Capital BlueCross
OUTPATIENT PSYCHIATRIC FACILITIES SURVEY

Provider Name: ____________________
CBC #: __________ **Medicare #:** __________ **Medicaid #:** __________
Accrediting Organization: __________ **Date of most recent accrediting survey:** __________
Person completing survey: __________ **Phone:** __________ **Date:** __________
Contact person (if different than above): __________ **Phone:** __________

Directions: Please complete each line with appropriate information.
Where applicable please indicate with a check mark (✓).

ADMINISTRATION

Business hours: __________
Program hours: __________
Program capacity: __________
Ages served: __________
Average daily census: __________
Average Length of Stay: __________
Handicap accessible ☐ Yes ☐ No
Written policy for treatment of minors ☐ Yes ☐ No
Written patient medical emergency plan ☐ Yes ☐ No
Written plan for patient pyschiatric emergency ☐ Yes ☐ No
Access to emergency psychiatric medications ☐ Yes ☐ No
Emergency supplies / first aid kit available ☐ Yes ☐ No
Written transfer agreements with acute care facilities ☐ Yes ☐ No
If **yes**, list facilities: __________

____

Written agreement for emergency transport ☐ Yes ☐ No
If **no**, access to 911 ☐ Yes ☐ No
On-call policy ☐ Yes ☐ No
Written confidentiality policy ☐ Yes ☐ No
Services available within 48 hours of intake/assessment ☐ Yes ☐ No

QUALITY MANAGEMENT

Quality Activities
Performance Improvement Program ☐ Yes ☐ No
Performance Improvement Committee ☐ Yes ☐ No
If **no**, are quality issues discussed at staff meetings? ☐ Yes ☐ No
Staff meetings documented: ☐ Yes ☐ No
Frequency of meetings: __________

Position accountable for Performance Improvement activity: __________
Quality Reports forwarded to the Board of Directors ☐ Yes ☐ No
List two current Quality Studies:
1. __________
2. __________

Infection Control policies ☐ Yes ☐ No
Written policy on communicable diseases ☐ Yes ☐ No

Patient Satisfaction
Patient Satisfaction Surveys utilized ☐ Yes ☐ No
Annual return rate for surveys: __________ **%**
Most frequent issues identified:
1. __________
2. __________

Patient/family complaint process ☐ Yes ☐ No

Physician Satisfaction

Provider Name:

Physician Satisfaction Survey utilized ☐ Yes ☐ No

Annual return rate for surveys: ________ %

Clinical Management

Staff to patient ratio: ________

Written admission criteria ☐ Yes ☐ No

Average time frame between initial referral and admission: ________

Written continued stay criteria ☐ Yes ☐ No

Written discharge criteria ☐ Yes ☐ No

Administrative discharge criteria ☐ Yes ☐ No

Written attendance policy ☐ Yes ☐ No

Written policy for administering meds ☐ Yes ☐ No

Restraint policy ☐ Yes ☐ No

Written policy for other agency referrals ☐ Yes ☐ No

Time frame to develop initial treatment plan: ________

Time frame to develop master treatment plan: ________

Frequency of treatment plan updates: ________

Clinical Management (cont'd)

Time frame for completion of Psychiatric evaluation: ________

Frequency of Physician visits: ________

Case Management program ☐ Yes ☐ No

Disciplines involved in discharge planning:

____

Clinical pathways utilized ☐ Yes ☐ No

Indicate number of pathways developed: ________

Written aftercare plan provided to patients/family ☐ Yes ☐ No

Written policy for patient follow-up ☐ Yes ☐ No

Patient Education/Public Health

Patient/Family education ☐ Yes ☐ No

Education materials distributed to patients/family ☐ Yes ☐ No

Services for hearing impaired ☐ Yes ☐ No

Services for speech impaired ☐ Yes ☐ No

Services for visually impaired ☐ Yes ☐ No

Bilingual services ☐ Yes ☐ No

Bilingual patient education materials ☐ Yes ☐ No

Languages offered: ________

Data Collection

Diagnosis ☐ Yes ☐ No

Average Length of Stay ☐ Yes ☐ No

Transfers to Acute Care ☐ Yes ☐ No

Readmissions ☐ Yes ☐ No

Transfers to Substance Abuse facility ☐ Yes ☐ No

Transfers to Residential Treatment facility ☐ Yes ☐ No

Administrative Discharges ☐ Yes ☐ No

Referral sources ☐ Yes ☐ No

Therapeutic Blood Levels ☐ Yes ☐ No

Incident Reports ☐ Yes ☐ No

STAFF

Clinical Competency Evaluation ☐ Yes ☐ No

Frequency: ________

Annual performance evaluation of staff ☐ Yes ☐ No

Minimum number of educational programs annually attended by staff: ________

Written policy for credentialing of:

- Physicians ☐ Yes ☐ No
- Nursing ☐ Yes ☐ No
- Allied Health ☐ Yes ☐ No

Written policy for verification of education / training and licensure / certifications of clinical staff

Provider Name:

Written policy for supervision of clinical staff ☐ Yes ☐ No

☐ Yes ☐ No

Medical Staff

Medical Director ☐ Yes ☐ No

Name: ______

☐ Full Time ☐ Part Time

Number of hours/week ______

Board Certified ☐ Yes ☐ No

Specialty: ______

______ # of Psychiatrists

______ # of Psychiatrists Board Certified in Adult Psychiatry

______ # of Psychiatrists Board Certified in Child and Adolescent Psychiatry

Nursing Staff

Certified Nurse Practitioner ☐ Yes ☐ No

If yes, specialty: ______

______ # of RNs

______ # of Certified Psychiatric Nurses

______ # of LPNs

Other Staff

______ # of Licensed Psychologists

______ # of Bachelor Level Counselors

______ # of Psychiatric Social Workers

______ # of Psychiatric Technicians/Aides

______ # of Recreational / Activity Therapists

______ # of CACs

Other: ______

Written policy on CPR certification ☐ Yes ☐ No

Minimum of one CPR certified staff present at all times ☐ Yes ☐ No

______ % Direct patient care givers CPR certified

SERVICES

Services provided to:

Adults	☐ Yes ☐ No
Men	☐ Yes ☐ No
Women	☐ Yes ☐ No
Adolescents	☐ Yes ☐ No
Children	☐ Yes ☐ No
Geriatric	☐ Yes ☐ No

Other: ______

Therapies offered:

Couple	☐ Yes ☐ No
Dual diagnosis	☐ Yes ☐ No
Family	☐ Yes ☐ No
Group	☐ Yes ☐ No
Individual therapy	☐ Yes ☐ No
Intensive outpatient	☐ Yes ☐ No
Outpatient	☐ Yes ☐ No
Vocational Rehab	☐ Yes ☐ No

Other: ______

Transportation

Public transportation route ☐ Yes ☐ No

Facility owned van ☐ Yes ☐ No

Other: ______

FACILITY / SAFETY

Written emergency preparedness plan ☐ Yes ☐ No

Plan includes procedures for the following:

Fire	☐ Yes ☐ No
Loss of utilities	☐ Yes ☐ No
Inclement weather	☐ Yes ☐ No

Number of fire extinguishers: ______

Number of fire drills per year: ______

Fire extinguishers checked annually ☐ Yes ☐ No

Fire evacuation plan posted within facility ☐ Yes ☐ No

COMMENTS

Provider Name:

As a reminder, please be sure to include:

- ***Facility Information Sheet***
- ***Name sheet for branch offices***
- ***Affiliate or owned services***
- ***Program Description***

Provider Name:

Please complete the following based upon corporate ownership of off-site business initiatives and indicate specific services performed at the office site.

Branch Offices

Name:
Services Provided:
Billing Site Only ☐ Yes ☐ No
Date of Acquisition or Establishment:
Address:
City:
Phone:
Contact Person:
Counties Served:

Name:
Services Provided:
Billing Site Only ☐ Yes ☐ No
Date of Acquisition or Establishment:
Address:
City:
Phone:
Contact Person:
Counties Served:

Name:
Services Provided:
Billing Site Only ☐ Yes ☐ No
Date of Acquisition or Establishment:
Address:
City:
Phone:
Contact Person:
Counties Served:

Name:
Services Provided:
Billing Site Only ☐ Yes ☐ No
Date of Acquisition or Establishment:
Address:
City:
Phone:
Contact Person:

Counties Served:

Name:
Services Provided:
Billing Site Only ☐ Yes ☐ No
Date of Acquisition or Establishment:
Address:
City:
Phone:
Contact Person:
Counties Served:

Name:
Services Provided:
Billing Site Only ☐ Yes ☐ No
Date of Acquisition or Establishment:
Address:
City:
Phone:
Contact Person:
Counties Served:

Name:
Services Provided:
Billing Site Only ☐ Yes ☐ No
Date of Acquisition or Establishment:
Address:
City:
Phone:
Contact Person:
Counties Served:

Name:
Services Provided:
Billing Site Only ☐ Yes ☐ No
Date of Acquisition or Establishment:
Address:
City:

Provider Name:

Phone: ______________________ Counties Served: ______________________

Contact Person: ______________________

HEALTHCARE FACILITY INFORMATION FORM

Provider Name:____
Parent:____
Affiliation:____
Affiliation:____

Number of Years in business:_________________________

Type of Control

- ☐ **Voluntary Nonprofit**
- ☐ **Proprietary** (Identify all individuals, members of partnership, major stockholders, etc. If 'Other' explain.)
  - ☐ Individual ________________________________
  - ☐ Partnership________________________________
  - ☐ Corporation________________________________
  - ☐ Other____________________________________
- ☐ **Government**
  - ☐ Federal
  - ☐ State
  - ☐ County
  - ☐ Other, explain:____________________________

Additional Information Requested

Has the facility, any corporate officer, employee or any agent acting on behalf of the facility been involved in or convicted of healthcare fraud or abuse in the last five (5) years?

- ☐ Yes, explain:________________________________
- ☐ No

Have you or any of your affiliates, entered into a corporate integrity agreement with any state or federal agency?

- ☐ Yes
- ☐ No

If yes, provide a copy to Capital Blue Cross

Provide copies of the following:

- State Licensure certificate(s)
- List of Board of Directors
- Most recent accreditation letter
- Most recent DOH Report
- Evidence of current malpractice insurance
- Current organizational chart

COMMENTS: ____

Provider Name:

Please indicate the counties within your service area. If services are limited to only a portion of the county, please identify.

- Adams ❑ ____________________
- Berks ❑ ____________________
- Centre ❑ ____________________
- Columbia ❑ ____________________
- Cumberland ❑ ____________________
- Dauphin ❑ ____________________
- Franklin ❑ ____________________
- Fulton ❑ ____________________
- Juniata ❑ ____________________
- Lancaster ❑ ____________________
- Lebanon ❑ ____________________
- Lehigh ❑ ____________________
- Mifflin ❑ ____________________
- Montour ❑ ____________________
- Northampton ❑ ____________________
- Northumberland ❑ ____________________
- Perry ❑ ____________________
- Schuylkill ❑ ____________________
- Snyder ❑ ____________________
- Union ❑ ____________________
- York ❑ ____________________

Other ❑ ____________________