Data Supplement for Haselden et al. (10.1176/appi.ps.201900028)

# Hospital Discharge Planning and Transition to Outpatient Psychiatric Care
# Medical Record Review Guidelines

## General guidelines

For each focal admission, reviewers will fill out a 'Medical Record Review Data Extraction Form' using REDCap. The reviewer will document general tracking information (points 1-2 below) and whether the inpatient mental health treatment team completed the specified discharge planning activities (points 3-6 below):

## Record review procedures

| STEPS | INSTRUCTIONS |
|---|---|
| Log into REDCap | 1. Go to 'My Projects' (second from the left on the bar at the top of the page)<br>2. Click on the Project<br>3. On the left hand side of the page locate the 'Data Collection' heading and click on 'Add/Edit Records' |
| Select a record | Start with the first incomplete record on the list and work down the list—do not start a new review until the prior record is completed and closed. *EXCEPTION: if you have a question about a record that prevents you from completing and closing it, contact the appropriate party (either the PI or research team); if you are unable to get an immediate response to your question then you can continue on to the next record while waiting for a response. |
| Locate the patient's medical record | Refer to the 'master list' of patients and use the personal information associated with the Record/Study ID of the record you will review. Use the person's name, DOB, and/or date of admission and discharge to locate the medical record in your internal system. *Note: There may be discrepancies between the 'master list' and your database. Our list may have a slight misspelling of the person's name; day and month of DOB flipped; or admit and dc dates off by 1-2 days. You may have to try a variety of search combinations to locate the correct record and admission. |
| 1. Fill out: *Medical Record Information* | See **pages 2** for further instructions. |
| 2. Fill out: *Reviewer Information* | See **pages 3** for further instructions. |
| 3. Fill out: *Contacted Previous Provider(s)* | See **pages 4-13** for further instructions. |
| 4. Fill out: *Outpatient Appointment(s)* | See **pages 14-20** for further instructions. |
| 5. Fill out: *Discharge Summary* | See **pages 21-24** for further instructions. |
| 6. Fill out: *Family Involvement* | See **pages 25-29** for further instructions. |
| Fill out: *Notes* | See **page 30** for further instructions. |
| Close record | When you have completed all of the forms and there are no outstanding questions, save the record and change the status to 'Complete'. |

# Medical Record Information

Record/Study ID ___pre recorded___

Date of admission ___pre recorded___

Is the pre-recorded date of admission correct?
◯ Yes
◯ No

What does the medical record list as the date of admission? ___*appears if ^ is no*___

Date of discharge ___pre recorded___

Is the pre-recorded date of discharge correct?
◯ Yes
◯ No

What does the medical record list as the date of discharge? ___*appears if ^ is no*___

Does the Medicaid ID from the list of names match the Medicaid ID of the patient whose medical record you are reviewing?
**IF NO DO NOT REVIEW THE RECORD.**
Yes ◯
No ◯

*RULES: The medical record is eligible for rating as long as the admission and discharge dates in the electronic record vary by no more than 2 days from the prerecorded dates in REDCap. Regardless of variations in reported dates, the patient's Medicaid ID in the medical record (typically available in the Face Sheet or admission documents) must always match the ID from the master list. If the dates of admission and/or discharge are more than 2 days off, but the ID matches, contact the research team to discuss eligibility of rating the record. If the ID does not match, the record is not eligible for rating and the reviewer should move on to the next name.*

*NOTES: It is common to see variations of 1 or 2 days because of confusion regarding ER/ED admission date, or the discharge is delayed by members of the clinical team. Additionally, the admission/discharge dates as seen on the search page/screen are occasionally recorded incorrectly. Therefore, the definitive dates can be determined by documents in the electronic health record (particularly the first non-ED progress note and the last progress note). If the date of admission and/or discharge is 1-2 days off in the electronic record, rate NO for question(s) regarding the pre-recorded date and use the following question(s) to record the correct date.*

# Reviewer Information

Reviewer name ○ ○ ○ ○ ○

**appears if ^ other is selected**
Name of 'other' reviewer: ______________________________

Date reviewed ______________________________

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**Guiding Principles for ALL Ratings:**

- Is there objective evidence?
    - When a rating is unclear based solely on content in the EHR, can objective evidence be obtained by a google search? For example, if the record references a place where the patient stayed, and you are unsure why the patient was there or what the place/entity offers, then objective evidence would be an official website that describes the services the place/entity offers.

- Ask yourself: if the research PI and Project Coordinator were sitting next to me and asked me to prove it, could I prove it? If you are unsure if the answer is Yes or No, contact us and ask.

# Contacted Previous Provider(s)

**appears for all cases**
Is there evidence that the patient has received prior psychiatric care? (at any time throughout his or her life)

- ◯ Yes
- ◯ No

| Rating | Criteria |
| --- | --- |
| YES | If the medical record indicates that the patient has received emergency, inpatient or outpatient services for mental health problems. The current admission and ER/ED visit leading to the admission do not count. Evidence includes:<br>• mention of previous encounters in the notes of the current admission.<br>• record of other encounters viewable on the search page/screen that are identifiable (by name) as behavioral health related and occurred BEFORE the current admission. NOTE: do not open/review these other encounters.<br>• If the record notes that the patient was prescribed or taking psychotropic medications prior to admission that is sufficient evidence to rate yes.<br>• If the record states the patient “may have had” inpatient, outpatient and/or ER/ED treatment for mental health problems this is sufficient evidence to rate yes.<br>• If the record notes prior outpatient treatment for substance use disorder (SUD) (such as rehab). |
| NO | If the medical record does NOT include any of the evidence above. If the only prior treatment was a detox admission. |

**appears if ‘prior psychiatric care’ is yes**
What type of prior psychiatric care has the patient received? (check all that apply)
Outpatient mental health care includes therapists, psychiatrists, or services at a mental health or substance use disorder treatment agency.

- ☐ inpatient psychiatric hospitalization
- ☐ ER
- ☐ outpatient mental healthor substance use disorder treatment

| Rating | Criteria/Notes |
| --- | --- |
| **Inpatient psychiatric hospitalization** | The reviewer should search documents in the current admission for any mention of previous hospitalizations for mental health problems. The current admission does NOT count. Detox admissions do NOT count. Evidence stating the patient *may have had* or *possible* inpatient hospitalization (for example during their childhood or patient report but not noted in medical record) is sufficient to rate yes. If the reviewer does not see any mention of hospitalizations, he/she should double check by scanning the record of encounters on the search page/screen, only considering instances before the current admission, and search for evidence of psychiatric hospitalization (again, the rater should not open or review EHRs for any episode of care other than the identified admission). |
| **ER** | Same as above. Again, the ER visit that resulted in the current admission does NOT count. Mention of prior psychiatric hospitalization alone does not |

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|---|---|
| | count as evidence of ER for psychiatric problems. While most psychiatric hospitalizations are preceded by ER, not all are, and thus we cannot assume. Mention of previous ER/ED encounters may be documented in ER/ED nursing and/or provider progress notes. |
| **Outpatient mental health or substance use disorder treatment** | The reviewer should search for any mention of previous outpatient MH or SUD treatment following the guidelines mentioned above for inpatient psychiatric hospitalization. Outpatient MH treatment providers include: mental health clinics, psychiatrists, psychologists, therapists, social workers, nurses, or nurse practitioners. Other community MH providers include: care or case managers, Assertive Community Treatment (ACT) teams, and Personalized Recovery Oriented Services (PROS), and residential facilities for youth. School psychologists, counselors or social workers count as long as it is clear that they are trained/qualified to provide mental health supportive services and they have provided such services to the patient. Primary care physicians (PCP) count if they treated the patient for mental health conditions (e.g. prescribed him/her psychiatric medications). Outpatient SUD providers include: residential and non-residential agencies that specialize in SUD treatment.<br><br>Entities that do NOT count as MH outpatient treatment include: group homes, home attendants, teachers, medical treatment providers for non-mental health conditions (e.g. treatment for HIV, cardiovascular problems, obesity etc.). HOWEVER, if professionals in group homes or other organizations assume case management responsibilities for the patient, communicate with the inpatient team and provide clinical information about the patient, they can be counted as an outpatient MH provider when rating contact with current or prior providers (check with RFMH research team to confirm these cases). Entities that do NOT count as SUD outpatient treatment include: substance related anonymous groups (e.g. AA, NA etc.)<br><br>If an agency is mentioned and you are unsure if it is outpatient MH or SUD treatment see if a google search answers the question. When in doubt contact the RFMH research team. |
| | IF OUTPATIENT MH TREATMENT IS NOT SELECTED, RECORD ANY NOTES AND CONTINUE TO THE NEXT FORM. |

**appears if 'prior psychiatric care', 'outpatient MH treatment' is selected**

Does the record indicate that the patient discontinued outpatient MH or SUD treatment prior to the admission AND the hospital team (inpatient and ED team) made no effort to contact a provider that may have had information about the patient? NOTE: rate YES when patient clearly had NO contact (phone or in person) with an outpatient provider in the recent period (at least 6 months) such that it appears there is no clinician available to provide information that could potentially inform the treatment plan. Many patients show marginal or limited involvement in care. If the record notes "intermittent" participation or that the patient rarely attends sessions, rate NO. In these instances, the outpatient provider likely has information about the

○ Yes
○ No

patient's poor engagement in care that would be important for the inpatient team to know. Similarly, if the patient has had no recent contact with a previous provider (e.g., no contact in prior 6 months) but the provider has a significant prior treatment relationship (e.g., the provider treated the patient for 2 years prior to the discontinuation 6 months ago) such that it is likely the provider could potentially inform the treatment plan, rate NO.

| Rating | Criteria | Examples |
|---|---|---|
| **YES** | If the medical record indicates positive evidence that the patient clearly had NO contact (phone or in person) with an outpatient provider in the recent period (at least 6 months) such that it appears there is no clinician available to provide information that could potentially inform the treatment plan; AND the hospital team (inpatient and ED team) made no effort to contact a provider that may have had information about the patient. | *Minimally acceptable evidence:*<br>• Pt has history of non-compliance with outpatient treatment. Frequents ED for psychiatric treatment.<br>• Has been lost to follow up for 1 yr.<br>• Patient recalls receiving services at *clinic* years ago. Past records show *year*.<br>*The above examples are only sufficient when there was no recent outpatient treatment, at least 6 months, AND the previous provider(s) had minimal interaction with the patient such that they would not have relevant information for the inpatient team.* |
| **NO** | If no positive evidence of discontinuation (such as examples above). If patient has discontinued care but the hospital team (inpatient or ED), contacted and communicated with the outpatient provider, rate NO. The spirit of this question is capturing instances where there was no communication between inpatient and outpatient team.<br>NOTES: medication non-compliance alone is not sufficient to rate discontinuation if the patient is still communicating with the provider. If the record notes "intermittent" participation or that the patient rarely attends sessions, rate NO. In these instances, the outpatient provider likely has information about the patient's poor engagement in care that would be important for the inpatient team to know. Similarly, if the patient has had no recent contact with a previous provider (e.g., no contact in prior 6 months) but the provider has a significant prior treatment relationship (e.g., the provider treated the patient for 2 years prior to the discontinuation 6 months ago) such that it is likely the provider could potentially inform the treatment plan, rate NO. | •Pt was taking Zyprexa 6 months ago, prescribed by his psychiatrist. Stopped taking medication because pharmacy was far away and has not followed up with psychiatrist.<br>*If the inpatient team did not attempt to contact the patient's psychiatrist, rate NO. Although the patient has discontinued care the psychiatrist was prescribing medication to the patient likely had information that would have influenced the inpatient treatment plan.*<br>•One progress note states: "patient attended outpatient rehabilitation in the past 4 month and stopped going because patient did not get along with Social Worker." Another progress note states: "No outpatient treatment in past year"<br>*As in the above example, records may have conflicting information. One note may say no treatment in the past year while another note says the patient discontinued in the* |

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|---|---|---|
| | | *past four months because he/she did not like the therapist. The latter statement suggests that the patient recently saw a provider who the inpatient team should have contacted. If the inpatient team did not contact the provider, rate NO.* |

**appears if 'prior psychiatric care', 'outpatient MH treatment' is selected**

Does the record indicate that the patient's current or prior outpatient MH or SUD provider at the time of admission was at a clinic affiliated with the institution?

- ◯ Yes
- ◯ No
- ◯ Not specified/can't tell from record

**appears if 'prior psychiatric care', 'outpatient MH treatment' is selected**

Does the record indicate that the inpatient staff (clinical or administrative) attempted to contact a current (at the time of admission) or prior outpatient MH or SUD provider? NOTE: also rate YES if contact was initiated by the outpatient provider (e.g. outpatient provider called inpatient team), and the contact resulted in communication with the inpatient team. If such contacts result in discussion of patient's clinical information, also rate YES to the question below, "Does the record indicate that the outpatient MH or SUD provider provided clinical information about the patient to the inpatient team?" (see guide for examples of what constitutes attempted contact)

- ◯ Yes
- ◯ No

| Rating | Criteria | Examples |
|---|---|---|
| **YES** | If the medical record indicates that the inpatient staff attempted to contact a current or prior MH or SUD outpatient provider at any point throughout the hospitalization (including discharge). Minimally acceptable criteria to rate YES is evidence of an appointment scheduled with the patient's current or prior outpatient provider, or an intake appointment at a clinic where patient was previously treated. Also rate YES if contact was initiated by the outpatient provider (e.g. outpatient provider called inpatient team), and the contact resulted in communication with the inpatient team.<br><br>*See page 5 for what constitutes an outpatient MH or SUD provider.* | *Minimally acceptable evidence:*<br>• Called patient's previous psychiatrist, Dr. *X* and left voicemail<br>• Faxed ROI [release of information] papers to pts therapist<br>• Dr. *X* [patient's previous psychiatrist and the aftercare provider] is aware of discharge<br>• Aftercare appointments: Pt will see Dr. *X* on *xx/xx/xx*; *OR:* Pt has intake appt. at Strong Ties on *xx/xx/xx*<br>*The above examples are only sufficient when it is clear the provider and/or clinic was treating the patient prior to admission An intake appointment is sufficient in these instances since the clinic maintains the patient's medical record.*<br>• Patient's psychiatrist, Dr. *X,* called to inform tx team of admission. Dr. *X* saw patient on Tuesday and patient was experiencing psychotic symptoms. Dr. *X* sent patient to ER.<br>*Even though the outpatient provider* |

| | | |
|---|---|---|
| | | *initiated the contact, the inpatient team communicated with the provider and received clinical information. In such instances, rate YES.* |
| **NO** | If the medical record does NOT indicate that the inpatient staff attempted to contact a current or prior MH or SUD outpatient provider. | • Patient recalls receiving services at *clinic* years ago. Past records show *year*.<br>*The reviewer should document the above quote in the notes question (see page 13) and include a brief statement that you were unable to find any other evidence that the inpatient staff contacted the agency or a provider.*<br>• ED team contacted *clinic* where patient was treated back in *year*. Pt. sporadically attended appointments and was prescribed *X* and *Y* but was lost to follow up.<br>*In the above example, there is evidence that the ED team contacted the patient's previous outpatient provider. If there is no further evidence that the inpatient team attempted contact, and the aftercare appointment scheduled is with a different provider, the reviewer should rate no.* |
| | IF NO, ANSWER THE FOLLOWING QUESTION<br>IF YES, SKIP TO 'WHAT WAS THE NATURE OF THE CONTACT?' | |

*appears if 'attempted to contact' is no*

Does the record describe a reason why the inpatient staff did not attempt to contact the patient's previous outpatient MH or SUD provider?

◯ Yes
◯ No

| Rating | Criteria | Examples |
|---|---|---|
| **YES** | If the medical record specifies a reason why the inpatient team did not attempt to contact the current or prior outpatient provider identified. | • Pt reports seeing a therapist years ago but could not provide name or contact information. Could not obtain collateral from family.<br>*The reviewer will document the above quote in the following question (see below).* |
| **NO** | If the medical record does NOT specify a reason why the inpatient team did not attempt to contact the current or prior outpatient provider identified. | • Pt was taking Zyprexa 6 months ago, prescribed by his psychiatrist. Stopped taking medication because pharmacy was far away and has not followed up with psychiatrist.<br>*In the above example the inpatient team should have attempted to identify and contact the prior psychiatrist. Noting that the patient had discontinued care with the psychiatrist is not sufficient reason to justify lack of effort to contact the psychiatrist. In instances where there is reference to outpatient providers, but there is no* |

| | |
|---|---|
| | *specified reason for lack of attempted contact, the reviewer should document any relevant quotes in the notes question (see page 13) and include a brief statement that you were unable to find any other evidence that the inpatient staff contacted the psychiatrist.*<br>• ED team contacted *clinic* where patient was treated back in *year*. Pt. sporadically attended appointments and was prescribed *X* and *Y* but was lost to follow up.<br>*In the above example there is evidence that the ED team contacted the patient's outpatient provider and obtained clinical information. This does not count as a reason for why the inpatient team did not contact the patient's outpatient provider. However, a question below captures such scenarios where information from the outpatient provider, not elicited by members of the inpatient team, is present in the record.* |

**appears if 'reason staff did not attempt to contact' is yes**
Explain the reason why the inpatient staff did not attempt to contact the patient's previous outpatient MH or SUD provider: NOTE: include - 1) where the relevant note was documented in the medical record, 2) date of the note, 3) who documented the note, and 4) quote direct text for clarity. If the note includes the patient's name, substitute "patient" for the patient's name. For other personal identifiers substitute a general identifier (e.g. phone number, address, etc.) ______________________________

FOR THE EXAMPLE ABOVE: SW progress note dated *xx/xx/xx* states: "Pt reports seeing a therapist years ago but could not provide name or contact information. Could not obtain collateral from family."

**appears if 'attempted to contact' is yes**

What was the nature of the direct contact between inpatient team and outpatient provider? Check all that apply.

- ☐ Phone
- ☐ Email
- ☐ Face-to-face
- ☐ Fax
- ☐ Scheduled an appointment (applies when previous provider is also aftercare provider)
- ☐ Not specified/can't tell from record
- ☐ Other

If a previous provider is also the aftercare provider and a case summary was faxed at discharge, check fax.

**appears if 'nature of contact', 'other' is selected**
Describe the 'other' contact: ______________________________

**appears if 'attempted to contact' is yes**
Does the record indicate that the outpatient MH or SUD

- ○ Yes
- ○ No

provider responded? NOTE: OR if the inpatient team responded in the instance where the outpatient provider initiated contact.
(See guide for examples of what constitutes a response)

| Rating | Criteria | Examples |
|---|---|---|
| **YES** | If the medical record indicates that the outpatient provider responded, regardless if it resulted in conversation or discussion of the patient. Also rate YES if the outpatient provider initiated contact and there was communication with the inpatient team that resulted in exchange of clinical information. Minimally acceptable criteria to rate YES is communication with secretaries or administrative persons at outpatient clinics. | • Patient's previous psychiatrist Dr. *X* left a VM saying he would not discuss patient without consent<br>• Spoke with patient's previous psychiatrist, Dr. *X* who confirmed medical history<br>• Aftercare appointments: Pt will see Dr. *X* on *xx/xx/xx*<br>*The above example is only sufficient when it is clear the provider was treating the patient prior to admission.*<br>• Patient's psychiatrist, Dr. *X,* called to inform tx team of admission. Dr. *X* saw patient on Tuesday and patient was experiencing psychotic symptoms. Dr. *X* sent patient to ER.<br>*If the outpatient provider initiated contact this is sufficient to rate YES to provider responded and provided clinical information about the patient.* |
| **NO** | If the medical record does NOT indicate that the outpatient provider | Called patient's previous psychiatrist, Dr. *X* and left VM [voicemail]<br>*If this is the only evidence noted in the record, rate NO.* |

| | responded or attempted to make contact with the treatment team. |
|---|---|

**appears if 'provider responded' is yes**

Does the record indicate that the outpatient MH or SUD provider provided clinical information about the patient to the inpatient team?
CLINICAL INFORMATION DEFINITION: information regarding the patient's medical/clinical history or status, personal characteristics/behaviors that relate to their mental health or SUD treatment, circumstances leading to the current admission, or information relevant to discharge planning and aftercare.
(See guide for examples of what constitutes providing clinical information)

◯ Yes
◯ No

| **Rating** | **Criteria** | **Examples** |
|---|---|---|
| **YES** | If the medical record indicates that the outpatient provider's response(s) included clinical information, defined as information regarding the patient's medical/clinical history or status, personal characteristics/ behaviors that relate to their mental health or SUD treatment, circumstances leading to the current admission, or information relevant to discharge planning and aftercare. Minimally acceptable criteria to rate yes is a note that simply says "spoke to *X*", as it is likely the conversation was regarding clinical information about the patient (conversations between inpatient team and secretaries or administrative staff at clinics are acceptable). | *Minimally acceptable evidence:*<br>• Dr. *X* [patient's previous psychiatrist and the aftercare provider] is aware of discharge<br>• The outpatient provider returned a call and left a VM that said patient often sporadic about taking medication<br>• We were trying to figure out what medications patient has taken. Spoke to Dr. *X* on Thursday and prescribed *x, y, z*<br>*While the inpatient provider did not document Dr. X's response regarding medication, from the context of the entry the rater can infer that the discussion with Dr. X included a discussion of medication.*<br>• Patient wants to be discharged early and team is concerned about stability; talked to Dr. *X* and determined it would be better to discharge next week<br>*While it is unclear what information Dr. X provided, the context indicates that the provider's clinical input was obtained in time to inform the inpatient team's treatment planning.* |
| **NO** | If the medical record does NOT indicate that the outpatient provider's response included clinical | • Patient's previous psychiatrist Dr. *X* left a VM saying he would not discuss patient without consent<br>• Aftercare appointments: Pt will see Dr. *X* on *xx/xx/xx* |

| information about the patient. | *While documentation of a scheduled outpatient appointment is minimally acceptable evidence to rate yes for attempted contact and yes for provider responded, it is not sufficient evidence to rate yes for provided clinical information. In order to rate yes, there needs to be evidence that the outpatient provider acknowledged the patient's discharge (see above example for YES).* |
|---|---|

IF NO, ANSWER THE QUESTION ABOUT WHY THEY DID NOT PROVIDE CLINICAL INFORMATION.
IF YES, RECORD ANY NOTES AND SKIP TO THE QUESTION ABOUT A 2ND PROVIDER.

**appears if 'provided clinical information' is no**

Does the record indicate the reason why the outpatient MH or SUD provider did NOT provide clinical information about the patient?

- ○ Outpatient MH or SUD provider responded to contact but no communication established with any member of the team (e.g., phone tag)
- ○ Outpatient MH or SUD provider not willing to communicate without consent and consent was not obtained
- ○ Not specified/can't tell from record
- ○ Only an appointment was scheduled
- ○ Other

**appears if 'reason provider did not provide clinical information', 'other' is selected**

Describe the 'other' reason why the outpatient MH or SUD provider did NOT provide clinical information about the patient: ______________________________

**appears for all cases**

If the medical record shows conflicting or confusing information about contacting a previous MH or SUD outpatient provider, please summarize. When describing the notes in question, be as clear as possible by including: 1) where the relevant note was documented in the medical record, 2) date of the note, 3) who documented the note, and 4) direct text in quotations for clarity. If the note includes the patient's name, substitute "patient" for the patient's name. For other personal identifiers substitute a general identifier (e.g. phone number, address, etc.) ______________________________

**appears if 'prev psych care', 'outpatient MH treatment' is selected**

Does the record indicate that the inpatient staff (clinical or administrative) attempted to contact more than one current (at the time of admission) or prior outpatient Mental Health (MH) or SUD provider?

- ○ Yes
- ○ No

If a second provider was contacted, answer the same questions for provider 2. See REDCap. Refer back for examples.

See guidance above for the first "attempted to contact" question.

**appears if 'prior psychiatric care', 'outpatient MH treatment' is selected**

Is there clinical information in the medical record from the patient's current or prior outpatient provider that was not elicited by members of the inpatient team (e.g. obtained from ED team, obtained from patient's medical record, or a

- ○ Yes
- ○ No

written note submitted by an outpatient provider) along
with evidence that the inpatient team included the information
in their documentation and or care planning?
NOTE: this question should capture scenarios where there
was NO direct communication between the inpatient team
and outpatient provider (e.g., the communication was between
the ED team and outpatient provider). The spirit of this
question is that it captures a 2nd level of communication
between the outpatient and inpatient provider such that
important information from the outpatient provider was
ultimately relayed to the inpatient team. CLINICAL
INFORMATION DEFINITION: information regarding the
patient's medical/clinical history or status, personal
characteristics/behaviors that relate to their mental
health treatment or SUD, circumstances leading to the current
admission, or information relevant to discharge planning
and aftercare.
(See guide for what constitutes clinical information from
the patient's outpatient provider that was not elicited by the inpatient team.)

| Rating | Criteria | Examples |
|---|---|---|
| **YES** | The reviewer will rate yes when BOTH of the criteria below are met*:*<br>1- Presence of clinical information about the patient that was clearly communicated or provided by the patient's current or prior outpatient provider but was not elicited by the inpatient team. Examples include clinical information obtained by ED staff or other medical departments preceding the psychiatric admission; statements that say the information was obtained from the patient's medical record; or written notes sent by the outpatient provider. Clinical information is defined as information regarding the patient's medical/clinical history or status, personal characteristics/behaviors that relate to their mental health or SUD treatment, circumstances leading to the current admission, or information relevant to discharge planning and aftercare; AND<br>2- Evidence that the inpatient team included the information in their documentation and or care planning. | *Minimally acceptable evidence:*<br>• ED team contacted pt's outpatient psychiatrist, Dr. *X* who said pt has been noncompliant with *X* and *Y* [medications].<br>• Patient is currently in outpatient treatment at *clinic* [affiliated with hospital]. I have reviewed pt's medical record and notes from psychiatrist Dr. *X*. We will start patient on *X* medication. |
| **NO** | If no positive evidence of BOTH criteria above. Clinical information that was obtained from past hospitalization records | |

| does not count unless it is referring to information provided by the patient's outpatient provider. |
|---|
| IF YES, ANSWER THE FOLLOWING QUESTION |

**appears if 'clinical info from OP provider not elicited by IP team' is yes**

TEXT ENTRY follow-up question to "clinical information not elicited" (above): Describe the circumstances of the communication with the patient's current or prior outpatient provider. Document how the clinical information was obtained/communicated, what was communicated, and how/where the inpatient team included the information in their documentation and or care planning.

NOTE: include - 1) where the relevant note was documented in the medical record, 2) date of the note, 3) who documented the note, and 4) quote direct text for clarity. If the note includes the patient's name, substitute "patient" for the patient's name. If the note includes the patient's name, substitute "patient" for the patient's name. For other personal identifying information substitute a general identifier (e.g. phone number, address, etc.) *appears if 'attempted to contact' is yes*

______________________________

**appears for all cases**

Record any additional notes: When referring to specific notes in the medical record be as clear as possible by including: 1) where the relevant note was documented in the medical record, 2) date of the note, 3) who documented the note, and 4) direct text in quotations for clarity. If the note includes the patient's name, substitute "patient" for the patient's name. For other personal identifiers substitute a general identifier (e.g. phone number, address, etc.)

______________________________

EXAMPLE ABOUT ATTEMPTED CONTACT, (PG. 7):

SW progress note, dated xx/xx/xx, states: "Patient recalls receiving services at *clinic* years ago. Past records show *year*." No other evidence in record that the inpatient team attempted to contact the clinic.

*NOTE: This case would be sufficient to rate YES to the question discontinued outpatient treatment.*

EXAMPLE ABOUT REASON WHY NO ATTEMPTED CONTACT, (PG. 8):

Record showed that patient had a previous psychiatrist as noted by SW in psychosocial report, dated xx/xx/xx: "Pt was taking Zyprexa 6 months ago, prescribed by his psychiatrist. Stopped taking medication because pharmacy was far away and has not followed up with psychiatrist." No other evidence in the record that the inpatient team attempted to contact.

# Outpatient Appointment(s)

**appears for all cases**

Does the record indicate that an appointment for outpatient MH treatment was part of the discharge plan?

◯ Yes- 1 appointment
◯ Yes- 2 appointments
◯ Yes- 3 appointments
◯ No

| Rating | Criteria | Examples |
| --- | --- | --- |
| **YES** | If the medical record indicates that an appointment for outpatient MH treatment was made, and specifies a date and a provider or agency name. If a date is not provided, but the record specifies a day for the appointment (i.e. today, Monday, Tuesday etc.), this is minimally acceptable evidence to rate yes but the reviewer will leave the date blank in the following question and explain why. | *Minimally acceptable evidence:*<br>• Confirmed appointment with patient's psychiatrist, Dr. *X* [*been in contact with treatment team throughout hospitalization*], for next Tuesday<br>• Scheduled appointment at *X* clinic for next Tuesday<br>*If there is evidence of an appointment but only a day is recorded (i.e. Monday, Tuesday etc., but no date listed), the reviewer will rate YES but leave the date blank in the following question. The reviewer must also report the reference to the day (Monday, Tuesday, etc.) in the rating text so the research team can determine the actual date if needed.* |
| **NO** | If the medical record does NOT indicate that an appointment was made. OR the record indicates an appointment was made but does not have a clearly discernable date OR does not specify a provider or agency name.<br>If an appointment was made with an agency that does not offer MH treatment (e.g. a home attendant) this does not count for an outpatient MH treatment appointment but the reviewer should document the information in the notes section. | • Aftercare appointments: Patient to continue outpatient treatment at *clinic* [patient's current provider at the time of admission]<br>*If this is the only evidence the reviewer will rate no. Although the aftercare provider is the patient's current outpatient treatment provider there must be a date or day specified to rate yes for an appointment. However, a question below captures such scenarios where an aftercare provider was identified but an appointment was not scheduled.* |
| | IF NO, ANSWER THE QUESTION ABOUT SUD TREATMENT.<br>IF YES, ANSWER THE FOLLOWING QUESTIONS ABOUT THE APPOINTMENT. | |

**appears if MH appt. is yes- 1, 2, or 3 appts.**

Date of appointment 1 for outpatient MH treatment:
(If the date is not specified or unclear, leave blank and explain why in the following question)

____________________________

**appears if 'date of outpatient MH appt. 1' is blank**

If the date of outpatient MH appointment 1 is not specified or is unclear in the medical records, explain why: NOTE: include - 1) where the relevant note was documented in the medical record, 2) date of the note,



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3) who documented the note, and 4) direct text in quotations for clarity. If the note includes the patient's name, substitute "patient" for the patient's name. For other personal identifiers substitute a general identifier (e.g. phone number, address, etc.) __________________________________

**appears if MH appt. is yes- 1, 2, or 3 appts.**

Does the record specify the name of the outpatient MH treatment (appointment 1) clinician? (e.g. Dr. Smith)

◯ Yes
◯ No- not specified/can't tell from record

**appears if 'name of clinician' is yes**
Name of outpatient MH treatment (appointment 1) clinician: __________________________________

**appears if MH appt. is yes- 1, 2, or 3 appts.**
Does the record specify the name of an outpatient MH treatment (appointment 1) agency? (e.g. Strong Ties Clinic)

◯ Yes
◯ No- not specified/can't tell from record
◯ N/A- provider was a private practice

**appears if 'name of agency' is yes**
Name of outpatient MH treatment (appointment 1) agency: __________________________________

| **Provider type** | **Examples** |
|---|---|
| Private psychiatrist | Name? Yes<br>Name: Dr. *X*, M.D.<br><br>Agency name?: N/A<br>Agency name: |
| Clinic, no provider specified | Name? No<br>Name:<br><br>Agency Name? Yes<br>Agency Name: Strong Ties Clinic |
| Social worker, clinic | Name? Yes<br>Name: *Xxxx Xxxx*, LSW<br><br>Agency Name? Yes<br>Agency Name: Bronx Lebanon outpatient clinic |

**appears if 'name of clinician' and 'name of agency' are no**
Explain why there was no clinician name AND no treatment agency name (appointment 1):
NOTE: include - 1) where the relevant note was documented in the medical record, 2) date of the note, 3) who documented the note, and 4) direct text in quotations for clarity. If the note includes the patient's name, substitute "patient" for the patient's name. For other personal identifiers substitute a general identifier (e.g. phone number, address, etc.)

__________________________________

**appears if MH appt. is yes- 1, 2, or 3 appts.**
Does the record indicate that the outpatient MH clinician or agency (appointment 1) offers psychiatric care/medication management?
(See guide for examples of what constitutes psychiatric care/medication management)

◯ Yes
◯ No
◯ Not specified/can't tell from record

| Rating | Criteria/Examples |
|---|---|
| **YES** | If the medical record indicates that the outpatient provider or agency may prescribe psychiatric medication.<br>Provider types that prescribe: psychiatrist, physicians, nurse practitioner, anyone with MD or DO.<br>Entities/agencies that will always offer psychiatric services include: entity with the word 'clinic' (e.g. mental health clinic (MHC); hospital clinics), ACT teams, and continuing day treatment programs. |
| **NO** | If the medical record indicates that the outpatient provider/agency is not authorized to prescribe medication.<br>Provider types that cannot prescribe: social worker, therapist, non-medical professionals. |

> If more than 1 appointment for outpatient MH treatment was made, answer the same questions for the other appointment(s). See REDCap. Refer back for examples.
> IF NO OTHER MH APPOINTMENTS SKIP TO SUD APPOINTMENT QUESTIONS.

*appears for all cases*
Does the record indicate that an appointment for outpatient substance use disorder (SUD) treatment was part of the discharge plan?

- ◯ Yes- 1 appointment
- ◯ Yes- 2 appointments
- ◯ Yes- 3 appointments
- ◯ No

| Rating | Criteria | Examples |
|---|---|---|
| **YES** | If the medical record indicates that an appointment was made with a program or provider that will treat the patient specifically for substance use, and specifies a date and a program/provider name. The reviewer may need to google the specified aftercare entity to figure out whether or not it is a substance use treatment program. If a date is not provided, but the record specifies a day for the appointment (i.e. today, Monday, Tuesday etc.), this is minimally acceptable evidence to rate yes but the reviewer will leave the date blank in the following question and explain why. | *Minimally acceptable evidence:*<br>• Confirmed appointment with patient's psychiatrist, Dr. *X* [been in contact with treatment team throughout hospitalization; treats patient for substance use], for Tuesday<br>• Patient to be seen Monday at methadone *X* OTP clinic<br>• Patient to attend substance abuse rehab program at *XX* beginning xx/xx/xxxx |
| **NO** | If the medical record does NOT indicate that an appointment was made with a program or provider that will treat the patient specifically for substance use, OR the record indicates an appointment was made but does not have a clearly | |

| | |
|---|---|
| | discernable date OR does not specify a program/provider name. |
| | IF NO, SAVE AND GO TO NEXT FORM.<br>IF YES, ANSWER THE FOLLOWING QUESTIONS ABOUT THE APPOINTMENT. |

**appears if SUD appt. is yes- 1, 2, or 3 appts.**
Date of appointment 1 for outpatient SUD treatment:
(If the date is not specified or unclear, leave blank and explain why in the following question) ______________________________

**appears if 'date of outpatient SUD appt. 1' is blank**
If the date of outpatient SUD appointment 1 is not specified or is unclear in the medical records, explain why: NOTE: include - 1) where the relevant note was documented in the medical record, 2) date of the note, 3) who documented the note, and 4) direct text in quotations for clarity. If the note includes the patient's name, substitute "patient" for the patient's name. For other personal identifiers substitute a general identifier (e.g. phone number, address, etc.) ______________________________

**appears if SUD appt. is yes- 1, 2, or 3 appts.**
What type of program was the outpatient SUD appointment 1 with?

- ◯ Outpatient Treatment
- ◯ Outpatient Methadone Maintenance
- ◯ OutP Chemical Dependency Program for Youth
- ◯ Intensive Residential Program
- ◯ Other

| Rating | Criteria | Examples |
|---|---|---|
| **Outpatient Treatment** | If the medical record indicates an appointment was made for substance use but does not specify characteristics of the other categories below (methadone, youth, residential). | • Patient to attend substance abuse rehab program at *XX* beginning xx/xx/xxxx<br>• Confirmed appointment with Patient's psychiatrist, Dr. *X* [been in contact with treatment team throughout hospitalization; treats patient for substance use], for Tuesday |
| **Outpatient Methadone Maintenance** | If the medical record indicates that the outpatient appointment is with an opioid treatment program (OTP) and/or methadone maintenance. A sign to look for is mention of heroin or other opiate usage. | Patient to be seen Monday at methadone *X* OTP clinic<br>*If it is not obvious what the type and purpose of the program is, the reviewer should try to search the title online for clarity.* |
| **Outpatient Chemical Dependency Program for Youth** | If the medical record indicates that the patient is 18 years or younger and will be treated for alcohol and/or drug usage at a program. The reviewer may have to research the program online to confirm it is for youth. | Patient [age 16] to attend substance abuse rehab program at XX beginning xx/xx/xxxx<br>*Again, the reviewer may have to look up the title of the program to determine if it is a youth program.* |

| **Intensive Residential Program** | If the medical record indicates that the substance use program is residential. | Patient to begin intensive residential program at XX beginning xx/xx/xxxx<br>*Same suggestion as above.* |
|---|---|---|
| **Other** | If the medical record indicates the substance use treatment program is none of the above. | |

**appears if 'type of SUD program', 'other' is selected**
Describe the 'other' outpatient SUD program (appointment 1) type: ______________________________

**appears if SUD appt. is yes- 1, 2, or 3 appts.**
Does the record indicate that the outpatient SUD program (appointment 1) offers psychiatric care/medication management?
(See guide for examples of what constitutes psychiatric care/medication management)

- ◯ Yes
- ◯ No
- ◯ Not specified/can't tell from record

| **Rating** | **Criteria/Examples** |
|---|---|
| **YES** | If the medical record indicates that the outpatient SUD program may prescribe psychiatric medication. Programs that will always offer psychiatric services include: programs with the word 'clinic'; programs for methadone maintenance.<br>Note: this question is particularly important when the patient's only aftercare appointment is with the SUD program; if this is the case, make sure you can prove/confirm whether or not the program offers psychiatric care. If the patient has a separate appointment at a MH clinic then this question is less important. |
| **NO** | If the medical record indicates that the outpatient SUD program is not authorized to prescribe medication. |

If more than 1 appointment for SUD treatment was made, answer the same questions for the other appointment(s). See REDCap. Refer back for examples.

**appears if MH appt. is no, AND SUD appt. is no**
Does the record indicate that an outpatient treatment provider was identified to provide aftercare MH and/or SUD services?
(See guide for examples of what constitutes an outpatient treatment provider was identified.)

- ◯ Yes
- ◯ No

| **Rating** | **Criteria** | **Examples** |
|---|---|---|
| **YES** | If the medical record indicates that the patient was to receive services with a specified provider or agency after discharge, but no date or day was documented in the record. If the record specifies that a referral was successfully made this is sufficient evidence to rate yes. | *Minimally acceptable evidence:*<br>• Aftercare appointments: Patient to continue outpatient treatment at *clinic* [patient's current provider at the time of admission]<br>*If this it the extent of evidence in the record, and no date is documented, the reviewer would rate YES (and rate NO to the appointment questions above).* |

| | | |
|---|---|---|
| | NOTE: This question is only asked once and therefore includes MH and/or SUD providers. | • Referral was made with *X* [substance use program]. Patient to follow up with *X* after discharge.<br>*If the record shows positive evidence that a referral was made to a program and that the program responded and accepted the referral, this is minimally acceptable evidence to rate yes.* |
| **NO** | If the medical record does NOT indicate that the patient was to receive services with a specified provider or agency after discharge. | |
| | IF NO, SAVE AND GO TO NEXT FORM.<br>IF YES, ANSWER THE FOLLOWING QUESTIONS ABOUT THE APPOINTMENT. | |

**appears if 'outpatient treatment provider was identified' is yes**
Describe the circumstances of the patient's anticipated outpatient aftercare. Document evidence about the identified outpatient treatment provider and confirm that there was no appointment date specified:
NOTE: include - 1) where the relevant note was documented in the medical record, 2) date of the note, 3) who documented the note, and 4) direct text in quotations for clarity. If the note includes the patient's name, substitute "patient" for the patient's name. For other personal identifiers substitute a general identifier (e.g. phone number, address, etc.) ______________________

**appears if 'outpatient treatment provider was identified' is yes**
Does the record specify the name of the outpatient treatment clinician? (e.g. Dr. Smith)

- ○ Yes
- ○ No- not specified/can't tell from record

**appears if 'name of outpatient clinician' is yes**
Name of outpatient treatment clinician:
NOTE: If the record indicates that the clinician will treat the patient for mental health problems, write "(MH treatment)" after the name. If the record indicates that the clinician will treat the patient for SUD, write "(SUD treatment)"after the name. If the record indicates that the clinician will treat the patient for both, write "(MH and SUD treatment)" after the name. ______________________

**appears if 'outpatient treatment provider was identified' is yes**
Does the record specify the name of the outpatient treatment agency? (e.g. Strong Ties Clinic)

- ○ Yes
- ○ No- not specified/can't tell from record
- ○ N/A- provider was a private practice

**appears if 'name of outpatient agency' is yes**
Name of outpatient treatment agency:
NOTE: If the record indicates that the clinician will treat the patient for mental health problems, write "(MH treatment)" after the name. If the record indicates that the clinician will treat the patient for SUD, write "(SUD treatment)"after the name. If the record indicates that the clinician will treat the patient for both, write "(MH and SUD treatment)" after the name. ______________________

**appears if 'name of clinician' and 'name of agency' are no**
Explain why there was no clinician name AND no

treatment agency name for the outpatient treatment provider that was identified to provide aftercare MH and/or SUD services:
NOTE: include -1) where the relevant note was documented in the medical record, 2) date of the note, 3) who documented the note, and 4) direct text in quotations for clarity. If the note includes the patient's name, substitute "patient" for the patient's name. If the note includes the patient's name, substitute "patient" for the patient's name. For other personal identifying information substitute a general identifier (e.g. phone number, address, etc.) ______________________________

**appears if 'outpatient treatment provider was identified' is yes**
Does the record indicate that the outpatient treatment clinician or agency (for MH and/or SUD) offers psychiatric care/medication management? (See guide for examples of what constitutes psychiatric care/medication management)

- ◯ Yes
- ◯ No
- ◯ Not specified/can't tell from record

**appears for all cases**
Record any additional notes:

When referring to specific notes in the medical record be as clear as possible by including: 1) where the relevant note was documented in the medical record, 2) date of the note, 3) who documented the note, and 4) direct text in quotations for clarity. If the note includes the patient's name, substitute "patient" for the patient's name. For other personal identifiers substitute a general identifier (e.g. phone number, address, etc.) ______________________________

# Discharge Summary

**appears for all cases**

Is a discharge or case summary present in the medical record?

◯ Yes
◯ No

| Rating | Criteria |
|---|---|
| **YES** | If there is a signed discharge or case summary present in the medical record. The document will be signed and dated by a member of the inpatient treatment team, usually the treating psychiatrist. |
| **NO** | If there is not a signed discharge or case summary present in the medical record. |
| IF NO, ANSWER THE QUESTION ABOUT TRANSMITTING TO AFTERCARE PROVIDER. IF YES, ANSWER THE FOLLOWING QUESTION ABOUT THE DATE. | |

**appears if 'discharge summary present' is yes**
What date was it completed and signed by a member of the treatment team?

__________________________

Use the date of the supervisor's signature (i.e. the doctor not the social worker). If the supervisor did not sign off until multiple days after the patient was discharged (or longer), the reviewer should record in the notes section what date the discharge summary was created, and by who. For example: DC summary created and signed by NP *xx/xx/xx*; cosigned by MD *xx/xx/xx*

**appears if MH appt. is yes- 1, 2, or 3 appts.**
Does the record indicate that 1 or more outpatient MH aftercare appointment providers were affiliated with the institution?

◯ Yes
◯ No

**appears if MH appt. is yes- 1, 2, or 3 appts.**
Does the record indicate that a case summary/discharge summary was transmitted to 1 or more outpatient MH treatment aftercare providers?

◯ Yes
◯ No

| Rating | Criteria | Examples |
|---|---|---|
| **YES** | If the medical record indicates that a case summary/discharge summary was transmitted (mailed, faxed, sent electronically) to the outpatient MH aftercare provider. The record may indicate that a case summary or document, separate from the formal discharge summary, was transmitted to the aftercare provider. This is sufficient evidence to rate yes as long as the record indicates that the document summarized the patient's discharge and aftercare information. Acceptable documentation includes a fax cover sheet or | *Minimally acceptable evidence:*<br>• Scheduled appointment with Dr. *X* for xx/xx/xxxx and forwarded discharge summary today<br>• Faxed discharge summary to Dr. *X*<br>*If a note says the summary was sent but does not specify the day or date the reviewer should record the date of the note in the following question.*<br>• Scheduled appointment with Dr. *X* for *xx/xx/xx* and forwarded discharge summary on Tuesday<br>*While the exact date of transmission is* |

| | | |
|---|---|---|
| | text (written in a progress note or elsewhere) that says the summary was sent (past tense). | *not documented, a day (Monday, Tuesday etc.) is minimally acceptable as long as it was in the past. The reviewer should record the date of that Tuesday in the following question.* |
| **NO** | If there is a lack of the above evidence in the medical record that the case summary/discharge summary was transmitted to the outpatient MH aftercare provider. Text in progress notes that states the discharge summary will be sent (future tense) does not count. There must be evidence that it was done. | Following patient's discharge from the unit, discharge instructions and clinical documentation from the patient's admission will be sent to outpatient providers<br>*If there is no other evidence indicating that this was done, the reviewer will rate no. However, a question below captures such scenarios where there was intent to fax or transmit.* |
| | IF NO, ANSWER THE QUESTION ABOUT INTENT TO TRANSMIT.<br>IF YES, ANSWER THE FOLLOWING QUESTION ABOUT THE DATE. | |

**appears if 'transmitted to outpatient MH provider' is yes**
Date case/discharge summary transmitted to the anticipated outpatient MH treatment aftercare provider:
NOTE: if there is evidence that the discharge summary was transmitted to more than one aftercare provider, record the date of the earliest/first transmission.
(If the date is not specified or unclear, leave blank and explain why in the following question)

______________________________

**appears if 'date transmitted to outpatient MH provider' is blank**
If the date of case/discharge summary transmission (to the outpatient MH provider) is unclear or not specified in the medical record, explain why: NOTE: include 1) where the relevant note was documented in the medical record, 2) date of the note, 3) who documented the note, and 4) direct text in quotations for clarity. If the note includes the patient's name, substitute "patient" for the patient's name. For other personal identifiers substitute a general identifier (e.g. phone number, address, etc.)

______________________________

**appears if 'transmitted to outpatient MH provider' is no**
Is there documentation in the record, by a social worker or other staff person, noting the intent to fax or transmit the case/discharge summary to the anticipated outpatient MH aftercare provider?
(see guide for examples of what constitutes intent to fax or transmit)

◯ Yes
◯ No

| Rating | Criteria | Examples |
|---|---|---|
| **YES** | If there is no evidence (fax cover sheet or progress note) in the record that states the case/discharge summary *was* transmitted, but there is documentation (by an inpatient staff member) that states intent to send the case/discharge summary to the anticipated | *Minimally acceptable evidence:*<br>• SW will fax discharge summary<br>• Following patient's discharge from the unit, discharge instructions and clinical documentation from the patient's admission will be sent to |

| | | |
|---|---|---|
| | outpatient MH aftercare provider. | outpatient providers |
| **NO** | If there is no evidence in the record whatsoever that states the case/discharge summary was sent or will be sent to the anticipated outpatient MH aftercare provider. | |

If applicable, answer the same questions for SUD appointment(s) made. Refer back for guidance.

*appears if SUD appt. is yes- 1, 2, or 3 appts.*

Does the record indicate that 1 or more outpatient SUD treatment team appointment(s) were affiliated with the institution?

◯ Yes
◯ No

*appears if SUD appt. is yes- 1, 2, or 3 appts.*
Does the record indicate that a case summary/discharge summary was transmitted to the anticipated outpatient SUD treatment team?

◯ Yes
◯ No

*appears if 'transmitted to outpatient SUD team' is yes*
Date case/discharge summary transmitted to the anticipated outpatient SUD treatment team:
NOTE: if transmitted to more than one outpatient SUD treatment team, record the date of the earliest/first transmission.
(If the date is not specified or unclear, leave blank and explain why in the following question)

__________________________________

*appears if 'date transmitted to outpatient SUD team' is blank*
If the date of case/discharge summary transmission (to the outpatient SUD treatment team) is unclear or not specified in the medical record, explain why: NOTE: include - 1) where the relevant note was documented in the medical record, 2) date of the note, 3) who documented the note, and 4) direct text in quotations for clarity.
If the note includes the patient's name, substitute "patient" for the patient's name. For other personal identifiers substitute a general identifier (e.g. phone number, address, etc.)

__________________________________

*appears if 'transmitted to outpatient SUD team' is no*

Is there documentation in the record, by a social worker or other staff person, noting the intent to fax or transmit the case/discharge summary to the anticipated outpatient SUD treatment team?
(see guide for examples of what constitutes intent to fax or transmit)

◯ Yes
◯ No

If applicable, answer the same questions for the provider identified to provide aftercare when a date of appointment is missing. Refer back for guidance.

*appears if MH appt. is no; SUD appt. is no; AND 'outpatient treatment provider was identified' is yes*
Does the record indicate that the outpatient treatment provider identified to provide aftercare MH and/or SUD services was affiliated with the

◯ Yes
◯ No

institution?

*appears if MH appt. is no; SUD appt. is no; AND ‘outpatient treatment provider was identified’ is yes*

Does the record indicate that a case summary/discharge summary was transmitted to the outpatient treatment provider identified to provide MH and/or SUD services?

◯ Yes
◯ No

*appears if ‘transmitted to outpatient treatment provider identified’ is yes*

Date case/discharge summary transmitted to the outpatient treatment provider identified to provide MH and/or SUD services?
(If the date is not specified or unclear, leave blank and explain why in the following question)

______________________________

*appears if ‘date transmitted to outpatient treatment provider identified’ is blank*

If the date of case/discharge summary transmission (to the outpatient MH and/or SUD treatment provider) is unclear or not specified in the medical record, explain why:
NOTE: include - 1) where the relevant note was documented in the medical record, 2) date of the note, 3) who documented the note, and 4) direct text in quotations for clarity. If the note includes the patient's name, substitute "patient" for the patient's name. For other personal identifiers substitute a general identifier (e.g. phone number, address, etc.)

______________________________

*appears if ‘transmitted to outpatient treatment provider identified’ is no*

Is there documentation in the record, by a social worker or other staff person, noting the intent to fax or transmit the case/discharge summary to the outpatient treatment provider identified to provide MH and/or SUD services?
(see guide for examples of what constitutes intent to fax or transmit)

◯ Yes
◯ No

*appears for all cases*

Record any additional notes:

When referring to specific notes in the medical record be as clear as possible by including: 1) where the relevant note was documented in the medical record, 2) date of the note, 3) who documented the note, and 4) direct text in quotations for clarity. If the note includes the patient's name, substitute "patient" for the patient's name. For other personal identifiers substitute a general identifier (e.g. phone number, address, etc.)

______________________________



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# Family Involvement

**appears for all cases**
Does the record indicate that the hospital inpatient staff (clinical or administrative) contacted or attempted to contact a family member or support person of the patient?
(See guide for examples of what constitutes a family member or support person, and attempted contact)

- ◯ Yes, contacted family or support person
- ◯ Yes, attempted to contact family or support person but was not successful
- ◯ No

| Rating | Criteria | Examples |
|---|---|---|
| **YES, contacted family or support person** | If the medical record indicates that the inpatient staff had a conversation with a family member or support person identified by the patient (method of contact determined by contact information the patient is able to provide) OR If the person accompanies the patient to the hospital or visits the patient at the hospital and the hospital staff speak to this person. Family members or support persons do not have to be blood related. They can be anyone who is close to the patient and provides support but does not do so as part of their paid job. This could include boyfriends/girlfriends, partners, friends, colleagues etc. One clear exception is foster parent/foster family. | *Minimally acceptable evidence:* Patient does not have family; called a close friend and they will visit tomorrow |
| **YES, attempted to contact family or support person but was not successful** | If the medical record indicates that the hospital staff attempted to contact a FM/SP of the patient but was unable to have a conversation. | Called patient's sister and left two voicemails. Never heard back |
| **NO** | If the medical record indicates that the inpatient hospital staff never contacted a FM/SP. Emergency Department communication with family does not count. FM/SP excludes anyone who is providing support/involved in discharge planning as part of a job they are trained and paid to do – including parole officers, county workers, case managers, and paid peer specialists. | |

**appears if 'attempted to contact' is 'yes, attempted but not successful'**
Describe the attempted contact and why it was not successful. (e.g. record indicates inpatient staff called family member but never heard back). Be as clear as possible by including: 1) where the relevant note was documented in the medical record, 2) date of the note, 3) who documented the note, and 4) direct text in quotations for clarity. If the note includes the patient's name, substitute "patient" for the patient's name. For other personal identifiers substitute a general identifier (e.g. phone number, address, etc.) ______________________

**appears if 'attempted to contact' is no**

Does the record indicate why inpatient staff did not attempt to contact a family member or support person?

- ◯ The patient indicated that he or she has no connection with family members or support persons
- ◯ The patient identified family members or support persons but refused to involve them in treatment or would not give permission to the treatment team to contact them
- ◯ The patient identified a family member or support person but was unable to provide contact information and inpatient staff was unable to obtain contact information
- ◯ The patient identified a family member or support person and there was no specified reason for why the inpatient team did not attempt to contact them
- ◯ No mention of family members or support persons throughout the medical record of the current hospitalization.
- ◯ The patient identified a family member or support person but reports a strained relationship or abuse from family member/support person
- ◯ Other

**appears if 'why staff did not attempt contact', 'other' is selected**

Describe the 'other' reason why the inpatient staff did NOT attempt to contact a family member or support person: ______________________________

**appears for all cases**

Does the record indicate that a family member or support person of the patient did any of the following actions during the hospitalization? Check all that apply

- ☐ Spoke to the patient on the phone
- ☐ Visited the patient (includes picking patient up at discharge)
- ☐ Attended multi-family meetings or utilized other family support services (e.g. NAMI support groups; this does NOT include family meetings with the treatment team)
- ☐ Attended sessions with the treatment team (including in-person or by phone, with or without the patient) to review the patient's treatment plan and/or participate in family therapy (e.g. family meetings)

| Rating | Criteria |
|---|---|
| **Spoke to the patient on the phone** | Positive evidence that there was a phone conversation.<br><br>*(NOTE: when it is unclear use your best judgment for rating and explain the evidence in the notes section)* |
| **Visited the patient** | Positive evidence that the family/support person visited. Picking patient up on day of discharge counts.<br><br>*(NOTE: when it is unclear use your best judgment for rating and explain the evidence in the notes section)* |

| | |
|---|---|
| **Attended multi-family meetings or utilized other family support services** | Services that <u>are not</u> specific to the patient's treatment. The services are not facilitated by the patient's treatment team and are typically group based to address general mental health topics. For example, NAMI programs, psychoeducation groups or support groups. |
| **Attended sessions with the treatment team to review the patient's treatment plan and/or participate in family therapy (either with or without the patient)** | Services that <u>are</u> specific to the patient's treatment and are facilitated by the inpatient treatment team. Families may meet with the inpatient team independently to review the patient's treatment plan or they may meet collectively with the patient to have a family meeting or family therapy. Family meetings held by phone count. |

**appears if 'contact' is yes, contacted**

Does the record indicate that the family member or support person was involved in the patient's care during the hospitalization?
(See guide for examples of what constitutes involvement in patient's care)

◯ Yes
◯ No

| Rating | Criteria | Examples |
|---|---|---|
| **YES** | If the medical record indicates that the FM/SP did more than just receive a call from the inpatient staff. This could be providing inpatient staff with information about the patient's past medical or psychiatric history, participating in the patient's current treatment during the hospitalization, or participating in discharge planning and/or making plans to help the patient with care after discharge. | *Minimally acceptable evidence:*<br>• Patient's family requested information on treatment<br>• Patient's mother picked him up at discharge |
| **NO** | If the medical record indicates the identified FM/SP did not do any of the above activities. | |
| | IF NO, ANSWER THE FOLLOWING QUESTION ABOUT WHY.<br>IF YES, ANSWER THE QUESTION ABOUT FM/SP COMMUNICATION. | |

**appears if 'family or SP was involved' is no**

Does the record indicate why the family member or support person was NOT involved in the patient's care during the hospitalization?

◯ Family member or support person was invited, but declined to participate
◯ Family member or support person wanted to participate but were unable to because of transportation or other logistical barriers
◯ Other

**appears if 'why family or SP was not involved', 'other' is selected**

Describe the 'other' reason why the family member/support person was not involved in the patient's care during the hospitalization:

______________________________

**appears if 'family or SP was involved' is yes**

Does the record indicate that the inpatient staff and family members or support persons communicated

☐ Services offered to family members/support persons
☐ Patient's health or mental health status
☐
☐
☐
☐

regarding the following topics? Check all that apply. NOTE: If family attended a family meeting, you will likely rate YES to multiple answers. For example, rate YES to "services offered to family members/support persons." Rate YES to spoke to inpatient staff by phone OR in-person, depending on the nature of the family meeting. See guide for guidance on rating other answers.

Date of the discharge
Patient's treatment plan following discharge
Patient's residence after discharge
Warning signs of decompensation or ways to prevent hospital readmission
☐ Spoke to inpatient staff by PHONE and reviewed patient's medical/psychiatric history, treatment plan and/or discharge plan
☐ Spoke to inpatient staff IN PERSON and reviewed patient's medical/psychiatric history, treatment plan and/or discharge plan

| Rating | Minimally acceptable evidence |
|---|---|
| **Services offered to FMs/SPs** | Called patient's father to discuss family meeting. He is unable to come this week; will try back later |
| **Patient's health or mental health status** | Spoke to patient's mom over the phone and gave update |
| **Date of the discharge** | Patient's girlfriend took him home |
| **Patient's treatment plan following discharge** | Provided family with information regarding discharge plan |
| **Patient's residence after discharge** | Patient discharged home |
| **Warning signs of decompensation or ways to prevent hospital readmission** | Had family meeting before discharge; discussed patient's safety plan and coping mechanisms |
| **Spoke to inpatient staff by PHONE and reviewed patient's medical/psychiatric history, treatment plan and/or discharge plan** | Spoke to son on the phone who is aware of discharge<br><br>*(NOTE: when it is unclear use your best judgment for rating and explain the evidence in the notes section)* |
| **Spoke to inpatient staff IN PERSON and reviewed patient's medical/psychiatric history, treatment plan and/or discharge plan** | Patient's parents came in for family meeting<br><br>*(NOTE: when it is unclear use your best judgment for rating and explain the evidence in the notes section)* |

**appears if 'involved in care' is yes**
Does the record indicate that the family members/support persons expressed concerns surrounding discharge and/or aftercare treatment? (See guide for examples of what constitutes expressed concerns)

○ Yes
○ No

| Rating | Criteria | Examples |
|---|---|---|

| | | |
|---|---|---|
| **YES** | If the medical record has any positive evidence that the FM/SP expressed concerns. | *Minimally acceptable evidence:*<br>• Patient's girlfriend expressed concerns about drug relapse<br>• Patient's son concerned about him returning home after discharge |
| **NO** | If the medical record does not have any positive evidence that the FM/SP expressed concerns. Questions about logistics are not sufficient to rate yes for concerns. | |

**appears if 'family or SP expressed concerns' is yes**
Describe the concerns expressed by the family members/support persons: ______________________________

**appears if 'expressed concerns' is yes**
Does the record indicate that the inpatient team addressed the family member/support persons' expressed concerns surrounding discharge and/or aftercare treatment?
(See guide for examples of what constitutes addressed expressed concerns)

○ Yes
○ No

| Rating | Criteria | Examples |
|---|---|---|
| **YES** | If the medical record has any positive evidence that the inpatient team addressed the FM/SP concerns. | *Minimally acceptable evidence:*<br>• Discussed ways to prevent relapse<br>• Had family meeting with patient and patient's son; patient agreed to follow son's house rules and patient will be discharged tmrw to live with son |
| **NO** | If the medical record does not have any positive evidence that the inpatient team addressed the FM/SP concerns. | |

**appears if 'addressed expressed concerns' is yes**
Describe HOW the inpatient team addressed the family member/support persons' expressed concerns surrounding discharge and/or aftercare treatment: ______________________________

**appears for all cases**
If the medical record shows conflicting or confusing information about family involvement, please summarize. When describing the notes in question, be as clear as possible by including: 1) where the relevant note was documented in the medical record, 2) date of the note, 3) who documented the note, and 4) direct text in quotations for clarity. If the note includes the patient's name, substitute "patient" for the patient's name. For other personal identifiers substitute a general identifier (e.g. phone number, address, etc.) ______________________________

**appears for all cases**
Record any additional notes:

When referring to specific notes in the medical record be as clear as possible by including: 1) where the relevant note was documented in the medical record, 2) date of the note, 3) who documented the note, and 4) direct text in quotations for clarity. If the note includes the patient's name, substitute "patient" for the patient's name. For other personal identifiers substitute a general identifier (e.g. phone number, address, etc.)

# Notes

Document any remaining notes or comments here.
If you have questions about, or were confused by the medical record, document the issue and describe in detail.

When referring to specific notes in the medical record be as clear as possible by including: 1) where the relevant note was documented in the medical record, 2) date of the note, 3) who documented the note, and 4) direct text in quotations for clarity. If the note includes the patient's name, substitute "patient" for the patient's name. For other personal identifiers substitute a general identifier (e.g. phone number, address, etc.) ______________________________