PSYCHIATRIC STANDARDS OF CARE—
A POLICY ENDORSEMENT

By David H. Rosen*

The Mental Health Committee of the San Francisco Medical Society recommended—and the Board of Directors of the SFMS subsequently approved—endorsement of a set of psychiatric standards of care and draft policies developed by the San Francisco Peer Review Organization.

These standards and draft policies were developed by SFPRO's Psychiatric Policy and Monitoring Committee in response to problems experienced in Medi-Cal review of PSRO-approved cases.

The standards of care and the draft policies endorsed by the SFMS for use in peer review are:

PSYCHIATRIC STANDARDS OF CARE

• **Passes.** It is a community standard of quality of care that to evaluate the patient's functional capacity outside of the hospital environment or as a part of the discharge process unsupervised passes issued to psychiatric inpatients are often an essential component of acute care.

• **Definition of acute level of care.** It is a community standard of quality of care for psychiatric patients that acute care includes diagnosis and management of the admitting symptoms/signs and sufficient time in the hospital setting to stabilize the improvement, assess functional capacity, and allow for the patient's active participation in treatment, including dispositional planning if possible.

• **Skilled nursing facility (L-facility) short stays.** It is a community standard of quality of care that psychiatric patients must have preserved the continuity of their care with the same treating staff. Therefore, it is unacceptable to transfer patients until they can withstand separation without significant adverse clinical impacts.

• **Assessment of patient’s functional capacity in a non-protective environment; or**

• **Assessment of patient's ability to cope with the source(s) of stress which initially prompted his psychiatric hospitalization; or**

• **The need for unsupervised integration into a less structured environment (e.g., halfway house or three-quarter-way house);**

• **Documentation of his decision on the coordinator worksheet.**

If the reason for the pass is not reflective of one of the above-mentioned components of acute care, then the case must be decertified.

• **Acute psychiatric care certification.** When a patient's medical record reflects that his clinical status is improved; he is beginning to participate in therapy and dispositional planning; and the attending physician anticipates no more than three to five days continued acute inpatient care, then the physician advisor may certify the case at an acute level and document his decision on the coordinator worksheet.

If the documentation indicates that a longer period of time is needed to allow for improvement or reintegration into a non-protective environment, or that the patient is not expected to improve significantly enough to plan for immediate discharge, then the case must be decertified.

• **SNF (L-facility) short stays.** When a patient's medical record reflects that although medically stable there is still evidence of patient behavior which would contraindicate brief separation from his treating staff, then the physician advisor may certify the case at an acute level and document his decision on the coordinator worksheet.

If the medical record does not reflect the above, or reflects a chronic behavior disorder which would preclude establishment of a therapeutic outpatient relationship, then the case must be decertified.

The Committee also approved a request that the SFMS write to the Center for Health Statistics in Washington, DC, and ask that the ICD-9-CM categorization of “homosexuality” as a disease entity not be used.

*David H. Rosen is chairman of the SFMS Mental Health Committee.

December, 1980