Consensus Statement on the Continuity of Medication Therapy for the Treatment of Schizophrenia & Other Serious Mental Illnesses

March 27, 2007

National Council for Community Behavioral Healthcare

www.nccbh.org

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About the National Council Consensus Development Program

This National Council consensus statement was prepared by an independent panel of experts concerned about the continuity of care in treating persons with schizophrenia and other serious mental illnesses when transitioning from inpatient to community-based care. Participants included consumers of mental health services, family members, researchers, state authorities, psychiatric leaders, accrediting organizations, and hospital and community treatment organizations. The roundtable discussion focused on a vision for seamless continuity of treatment; a description of the current situation; the complexity of moving from the current state to the desired state; and recommendations for consideration by the stakeholder groups represented at the meeting.

The statement reflects the panel's assessment of knowledge available at the time, as well as the collective experience of the attendees. Thus, it provides a "snapshot in time" of the state of knowledge on continuity of therapy. When reading the statement, keep in mind that new knowledge is inevitably accumulating through additional medical research.

Reference Information

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Disclosure Statement

All of the attendees who participated in this roundtable and contributed to the writing of this statement were identified as having no financial or scientific conflict of interest in its recommendations.

Abstract

Objective
To set forth a vision for seamless continuity of treatment for consumers with schizophrenia or other serious mental illnesses and to develop recommendations for enhancing continuity of therapy for consideration by all stakeholder groups.

Participants
The National Council convened a 24-member expert panel for the roundtable discussion on continuity of therapy. Participants included consumers of mental health services, family members, researchers, state authorities, mental health professionals, psychiatric thought leaders, accrediting organizations, and executives of hospital and community treatment organizations.

Roundtable Process
The roundtable process included the development of a background and discussion paper on Continuity of Therapy for review by all participants prior to the roundtable meeting. The roundtable discussion was conducted by a facilitator on December 6, 2006 in Washington, D.C. The consensus statement was drafted by staff members at the National Council and *OPEN MINDS* and submitted to all participants for comment. Comments were incorporated into the final version of the consensus statement, and participants then formally endorsed the statement.

Conclusions
For the millions of Americans who experience schizophrenia or other serious mental illnesses and their family members, one of the most critical periods in an individual's recovery is the transition from intense inpatient (hospital) care settings to community-based services. When taking into account the complex nature of mental illnesses and the multiplicity of treatments and services that are needed by people in search of recovery, continuity of care and the coordination of treatment and services are important factors in assuring quality of mental health care. More specifically, given the important role that medications play in allowing for symptom reduction or alleviation; the ability of consumers to live in the community; and the facilitation of consumer participation in vocational, educational, and other rehabilitative activities, ensuring continuity of medication therapy must receive higher priority.

A continuity of therapy initiative is likely to result in a number of benefits for consumers, mental health professionals, and behavioral health provider organizations. Continuity of therapy initiatives are likely to decrease inappropriate use of emergency room services by consumers with schizophrenia or other serious mental illnesses by assuring consistency in the disease management approaches and medications used by professionals and provider organizations that are part of the continuum of care

In addition to this financial and service system resource benefit, continuity of therapy initiatives provide consumers with stability by assuring access to required treatment components in all settings. And, for community hospitals, continuity of therapy

initiatives provide another very tangible benefit—the relationships, process, and infrastructure for an overall discharge planning function for all consumers with mental illnesses.

Introduction

For the millions of Americans who experience schizophrenia or other serious mental illnesses and their family members, one of the most critical periods in an individual's recovery is the transition from intense inpatient (hospital) care settings to community-based services. When taking into account the complex nature of mental illnesses and the multiplicity of treatments and services that are needed by people in search of recovery, continuity of care and the coordination of treatment and services are important factors in assuring quality of mental healthcare. More specifically, given the important role that medications play in allowing for symptom reduction or alleviation and the ability of consumers to participate in vocational, educational, and other rehabilitative activities, ensuring continuity of therapy in the form of access to medications must receive a higher priority.

In the context of mental health, continuity of care is defined as "a process involving the orderly, uninterrupted movement of patients among the diverse elements of the service delivery system" (Bachrach, 1981). While we know that continuity of care, including continuity of medication, are important, we also know however, that systems designed to serve mental health consumers experience serious shortcomings when it comes to the level and depth of communication, cooperation, and coordination of treatment and services that are necessary to avoid service fragmentation and discontinuity.

After discharge from inpatient settings, individuals are often placed on long waiting lists for community-based services only to have their intake and clinical appointments scheduled weeks apart. They often find that their treatment history has not been transferred from one provider to another or that they have an insufficient supply of medications causing, in too many cases, chaos and confusion that leads to an interruption, if not a discontinuation, of care. As an illustration of the seriousness of this issue, one study conducted by Janssen (2005) found that an alarming 50 percent of consumers diagnosed with schizophrenia who were discharged from a sample of psychiatric hospitals were lost in transition. In other words, they did not reappear in the community-based programs to which they were referred.

Medication is frequently a cornerstone of treatment for people with serious mental illnesses (Lieberman, et al., 2004), not only providing for symptom reduction or alleviation, but also allowing for participation in rehabilitative, educational, and vocational programs. If we cannot guarantee continuity of medications, how can we hope to achieve recovery?

Recent federal statistics confirm an over-representation of persons with mental health disorders in our jails and prisons, and the Institute of Medicine describes our nation's emergency rooms as overcrowded and dysfunctional when it comes to meeting the needs of patients who present mental health issues. Many communities have insufficient access to crisis and acute care beds. At the same time, policymakers and payers are increasingly calling for higher quality in healthcare with demonstrable improvements in consumer outcomes.

The results of this lack of system and services coordination and potential abatement of therapy can be disastrous and cause crises for consumers and their family members, with results including re-hospitalization and/or increased demand for other community services such as emergency room care or police involvement. Research continues to verify that appropriate follow-up care can help in reducing the need for re-hospitalization and it can also be helpful in identifying consumers needing more intense services before they reach a point of crisis (Boydell, et al., 1991).

The costs of poor care transition among service settings are high, yet many State policymakers and elected officials are unaware of the financial burden that their States bear due to a lack of continuity. Clearly, the field must respond to these problems in a proactive way.

The concepts of service fragmentation and discontinuity of care are not new issues to the behavioral health field. State mental health authorities, county administrators, and local providers have struggled with these challenges, but have yet to find and apply wide-scale, appropriate solutions.

Background and Understanding of the Issues

In 1963, the landmark Community Mental Health Centers Act was passed in response to a national goal of moving people out of institutions and into communities where they were to be served by locally-based treatment and service providers. This Act led to the establishment of more than 750 federally funded community mental health centers (CMHCs) across the country.

The push for deinstitutionalization and the downsizing and closing of psychiatric hospitals came about due to a number of factors, including the development of a number of new antipsychotic medications, the emergence of a consumer rights movement, the recognition that the vast majority of people with mental illnesses did not need to be hospitalized for years on end,. According to the World Health Organization, deinstitutionalization was complex and should have led to "the implementation of a network of alternatives outside psychiatric institutions." The report goes on to lament that these networks never developed due to a lack of appropriate community services and funding (World Health Organization, 2001).

In the 1980s, direct federal funding of CMHCs was ended and replaced with a federal block grant to State mental health authorities. These shifts to State-based block grants came about, in part, due to the premise that States were better positioned to meet local needs, coordinate services, and more efficiently administer service delivery programs than the federal government.

In April 2002, President George W. Bush created, by Executive Order, the "President's New Freedom Commission on Mental Health." President Bush said in his address announcing the Commission, "Our country must make a commitment: Americans with mental illness deserve our understanding, and they deserve excellent care" (Commission Final Report, 2003). The New Freedom Commission identified stigma,

unfair treatment limitations and financial requirements, and fragmentation of the delivery system as areas of weakness in the current mental healthcare system. The New Freedom Commission recommended "complete transformation" of the mental health system in America. Six goals were identified to serve as the foundation for this transformation:

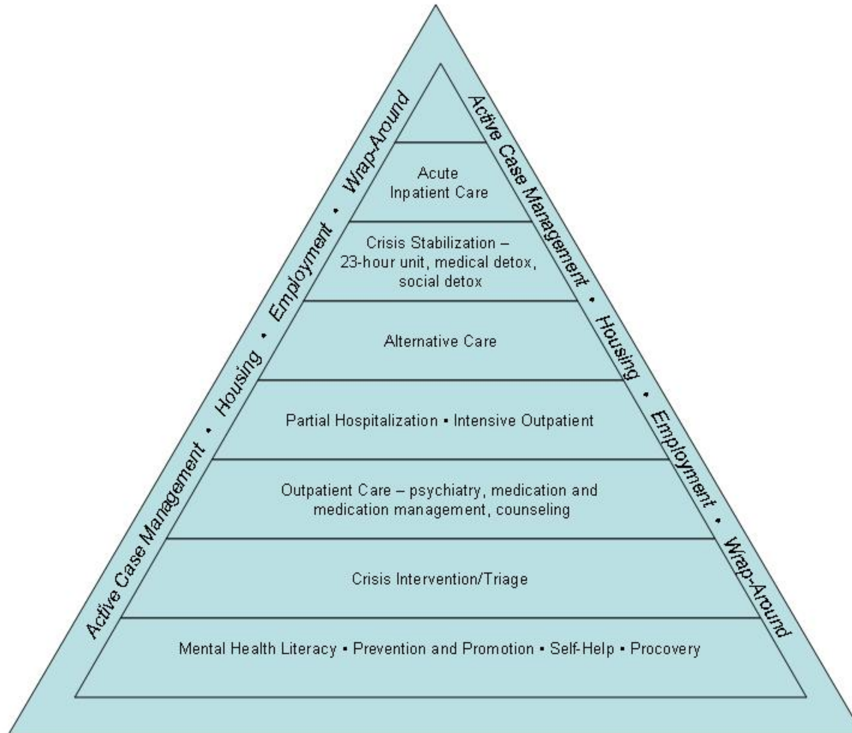
1. Americans understand that mental health is essential to overall health.
2. Mental healthcare is consumer and family driven.
3. Disparities in mental health services are eliminated.
4. Early mental health screening, assessment, and referral to services are common practice.
5. Excellent mental healthcare is delivered and research is accelerated.
6. Technology is used to access mental healthcare and information.

One of the fundamental problems with the U.S. mental health system, as reinforced by the Commission's final report, is the fragmentation of treatment, services, and supports. Accompanying this fragmentation are myriad financing and funding sources that include complex eligibility and reimbursement mechanisms. Failure to ensure continuity of care, including continuity of medications, for people with mental illnesses is the direct consequence of systems, services, and funding fragmentation.

Understanding Continuity of Therapy in the Context of a Continuum of Care

Mental health services can take the form of a number of interventions and services ranging from crisis stabilization, assessment and diagnosis, medications and medications management, and talk therapy and other forms of counseling, among others. As Figure 1 depicts, these services should be provided within the overall context of other services and supports that consumers need to successfully live, work, and learn in the communities of their choosing. These supports include active case management, affordable housing, education, vocational rehabilitation, and wrap around services, particularly for children with serious emotional disturbances.

Figure 1. Continuum of Care Pyramid



Important studies, such as the Clinical Antipsychotic Trials of Intervention Effectiveness (known as the CATIE study), funded by the National Institute of Mental Health, reiterated that medications play a crucial role in treating serious mental illnesses such as schizophrenia (Lieberman, et al., 2005). The CATIE study clearly demonstrates increased consumer outcomes associated with maintenance of medication therapy. Indeed maintenance of medication is frequently fundamental for the ability to participate in other forms of treatment and rehabilitation. However, barriers to continuity of care within mental health systems and between mental health and other human service systems contribute substantially to discontinuation of medications or lack of access to them. States, communities, and providers must understand how consumers are moving within service systems in order to evaluate how consumers receive—or do not receive—the services they need, including medication therapy (NASMHPD, 2006).

Despite the link between positive consumer outcomes and continuity of therapy, it remains unclear, in many cases, how referrals are made throughout the system of care; how hospital and program admission criteria are developed and applied; how consumers are discharged from hospital settings and into the community; and who is responsible for their care. Data regarding who is going to hospital emergency departments for acute psychiatric care and why they are in that setting rather than in a

community mental health program are scarce, as are data about individuals who could be moved out of hospital emergency rooms if consumers were provided with better transition services or if appropriate acute psychiatric care were available in other settings. The same observation can be made regarding those individuals who could be moved out of state psychiatric hospitals if appropriate services such as care management, medication management, housing, and employment supports were available in the community (NASMHPD, 2006).

Accrediting Bodies & Continuity of Therapy

The National Committee for Quality Assurance (NCQA) is an organization that monitors and provides information on the quality of hundreds of U.S. managed healthcare plans. In making the case that treatment for mental illnesses and continuity of care can reduce the duration of disability and the likelihood of recurrence, NCQA conducts an assessment of health plans known as the "Follow-Up After Hospitalization for Mental Illness." The measures used by NCQA indicate that greater success accompanies "health plan members age six and older who received inpatient treatment for a mental health disorder and had an ambulatory or day/night follow-up visit after being discharged. The measure includes hospitalizations for depression, schizophrenia, attention deficit disorder, and personality disorders and it collects the percentage of members who received follow-up care within seven days and those that received follow-up care within 30 days" (NCQA, 2003).

In analyzing the results from the NCQA survey of managed care plans, some disturbing findings on follow-up rates were reported including: (1) large rates of variability across plans; (2) high variations between regions; and (3) large differences depending on whether the consumer's services were paid for under a private, commercial health plan versus Medicaid or Medicare. According to NCQA:

- "Variations in plan performance decreased slightly compared to last year, but are still high. The lowest-performing plans nationally reported an average 7-day follow-up rate of less than 35 percent, compared to more than 68 percent for the top plans.
- There was also high variation between regions, with the South Central and South Atlantic regions having low scores on average.
- In 2000, Medicaid plan [follow-up] rates were approximately 15 points lower than those of commercial plans (only 31 Medicaid plans reported data for these measures).
- In 2000, Medicare plan rates were approximately 12 points lower than for commercial plans" (NCQA, 2003).

In a more positive finding, NCQA's measures found that for commercial organizations, the 2001 7-day follow-up rates increased by three percentage points; 30-day follow-up rates increased by two points (NQCA, 2003).

Additionally, the Joint Commission, an organization that provides accreditation to healthcare organizations, requires facilities seeking to gain or maintain Joint Commission accreditation to adhere to a number of patient safety goals and requirements. Several of their standards are applicable to both accredited hospitals and behavioral health organizations, and have relevance to this discussion of continuity of care, and more specifically, continuity of therapy.

As an illustration of a standard that directly addresses continuity of therapy, the Joint Commission's Patient Safety Goal #8 states that its accredited organizations "accurately and completely reconcile medications across the continuum of care." This goal applies only to behavioral health organizations that provide among their services licensed independent practitioners who prescribe medications. Even so, for community-based organizations that do not prescribe medications, it is also good practice for those providers to query consumers about medications during the initial intake and assessment process.

Further, within Goal #8, the Joint Commission requires that there is a process for comparing the consumer's current medications with those ordered for the consumer while under the care of the organization. To fulfill these requirements, the Joint Commission has issued specific implementation expectations where:

- The organization, with the consumer's involvement, creates a complete list of the consumer's current medications at admission/entry.
- The medications ordered for the consumer while under the care of the organization are compared to those on the list for any discrepancies (for example, omissions, duplications, and potential interactions) to be resolved.

An appendix to this paper includes discharge planning standards from the Joint Commission's Comprehensive Accreditation Manual for Hospitals (CAMH) and lists the current standards and changes that will go into effect July, 2007. In addition, the Joint Commission's hospital program will be introducing into the hospital accreditation survey process a new "tracer" focused on the discharge process.

The tracer activity will begin with a focus on consumers who are about to be discharged at the time of the Joint Commission survey or have been discharged within the past 48 hours. For consumers about to be discharged, the surveyor will observe the provision of discharge instructions, review the medical record for discharge orders, and the written instructions provided to the consumer, looking specifically for a focus on clarity. For consumers discharged within the past 48 hours, the surveyor will review discharge instructions, conduct a telephone interview focused on the consumer' perception of their ability to self care and the adequacy of the information provided.

As an idea under preliminary discussions only, the Joint Commission is exploring the feasibility of defining and requiring the transmission of a core data set of information to consumers and other care-givers at the time of care transitions. Such a data set might include information on medications, diagnosis, past health procedures, health insurance status and provider, and current service providers. This core data set could be provided

to the consumer or the consumer's authorized representative and subsequent providers could then update this information based on their contact with the consumer.

Similar to the Joint Commission, the Commission on the Accreditation of Rehabilitation Facilities (CARF) also requires the human services organizations that it accredits to demonstrate responsiveness, specific procedures, and quality improvement processes across a number of specific domains. Many of these domains, which are all part of CARF accreditation surveys, are relevant to continuity of therapy, such as: outcomes management, screening and access to services, individual planning, transition/recovery support services, pharmacotherapy, and records of the persons served. In addition, standards require the identification of personnel responsible for follow-up after discharge in all programs seeking accreditation.

Qualitative Research on Continuity of Therapy in the Treatment of Schizophrenia

In 2005, a Pharmastrat, Inc study commissioned by Janssen to examine the extent of the problem of discontinuation of therapy and the factors that influenced whether consumers continued with their course of prescribed medications or not. As part of the study, 76 in-depth qualitative interviews were conducted with a panel of inpatient hospital psychiatrists and discharge planners and outpatient (community mental health center) psychiatrists and intake coordinators from across four states. The respondents stated that on average, 50 percent of consumers discharged from inpatient facilities do not appear for their initial intake appointment at the outpatient/community-based program to which they were referred.

Several factors were identified on the system-, program/provider-, and individual-levels that were related to such a poor rate of continuity of therapy for approximately half of the study participants.

System-level barriers.

- The system is fragmented and fractured.
- The basics of the discharge and intake processes are similar across states; however, the flow of communication varies significantly by state and consumer profile.
- Certain prescribed psychotropic medications do not appear on hospital formularies, thus creating transition issues for consumers both within inpatient settings and post-discharge.
- Financing and cost considerations.

Facility/program-level barriers.

- The role of inpatient short-stay hospitals is clearly defined as triage, stabilization and, discharge.
- Most outpatient facilities see their responsibility for the continuum of care beginning only when the consumer actually shows up for intake.
- Neither setting (inpatient or outpatient) is appropriately set up to ensure continuity of care.
- Communication breakdown between settings.
- Psychiatrists from both inpatient and outpatient settings report they very rarely interact with their counterparts in the other setting.
- Most communication between inpatient and outpatient facilities takes place between the inpatient discharge planner (typically a social worker) and the outpatient intake coordinator (typically a case manager).
  - These respondents, the primary conduits of information flow between settings, characterize their work environment as “overburdened” and “overworked.”

- Unless specifically mandated or required, processes pertaining to discharge or intake are unlikely to be put in place, let alone followed consistently; when policies exist, they tend to be idiosyncratic to the particular facility.

Provider- and individual-level barriers.

- It was very clear that many consumers, upon discharge, were not completely stabilized and had little specific awareness of their medications beyond the name(s).
- Issues faced by consumers including: stigma, side effects from medications, co-occurring disorders, homelessness, lack of transportation, and lack of support systems.
- Consumers acknowledged they were provided information about their medications at discharge, but report the information was given in very general terms (e.g. "this will make you feel stable") and there was little recall regarding details.

Factors Promoting Continuity of Therapy

This same study found that a strong family/caregiver support system, particularly during transition between inpatient and outpatient settings, is critical to assist with medication adherence to ensure consumers appear for their appointments with service providers. However, when discussing family support systems with the interviewers, physicians reported that less than half of consumers have an "adequate" social support system to meet their daily needs.

The study identified three additional factors that positively influence the efficiency of the transition process between inpatient facility discharge and intake with a community-based program. These include:

- when communication occurs "within system"
- when computer systems/consumer records are shared
- when an ACT (or similar) team is involved

Recommendations for Consideration: Promising Models and Practices

From a systems perspective, matters involving policy and financing issues impacting continuity of care can be conceptualized along two broad approaches (Brand, 2005):

a.) Building service coordination into the payment rates and expectations for certain services. This approach is conceptually similar to what is referred to as Primary Care Case Management or some disease management or chronic care programs

b.) Defining certain consultation and care coordination services as covered benefits

Under the first approach, consultation and care coordination would be a defined benefit with its own billing codes and defined coverage limits, eligible providers, allowed situations, and limitations and exclusions. For example, situations where this might be applicable include: hospital discharge planning and short-term transition support; developmental transitions (e.g. child to adult); coordination between primary care and mental health providers; consultation with primary care; consultation with other professionals to implement treatment plans (e.g. schools, residential programs); clinical coordination among multi-disciplinary teams, especially home-based services.

Under the second approach, coordination of care is built into "programs of care" or episodes of care. This concept is seen in current disease management models and chronic care models and can include: assertive community treatment, multi-systemic therapy, and Dialectical Behavioral Therapy (DBT). Hospital payment methods assume linkage with step-down, aftercare, and outpatient services, similar conceptually to Medicare Part A that covers hospital stays and 100 days of nursing home or home health rehabilitation as follow-up, when necessary.

Levels of communication between various clinicians and other staff in inpatient and outpatient settings can vary greatly, impacting continuity of therapy. Typically, there is very little communication between psychiatrists in inpatient and outpatient facilities and this applies as well to nursing staff in these two settings. The most frequent communications occur between inpatient discharge planners and outpatient intake coordinators. The Janssen study identified three specific models of interaction between inpatient and outpatient facilities. These include:

- "**Push" Model:** In this model, the outpatient setting is highly dependent on the inpatient setting and/or the consumer for receiving documents.
- "**Integrated" Model:** With this model, the sharing of resources provides a continuum of care for consumers, so there is never really a "gap" between discharge and intake.
- **"Pull" Model:** For this model, a member of the outpatient treatment team actively participates in the discharge process, which leads to the timely receipt of appropriate/relevant documents, as well as increased consumer participation.

The study also identified a number of best practices across and within service settings that positively impact continuity of therapy. These include:

Inpatient settings:

- Providing earlier notification of discharge to intake coordinators in community-based programs.
- Scheduling an appointment with an outpatient psychiatrist prior to the consumer being discharged.
- Achieving consistency in sending medical information.
- Inviting outpatient team members to discharge planning meetings.

- Obtaining verification of benefits to cover the consumer in the outpatient setting.

Transition between settings:

- Narrowing the time period between discharge and intake appointments to less than two weeks.
- Designating a point person in the outpatient setting to make contact with the consumer and/or caregiver prior to the initial intake appointment.
- Sharing of electronic medical records (within HIPAA guidelines).
- Having inpatient psychiatrists offer their name and contact information for consumers' use if needed.
- Facilitating a pilot program to develop protocols for the sharing of information between inpatient and outpatient facilities.
- Leveraging use of alternate sites of care during transition.

Outpatient settings:

- Integrating an outpatient treatment team member into the discharge planning process ("Pull" Model).
- Assigning/designating a point person in the outpatient setting who has responsibilities for ensuring new consumers show up for their initial intake and that all necessary clinical and other paperwork has been transferred.
- Expanding the ACT program to provide broader intensive case management for consumers with schizophrenia.
- Requiring that all consumers with schizophrenia have a case manager.
- Scheduling both intake appointments on the same day/at the same location.
- Utilizing "telemedicine" for consumers who lack readily available access/transportation.
- Issuing reminder calls for appointments to new clients and placing follow-up calls to consumers who do not show up for appointments.

Consensus Principles to Increase Continuity of Care Between Treatment Settings

The expert roundtable developed a set of nine recommendations for enhancing continuity of medication therapy for persons with schizophrenia or serious mental illness. They are as follows:

Recommendation #1: Encourage collaborations between hospitals and community-based organizations. Use fiscal incentives to foster collaborations including the standardization of information and shared electronic health records.

Recommendation #2: Use a quality improvement approach to enhance continuity of therapy by benchmarking at the organizational level performance and outcomes standards regarding continuity of care.

Recommendation#3: Ensure all consumers have a level of care management for the transition from inpatient to community. Care management services should be reimbursable by all payers and the disincentives to providing it should be removed.

Recommendation #4: Hospitals and community providers should focus on the "Pull Model" of transition from inpatient to outpatient care. The Pull Model focuses on involving community-based providers in the transition planning process from the beginning. Provider organizations should focus on staff competency in engagement and strategies and motivational interviewing.

Recommendation #5: Accreditation standards should be aligned to address and improve continuity of therapy in treating mental illness. This may include developing standards to ensure evidence of an active process of care management and transition between levels of care, a quality review of the success of transition plans, and measuring engagement.

Recommendation #6: Consumers and their families should be educated about the benefits of maintaining their personal health care history. Ensuring that consumers have detailed information about their illnesses and treatment history will help ensure that providers have access to the information they need to provide appropriate care in a timely manner. The options here range from simple paper and pencil logs and medication histories to electronic records on memory sticks.

Recommendation #7: Consumer-driven recovery planning should include and the appropriate and necessary use of hospitalization. More thoughtful use of inpatient services could lead to a reduction in emergency room use and ultimately to a decrease in the number of hospitalizations.

Recommendation #8: Parties who collect data about mental health services and performance should share it with appropriate stakeholders in usable and timely ways. Many payers and public entities collect both population and individual specific information about mental health consumers and services. Population-based data should be shared with all stakeholders, including families and consumers to aid in enhancing the system of care..

Recommendation #9: There should be meaningful involvement of consumers and their advocates in all levels of system delivery and evaluation. Global involvement of consumers and their advocates in the care delivery process is essential. Examples include using peer specialists as part of a treatment team, active involvement in policy and planning, as well as involvement in developing and implementing performance measurement and evaluation.

Conclusion

While we have learned that maintaining continuity of therapy has a positive impact on consumer outcomes, the barriers and other impediments to ensuring this continuum of care have been long entrenched in mental health and related care systems. An unacceptably high number of people with serious psychiatric issues are "falling between the cracks" in the transition between acute inpatient settings and the community causing harm and disruption in their own lives and those of their families and often bringing their recovery process to a halt.

A continuity of therapy initiative is likely to decrease inappropriate use of emergency room services by consumers with schizophrenia or other serious mental illnesses by assuring consistency in the disease management approach used by all community provider organizations. Both of these likely outcomes of continuity of therapy provide cost reductions for the hospital and cost offset for the investments in a continuity of therapy initiative and related therapies.

In addition, the continuity of therapy initiative provides the community hospital with another very tangible benefit. The continuity of therapy initiative provides the relationships, process, and infrastructure for an overall discharge planning functionality for all consumers with mental illnesses. This discharge planning functionality is a new, and critical, element in the JCAHO behavioral health standards that are entering test phase in 2007. Also, new CARF inpatient standards for 2007 require that the program ensure that consumer's have an established appointment and/or sufficient medication upon discharge.

Thus, continuity of therapy is a vital component of quality care for people with serious mental illnesses and must be given more attention by consumers themselves, family members, advocates, providers, administrators, and researchers alike. At the moment, there is an important opportunity to develop a national consensus statement on the principles and practice standards that should form the basis of a continuum of therapy designed to provide realistic assurance that consumers can access vital medications when and where they are needed. Important strides have been made in identifying the specific factors which promote continuity of therapy—it is time to seize this important opportunity as yet another stepping stone to achieving the transformation of America's mental healthcare system for the benefit of consumers and their families, our communities, and our Nation.

State-of-the-Science Panel

Participating Experts

- American Association of Community Psychiatrists (AACP)
  - Anita Everett, M.D., D.F.A.P.A., Johns Hopkins School of Medicine (MD)
- Assertive Community Treatment Association (ACTA)
  - Cheri M. Sixbey, MA, LMSW, LPC, Executive Director (MI)
- Commission on Accreditation of Rehabilitation Facilities (CARF)
  - Nikki Migas, Managing Director, Behavioral Health/Child and Youth Services (AZ)
- Consumers
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  - Liz Carignan – consumer presenter (ME)
- Mental Health America (MHA)
  - Dianne Dorlester, Senior Director, Adult Mental Health Services, Director, NCSTAC
- National Alliance on Mental Illness (NAMI)
  - Mary Giliberti, J.D., Director of Public Policy and Advocacy
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- National Association of Psychiatric Health Systems (NAPHS)
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Appendix: Joint Commission Discharge Planning Standards

Patients may be discharged from the hospital entirely or transferred to another level of care, treatment, and services, to different health professionals, or to settings for continued services. The hospital's processes for transfer or discharge are based on the patient' assessed needs. To facilitate discharge or transfer, the hospital assesses the patient's needs; plans for discharge or transfer, facilitates the discharge or transfer process, and helps to ensure that continuity of care, treatment and services is maintained.

JCAHO Standard	Element of Performance	July 2007 language and new requirements
PC.4.10 Development of a plan for care, treatment, and services is individualized and appropriate to the patient's needs, strengths, limitations, and goals.	1. Care, treatment, services are planned to ensure that they are appropriate to the patient's needs. 2. Development of a plan for care, treatment and services is based on the data from assessments. 6. Patient needs, goals, time frames, settings, and services required to meet the patient needs and/or goals determine the plan for care, treatment and services. 12. The patient's evaluation is based on the patient's care goals and plan for care, treatment and services. 13. The goals of care, treatment and services are revised when necessary. 14. Plans for care, treatment, and services are revised when necessary.	1. Care, treatment, and services are planned to ensure that they are individualized to the patient's needs. 12. Evaluation of the patient is based on the patient care goals and the patient's plan for care, treatment, and services.
PC.5.50 Care, treatment, and services are provided in an interdisciplinary, collaborative manner.	1. Care, treatment and services are provided in an interdisciplinary, collaborative manner.	1. Care, treatment, and services are provided in an interdisciplinary, collaborative manner as appropriate to the needs of the patient and the hospital's scope of services.

JCAHO Standard	Element of Performance	July 2007 language and new requirements
PC.6.10 The patient receives education and training specific to the patient's needs and as appropriate to the care, treatment and services provided.	1. Education is provided appropriate to the patient's needs. 2. The assessment of learning addresses cultural and religious beliefs, emotional barriers, desire and motivation to learn, physical or cognitive limitations, and barriers to communication as appropriate. 3. As appropriate to the patient's condition and assessed needs and the hospitals scope of service, the patient is educated about the following : Plan of care, treatment and services.	1. Education provided is appropriate to the patient's needs. 2. The assessment of learning needs addresses cultural and religious beliefs, emotional barriers, desire and motivation to learn, physical or cognitive limitations, and barriers to communication as appropriate. 3. As appropriate to the patient's condition and assessed needs and the hospital's scope of services, the patient is educated about the following: The plan for care, treatment, and services
PC.6.30 The patient receives education and training specific to the patient's abilities as appropriate to the care, treatment, and services provided by the hospital.	1. Education provided is appropriate to the patient's abilities. 2. Education is coordinated among the disciplines providing care, treatment and services. 3. The content is presented in an understandable manner. 4. Teaching methods accommodate various learning styles. 5. Comprehension is evaluated.	6.30 The patient receives education and training specific to the patient's abilities as appropriate to the care, treatment, and services provided by the hospital. 1. Education provided is appropriate to the [patient]'s abilities.

JCAHO Standard	Element of Performance	July 2007 language and new requirements
PC.15.10 A process addresses the needs for continuing care, treatment, and services after discharge or transfer.		
	1. The process addresses the following: • The reason for transfer or discharge • The conditions under which transfer or discharge can occur. • Shifting responsibility for a patient's care from one clinician, organization, organizational program, or service to another (which could include transferring complete responsibility for the patient and his/her care, treatment, and services to others or referring the patient to others, such as one or more agencies or professionals, to provide one or more specific services. • Mechanisms for internal and external transfer. • The accountability and responsibility for the patient's safety during transfer of both the hospital initiating the transfer and the hospital receiving the patient.	
PC.15.20 The transfer or discharge of a patient to another level of care, treatment, and services, different professionals, or different settings is based on the patient's assessed needs and the hospitals capabilities.		

JCAHO Standard	Element of Performance	July 2007 language and new requirements
	1. The patient's needs for continuing care to meet physical and psychosocial needs are identified.	
	2. Patients are told in a timely manner of the need to plan for discharge or transfer to another organization or level of care.	
	3. Planning for transfer or discharge involves the patient and all appropriate licensed independent practitioners, staff, and family members involved in the patient's care, treatment and services.	
	4. When the patient is transferred, information provided to the patient includes the following: • The reason they are being transferred • Alternatives to transfer, if any.	
	5. The discharge planning process is initiated early in the care, treatment and services process.	
	6. When the patient is discharged, information provided to patients includes the following: • The reason they are being discharged • The anticipated need for continued care, treatment, and services after discharge.	

JCAHO Standard	Element of Performance	July 2007 language and new requirements
	7. When indicated, the patient is educated about how to obtain further care, treatment, and services to meet his or her identified needs.	
	8. When indicated and before discharge, the hospital arranges or helps the family arrange for services needed to meet the patient's needs after discharge.	
	9. Written discharge instructions in a form the patient can understand are given to the patient and/or those responsible for providing care.	
PC.15.30 When patients are transferred or discharged, appropriate information related to the care, treatment, and services provided is exchanged with other service providers.		
	1. The hospital communicates appropriate information to any organization or provider to which the patient is transferred or discharged.	

JCAHO Standard	Element of Performance	July 2007 language and new requirements
	4. The information shared includes the following, as appropriate to the care, treatment, and services provided: • The reason for transfer or discharge • The patient's physical and psychosocial status • A summary of care, treatment, and services provided and progress toward goals • Community resources or referrals provided to the patient.	Now EP 2
RI.1.10 The hospital follows ethical behavior in its care, treatment and services and business practices.		
	EP.3 The hospital's policies and procedures reflect ethical practices for marketing, admission, transfer, discharge, and billing.	
RI.1.40 When care, treatment, and services are subject to internal or external review that results in the denial of care, treatment, services or payment, the hospital makes decisions regarding the provision of ongoing care, treatment, services or discharge based on the assessed needs of the patients.		When internal or external review results in the denial of care, treatment, services, or payment, the hospital makes decisions regarding the ongoing provision of care, treatment, and services, discharge or transfer based on the assessed needs of the patients.

JCAHO Standard	Element of Performance	July 2007 language and new requirements
	EP.1 The hospital makes decisions regarding the provision of ongoing care, treatment, services or discharge based on the care treatment and services required by the patient. EP.2 The patient and/or the family are involved in these decisions.	
RI.2.30 Patients are involved in decisions about care, treatment, and services provided.		
	EP.1 Patients are involved in decisions about their care, treatment and services.	
IM 6.10 The hospital has a complete and accurate medical record for every patient assessed or treated.		The hospital has a complete and accurate medical record for patients assessed, cared for, treated, or served.
	A concise discharge summary providing the information to other caregivers and facilitating continuity of care includes the following: * The reason for hospitalization * Significant findings * Procedures performed and care, treatment and services provided * The patient's condition at discharge * Instructions to the patient and family as appropriate.	7. *Information provided to the patient and family as appropriate. 9. The hospital defines a complete record and the timeframe within which the record is completed after discharge, not to exceed 30 days after discharge.

JCAHO Standard	Element of Performance	July 2007 language and new requirements
IM.6.20		6.20 Records contain patient-specific information, as appropriate, to the care, treatment, and services provided. 1. Medical records contain, as applicable, the following clinical/case information: ….*Medications dispensed or prescribed on discharge
IM.6.30		6.30 The medical record thoroughly documents operative or other high risk procedures and the use of moderate or deep sedation or anesthesia. 7. The use of approved discharge criteria to determine the patient's readiness for discharge is documented in the medical record. 8. Postoperative documentation records the name of the licensed independent practitioner responsible for discharge.