## 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.

The performance specifications contained within pertain to the following inpatient services:
- Inpatient Mental Health Services
- Observation/Holding Beds

Please refer to the performance specifications attachments for specialty services.

**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 individuals in need of inpatient mental health services who are referred by an Adult Mobile Crisis Intervention provider or an Emergency Department Behavioral Health Crisis Evaluation, regardless of the availability of insurance, capacity to private pay, or clinical presentation.

### Components of Service

1. The provider accepts admissions 24 hours per day, 7 days per week, 365 days per year.
2. 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.
3. 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 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, as applicable
   j. Peer support and/or other recovery-oriented services
4. 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.
5. 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 he/she has 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 provider (PCP) and/or primary care team (PCT); and
   e. communicating the new list to the Member and, with consent, to appropriate caregivers, the Member's PCP and/or PCT, and other treatment providers.

   All related activities are documented in the Member's health record.
6. 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.
7. 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 family members, legal counsel, or caregivers, as legally allowed and clinically indicated.
8. The provider provides the Member and guardian/caregiver specific information on the inpatient unit at the time of admission. The information includes but is not limited to legal and human rights, services available, treatment schedule, visitation hours and policies, grievance procedures, discharge criteria, and information about family support and peer and recovery-oriented services.

9. 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.

**Staffing Requirements**

1. The provider complies with the staffing requirements of the applicable licensing body, the staffing requirements in the Senior Whole Health service-specific performance specifications, and the credentialing criteria outlined in the Senior Whole Health Provider Manual, as referenced at www.SWHMA.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 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 who meets Senior Whole Health's credentialing criteria.
    b. 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.
    c. The medical director's role also includes the following functions, directly and/or in delegation to other attending psychiatrists who meet Senior Whole Health's credentialing criteria, particularly in larger, multi- unit facilities:
        i. Attendance at multi-disciplinary team meetings; and
        ii. Consulting with the multi-disciplinary team.
    d. 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 person-centered and family-centered.

6. The provider assigns an on-site attending psychiatrist to each Member.
7. Psychiatric care is provided by the medical director and/or other psychiatrists who are board certified and/or who meet Senior Whole Health'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 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.
8. For inpatient hospitals that utilize a psychiatry fellow/trainee to perform psychiatry functions, all of the following apply:
   a. The psychiatry fellow/trainee must be provided sufficient supervision from psychiatrists to enable him/her to establish working relationships that foster identification in the role of a psychiatrist;
   b. The 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.
9. 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; and consultation log including dates of consultation meetings and list of all Members reviewed. The agreement specifies

whether the PNMHCS or the medical director, or another attending psychiatrist will be responsible for this documentation;

b. The supervision/consultation between the PNMHCS and the medical director, or another attending 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, and the PNMHCS outlining how the PNMHCS can access the medical director, or another attending psychiatrist, when needed for additional consultation;
d. The medical director, or another 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; and
e. There is documented active collaboration between the medical director, or another attending psychiatrist, and the PNMHCS relative to Members' medication regimens, especially those Members for whom a change in their regimen is being considered.

10. 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 Senior Whole Health'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.
11. 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.
12. 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.
13. 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), 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.
14. 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.

15. The provider provides all staff with supervision in compliance with Senior Whole Health's credentialing criteria.
16. The provider ensures that Members, upon their request, receive visits and telephone calls from appropriately trained clergy.
17. The provider ensures that discharge planning staff are aware of and utilize available community resources to assist with discharge planning for members experiencing homelessness or at risk of homelessness. This includes providing regular training to discharge planning staff on available resources and/or up-to-date resource guides available on Helping Patients who are Homeless or Housing Unstable.

**Process Specifications**

**Assessment, Treatment Planning, and Documentation**

1. Upon receipt of a referral call from an Adult Mobile Crisis Intervention provider or an Emergency Room's Behavioral Health Crisis Evaluation 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, a psychiatric resident, PNMHCS, or 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 including input from Member, and, with consent, family members, caregivers, the Member's PCP and/or PCT, 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 every 48 hours (a maximum of 72 hours between reviews on weekends), 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.), he/she designates 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 psychiatric nurse mental health clinical specialist (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 caregivers/guardians, and other treatment providers, including PCPs and/or PCT, 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.
12. For Members experiencing or at risk of homelessness, at the time of admission, the hospital must notify the Plan in order to collaborate in identifying resources to assist with the housing situation.
13. For Members experiencing or at risk of homelessness, at the time of admission, assess each admitted member's current housing situation. At a minimum, assess whether the member is experiencing or at risk of homelessness. Ensure that discharge planning staff screen admission data, including but not limited to age, diagnosis, and housing status, within 24 hours of admission.
14. For Members experiencing or at risk of homelessness, commence such activities no later than

three working days upon the Member's admission.

15. The provider must determine whether any non-DMH, non-DDS, or non-MRC involved member experiencing or at risk of homelessness may be eligible to receive services from some or all of those agencies. For any such member, the hospital must, within two business days of admission, and to the extent consistent with all applicable federal and state privacy laws and regulations, offer to assist the member with completing and submitting an application to receive services from DMH, DDS, or MRC, as appropriate.
16. The provider must assess whether any member experiencing or at risk of homelessness has any substance use disorder. For any such member, the provider must contact the DPH-sponsored Helpline at 800-327-5050, the statewide, public resource for finding substance use treatment, recovery options, and assistance with problem gambling.
17. For purposes of these performance specifications, #12 through #15 are requirements provided in MassHealth Managed Care Entity Bulletin 64, July 2021 located at https://www.mass.gov/doc/managed-care-entities-bulletin/download.

**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 Member by qualified staff who are knowledgeable about the medical necessity criteria for all Senior Whole Health covered 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 he/she has 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 Adult Mobile Crisis Intervention provider or Emergency Department who conducted the behavioral health crisis evaluation 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 Adult Mobile Crisis Intervention 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 Adult Mobile Crisis Intervention providers director at the Member's local Adult Mobile Crisis Intervention provider with Member consent.
4. The provider, with Member consent, invites and encourages the following persons to participate in or otherwise contribute to such Member's discharge planning activities:
   a. Member;
   b. Family members/caregiver
   c. Guardians;
   d. Primary care providers and/or primary care team; (PCT)
   e. Geriatric Support Services Coordinator
   f. Behavioral health providers;

g. Emergency shelter outreach or case management staff, or care coordinators;
h. Any other supports identified by the member;
i. Department of Mental Health (DMH) staff, if applicable;
j. Department of Developmental Services (DDS) staff, if applicable; and/or
k. Massachusetts Rehabilitation Commission (MRC) staff, if applicable.

5. For any member experiencing homelessness who is expected to remain in the hospital for fewer than 14 days, the hospital must contact:
   a. The emergency shelter in which the member most recently resided, if known, to discuss the member's housing options post discharge; or
   b. If the member has not resided in an emergency shelter, or if the emergency shelter in which the member most recently resided is unknown, the local emergency shelter to discuss the member's housing options post discharge. The names and contact information for emergency shelters is available at https://hedfuel.azurewebsites.net/iShelters.aspx.
6. Hospitals must make all reasonable efforts to prevent discharges to emergency shelters of members who have skilled care needs, members who need assistance with activities of daily living, or members whose behavioral health condition would impact the health and safety of individuals residing in the shelter. For such members, hospitals should seek placement in more appropriate settings, such as DMH community-based programs or skilled nursing facilities. EOHHS has established a website to assist hospital discharge staff when helping members with skilled nursing or other long-term care needs. This website also includes information about EOHHS's new Long Term Care Discharge Support Line.
7. For certain members experiencing or at risk of homelessness, discharge to an emergency shelter or the streets may be unavoidable. For example, certain members may choose to return to the streets or go to an emergency shelter despite the best efforts of the hospital. For these members, the hospital shall:
   a. Discharge the member only during daytime hours;
   b. Provide the member a meal prior to discharge;
   c. Ensure that the member is wearing weather appropriate clothing and footwear;
   d. Provide the member a copy of their health insurance information;
   e. To the extent clinically appropriate and consistent with all applicable laws and regulations, provide the member with a written copy of all prescriptions and at least one week's worth of filled prescription medications;
   f. If the member is to be discharged to an emergency shelter:
      i. Provide at least 24 hours advance notice to the shelter prior to discharge;
      ii. Provide the member with access to paid transportation to the emergency shelter;
      iii. Ensure that the shelter has an available bed for the member. In the event that a shelter bed is unavailable on the planned discharge date, but a bed will be available soon, the hospital should delay discharge until a bed is available. In these cases, the hospital may bill the Administratively Necessary Day (AND) rate for each such day on which the member remains in the hospital.
8. For members experiencing and/or at risk of homelessness, the provider must document in each member's medical record all efforts related to the discharge planning activities described above, including options presented to the member and, if applicable, the member's refusal of any alternatives to discharge to the streets or emergency shelters; and track discharge of members to local emergency shelters or the streets.

9. Prior to discharge, the provider assists Members in obtaining post-discharge appointments, as follows: within **seven** calendar days of discharge for follow-up PCP visit; within **seven** 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 Senior Whole Health's Utilization Management team as soon as possible to obtain assistance. All such activities are documented in the Member's health record.
10. The Provider provides, with Member consent, a written discharge summary (or other such document(s) that contain the required elements) no later than seven days of the Member's discharge to the Member, guardians/caregivers, PCPs and/or PCT, 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), or Massachusetts Rehabilitation Commission (MRC).
11. Discharge information required by Senior Whole Health is submitted by the provider to Senior Whole Health electronically via fax or provider portal no later than four calendar 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 Senior Whole Health and/or aftercare providers may outreach to the Member and facilitate compliance with aftercare services within seven days.
12. For purposes of these performance specifications, #4 through #8 are requirements provided in MassHealth Managed Care Entity Bulletin 64, July 2021 located at https://www.mass.gov/doc/managed-care-entities-bulletin/download.

**Service, Community, and Collateral Linkages**

1. The provider is responsible for developing and maintaining an active working relationship with each of the local Adult Mobile Crisis Intervention providers who are high-volume referral sources for the hospital. The inpatient provider holds regular meetings or has other contacts and communicates with the Adult Mobile Crisis Intervention provider 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 Adult Mobile Crisis Intervention provider and/or Emergency Department that conducted the behavioral health crisis evaluation upon a Member's admission to ensure the Adult Mobile Crisis Intervention or Emergency Department that conducted the behavioral health crisis evaluation that the evaluation and treatment recommendations are received, and that any existing crisis prevention plan and/or safety plan is obtained from the Adult Mobile Crisis Intervention provider and/or the Emergency Department.

2. The provider maintains active working relationships with the step-down programs for adults 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 Senior Whole Health Members who are DMH consumers, the provider notifies the DMH case manager, and/or DMH Adult Community Clinical Services (ACCS) program and/or DMH area office by noon of the following business day post-admission or within one business day of identifying the Member's involvement with this state agency and/or their service providers.
4. 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.