INPATIENT MENTAL HEALTH SERVICES

PURPOSE

Performance specifications are intended to enhance MassHealth Enrollee experience and outcomes by promoting transparency and consistency across Plans and providers. Performance specifications are expectations imposed on providers who contract for these specific and related services. Information contained in this document is based on publicly available documents, Plan expectations, your contract, and MassHealth guidance. This information should be and will look materially like any other MassHealth contracted Plan. Performance specifications, your provider manual, and other requirements can be found at providerexpress.com.

Providers contracted for this level of care or service are 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, providers of all contracted services are held accountable to the General Performance Specifications. Where there are differences between the service-specific and General Performance Specifications, the service-specific specifications take precedence.

OVERVIEW

Inpatient Mental Health Services represents 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 Enrollees 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 Enrollee 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 individuals in need of inpatient mental health services who are referred by an Emergency Services Program/Mobile Crisis Intervention (ESP/MCI) provider, and Acute Outpatient Hospital Emergency Departments 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 Enrollees of all ages. Specific requirements for those providers serving youth are noted throughout.

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

- Inpatient Mental Health Services
- Inpatient Mental Health Services for Individuals with Intellectual Disabilities

- Inpatient Mental Health Services for Children/Adolescents with Intellectual Disabilities/Autism Spectrum Disorders
- Inpatient Eating Disorders Services
- Observation/Holding Beds

SERVICE COMPONENTS

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, and 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 Enrollee 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
    k) Educational component for youth, including coordination with an Enrollee'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 Enrollee, 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 Enrollee's health record documents the rationale.
7. The provider is responsible for supplying each Enrollee with medications prescribed for physical and behavioral health conditions, and documents so in the Enrollee's health record.

8. Prior to supplying medications to the Enrollee, the provider engages in a medication reconciliation process to avoid inadvertent inconsistencies in medication prescribing that may occur in transition of an Enrollee from one care setting to another. The provider does this by reviewing the Enrollee'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 Enrollee's newly issued medication orders by the inpatient prescriber to all medications that he/she has been taking to avoid medication errors. This involves:
    a) developing a list of current medications, i.e., those the Enrollee 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 Enrollee's primary care clinician (PCC); and
    e) Communicating the new list to the Enrollee and, with consent, to appropriate caregivers, the Enrollee's PCC, and other treatment providers.
    f) All related activities are documented in the Enrollee'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 Enrollee 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 these services are documented in the Enrollee'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, 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 Plan. If the admitting hospital does not hold a limited Class VI license, the provider must obtain an Enrollee-specific waiver from the DMH licensing department to admit a youth under 18 years old. All Plan 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 parents, guardians, family members, or caregivers. 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 Enrollee's health record.
12. The provider provides accommodations for Enrollees to use telephones (free of charge), including allowing Enrollees to speak with family members in their native language, 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 Enrollee and parent/guardian/caregiver at the time of admission. The handbook includes but is not limited to Enrollee 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 (MABHAccess.com). The provider is also responsible for keeping all administrative and contact information up to date on the website and training staff on the use of the website to locate other services for Enrollees, 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 Enrollees 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 Plan service-specific performance specifications and the credentialing criteria outlined in your provider manual that can be found at providerexpress.com.
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 psychiatrists, nurses, social workers, psychologists, and other mental-health professionals, in compliance with its licensed capacity daily.
3. The provider is staffed with sufficient appropriate personnel to accept and admit Enrollees 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 who meets the plan's credentialing criteria. (Note: Credentialing criteria for psychiatrist's 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 Plan's credentialing criteria for a child/adolescent psychiatrist.
c) The medical director's role may include the provision of direct psychiatry service and 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 Plan'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 Enrollee's needs and strengths into a coherent narrative that can be used for treatment planning within the unit and in the Enrollee'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 Enrollees 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 Enrollee.
7. For children and adolescents under the age of 14, the attending psychiatrist is one who meets Plan'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 Plan's credentialing criteria. Psychiatric care consists of the provision of psychiatric and pharmacological assessment and treatment to Enrollees 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 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 him/her 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 Enrollee.
        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, 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 Enrollees reviewed. The agreement specifies whether the PNMHCS or the medical director, or 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 full- time. 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 outlining 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 Enrollee, when a PNMHCS is utilized to provide direct psychiatry services to a given Enrollee. The PNMHCS is not the attending for any Enrollee; and

e) There is documented active collaboration between the medical director, or another attending psychiatrist or attending child psychiatrist, and the PNMHCS relative to Enrollees' medication regimens, especially those Enrollees 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, and 365 days per year to respond to medical emergencies. During weekday business hours, the physician is a psychiatrist who meets Plan'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 24/7/365, 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. Enrollees have access to supportive milieu and clinical staff, as clinically indicated, 24 hours per day, seven days per week, and 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 Enrollees 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 can 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 Plan's credentialing criteria.
17. The provider ensures that Enrollees, upon their request, receive visits and telephone calls from appropriately trained clergy.

SERVICE, COMMUNITY AND OTHER 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 Enrollees. On an Enrollee-specific basis, the provider collaborates with any involved ESP/MCI providers upon an Enrollee'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 Enrollees to the inpatient provider and/or to which the inpatient provider refers high volumes of Enrollees, to enhance continuity of care for Enrollees. It is considered best practice to maintain written Affiliation Agreements or Memoranda of Understanding (MOU) with such providers.
3. With Enrollee consent, for plan Enrollees 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 Enrollee'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 Enrollee consent, for Enrollee 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 Enrollee's involvement with this state agency and/or their service providers.
7. With Enrollee consent, the provider contacts the appropriate local education authority (LEA) if the school system is involved with the Enrollee 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 Enrollees 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.

PROCESS SPECIFICATIONS

Assessment, Treatment Planning and Documentation

1. Upon receipt of a referral call from an ESP/MCI provider 24/7/365, the provider confirms bed availability and makes every effort to accept the Enrollee 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 Enrollee, conducts a comprehensive evaluation of each Enrollee within 24 hours of admission, consisting of a medical history and an assessment of the psychiatric, pharmacological, and treatment needs of the Enrollee, including a clinical formulation that explains the Enrollee's acute condition and maladaptive behavior. On weekends and holidays, the initial evaluation may be completed by a covering psychiatrist, or a psychiatric resident or PNMHCS or psychiatry or child psychiatry fellow/trainee, all acting under the attending psychiatrist's or the medical director's Enrollee-specific supervision. In such situations, the attending psychiatrist must evaluate the Enrollee 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 Enrollee within 24 hours of admission, and documents so in the Enrollee'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 Enrollee's PCC, other involved providers, and supports identified by the Enrollee. The treatment plan, signed, dated, and documented in the Enrollee's health record, includes, but is not limited to objective and measurable goals, time frames for expected outcomes, the Enrollee's strengths, links to primary care for Enrollees 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 Enrollee's diagnosis, describes all services needed during treatment, and reflects continuity and coordination of care.
5. The provider assigns a multi-disciplinary treatment team to each Enrollee 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 every 48 hours (a maximum of 72 hours between reviews on weekends), and are updated accordingly, based on each Enrollee's individualized progress. All assessments, treatment and discharge plans, reviews, and updates are documented in the Enrollee's health record.
7. Every Enrollee is assigned an on-site attending psychiatrist who consistently provides, and is responsible for, the day to day and overall care of the Enrollee when hospitalized. The attending psychiatrist meets with the Enrollee daily, writes daily psychiatry notes in the Enrollee's health record, and ultimately serves as the Enrollee's primary physician.
8. The attending psychiatrist is an active participant on the Enrollee's treatment team and is available to consult with other Enrollees of the treatment team throughout the Enrollee's length of stay. Other psychiatrists and/or a PNMHCS may also be available to consult with other Enrollees of the treatment team throughout the Enrollee's length of stay. However, the attending psychiatrist maintains the role as the Enrollee's primary physician throughout the Enrollee'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.), he/she designates a consistent substitute, as much as possible, to ensure that the Enrollee receives continuity of care. In these instances, the functions of meeting with the Enrollee daily and writing daily psychiatry notes in the Enrollee's health record may be designated to another psychiatrist, psychiatric resident, or psychiatric nurse mental health clinical specialist (PNMHCS) acting under the attending psychiatrist's or the medical director's Enrollee- specific supervision.
10. The provider ensures that each Enrollee has daily individual contactwith 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 Enrollee's individualized treatment plan.
11. With Enrollee 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 Enrollee's health record.

Discharge Planning and Documentation

1. The provider conducts discharges 7 days per week, 365 days per year.
2. The provider ensures that active and differential discharge planning is implemented for each Enrollee by qualified staff that is knowledgeable about the medical necessity criteria for all Plan covered services, including but not limited to the entire Children's Behavioral Health Initiative (CBHI) services.
3. At the time of discharge, and as clinically indicated, the provider ensures that the Enrollee has a current crisis prevention plan and/or safety plan in place and that he/she has a copy of it. The provider works with the Enrollee 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 Enrollee prior to discharge. With Enrollee consent and as clinically indicated, the provider may contact the Enrollee'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 Enrollee's local ESP/MCI with Enrollee consent.
4. Prior to discharge, the provider assists Enrollees 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 Enrollee to be completed before or after the Enrollee's discharge. These discharge planning activities, including the specific aftercare appointment date/time/location(s), are documented in the Enrollee's health record. If there are barriers to accessing covered services, the provider notifies the Plan Clinical Access Line and/or the regional office as soon as possible to obtain assistance. All such activities are documented in the Enrollee's health record.
5. The provider provides, with Enrollee consent, a written discharge summary (or other such document(s) that contain the required elements) no later than within two weeks of the Enrollee's discharge to the Enrollee, 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 Enrollee's progress;
    c. The treatment interventions and behavior management techniques that were effective in supporting the Enrollee'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 Enrollees 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 Enrollee's discharge. Best practice calls for the submission of this information within 24 hours of the Enrollee's discharge, so that aftercare providers may outreach to the Enrollee 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 Enrollees under the age of 21 as a part of the discharge planning process. A copy of the CANS is maintained in the Enrollee'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 Enrollees 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

1. The provider will develop and maintain a quality management plan that is consistent with their contractual responsibilities to Optum, 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 may include outcome measures and satisfaction surveys to measure and improve the quality of care and services delivered to Enrollees, including youth and their families.
3. Clinical outcomes data must be made available to Optum upon request and must be consistent with the performance specifications of this service.
4. Providers must report any adverse incidents and other reportable events that occur to the relevant authorities.