Partial Hospitalization Program
Performance Specifications

Providers contracted for this level of care or service are expected to comply with all the requirements of these service-specific performance specifications. Additionally, providers contracted for this service and all contracted services are held accountable to the General performance specifications. The requirements outlined within these service-specific performance specifications take precedence over those in the general performance specifications.

Partial Hospitalization Program (PHP) is a non-24-hour diversionary treatment program that is hospital-based or community-based. The program is a short-term day program consisting of intensive, acute treatment within a stable therapeutic milieu. PHPs must be available at least five days per week, although seven-day availability is preferable. Programming runs at least a minimum of 4-6 hours per day. A PHP requires psychiatric management and active treatment comparable to that provided in an inpatient setting and is under the supervision of a physician. Program oversight is by a medical or licensed program director.

PHP may be appropriate when a Member does not require the more restrictive intensive environment of a 24-hour inpatient setting but does need clinical services, multiple days per week. PHP is used as a time-limited response to stabilize acute symptoms. PHP 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 a Member's acute or behavioral symptoms and to support a Member in remaining in the community and avert hospitalization. PHP treatment efforts focus on the Member's response during treatment program hours, as well as the continuity and transfer of treatment gains during the Member's non-program hours in the home/community. Length of stay generally ranges between two days and two weeks and declines in intensity or frequency as Member establishes community supports and resumes normal daily living activities.

COMPONENTS OF SERVICES:

- The PHP has a qualified psychiatrist who oversees medication management and daily active treatment, as described within the process specification section of this performance specification, and documents a patient visit with a psychiatrist (or nurse practitioner working under the direct supervision of a psychiatrist) at least once a week.
- The PHP offers short-term day programming consisting of therapeutically intensive and acute treatment.
- The PHP is maintained and operated as a separate and distinct program from inpatient or other 24-hour care settings.
- 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 are not limited to, the following:
    - Bio-psychosocial evaluation
    - Psychiatric evaluation
    - Medical history
    - Physical examination/medical assessment (to assess medical issues)
    - Pharmacology
    - Nursing assessment and services, or similar service provided by the program's staffing.
    - Individual, group, and family therapy
    - Case and family consultation
    - Peer support and/or other recovery-oriented services
    - Eating disorder assessment and counseling

    - Substance use assessment and counseling
    - Development of behavioral plans and crisis prevention plans, recovery/relapse plans, and/or safety plans, as applicable
- For Members who give consent, the provider makes documented attempts to contact the guardian, family members, and/or significant others within 48 hours of admission, unless clinically or legally contraindicated. The provider provides the Members support with all relevant information related to maintaining contact with the program and the Member, including names and phone numbers of key nursing staff, primary treatment staff, social worker/care coordinator or discharge planner. If contact is not made, PHP staff must document the barrier to success in the Member's medical record.
- The provider engages in a medication reconciliation process in order to avoid inadvertent inconsistencies in medication prescribing that may occur in transition of a Member from one care setting to another. The provider does this by reviewing the Member's complete medication list and administration at the time of admission (e.g., transfer and/or discharge from another setting or prescriber) and compares this to the medication administration being considered in the PHP. The provider engages in the process of comparing the Member's medication orders newly issued by the PHP to all of the medications that they have been taking to avoid medication errors. This involves:
    - Developing a list of current medications prescribed to the Member prior to admission to the PHP
    - Developing a list of medications to be prescribed by the PHP
    - Comparing the medications on the two lists
    - Making clinical decisions based on the comparison and, when indicated, in coordination with the Member's PCP
    - Communicating the new medication list to the Member and, with consent, to appropriate caregivers, the Member's PCP, Commonwealth Care Alliance (CCA's) Care Team and other treatment providers
    - All related activities are documented in the Member's health record
- If an admitted PHP Member is experiencing a behavioral health crisis and contacts the provider during business hours or outside business hours, the provider, based on their assessment of the Member's needs and under the guidance of their supervisor, may: 1) offer support and intervention through the services of the PHP program, during business hours; 2) implement interventions to support the Member and enable them to remain in the community, when clinically appropriate, e.g., highlight elements of the Member's crisis prevention plan and/or safety plan and encourage implementation of the plan, offer constructive, step-by-step strategies which the Member may apply, and/or follow-up and assess the safety of the Member and other involved parties, as applicable; 3) refer the Member to their outpatient provider; and/or 4) refer the Member to an Adult Mobile Crisis Intervention (AMCI) provider for emergency behavioral health crisis assessment, intervention, and stabilization. Outside business hours, the provider offers live telephonic coverage and /or has access to or has an arrangement with other services that offer off-hours coverage. An answering machine or answering service directing callers to call 988, 911, nearest MCI, or go to nearest hospital emergency department does not meet the after-hours on-call requirements.

STAFFING REQUIREMENTS:

- The program will include staff with training and experience appropriate to the population being served at a minimum include the disciplines of psychiatry, nursing, psychology, social worker, occupational therapy, and vocational rehabilitation.
- The program will have a program director, and this individual will, or their designee will be available to handle urgent or emergency situations.
- The program will include a psychiatrist and/or nurse practitioner working under the direct supervision of a psychiatrist both of whom are available to the program during business hours.

- There must be a minimum of one full-time clinician within the program.
    - Clinical supervisor: shall be a licensed individual with a minimum of a doctorate or master's degree in one of the following disciplines or a closely related field:
        - Clinical psychology
        - Education-counseling
        - Medicine
        - Psychology
        - Nursing
        - Rehabilitation counseling
        - Social work
        - A minimum of one year of clinical supervisory experience and three years of counseling experience
    - Clinician: shall be an individual with a minimum of a master's degree in any of the disciplines mentioned above, or an RN, under an independent licensed clinical supervisor with a minimum of one year experience related to SUD. If providing supervision, one year of supervisory experience is also required.
- Staffing should reflect the cultural, gender, and linguistic needs of the community it serves.

TRAINING EXPECTATIONS:

It is the expectation of CCA that all contracted providers will offer ongoing staff training in order to best serve the diverse identities and experiences of the CCA Member population. Staff training should be inclusive of, but not limited to:

- Social determinants of health (SDOH)
- Trauma-informed behavioral health and medical care (including, but not limited to, ways in which the ACE study informs care delivery for Members, and trauma-specific treatment approaches)
- Best practices in delivering LGBTQIA+ inclusive and affirming— and, specifically, transgender inclusive and affirming— behavioral health and medical care (i.e., consistently using the name and pronouns that the Member uses for themselves)
- Best practices in delivering culturally responsive, inclusive, and anti-racist behavioral health and medical care
- Best practices in health equity and inclusivity for Members of various racial, ethnic, and cultural backgrounds, as well as disabled Members, Members of various religious backgrounds, and Members with multiply marginalized identities
- Organizational strategies and resources for accessing interpreter services for Members who primarily communicate in languages other than English (including ASL)

PROCESS SPECIFICATIONS: ASSESSMENT, TREATMENT AND DOCUMENTATION:

- The program ensures timely admission of Members that meet the individuals' needs for diversionary and step-down placement and accepts admission 5 days per week, preferably 7 days per week.
- The program ensures comprehensive assessment are completed, that a multidisciplinary treatment team has been assigned to each Member, and that treatment team has met to review the assessment and initial plan within 24 hours of admission.
- The multi-disciplinary treatment team establishes a provisional treatment and discharge plan within 24 hours of the Member's admission. The Member is encouraged to participate in the treatment and discharge planning. If the Member does not participate in the treatment and discharge planning,

provider clearly documents the reason in Member's record. Provider documents the Member's understanding of the treatment goals and discharge plan in the Member's own words. The plan is signed by the Member/guardian and is stored in Member's medical record.

- Subsequent treatment and discharge plans show significant involvement of Member, family/guardian, providers and other entities and agencies that are significant to Member's aftercare, unless clinically or legally contraindicated. Proper consent must be documented in the Member's medical record.
- The ongoing treatment and discharge plan is formulated within 48 hours of admission by the treatment team. The Member-specific treatment plan is developed, reviewed, and updated at least every 48 hours (a maximum of 72 hours between reviews and updates is allowed on weekends).
- All Member records must show evidence of daily progress notes on days of attendance at the program.
- A psychiatrist or nurse practitioner meets with the Member within 24 hours of admission.

DISCHARGE PLANNING, COMMUNITY AND COLLATERAL LINKAGES:

- The staff member responsible for discharge planning develops a preliminary written discharge plan within 24 hours of admission.
- The provider ensures that the discharge plan is developed in collaboration with each Member and that this collaboration is documented in the Members record as Member having participated with or declined participation in their discharge plan.
- **The discharge plan should include:**
    - A listing of the Members medication and one medication aftercare appointment scheduled within 14 days of discharge from the PHP
    - A listing of all aftercare appointments including dates and times
    - At least one aftercare appointment that is scheduled within 7 days of discharge from the PHP
    - If Member identified concerns including, but not limited to, housing, finances, health care, transportation, community supports, and recovery referrals to appropriate supports are made
    - All of the above are well documented in the Member's medical record
- The provider ensures that Members who are state agency involved (DMH, DDS, etc.) have discharge plans that are well coordinated with the appropriate state agency contact and that this collaboration is documented in the Members record.
- If there are barriers to accessing covered services, the **provider notifies CCA' s Clinical Team by calling CCA' s Provider Line at 866-420-9332** and asking to speak to the Members Care Team. Transportation is a CCA covered benefit service.
- **The Provider notifies CCA BH UM to alert CCA of Members discharge date and discharge plan. CCA BH UM can be contacted at 866-420-9332.**
- At the time of discharge the provider ensures that the Member has a current crisis prevention plan, recovery/relapse prevention plan and/or safety plan in place that has been updated to reflect the current needs of the Member and that the Member has a copy of the discharge plan upon discharge. The PHP provider may engage the AMCI provider that covers the catchment area where the Member lives to assist with the development of the crisis prevention plan, recovery/relapse prevention plan and/or safety plan.
- The completed discharge form, including referral to any agency, is available to and given to the Member, and when appropriate, the Member's family/guardian at time of discharge, which includes but is not limited to scheduled appointments, medication information, and emergency/crisis

resources.

EXPECTED OUTCOMES AND QUALITY MANAGEMENT:

- The facility will develop and maintain a quality management plan which utilizes appropriate measures to monitor, measure, and improve the activities and services it provides.
- The facility utilizes a continuous quality improvement process and will include outcome measures and satisfaction surveys, to measure and improve the quality of care and service delivered to members, including their families.
- Providers are required to collect and measure outcome data and incorporate the data in treatment plans and in medical records and inform clinical programming.
- Clinical outcomes data must be made available to Commonwealth Care Alliance (CCA) upon request and must be consistent with CCA' s performance standards for this level of care for quality management and Network Management purposes.
- The success of the program and the care and well-being of members rely on a collaborative partnership with Commonwealth Care Alliance and its provider network.
- Providers will comply with all applicable laws and regulations including but not limited to any and all applicable Medicare and/or Medicaid laws, regulations, and instructions of CMS and/or EOHHS relating to addressing and reporting Serious Reportable Events (SREs) and Adverse Incidents.
- Reportable adverse incidents must be reported to CCA and MassHealth Office of Behavioral Health within one business day as per policy and DMH licensing requirements. Providers must follow all laws and regulations for reporting Adverse Incidents (per MassHealth All Provider Bulletin 316).
- Network providers will comply with all requirements contained in their contract with CCA including any corrective actions required by CCA or applicable regulatory agencies.

DOCUMENT UPDATES:

- December 2024: Revised template
- March 2025: Annual review