentation is provided explaining why the Member did not participate in treatment planning. When a guardian is appointed by the court, the facility additionally involves the guardian in treatment planning and other decision making. A staff member records the Member's understanding of the goals of the treatment and discharge plan in the Member's own words. The plan is signed by the Member/guardian.
2. A facility-based case manager is identified and assigned upon admission. This staff member shall be involved in the establishment and implementation of treatment and discharge planning.
3. A comprehensive nursing assessment must occur within 8 hours and subsequent nursing staff observation is in place 24 hours/day,
4. A comprehensive medical history and physical exam must be conducted within 24 hours of admission.
5. A comprehensive psychosocial assessment must be completed within 48 hours of admission.
6. The Member's specific ongoing treatment and discharge plan is formulated and documented within 48 hours of admission by the treatment team.
7. The treatment plan shall include at least:
    i. Identification of the new acute clinical services, as well as supports, covered services and the continuing care with any established Providers, and the identification of any new providers and the covered services that will be added
    ii. Identification of the Member's state agency affiliation, release of information, and coordination with any state agency case worker assigned to the Member
    iii. Identification of non-clinical supports and the role they serve in the Member's treatment and aftercare plans
    iv. Scheduling of discharge/aftercare appointments in accordance with the access and availability standards
    v. Recommendation for the initial frequency of aftercare services and supports
    vi. Identification of barriers to aftercare, and the strategies developed to address such barriers
    vii. Procedures to monitor for the earliest identification of the next available aftercare resource required for the Member who has remained in the Behavioral Health Inpatient and 24-Hour Diversionary setting for non-medical reasons (e.g., the recommended aftercare resources were not yet available)

DISCHARGE PLANNING AND DOCUMENTATION

1. A Discharge Plan is initiated within 24 hours of admission.
2. Components of Discharge Planning incorporate the Member's identified concerns, including but not limited to: housing, finances, health care, transportation, familial, occupational, educational, and social supports.
3. The treatment team staff member who is responsible for implementing a Member's discharge plan documents in the medical record all of the discharge-related activities that have occurred while the Member is in the facility, and this reflects Member participation in its development.
4. Providers invite Members' family members, their guardians, outpatient individual practitioners, state agency staff, as appropriate and if applicable, and other identified supports to participate in Discharge Planning to the maximum extent practicable, including behavioral health treatment team meetings, developing the discharge plan, when appropriate, and for adult Members, only when the Member has consented to their involvement.

5. The facility must ensure that services contained in the Member's discharge plan are offered and available to Members within seven business days of discharge from an inpatient setting.
6. The facility must ensure that Members who require medication monitoring will have access to such services within 14 business days of discharge.
7. For those Members who are discharged on medication, at least one psychiatric medication monitoring appointment (including an outpatient medication evaluation, an initial evaluation by a physician or clinical nurse specialist or a medication group) is scheduled no more than 14 days from the Member's discharge from the facility and this is documented in the Member's medical record.
8. A written discharge plan must be provided to other providers working with the Member, including the PCP.
9. For MassHealth Members under age 21, a Child and Adolescents Needs and Strengths (CANS) assessment is completed at discharge.
10. The completed discharge form, including referral to any agency, is available to and given to the Member and, when appropriate, the Member's family or guardian at the time of discharge, which includes but is not limited to appointments, medication information, and emergency/crises information.
11. The facility must develop, in collaboration with the Member, an individualized discharge plan for the next service or program anticipating the Member's movement along a continuum of services.
12. The facility must ensure that the treatment and discharge plan for Members who are state agency clients is coordinated with appropriate state agency staff.
13. The facility must make best efforts to ensure a smooth transition to the next service or to the community.
14. The facility must document all efforts related to these activities, including the Member's active participation in Discharge Planning.
15. THPP pays for administratively necessary days if a Member is psychiatrically stable and ready for discharge, and the hospital is making regular efforts to move a Member to a more appropriate level of care that is not immediately available. The facility must participate in continued utilization management reviews at least weekly and must continue with disposition planning.

DOCUMENT HISTORY

- July 2020: Template updates