Capital BlueCross
INPATIENT PSYCHIATRIC FACILITY 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

Number of Beds: _____
Locked unit ☐ Yes ☐ No
If yes, number of beds: _____
Seclusion rooms ☐ Yes ☐ No
If yes, number of rooms: _____
Handicap access ☐ Yes ☐ No
Average daily census: _____
Average Length of Stay: _____
24 Hr/Day -7 Day/Wk coverage ☐ Yes ☐ No
Written plan for patient medical emergency ☐ Yes ☐ No
Written plan for patient pyschiatric emergency ☐ Yes ☐ No
Emergency medications/supplies available ☐ Yes ☐ No
Written policy for checking emergency meds/supplies: ☐ Yes ☐ No
Written transfer agreement to acute care ☐ Yes ☐ No
If **yes**, list facilities: _____
_____
_____
Written agreement for emergency transport ☐ Yes ☐ No
If **no**, access to 911 ☐ Yes ☐ No
Written on-call policy ☐ Yes ☐ No
Written policy for treatment of minors ☐ Yes ☐ No
Written confidentiality policy ☐ Yes ☐ No
Smoke-Free Facility ☐ Yes ☐ No

QUALITY MANAGEMENT

Quality Activities

Written Performance Improvement Program ☐ Yes ☐ No
Performance Improvement Committee ☐ Yes ☐ No
Frequency of meetings: _____
Position accountable for Performance Improvement activity: _____
Quality Reports forwarded to the Board of Directors ☐ Yes ☐ No
List two Quality Studies performed in previous year:
1. _____
2. _____
Participate in the JACHO-ORYX program ☐ Yes ☐ No
List two (2) clinical performance measures used for ORYX:
1. _____
2. _____
Written Infection Control policies ☐ Yes ☐ No
If **yes**, includes communicable diseases

Provider Name:

☐ Yes ☐ No

Patient Satisfaction

Patient Satisfaction Surveys utilized ☐ Yes ☐ No

Most frequent issues identified:

1. _____
2. _____

Written patient/family complaint process ☐ Yes ☐ No

Annual return rate for surveys: _____ %

Physician Satisfaction

Physician Satisfaction Survey utilized ☐ Yes ☐ No

Annual return rate for surveys: _____ %

Clinical Management

Written policy on maintenance and retention of patient records: ☐ Yes ☐ No

Written admission criteria ☐ Yes ☐ No

Written discharge criteria ☐ Yes ☐ No

Wrttien policy for patient follow-up ☐ Yes ☐ No

Written 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: _____

Time frame for completion of nursing assessment: _____

Time frame for completion of Psychiatric evaluation: _____

Frequency of patient evaluation by Psychiatrist: _____

Case Management and Discharge Planning

Internal case managers available ☐ Yes ☐ No

Types: ☐ RN

☐ Social Services

☐

Other: _____

Departments/services involved in discharge planning: _____

Written discharge instruction provided to patient/family ☐ Yes ☐ No

Patient Education/Public Health

Patient/Family education ☐ Yes ☐ No

Education materials distributed to patients/family ☐ Yes ☐ No

Clinical pathways utilized ☐ Yes ☐ No

Indicate number of pathways developed: _____

Pathways utilized in patient/family education ☐ 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

Most frequent admission DRGs	☐ Yes ☐ No
Transfers to Acute Care	☐ Yes ☐ No
Readmissions	☐ Yes ☐ No
Transfers to Substance Abuse facility	☐ Yes ☐ No
Transfers to Residential	☐ Yes ☐ No
Incident reports	☐ Yes ☐ No
Admissions via Emergency Room	☐ Yes ☐ No
AMA Discharges	☐ Yes ☐ No

STAFF

Written policy for credentialing of:

Provider Name:

Physicians ☐ Yes ☐ No

Nurses ☐ Yes ☐ No

Allied health ☐ Yes ☐ No

Written policy for re-credentialing of:

Physicians ☐ Yes ☐ No

Nurses ☐ Yes ☐ No

Allied Health ☐ Yes ☐ No

Written policy for verification of licensure/certification of staff ☐ Yes ☐ No

Written policy for verification of education/training of staff ☐ Yes ☐ No

Clinical Competency Evaluation ☐ Yes ☐ No

Frequency: _____

Minimum number of educational programs annually attended by staff: _____

Performance evaluation system in place ☐ Yes ☐ No

Written policy for supervision of clinical staff ☐ Yes ☐ No

Written policy for determining staffing levels ☐ Yes ☐ No

Medical Staff

Medical Director ☐ Yes ☐ No

Name: _____

☐ Full Time ☐ Part Time

☐ Employed ☐ Contracted

Board Certified ☐ Yes ☐ No

Specialty: _____

_____ Number of Psychiatrists

_____ Number of Psychiatrists Board Certified in Adult Psychiatry

_____ Number of Psychiatrists Board Certified in Child and Adolescent Psychiatry

Nursing Staff

Nurse Practitioner ☐ Yes ☐ No

If yes, specialty: _____

_____ # of Registered Nurses

_____ # of Certified Psychiatric Nurses

_____ # of Licensed Practical Nurses

_____ # of Certified Nursing Assistants

% Agency nurses used

Credentialing guidelines for use of agency nurses ☐ Yes ☐ No

Facility evaluation of agency nurse performance ☐ Yes ☐ No

Written policy on CPR certfication ☐ Yes ☐ No

Minimum of 2 CPR certified staff present at all times ☐ Yes ☐ No

% Direct patient care givers CPR certified

_____ Staff to patient ratio

Other Staff

_____ # of Certified Addiction Counselors

_____ # of Activity Therapists

_____ # of Licensed Psychologists

_____ # of Psychiatric Social Workers

_____ # of Psychiatric Technicians/Assistants

_____ # of Recreational Therapists

_____ # of Registered Dietitians

_____ # of Occupational Therapists

_____ # of Certified Occupational Therapy Assts.

_____ # of Licensed Pharmacists

_____ # of Pharmacy Assistants/Technicians

_____ # of Vocational Rehabilitation Specialists

Bioengineering specialist ☐ Yes ☐ No

Degreed ☐ Yes ☐ No

Trained ☐ Yes ☐ No

List other: _____

SERVICES

Programs:

Children ☐ Yes ☐ No

Provider Name:

Adolescents ☐ Yes ☐ No

Adults ☐ Yes ☐ No

Geriatrics ☐ Yes ☐ No

Therapies offered:

Individual: ☐ Yes ☐ No

Group: ☐ Yes ☐ No

Family: ☐ Yes ☐ No

Electroconvulsive: ☐ Yes ☐ No

Hours of therapy / day: _____

Weekend therapies available: ☐ Yes ☐ No

Other Psychiatric Services

	On-site	Off-site
Outpatient	☐ Yes ☐ No	☐ Yes ☐ No
Intensive Outpatient	☐ Yes ☐ No	☐ Yes ☐ No
Partial Hosp	☐ Yes ☐ No	☐ Yes ☐ No
Acute	☐ Yes ☐ No	☐ Yes ☐ No
Chronic	☐ Yes ☐ No	☐ Yes ☐ No
Dual Diagnosis	☐ Yes ☐ No	☐ Yes ☐ No
OP Vocational Rehab	☐ Yes ☐ No	☐ Yes ☐ No

Laboratory

Onsite ☐ Yes ☐ No

24hr access ☐ Yes ☐ No

7day/wk coverage ☐ Yes ☐ No

Pharmacy

Pharmacist ☐ Yes ☐ No

24hr access ☐ Yes ☐ No

7day/wk coverage ☐ Yes ☐ No

Services contracted out ☐ Yes ☐ No

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

Fire extinguishers available on each unit ☐ Yes ☐ No

Fire extinguishers checked annually ☐ Yes ☐ No

Number of fire drills per year: _____

Fire evacuation plan posted within facility ☐ Yes ☐ No

Written policy for preventative maintenance: ☐ Yes ☐ No

As a reminder, please be sure to include:

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

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

Branch Offices

Provider Name:

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: ____________________
Phone: ____________________
Contact Person: ____________________
Counties Served: ____________________

Provider Name:

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 ❑ _____

Provider Name: