PARTIAL HOSPITALIZATION PROGRAM (PHP)

PURPOSE

Performance specifications are intended to enhance MassHealth Enrollee experience and outcomes by promoting transparency and consistency across Plans and providers. Performance specifications are expectations imposed on providers who contract for these specific and related services. Information contained in this document is based on publicly available documents, Plan expectations, your contract, and MassHealth guidance. This information should be and will look materially like any other MassHealth contracted Plan. Performance specifications, your provider manual, and other requirements can be found at providerexpress.com.

Providers contracted for this level of care or service are expected to comply with applicable regulations set forth in the Code of Massachusetts Regulations, and all requirements of these service-specific performance specifications. In addition, providers of all contracted services are held accountable to the General Performance Specifications. Where there are differences between the service-specific and General Performance Specifications, the service-specific specifications take precedence.

OVERVIEW

Partial Hospitalization Program (PHP) is a non-24-hour diversionary treatment program that is hospital-based or community-based. The program provides diagnostic and clinical treatment services on a level of intensity similar to an inpatient program, but on less than a 24-hour basis. These services include therapeutic milieu; nursing; psychiatric evaluation; medication management; individual, group, and family therapy; peer support and/or other recovery-oriented services; substance use disorder evaluation and counseling; and behavioral plan development.

The environment at this level of treatment is highly structured, and there is a staff-to-Enrollee ratio sufficient to ensure necessary therapeutic services, professional monitoring, and risk management. PHP may be appropriate when an Enrollee does not require the more restrictive and intensive environment of a 24-hour inpatient setting but does need up to eight hours of clinical services, multiple days per week. PHP is used as a time-limited response to stabilize acute symptoms. As such, it can be used both as a transitional level of care, such as a step-down from inpatient services, as well as a stand-alone, diversionary level of care to stabilize an Enrollee’s deteriorating condition, support him/her in remaining in the community, and avert hospitalization. Treatment efforts focus on the Enrollee’s response during treatment program hours, as well as the continuity and transfer of treatment gains during the Enrollee’s non-program hours in the home/community

The performance specifications contained within pertain to the following services:

- Partial Hospitalization Program (PHP)
- Partial Hospitalization Program (PHP) for Eating Disorders

SERVICE COMPONENTS

1. The PHP offers short-term day programming consisting of therapeutically intensive, acute treatment within a stable therapeutic milieu. A psychiatrist oversees medication management and daily active treatment, as described within the Process Specifications section.
2. Full therapeutic programming is provided five days per week, with sufficient professional staff to conduct these services and to manage a therapeutic milieu. The scope of required service components provided in this level of care includes, but is not limited to, the following:
    a) Bio-psychosocial evaluation
    b) Psychiatric evaluation
    c) Medical history
    d) Physical examination/medical assessment (to assess for medical issues)
    e) Pharmacology
    f) Nursing assessment and services, or similar service provided by the program's MD staffing
    g) Individual, group, and family therapy
    h) Case and family consultation
    i) Peer support and/or other recovery-oriented services
    j) Substance use disorder assessment and counseling
    k) Development of behavioral plans and crisis prevention plans, and/or safety plans as part of the Crisis Planning Tools for youth, as applicable
3. For minor children and for adults who give consent, the provider makes documented attempts to contact the parent, guardian, family members, and/or significant others within 48 hours of admission, unless clinically or legally contraindicated. The provider provides them with all relevant information related to maintaining contact with the program and the Enrollee, including names and phone numbers of key nursing staff, primary treatment staff, social worker/care coordinator/discharge planner, etc. If contact is not made, the Enrollee's health record documents the rationale.
4. The provider engages in a medication reconciliation process to avoid inadvertent inconsistencies in medication prescribing that may occur in transition of an Enrollee from one care setting to another. The provider does this by reviewing the Enrollee's complete medication regimen at the time of admission (e.g., transfer and/or discharge from another setting or prescriber) and comparing it with the regimen being considered in the PHP. The provider engages in the process of comparing the Enrollee's newly issued medication orders by the PHP to the medications that he/she has been taking to avoid medication errors. This involves:
    a) developing a list of current medications, i.e., those the Enrollee was prescribed prior to admission to the PHP;

b) developing a list of medications to be prescribed in the PHP;
c) comparing the medications on the two lists;
d) making clinical decisions based on the comparison and, when
e) indicated, in coordination with the Enrollee's primary care clinician (PCC); and
f) communicating the new list to the Enrollee and, with consent, to appropriate caregivers, the Enrollee's PCC, and other treatment providers.
g) All related activities are documented in the Enrollee's health record.

5. If an Enrollee experiencing a behavioral health crisis contacts the provider, during business hours or outside business hours, the provider, based on his/her assessment of the Enrollee's needs and under the guidance of his/her supervisor, may:
   a) offer support and intervention through the services of the PHP program, during business hours;
   b) implement interventions to support the Enrollee and enable him/her to remain in the community, when clinically appropriate, e.g., highlight elements of the Enrollee's crisis prevention plan and/or safety plan, encourage implementation of the plan, offer constructive, step-by-step strategies which the Enrollee may apply, and/or follow-up and assess the safety of the Enrollee and other involved parties, as applicable;
   c) refer the Enrollee to his/her outpatient provider; and/or
   d) refer the Enrollee to an ESP/MCI for emergency behavioral health crisis assessment, intervention, and stabilization.
6. Outside business hours, the provider offers telephonic coverage. An answering machine or answering service directing callers to call 911, call the nearest ESP/MCI, or to go to a hospital emergency department (ED), does not meet the after-hours on-call requirements.

STAFFING REQUIREMENTS

1. The provider complies with the staffing requirements of the applicable licensing body, the staffing requirements in the Plan service-specific performance specifications, and the credentialing criteria outlined in the Plan provider manual found at providerexpress.com.
2. The staff includes a PHP Director or Supervisor who is an independently licensed, master's-level or doctoral-level clinician. He/she is responsible for the clinical oversight and quality of care within the PHP, in collaboration with the medical director, and ensures the provision of all PHP service components. He/she is available for consultations regarding emergency or urgent situations.
3. The PHP has a written staffing plan that delineates the number and credentials of its professional staff, including attending psychiatrists, nurses, social workers, and other mental health professionals to ensure that all required services are provided, and performance specifications are met. The Program Director or Supervisor collaborates with the medical director on the development and maintenance of the staffing plan for psychiatry.
4. Enrollees have access to supportive milieu and clinical staff throughout the PHP hours of operation.
5. The provider has adequate psychiatric coverage to ensure all performance specifications

related to psychiatry are met.

6. The provider appoints a medical director who is fully integrated into the administrative and leadership structure of the PHP and is responsible for clinical and medical oversight, quality of care, and clinical outcomes across all PHP service components, in collaboration with the PHP Director or Supervisor and the clinical leadership team.
    a. The medical director is a psychiatrist who is board-certified and/or who meets the plan's credentialing criteria including requirements related to board certification.
    b. For providers with PHP programs for children and/or adolescents: If the medical director is not a child/adolescent psychiatrist, the provider appoints a staff psychiatrist to have the primary responsibility to assess and evaluate children and adolescents, one who is board-certified in general psychiatry and child fellowship- trained and/or board-certified in child/adolescent psychiatry and/or who meets Plan's credentialing criteria for a child/adolescent psychiatrist.
    c. The medical director's role may include the provision of direct psychiatry services and includes:
        i. attendance at multi-disciplinary team meetings at least weekly;
        ii. teaching, training, coaching, and consulting with the multi- disciplinary team; and
        iii. oversight and monitoring of prescribing clinicians.
    d. The medical director's role also includes the following functions, in collaboration with the PHP Director or Supervisor and clinical leadership team:
        i. integration of the various assessments of the Enrollee's needs and strengths into a coherent narrative that can be used for treatment planning within the PHP and in the Enrollee's home and community;
        ii. development and utilization of the PHP's unifying theory of treatment to guide its mission, vision, and practice;
        iii. development of therapeutic programming; and
        iv. ensuring that programs remain family-centered, and, for programs serving youth, child-focused.
    e. For providers with PHPs for children and/or adolescents, the medical director ensures psychiatric practice consistent with the best available evidence-based practices and parameters developed by the American Academy of Child and Adolescent Psychiatry (AACAP) when evaluating and treating youth with complex needs and/or medication regimens, e.g., when Enrollees attending the program are on multiple psychiatric medications, or are in the custody of a state agency and are starting or continuing atypical antipsychotics. The medical director monitors this practice through oversight and supervision.
7. The provider assigns an attending psychiatrist to each Enrollee.
    a) For children and adolescents under the age of 14, the attending psychiatrist is one who meets the plan's credentialing criteria for a child/adolescent psychiatrist.
8. Psychiatric care is provided by the medical director and/or other psychiatrists who are board-certified and/or who meet Plan's credentialing criteria. Psychiatric care consists of the provision of psychiatric and pharmacological assessment and treatment to Enrollees in the PHP. The

program may also utilize a psychiatry fellow/trainee to provide psychiatric services, under the supervision of the medical director or another attending psychiatrist, in conformance with the Accreditation Council for Graduate Medical Education (ACGME), and in compliance with all Centers for Medicare and Medicaid Services (CMS) guidelines for supervision of trainees by attending physicians. The program may also utilize a psychiatric nurse mental health clinical specialist (PNMHCS) to provide psychiatric services, within the scope of their licenses and under the supervision of the medical director, as outlined within these performance specifications. The program may also utilize a psychiatric resident to provide psychiatric services, under the supervision of the medical director or another attending psychiatrist.

9. For PHPs that utilize a PNMHCS for medication management within their license and scope of practice, all of the following apply:
    a) There is documented maintenance of: a collaborative agreement between the PNMHCS and the medical director; and a consultation log including dates of consultation meetings and list of all Enrollees reviewed. The agreement specifies whether the PNMHCS or the medical director will be responsible for this documentation;
    b) the supervision/consultation between the PNMHCS and the medical director is documented and occurs at least one (1) hour per week for PNMHCS staff, or at a frequency proportionate to the hours worked for that PNMHCS staffs who works less than full-time. The format may be individual, group, and/or team meetings;
    c) a documented agreement exists between the medical director and the PNMHCS outlining how the PNMHCS can access the medical director when needed for additional consultation;
    d) the medical director, or another psychiatrist, is the attending psychiatrist for the Enrollee when a PNMHCS is utilized to provide direct psychiatry services to a given Enrollee. The PNMHCS is not the attending for any Enrollee; and
    e) there is documented active collaboration between the medical director and the PNMHCS relative to Enrollees' medication regimens, especially those Enrollees for whom a change in their regimen is being considered.
10. For PHPs that utilize a psychiatry fellow/trainee for medication management, the following apply:
    a) The psychiatry fellow/trainee must be provided sufficient supervision from a psychiatrist to enable him/her to establish working relationships that foster identification in the role of a psychiatrist; The psychiatry fellow/trainee must have at least two (2) hours of individual supervision weekly, in addition to teaching conferences and rounds; and
    b) the program must use the following classification of supervision:
        i. Direct supervision – the supervising physician is physically present with the fellow and Enrollee.
        ii. Indirect supervision**:**
            - With direct supervision immediately available – the supervising physician is physically within the program and is immediately available to provide direct supervision.
            - With direct supervision available – the supervising physician is not physically present within the program but is immediately available by means of telephonic and/or electronic modalities and is available to provide direct

supervision.

iii. Oversight – the supervising physician is available to provide review of procedures/encounters with feedback provided after care is delivered.

11. All staff directly responsible for providing any treatment components during an Enrollee's stay receive documented, program-related training, consistent with the individualized needs of the program and its target population, at least annually, on topics related to the treatment of individuals with behavioral health conditions.
12. The PHP ensures that master's-level or doctoral-level staff, who have training and experience in the assessment and treatment of substance use disorders and co-occurring disorders, or staff who are Licensed Alcohol and Drug Counselors (LADC), Certified Alcoholism and Drug Abuse Counselors (CADAC), Certified Addiction Counselors (CAC), or Licensed Alcohol and Drug Abuse Counselors (LADAC), are involved in the assessment and treatment of Enrollees whose diagnoses include those related to substance use disorders and/or co-occurring disorders, and that supervision and/or consultation relative to substance use disorders is made available to staff as needed.
13. The PHP provides all staff with supervision in compliance with Plan's credentialing criteria.

SERVICE, COMMUNITY AND OTHER LINKAGES

1. When requested and with Enrollee consent, if an Enrollee is referred to another treatment setting, the provider collaborates in the transfer, referral, and/or discharge planning process to ensure continuity of care.
2. The provider maintains linkages with step-down programs for adults, children, and adolescents, including but not limited to CBHI services, that refer a high volume of Enrollees to the provider and/or to which the provider refers a high volume of Enrollees, to enhance continuity of care for Enrollees.
3. The provider develops a working relationship with the Emergency Services Program/Mobile Crisis Intervention (ESP/MCI) provider that covers the catchment area in which the PHP is located, as delineated in the Service, Community, and Collateral Linkages section of the General performance specifications.
4. With Enrollee consent, the provider collaborates with the Enrollee's PCC as delineated in the Primary Care Clinician Integration section of the General performance specifications.

PROCESS SPECIFICATIONS

Assessment, Treatment Planning and Documentation

1. The PHP's admission procedures ensure timely admission of Enrollees commensurate with meeting each Enrollee's individual needs, for both diversionary and step-down referrals.
   a) A best practice is for PHPs to have mechanisms to accept referrals seven (7) days per week, so that Enrollees and referral sources do not need to wait until the next business day to make a referral.
   b) The PHP conducts admissions at least five (5) days per week.
2. A psychiatrist, preferably the attending psychiatrist to be assigned to the Enrollee, conducts a

comprehensive evaluation of each Enrollee on the Enrollee's first day in the PHP, consisting of a medical history, psychiatric evaluation, and an assessment of the psychiatric, pharmacological, and treatment needs of the Enrollee, including a clinical formulation that explains the Enrollee's condition and maladaptive behavior. When a psychiatrist other than the Enrollee's attending psychiatrist conducts the initial evaluation, the attending psychiatrist reviews the evaluation within one (1) business day.

   a) If open on weekends and holidays, the initial evaluation may be completed by a covering psychiatrist, a psychiatric resident, a psychiatry fellow/trainee, or a psychiatric nurse mental health clinical specialist (PNMHCS) acting under the attending psychiatrist's or the medical director's Enrollee-specific supervision. In such situations, the attending psychiatrist must evaluate the Enrollee on the next business day. However, the medical director or an attending psychiatrist is available for consultation by phone, as needed, until the psychiatrist conducts the face-to-face evaluation of the Enrollee.

3. A physical examination/medical assessment is also conducted on the Enrollee's first day in the PHP, by an MD or PNMHCS staff, to assess for medical issues.
4. The provider assigns a multi-disciplinary treatment team to each Enrollee within 48 hours of admission, consisting of a psychiatrist and one or more other discipline. A multi-disciplinary treatment team meets to review the assessment and develops an initial treatment plan and an initial discharge plan within 48 hours of admission. For PHPs that are open on weekends and holidays, the treatment plan may be developed by an abbreviated treatment team, with a review by the full treatment team on the next business day.
5. The provider completes a comprehensive and individualized treatment and discharge plan as delineated within the applicable performance specifications. A staff member records the Enrollee's understanding of the goals of the treatment plan and discharge plan.
6. The treatment and discharge plans are reviewed by the multi-disciplinary treatment team with the Enrollee at least every 72 hours and are updated accordingly based on each Enrollee's individualized progress. All assessments, treatment and discharge plans, reviews, and updates are documented in the Enrollee's health record.
7. The provider collaborates with the Enrollee, the ESP/MCI provider in the catchment area in which the Enrollee lives, and other clinical treatment providers to obtain the Enrollee's crisis prevention plan and/or safety plan. The provider collaborates with these entities to update the plan if needed or develops one if the Enrollee does not yet have one. With Enrollee consent, the ESP/MCI provider may share the plan with the provider who includes the plan and documents related collaboration in the Enrollee's health record.
8. Every Enrollee is assigned an attending psychiatrist, who may also be the medical director, who consistently provides, and is responsible for, the day to day and overall care of the Enrollee when attending the PHP. The attending psychiatrist serves as the Enrollee's primary physician and is an active participant on the Enrollee's treatment team.
   a) The attending psychiatrist participates in daily rounds and treatment team meetings and is available to consult with the treatment team throughout the Enrollee's length of stay.
   b) If the PHP utilizes a psychiatric resident, a psychiatry fellow/trainee, or a PNMHCS to provide psychiatric services within the PHP, he/she participates in daily rounds and treatment team meetings, with oversight and supervision provided by the medical director or another attending psychiatrist. The medical director or other attending

psychiatrist continues to serve as the Enrollee’s attending psychiatrist. He/she remains active within the PHP, keeping informed and overseeing the Enrollee’s care, is available daily and consults with the psychiatric resident, psychiatry fellow/trainee, or PNMHCS, as needed.

9. The PHP has the capacity to provide Enrollees with daily medication management, when clinically indicated. At a minimum, the program provides medication management to each Enrollee at least two (2) days per week, and up to daily as needed. If a PHP psychiatrist determines that the Enrollee’s clinical presentation does not warrant him/her being seen at least two days per week, the Enrollee’s health record documents the rationale, and the Enrollee may be seen once per week.
10. Medication management notes are written and documented in the Enrollee’s health record whenever he/she is seen.
11. If the program utilizes a PNMHCS for medication management within its license and scope of practice, the attending psychiatrist is the medical director, or another attending psychiatrist, who provides oversight and consultation to the PNMHCS, as outlined within the Staffing Requirements section of these specifications.
12. When the attending psychiatrist is not scheduled to work or is out for any reason (e.g., vacation, illness, etc.), he/she designates a consistent substitute, as much as possible, to ensure that the Enrollee receives continuity of care, ensuring compliance with the required medication management frequency of at least two contacts per week. In these instances, the functions of meeting with the Enrollee for medication management at least twice weekly and writing medication management notes in the Enrollee’s health record may be designated to another psychiatrist, a psychiatric resident, a PNMHCS, or a psychiatry fellow/trainee acting under the attending psychiatrist’s or the medical director’s Enrollee-specific supervision.
    a) If the PHP is open on weekends or holidays, a covering psychiatrist, or PNMHCS, acting under the attending psychiatrist’s or the medical director’s Enrollee-specific supervision, may complete these functions, ensuring compliance with the required medication management frequency of at least two contacts per week.
13. The provider ensures that each Enrollee has daily individual contact with program staff and that individual therapy, group therapy, and family therapy are provided at a frequency determined in each Enrollee’s individualized treatment plan.
14. The attending psychiatrist or medical director conducts a face-to-face psychiatric evaluation of each Enrollee prior to his/her discharge from the PHP.
15. With Enrollee consent and the establishment of the clinical need for such communication, coordination with parents/guardians/caregivers, relevant school staff, and other treatment providers, including primary care clinicians (PCCs) and behavioral health providers, is conducted by appropriate staff relative to treatment and care coordination issues. All such contact is documented in the Enrollee’s health record.

Discharge Planning and Documentation

1. The provider ensures that active and differential discharge planning is implemented for each Enrollee by qualified staff who are knowledgeable about the medical necessity criteria for all Plan covered services, including but not limited to all the Children’s Behavioral Health Initiative (CBHI) services.

2. At the time of discharge, and as clinically indicated, the provider ensures that the Enrollee has a current crisis prevention plan and/or safety plan in place and that he/she has a copy of it. The PHP provider works with the Enrollee to update the crisis prevention plan and/or safety plan that they obtained from the ESP/MCI provider at the time of admission, or, if one was not available, develops one before discharge. The PHP provider may ask the ESP/MCI provider that covers the catchment area where the Enrollee lives to assist with the development of the crisis prevention plan and/or safety plan.
3. At the time of discharge, the provider gives a written discharge plan to the Enrollee, listing his/her medications upon discharge and outlining all aftercare services arranged by the PHP provider and/or those in which the Enrollee is already engaged.
4. The provider ensures that the discharge plans for Enrollees who are involved with DMH, DDS, DYS, or DCF, are coordinated with the appropriate Area or Site Office. Difficulties determining or contacting the state agency case manager are communicated to the Department's Area Office. All contacts with state agencies are documented in the Enrollee's health record.

QUALITY MANAGEMENT

1. The provider will develop and maintain a quality management plan that is consistent with their contractual responsibilities to Optum, and which utilizes appropriate measures to monitor, measure, and improve the activities and services it provides.
2. A continuous quality improvement process is utilized and may include outcome measures and satisfaction surveys to measure and improve the quality of care and services delivered to Enrollees, including youth and their families.
3. Clinical outcomes data must be made available to Optum upon request and must be consistent with the performance specifications of this service.
4. Providers must report any adverse incidents and other reportable events that occur to the relevant authorities.