**Performance Specifications**

**Inpatient Services**

**Inpatient Mental Health Services**

Providers contracted for this level of care or service are expected to comply with all requirements of these service-specific performance specifications. Additionally, **providers contracted for this service and all contracted services are held accountable to the General performance specifications**. The requirements outlined within these service-specific performance specifications take precedence over those in the General performance specifications.

**Inpatient Mental Health Services** represent the most intensive level of psychiatric care, which is delivered in a general hospital with a psychiatric unit licensed by the Department of Mental Health (DMH) or a private psychiatric hospital licensed by DMH. Multi-disciplinary assessments and multimodal interventions are provided in a 24-hour, locked, secure and protected, medically staffed, and psychiatrically supervised treatment environment. Twenty-four hour skilled nursing care, daily medical care, and a structured treatment milieu are required. The goal of acute inpatient care is to stabilize Members who display acute psychiatric conditions associated with either a relatively, sudden onset and a short, severe course, or a marked exacerbation of symptoms associated with a more persistent, recurring disorder. Typically, the Member poses a significant danger to self or others, and/or displays severe psychosocial dysfunction.

Inpatient mental health providers comply with the following **No Reject Policy**: The provider accepts for admission all Members in need of inpatient mental health services who are referred by an Emergency Services Program/Mobile Crisis Intervention (ESP/MCI) provider, regardless of the availability of insurance, capacity to private pay, or clinical presentation. These Inpatient Mental Health Services performance specifications apply to providers that serve Members of all ages. Specific requirements for those providers serving youth are noted throughout.

The performance specifications contained within pertain to the following inpatient services:

1. Inpatient Mental Health Services;
2. Inpatient Mental Health Services for Members with Intellectual Disabilities;
3. Inpatient Mental Health Services for Children/Adolescents with Intellectual Disabilities/Pervasive Developmental Disorders/Autism Spectrum Disorders;
4. Inpatient Eating Disorders Services; and
5. Observation/Holding Beds.

**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. The provider accepts admissions 24 hours per day, 7 days per week, 365 days per year.
3. The provider must have written admission and discharge criteria.
4. Therapeutic programming is provided seven days per week, including weekends and holidays, with sufficient professional staff to maintain an appropriate milieu and conduct the services below, based on individualized Member needs.
5. The scope of required service components provided in this level of care includes, but is not limited to, the following:
   a. Psychiatric evaluation;
   b. Medical diagnostic services, including but not limited to medical history and physical examination/medical assessment;
   c. Bio-psychosocial evaluation;
   d. Psychological testing, if clinically indicated for stabilization and/or to addresses diagnostic and treatment questions central to the inpatient assessment, treatment, and discharge planning process;
   e. Substance use disorder assessment and counseling;
   f. Vocational assessment;
   g. Pharmacology;
   h. Individual, group, and family therapy;
   i. Development of behavioral plans and crisis prevention plans, and/or safety plans as part of the Crisis Planning Tools for youth, as applicable;
   j. Peer support and/or other recovery-oriented services; and
   k. Educational component for youth, including coordination with a Member’s Individualized Education Program (IEP), as applicable (excluding weekends and holidays).

6. For minor children (under the age of 16) and for adults who give consent, the provider makes documented attempts to contact the parent, guardian, family members, and/or significant others within 48 hours of admission, unless clinically or legally contraindicated. The provider provides them with all relevant information related to maintaining contact with the program and the Member, including names and phone numbers of key nursing staff, primary treatment staff, social worker/care coordinator/discharge planner, etc. If contact is not made, the Member’s health record documents the rationale.

7. The provider is responsible for supplying each Member with medications prescribed for physical and behavioral health conditions and documents so in the Member’s health record.

8. Prior to supplying medications to the Member, the provider engages in a medication reconciliation process in order to avoid inadvertent inconsistencies in medication prescribing that may occur in transition of a Member from one care setting to another. The provider does this by reviewing the Member’s complete medication regimen at the time of admission (e.g., transfer and/or discharge from another setting or prescriber), and comparing it with the regimen being considered in the inpatient mental health services program. The provider engages in the process of comparing the Member’s medication orders newly issued by the inpatient prescriber to all of the medications that they have been taking in order to avoid medication errors. This involves:
   a. Developing a list of current medications, i.e., those the Member was prescribed prior to admission to the inpatient mental health services program;
   b. Developing a list of medications to be prescribed in the inpatient mental health services program;
   c. Comparing the medications on the two lists;
   d. Making clinical decisions based on the comparison and, when indicated, in coordination with the Member’s primary care clinician (PCC);
   e. Communicating the new list to the Member and, with consent, to appropriate caregivers, the Member’s PCC, and other treatment providers; and
   f. All related activities are documented in the Member’s health record.

9. 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. All non-urgent consultation services related to the assessment and treatment of the Member while on the inpatient unit are provided in a timely manner, commensurate with the level of need. Routine medical care (not required for the diagnosis related to the presenting problem) may be deferred, when appropriate, if the length of stay on the inpatient unit is brief. All of these services are documented in the Member’s health record.

10. Youth under 18 years old are admitted to adult units only with careful consideration of clinical needs and safety factors. In such circumstances, all of the following conditions must be met: the admitting hospital must hold a DMH limited Class VI license, obtain the consent of the youth’s parent/guardian/caregiver, and obtain authorization from MBHP. If the admitting hospital does not hold a limited Class VI license, the provider must obtain a Member-specific waiver from the DMH licensing department to admit a youth under 18 years old. All MBHP performance specifications that apply to these youth when they are treated on a child or adolescent unit also apply to any youth who is placed on an adult unit under these circumstances.

11. During an admission, parental/guardian/caregiver access to their children is a right and is not to be denied, unless it is specifically clinically or legally contraindicated. The provider allows daily access to children and adolescents for parent(s), guardian(s), family Member(s), or caregiver(s). Parental access is never prohibited as part of behavioral programming. All decisions relative to visitation and/or contact with parents/guardians/significant others is documented in the Member’s health record.

12. The provider provides accommodations for Members to use telephones (free of charge), including allowing Members to speak with family members in their native language, in order to maintain contact with parents, guardians, family members, legal counsel, or caregivers, as legally allowed and clinically indicated.

13. A handbook specific to the inpatient unit is given to the Member and parent/guardian/caregiver at the time of admission. The handbook includes but is not limited to Member rights and responsibilities, services available, treatment schedule, visitation hours and policies, grievance procedures, discharge criteria, and information about family support and peer and recovery-oriented services.

14. For youth ages 3-21 who remain in the hospital 14 days or more: Consistent with 603 CMR 28.02(9) and 28.03(3)(c), the provider’s physician or appropriate designee is responsible for completing a Department of Elementary and Secondary Education (DESE) form 28R/3 and submitting it to the student’s principal or other appropriate program administrator, who shall arrange for provision of educational services in the home or hospital, excluding weekends and holidays (http://www.doe.mass.edu/pqa/ta/hhep_qa.html and http://www.doe.mass.edu/sped/28mr/28r3.pdf).

15. The provider is responsible for updating its available capacity, three times each day at a minimum, seven days per week, 365 days per year on the Massachusetts Behavioral Health Access website (www.MABHAccess.com). The provider is also responsible for keeping all administrative and contact information up to date on the website. The provider is also responsible for training staff on the use of the website to locate other services for Members, particularly in planning aftercare services.

16. For providers accessing online portals, privacy and personnel policies are in place, including but not limited to accessing information in accordance with Privacy Rules and allowing staff to access only relevant information as it pertains to specific Members and appropriate treatment sites within the facility.
Staffing Requirements

1. The provider complies with the staffing requirements of the applicable licensing body, the staffing requirements in the service-specific performance specifications, and the credentialing criteria outlined in the Provider Manual.

2. The provider has a written staffing plan that clearly delineates (by unit, day and shift) the number and credentials of its professional staff, including attending psychiatrist(s), nurses, social workers, psychologists, and other mental-health professionals, in compliance with its licensed capacity on a daily basis.

3. The provider is staffed with sufficient appropriate personnel to accept and admit Members 24 hours per day, 7 days per week, 365 days per year, and to conduct discharges 7 days per week, 365 days per year.

4. The provider has adequate psychiatric coverage to ensure all performance specifications related to psychiatry are met.

5. The provider appoints a medical director who is fully integrated into the administrative and leadership structure of the inpatient facility and is responsible for clinical and medical oversight, quality of care, and clinical outcomes across all inpatient mental health service components, in collaboration with the clinical leadership team.
   a. The Medical Director is a psychiatrist who is board-certified and/or who meets MBHP’s credentialing criteria (Note: Credentialing criteria for psychiatrists states that they must be board-certified in general psychiatry by the American Board of Psychiatry and Neurology (ABPN) within two years of contracting unless a waiver of this requirement is requested and received within two years of contracting).
   b. For providers with inpatient mental health units for children and/or adolescents, the provider appoints a medical director for its child and/or adolescent inpatient programs who is a child fellowship-trained psychiatrist, board-certified and/or who meets MBHP’s credentialing criteria for a child/adolescent psychiatrist.
   c. The medical director’s role may include the provision of direct psychiatry service and also includes:
      i. Teaching, training, and coaching; and
      ii. Oversight and monitoring of prescribing clinicians.
   d. The medical director’s role also includes the following functions, directly and/or in delegation to other attending psychiatrists who meet MBHP’s credentialing criteria, particularly in larger, multi-unit facilities:
      i. Attendance at multi-disciplinary team meetings; and
      ii. Consulting with the multi-disciplinary team.
   e. The medical director’s role also includes the following functions, in collaboration with the clinical leadership team:
      i. Integration of the various assessments of the Member’s needs and strengths into a coherent narrative that can be used for treatment planning within the unit and in the Member’s home and community;
      ii. Development and utilization of the inpatient mental health program’s unifying theory of treatment to guide its mission, vision and practice;
      iii. Development of therapeutic programming; and
      iv. Ensuring that programs remain family-centered and, for units serving youth, child-focused.
   f. For providers with inpatient mental health units for children and/or adolescents, the medical director ensures psychiatric practice consistent with the best available evidence-based
practices and parameters developed by the American Academy of Child and Adolescent Psychiatry (AACAP) when evaluating and treating youth with complex needs and/or medication regimens, e.g., when Members admitted to the unit are on multiple psychiatric medications or are in the custody of a state agency and are starting or continuing atypical antipsychotics. The medical director monitors this practice through oversight and supervision.

6. The provider assigns an on-site attending psychiatrist to each Member.

7. For children and adolescents under the age of 14, the attending psychiatrist is one who meets MBHP’s credentialing criteria for a child/adolescent psychiatrist.

8. Psychiatric care is provided by the medical director and/or other psychiatrists who are board-certified and/or who meet MBHP’s credentialing criteria. Psychiatric care consists of the provision of psychiatric and pharmacological assessment and treatment to Members in the inpatient hospital. The program may also utilize a psychiatry or child psychiatry fellow/trainee to provide psychiatric care under the supervision of the medical director or another attending psychiatrist, in conformance with the Accreditation Council for Graduate Medical Education (ACGME), and in compliance with all Centers for Medicare & Medicaid Services (CMS) guidelines for supervision of trainees by attending physicians. The program may also utilize a psychiatric nurse mental health clinical specialist (PNMHCS) to provide psychiatric care, within the scope of their licenses, and under the supervision of the medical director or another attending psychiatrist, as outlined within these performance specifications. The program may also utilize a psychiatric resident to provide psychiatric care, under the supervision of the medical director or another attending psychiatrist.

9. For inpatient hospitals that utilize a psychiatry or child psychiatry fellow/trainee to perform psychiatry functions, all of the following apply:
   a. The psychiatry or child psychiatry fellow/trainee must be provided sufficient supervision from psychiatrists or child and adolescent psychiatrists to enable them to establish working relationships that foster identification in the role of a psychiatrist or child and adolescent psychiatrist, respectively;
   b. The psychiatry or child psychiatry fellow/trainee must have at least two (2) hours of individual supervision weekly, in addition to teaching conferences and rounds; and
   c. The hospital must use the following classification of supervision:
      i. Direct supervision – the supervising physician is physically present with the fellow and Member;
      ii. Indirect supervision:
         ▪ With direct supervision immediately available, the supervising physician is physically within the hospital and is immediately available to provide direct supervision.
         ▪ With direct supervision available, the supervising physician is not physically present within the hospital, but is immediately available by means of telephonic and/or electronic modalities and is available to provide direct supervision.
      iii. Oversight – the supervising physician is available to provide review of procedures/encounters with feedback provided after care is delivered.

10. For inpatient hospitals that utilize a PNMHCS to perform psychiatry functions, all of the following apply:
   a. There is documented maintenance of: a collaborative agreement between the PNMHCS and the medical director or another attending psychiatrist or attending child psychiatrist; and a consultation log including dates of consultation meetings and list of all Members reviewed. The agreement specifies whether the PNMHCS, the medical director, another
attending psychiatrist, or attending child psychiatrist will be responsible for this documentation.

b. The supervision/consultation between the PNMHCS and the medical director or another attending psychiatrist or attending child psychiatrist is documented and occurs at least one (1) hour per week for the PNMHCS, or at a frequency proportionate to the hours worked for those PNMHCS staff who work less than fulltime. The format may be individual, group, and/or team meetings.

c. A documented agreement exists between the medical director, or another attending psychiatrist or attending child psychiatrist, and the PNMHCS outlines how the PNMHCS can access the medical director, or another attending psychiatrist or attending child psychiatrist, when needed for additional consultation.

d. The medical director, or another psychiatrist or child fellowship-trained psychiatrist, is the attending psychiatrist for the Member, when a PNMHCS is utilized to provide direct psychiatry services to a given Member. The PNMHCS is not the attending for any Member.

e. There is documented active collaboration between the medical director, or another attending psychiatrist or attending child psychiatrist, and the PNMHCS relative to Members’ medication regimens, especially those Members for whom a change in their regimen is being considered.

11. A physician (MD) is on the hospital grounds 24 hours per day, 7 days per week, 365 days per year in order to respond to medical emergencies. During weekday business hours, the physician is a psychiatrist who meets MBHP’s credentialing criteria. After 5 p.m. weekdays, and on weekends and holidays, the on-site physician available for emergency coverage may be a psychiatrically or non-psychiatrically trained physician capable of responding to, assessing, and treating medical emergencies within 15 minutes of being notified. If this staffing requirement is provided at any time by a non-psychiatrically trained physician, psychiatric consultation is provided by a psychiatrist on call who responds by telephone to a call within 15 minutes and, when needed, who has the capacity to come to the facility in person within 60 minutes of being notified.

12. The provider has trained nursing staff on site 24 hours per day, seven days per week, 365 days per year, in accordance with DMH licensure requirements, to perform functions related to but not limited to medical assessment and triage, admissions, and medication management and monitoring.

13. Members have access to supportive milieu and clinical staff, as clinically indicated, 24 hours per day, seven days per week, 365 days per year. The provider provides one-to-one staffing when needed for crisis intervention, safety and containment, and/or as included in the treatment plan.

14. The provider ensures that master’s-level or doctoral-level staff, who have training and experience in the assessment and treatment of substance use and co-occurring disorders, or staff who are licensed alcohol and drug counselors (LADC), certified alcoholism and drug abuse counselors (CADAC), certified addiction counselors (CAC), or licensed alcohol and drug abuse counselors (LADAC) are involved in the assessment and treatment of Members whose diagnoses include those related to substance use and/or co-occurring disorders and that supervision and/or consultation relative to substance use disorders is made available to staff as needed.

15. The program is able to provide one-to-one staffing for observation and management of significant clinical and/or safety issues, when clinically indicated, and/or as included in the treatment plan.

16. The provider provides all staff with supervision in compliance with MBHP’s credentialing criteria.

17. The provider ensures that Members, upon their request, receive visits and telephone calls from appropriately trained clergy.

Service, Community, and Collateral Linkages
1. The provider is responsible for developing and maintaining an active working relationship with each of the local ESPs/MCIs who are high-volume referral sources for the hospital. The inpatient provider holds regular meetings or has other contacts and communicates with the ESPs/MCIs on clinical and administrative issues, as needed, to enhance the referral and admission process and continuity of care for Members. On a Member-specific basis, the provider collaborates with any involved ESP/MCI providers upon a Member’s admission to ensure the ESP’s/MCI’s evaluation and treatment recommendations are received and that any existing crisis prevention plan and/or safety plan is obtained from the ESP/MCI.

2. The provider maintains active working relationships with the step-down programs for adults, children, and adolescents, including but not limited to CBHI services, especially with local providers of those levels of care that refer high volumes of Members to the inpatient provider and/or to which the inpatient provider refers high volumes of Members, to enhance continuity of care for Members. It is considered best practice to maintain written Affiliation Agreements or Memoranda of Understanding (MOU) with such providers.

3. With Member consent, for MBHP Members who are DMH consumers, the provider notifies the DMH case manager, and/or DMH Adult Community Clinical Services (ACCS) program, and/or Program of Assertive Community Treatment (PACT) provider, and/or DMH area office by noon of the following business day post-admission, or within one (1) business day of identifying the Member’s involvement with this state agency and/or their service providers.

4. For children/adolescents in the care and/or custody of DCF, the provider contacts the DCF case manager by noon of the following business day post-admission.

5. For children/adolescents who are detained by or committed to DYS, the provider contacts the DYS regional clinical coordinator by noon of the following business day post-admission.

6. With Member consent, for MBHP Members who are DDS consumers, the provider notifies the DDS service coordinator and/or DDS area office by noon of the following business day post-admission or within one (1) business day of identifying the Member’s involvement with this state agency and/or their service providers.

7. With consent, the provider contacts the appropriate local education authority (LEA) if the school system is involved with the Member around educational planning, curriculum, and/or resources.

8. When necessary, the provider provides or arranges transportation for services required external to the hospital during the admission and, upon discharge, for placement into a step-down, 24-hour level of care, if applicable. The provider also makes reasonable efforts to assist Members upon discharge to the community and/or non-24-hour levels of care with identifying transportation options when needed, including public transportation, Prescription for Transportation (PT-1) forms, etc.

Quality Management (QM)

1. The facility and/or program will develop and maintain a quality management plan that is consistent with that of MBHP and that utilizes appropriate measures to monitor, measure, and improve the activities and services it provides.

2. A continuous quality improvement process is used, 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 MBHP upon request and must be consistent with MBHP’s performance standards this service.
4. All Reportable Adverse Incidents will be reported to MBHP within one business day of their occurrence per MBHP 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 MBHP, or has recently been discharged from services managed by MBHP.

5. The facility and/or program will adhere to all reporting requirements of DPH and/or DMH regarding Serious Incidents and all related matters.

**Process Specifications**

**Assessment, Treatment Planning, and Documentation**

1. Upon receipt of a referral provider 24/7/365, the provider confirms bed availability and makes every effort to accept the Member as soon as possible and no later than within 30 minutes. The provider conducts admissions 24/7/365.

2. A psychiatrist, preferably the one assigned as the attending psychiatrist for the given Member, conducts a comprehensive evaluation of each Member within 24 hours of admission, consisting of a medical history and an assessment of the psychiatric, pharmacological, and treatment needs of the Member, including a clinical formulation that explains the Member’s acute condition and maladaptive behavior. On weekends and holidays, the initial evaluation may be completed by a covering psychiatrist, or a psychiatric resident, PNMHCS, or psychiatry or child psychiatry fellow/trainee, all acting under the attending psychiatrist’s or the medical director’s Member-specific supervision. In such situations, the attending psychiatrist must evaluate the Member on the next business day.

3. A physician, who may be a psychiatrist or a non-psychiatrist physician, conducts a physical examination/medical assessment of each Member within 24 hours of admission, and documents so in the Member’s health record.

4. The provider completes a comprehensive and individualized treatment plan built upon the assessment and developed with the parent/guardian/caregiver, and, with consent, family members, the Member’s PCC, other involved providers, and supports identified by the Member. The treatment plan, signed, dated, and documented in the Member’s health record, includes, but is not limited to: objective and measurable goals; time frames for expected outcomes; the Member’s strengths; links to primary care for Members with active co-occurring medical conditions; a plan to involve a state agency case manager, when appropriate; and treatment recommendations consistent with the service plan of the relevant state agency, if involved. The treatment plan is consistent with the Member’s diagnosis, describes all services needed during the course of treatment, and reflects continuity and coordination of care.

5. The provider assigns a multi-disciplinary treatment team to each Member within 24 hours of admission, consisting of a psychiatrist and one or more other discipline. A multi-disciplinary treatment team meets to review the assessment and develop an initial treatment plan and discharge plan within 24 hours of admission. On weekends and holidays, the treatment plan may be developed by an abbreviated treatment team, with a review by the full treatment team on the next business day.

6. The treatment and discharge plans are reviewed by the multi-disciplinary treatment team at least two times a week, and are updated accordingly, based on each Member’s individualized progress. All assessments, treatment and discharge plans, reviews, and updates are documented in the Member’s health record.

7. Every Member is assigned an on-site attending psychiatrist who consistently provides, and is responsible for, the day-to-day and overall care of the Member when hospitalized. The attending
psychiatrist meets with the Member daily, writes daily psychiatry notes in the Member’s health record, and ultimately serves as the Member’s primary physician.

8. The attending psychiatrist is an active participant on the Member’s treatment team and is available to consult with other members of the treatment team throughout the Member’s length of stay. Other psychiatrists and/or a PNMHCS may also be available to consult with other members of the treatment team throughout the Member’s length of stay. However, the attending psychiatrist maintains the role as the Member’s primary physician throughout the Member’s length of stay.

9. When the attending psychiatrist is not scheduled to work or is out for any reason (e.g., vacation, illness, etc.), they designate a consistent substitute, as much as possible, to ensure that the Member receives continuity of care. In these instances, the functions of meeting with the Member daily and writing daily psychiatry notes in the Member’s health record may be designated to another psychiatrist, psychiatric resident, or PNMHCS acting under the attending psychiatrist’s or the medical director’s Member-specific supervision.

10. 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.

11. With Member consent and the establishment of the clinical need for such communication, coordination with parents/guardians/caregivers, relevant school staff, and other treatment providers, including PCCs and behavioral health providers, is conducted by appropriate staff relative to treatment and care coordination issues. All such contact is documented in the Member’s health record.

Discharge Planning and Documentation
1. The provider conducts discharges 7 days a week, 365 days per year
2. The provider ensures that active and differential discharge planning is implemented for each Member by qualified staff who are knowledgeable about the medical necessity criteria for all MBHP covered services, including but not limited to all the Children’s Behavioral Health Initiative (CBHI) services.
3. At the time of discharge, and as clinically indicated, the provider ensures that the Member has a current crisis prevention plan and/or safety plan in place and that they have a copy of it. The provider works with the Member to update the crisis prevention plan and/or safety plan that they obtained from the ESP/MCI provider at the time of admission, or, if one was not available, develops one with the Member prior to discharge. With Member consent and as clinically indicated, the provider may contact the Member’s local ESP/MCI provider to request assistance with developing or updating the crisis prevention plan and/or safety plan. The provider sends a copy of the plan to the ESP/MCI director at the Member’s local ESP/MCI with Member consent.
4. Prior to discharge, the provider assists Members in obtaining post-discharge appointments, as follows: within seven (7) calendar days of discharge for outpatient therapy services (which may be an intake appointment for therapy services), if necessary; and within 14 calendar days of discharge for medication monitoring, if necessary. This function may not be designated to aftercare providers or to the Member to be completed before or after the Member’s discharge. These discharge planning activities, including the specific aftercare appointment date/time/location(s), are documented in the Member’s health record. If there are barriers to accessing covered services, the provider notifies the MBHP Northeast Access Line and/or the Provider Quality Team as soon as possible to obtain assistance. All such activities are documented in the Member’s health record.
5. The provider provides, with Member consent, a written discharge summary (or other such document(s) that contain the required elements) no later than within two weeks of the Member’s
discharge to the Member, parents/guardians/caregivers, PCCs, and current behavioral health providers. The discharge summary is documented in the Member’s health record and includes a summary of:

a. The course of treatment;
b. The Member’s progress;
c. The treatment interventions and behavior management techniques that were effective in supporting the Member’s progress;
d. Medications prescribed;
e. Recommended behavior management techniques when applicable; and
f. Treatment recommendations, including those that are consistent with the service plan of the relevant state agency for Members who are also involved with DMH, Department of Developmental Services (DDS), Department of Youth Services (DYS), or Department of Children and Families (DCF); and/or the youth’s Individual Care Plan (ICP) for those enrolled in Intensive Care Coordination (ICC).

6. Required discharge information is submitted by the provider electronically via eServices no later than seven (7) days of the Member’s discharge. Best practice calls for the submission of this information within 24 hours of the Member’s discharge, so that aftercare providers may outreach to the Member and facilitate compliance with aftercare services within seven (7) days.

7. For all youth under the age of 21, the provider makes best efforts to ensure a smooth transition for the return to home or discharge location, and to the next service, if any, by ensuring that a Child and Adolescent Needs and Strengths (CANS)-certified clinician at the facility completes a CANS tool for all Medicaid Members under the age of 21 as a part of the discharge planning process. A copy of the CANS is maintained in the Member’s health record. With parent/guardian/caregiver consent, the provider enters into the CANS online system (Virtual Gateway) the information gathered using the CANS tool. Even without consent, the provider ensures that the demographics and serious emotional disturbance (SED) determination, are entered into the CANS online system.

8. When necessary, the provider provides or arranges transportation for services required external to the hospital during the admission and, upon discharge, for placement into a step-down, 24-hour level of care, if applicable. The provider also makes reasonable efforts to assist Members upon discharge to the community and/or non-24-hour levels of care with identifying transportation options when needed, including public transportation, Prescription for Transportation (PT-1) forms, etc.