OUTPATIENT SERVICES

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 information, Plan expectations, your contract, and MassHealth guidance. This information should be 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

Outpatient Services are behavioral health services that are rendered in an ambulatory care setting, such as an office, clinic environment, an Enrollee's home, or other locations appropriate for psychotherapy or counseling. Services consist of time-effective, defined episodes of care that focus on the restoration, enhancement, and/or maintenance of an Enrollee's optimal level of functioning, and the alleviation or amelioration of significant and debilitating symptoms impacting at least one area of the Enrollee's life domains (e.g., family, social, occupational, educational). The goals, frequency, intensity, and length of treatment vary according to the needs of the Enrollee and the response to treatment. A clear treatment focus, measurable outcomes, and a discharge plan including the identification of realistic discharge criteria are developed as part of the initial assessment and treatment planning process and are evaluated and revised as needed.

The Outpatient Services performance specifications contained here pertain to organizational/facility-based outpatient providers, group practices, and individual practitioners. They also apply to the following services which are a subset of Outpatient Services:

- Outpatient Services - Home-Based and Non-Facility Based
- Outpatient Services - School-Based
- Psychological Testing (PT)

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- Dialectical Behavioral Therapy (DBT)
- Assessment for Safe and Appropriate Placement (ASAP)

SERVICE COMPONENTS

1. 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) Development and/or updating of crisis prevention plan, and/or safety plan as part of the Crisis Planning Tools for youth, as clinically indicated
    c) Care coordination, as required for a primary behavioral health hub in the provision of Children's Behavioral Health Initiative (CBHI) services for youth
    d) Use of the Child and Adolescent Needs and Strengths (CANS) tool whenever behavioral health services (i.e., diagnostic evaluation for outpatient therapy including individual counseling, group counseling, and couples/family counseling) are provided to Enrollees under age 21, except for clinics that have *only* a DPH outpatient substance abuse license (they are *not* required to use the CANS)
    e) Provision of the following covered services:
        i. Diagnostic evaluation
        ii. Individual, couples, group, and family therapy, including short-term, solution-focused outpatient therapy
        iii. Case and family consultation; collateral contacts
2. Outpatient Services providers provide the following directly or ensure access through an official Memorandum of Understanding (MOU) or Affiliation Agreement with another provider providing Psychopharmacology, including medication evaluation and ongoing medication monitoring and management, or Psychological Testing.
3. Outpatient Services providers provide initial crisis response 24 hours per day, seven days per week, to all Enrollees enrolled in the outpatient program/clinic/practice. These crisis responses are intended to be the first level of crisis intervention whenever needed by the Enrollee.
    a) During operating hours, these crisis responses are provided by a clinician via telephone and, if clinically indicated, face- to-face through emergent appointments.
    b) After hours, the program provides Enrollees with a telephone number that allows them to access a clinician either directly or via an answering service. That is, a live person must always answer the phone number.
    c) Calls identified as an emergency by the caller are immediately triaged to a clinician.
    d) A clinician must respond to emergency calls within 15 minutes and minimally provide a brief assessment and intervention by phone.
    e) Based upon these initial crisis responses conducted by the Outpatient Services provider both during operating hours and after hours, the provider may refer the Enrollee, if needed, to an Emergency Services Program/Mobile Crisis Intervention (ESP/MCI)

provider for emergency behavioral health assessment, crisis intervention and stabilization.

f) An answering machine or answering service directing callers to call 911 or the ESP/MCI program, or to go to a hospital Emergency Department (ED), does not meet the after-hours emergency on-call requirements.

4. Outpatient Services providers ensure that each Enrollee receives a program orientation describing the process of care, including after-hours emergency coverage, at the initiation of services.
5. Outpatient Services providers have documented policies and procedures, including those specific to the service being rendered (e.g., home-based, school-based, etc.). Also included is a documented policy and procedure for the management of no-shows and cancellations, which includes criteria for Enrollee notification, outreach, and discharge.
6. Outpatient Services providers make best efforts to develop and maintain the capacity to serve Enrollees with special needs in their communities (e.g., children, elders, those with developmental disabilities or cultural and linguistic needs, those who are homeless or who have co-occurring disorders, etc.). They adhere to their organizations' written protocols for treating such populations and/or offer appropriate referrals if they are unable to serve these Enrollees directly.
7. Outpatient Services providers that serve Enrollees with severe and persistent mental illness develop and maintain a treatment model designed to meet their unique needs. The model includes approaches and information that support and facilitate Enrollees' recovery-oriented principles and practices as well as linkages and coordination with an Enrollee's Primary Care Clinician (PCC), appropriate state agencies, consumer-operated and recovery-oriented services and supports, and natural resources.
8. For youth under age 21, Outpatient Services providers adhere to the hub expectations relative to the CBHI. Outpatient Services providers function as a primary behavioral health hub for youth under the age of 21 when those youth are not engaged in In-Home Therapy (IHT) or Intensive Care Coordination (ICC) services (Note: when those youth are engaged in IHT or ICC services, those IHT or ICC providers are responsible for hub-related activities). As a primary behavioral health hub, Outpatient Services providers are responsible for:
    a) Coordinating care and collaborating with other service providers;
    b) Coordinating referrals for the three hub-dependent services: Therapeutic Mentoring (TM), In-Home Behavioral Services (IHBS), and Family Support and Training (FST). The outpatient treatment plan must incorporate goals specific to TM skill-building needs, IHBS target behaviors, and FST caregiver needs when those services are authorized concurrently with Outpatient Services as the hub service (e.g., when there is no IHT, or ICC provider involved with the youth); and
    c) Regularly connecting with the hub-dependent service providers to coordinate care and obtain and provide updates on the youth's progress.
9. Outpatient Services providers educate Enrollees and, with informed consent and as clinically indicated, their families/guardians/significant others about the use and risks of medication, symptom management, and recovery. When an Enrollee begins to utilize psychopharmacology

services through the Outpatient Services provider's organization, the Outpatient Services provider engages in a medication reconciliation process to avoid inadvertent inconsistencies in medication prescribing that may occur, particularly in transition of an Enrollee's prescribing from one provider or care setting to another. The Outpatient Services provider does this by reviewing with the Enrollee, and with Enrollee consent, other treatment providers, the Enrollee's complete medication regimen when the Enrollee began treatment (e.g., transfer and/or discharge from another setting or prescriber) and comparing it with the regimen being considered in the Outpatient Services provider's organization to avoid medication errors. This involves:

a) Developing a list of current medications, i.e., those the Enrollee was prescribed prior to beginning treatment at the Outpatient Services provider's organization;
b) Developing a list of medications to be prescribed in the Outpatient Services provider's organization;
c) Comparing the medications on the two lists;
d) Making clinical decisions based on the comparison and, when indicated, in coordination with the Enrollee's PCC; and
e) Communicating the new list to the Enrollee; and
f) 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.

STAFFING REQUIREMENTS

1. Outpatient Services providers comply with the staffing requirements of the applicable licensing body, the staffing requirements in the Plan specific-service performance specifications, and the credentialing criteria outlined in the plan's provider manual found at providerexpress.com.
2. Facility-based Outpatient Services providers make available to all Enrollees a multi-disciplinary team appropriate to their needs, and inclusive of licensed professionals as set forth in the DPH outpatient mental health licensing regulations. For Facility-based providers, the multi-disciplinary team, at a minimum, must include a psychiatrist (MD, DO), and at least two of the following (one of whom must be independently licensed):
    a) Psychologist (PhD, PsyD, EdD)
    b) Licensed Independent Clinical Social Worker (LICSW)
    c) Licensed Clinical Social Worker (LCSW)
    d) Registered Nurse (RN)
    e) Psychiatric Nurse Mental Health Clinical Specialist (PNMHCS)
    f) Licensed Mental Health Counselor (LMHC)
    g) Certified Addiction Counselor (CAC)
    h) Licensed Alcohol and Drug Counselor (LADC)
    i) Certified Alcoholism and Drug Abuse Counselor (CADAC)
    j) Licensed Alcohol and Drug Abuse Counselor (LADAC)

k) Licensed Marriage and Family Therapist (LMFT)

3. For children and adolescents, the treating clinician has training and experience in working with children and adolescents and/or receives documented supervision by a clinician who does meet these competencies. Contracted providers shall develop and maintain resources to provide quality medication evaluations and management to both children and adolescents in a timely fashion. Such resources may include child psychiatrists, as well as adult psychiatrists, and advanced nurse practitioners who have experience in treating children and adolescents.
4. Outpatient Services providers provide all staff with supervision in compliance with credentialing criteria.
5. Supervisory clinical staff must be available for consultation to staff during all hours of operation. Staff also has access to a psychiatrist, or a PNMHCS, for consultation as needed during operating hours.

SERVICE, COMMUNITY AND OTHER LINKAGES

1. To facilitate continuity of care, Outpatient Services providers develop linkages and working relationships with other service providers frequently utilized by Enrollees enrolled in their outpatient services, including Inpatient, Intensive Community-Based Acute Treatment/Community-Based Acute Treatment (ICBAT/CBAT), ICC, FS&T, IHT, IHBS, TM, primary care practices, and providers of diversionary and 24-hour levels of care.
    a) Included in these efforts, Outpatient Services providers develop working relationships with their local ESPs/MCIs, hold regular meetings or have other contact, and communicate with the ESPs/MCIs on clinical and administrative issues, as needed, to enhance bi-directional referrals and continuity of care for Enrollees. On an Enrollee-specific basis, Outpatient Services providers collaborate with the ESP/MCI when an Enrollee has received ESP/MCI services, to ensure the ESP's/MCI's evaluation and treatment recommendations are received, and that any existing crisis prevention plan and/or safety plan is obtained from the ESP/MCI.
    b) These efforts to develop relationships with other service providers are documented through written Affiliation Agreements, MOU, active participation in local Systems of Care meetings, minutes of regularly scheduled meetings, and/or evidence of collaboration in Enrollees' health records.
2. Outpatient Services providers utilize case consultation, family consultation, and collateral contacts to involve parents/guardians/caregivers in the planning, assessment, and treatment for Enrollees, as clinically indicated, and to educate them on mental health and substance use disorder treatment and relevant recovery issues. Additionally, with Enrollee consent and as applicable, Outpatient Services providers utilize case consultation and collateral contacts to involve the collaterals identified within the Care Coordination section of the General Performance Specifications in the planning, assessment, and treatment for Enrollees. All such activities are documented in the Enrollee's health record.

PROCESS SPECIFICATIONS

Access

1. Enrollees who present with an urgent request for outpatient services but are determined not to be in crisis and not in need of immediate, emergent services, are offered an outpatient therapy appointment within 48 hours of the request. These Enrollees are also given the Outpatient Services after-hours telephone number with appropriate emergency instructions.
2. Enrollees with routine requests for outpatient services are offered an outpatient therapy appointment within 10 business days of the request.
3. Enrollees referred from an inpatient unit are offered an outpatient therapy appointment (which may be an intake appointment for therapy services) within 7 calendar days from the date of discharge from the inpatient unit.
4. Enrollees referred from an inpatient unit are offered a psychopharmacology appointment as soon as clinically indicated and within 14 calendar days from the date of discharge from the inpatient unit.
5. Outpatient Services providers are proactive and make best efforts to facilitate Enrollee attendance at initial and ongoing appointments, such as via outreach and follow-up, reminder telephone calls or mailed notices, assistance with transportation arrangements, etc.
6. If the Enrollee does not keep an appointment, the clinician follows the Outpatient Services provider's policies and procedures for the management of no-shows and cancellations, including documented attempts to contact him/her and/or the parent/guardian/caregiver.
7. Outpatient Services providers make best efforts to offer operating hours that are responsive to the needs of Enrollees and their families, including a range of appointment days and hours, and offer evening and weekend appointments as possible and appropriate.

Assessment, Treatment Planning and Documentation

1. When a newly referred Enrollee, or an Enrollee already receiving outpatient treatment at the Outpatient Services provider, has been evaluated by an ESP/MCI program, and/or has been admitted to a 24-hour level of care, and/or when an Enrollee is discharged from a 24-hour level of care, the Outpatient Services provider, with appropriate Enrollee consent:
    a) Receives and returns phone calls from these providers as soon as possible and no later than within one business day;
    b) Provides information (including the most recent CANS assessment, if applicable) and consultation to inform the assessment of the Enrollee by the ESP/MCI program and/or 24-hour level of care;
    c) Makes best efforts to participate, face-to-face or by telephone, in the 24-hour level of care's treatment and discharge planning meetings;
    d) Provides bridge consultations for Enrollees admitted to, or in the process of discharging from, 24-hour levels of care whenever possible;
    e) Facilitates the aftercare plan by ensuring access to outpatient therapy and psychopharmacology appointments that meet the access standards outlined above;
    f) Supports the Enrollee in implementing his/her aftercare plan; and
    g) Documents all such activities in the Enrollee's health record.

2. Outpatient Services providers collaborate with the Enrollee, the Enrollee's local ESP/MCI provider, and other clinical service providers such as discharging inpatient providers, to obtain the Enrollee's crisis prevention plan and/or safety plan, as clinically indicated. Outpatient Services providers collaborate with the Enrollee and these entities to update the plan if needed, or to develop one if the Enrollee does not yet have one. The crisis prevention plan and/or safety plan is included in the Enrollee's health record.
3. For Enrollees under the age of 21, Outpatient Services providers ensure that a MA-CANS certified clinician uses the CANS tool and the information gathered from its use during initial behavioral health clinical assessments and, at a minimum, every 180 days thereafter throughout treatment to inform treatment planning and discharge planning. The CANS is initially administered prior to or on the date of the completion of the comprehensive assessment, to document that the clinical data was integrated into the initial assessment process. An MA-CANS certified clinician, or provider, is required to update the assessment at least every 180 days after the initial assessment, or more often as clinically appropriate. This includes any significant changes in the youth's life. A copy of the CANS is maintained in the Enrollee's health record. With parent/guardian/caregiver consent, the provider enters the information gathered into the CANS IT System using the CANS tool. Even without consent, the provider ensures that the demographics and Serious Emotional Disturbance (SED) determination are entered into the CANS IT System, as required. With appropriate consent, Outpatient Services providers share the CANS with all involved providers (including hub and hub-dependent providers).
4. Outpatient Services providers ensure that comprehensive assessments and treatment plans are completed, according to the requirements delineated in the General Performance Specifications, before the third outpatient visit.
5. For Facility-based providers, each Enrollee's treatment plan is updated, and the treatment plan and progress are reviewed by one or more members of the multi-disciplinary team, at least annually. The frequency of treatment plan updates and multi-disciplinary case review is based upon the Enrollee's current problems, specific and concrete goals, and treatment. Treatment plan updates, multi- disciplinary team case review, and any resulting treatment plan changes are documented in the Enrollee's health record.
6. Group practices and individually contracted practitioners ensure that treatment plans are reviewed and updated at least annually and are documented in the Enrollee's health record. The frequency of reviewing and updating a given Enrollee's treatment plan is based upon the Enrollee's current problems, specific and concrete goals, and treatment.
7. Group practices document in the Enrollee's health record evidence of multi-disciplinary consultation and coordination of care within the practice, including, but not limited to, such contact between treating clinicians and prescribers.
8. Individual practitioners document in the Enrollee's health record evidence of clinical consultation as needed in treating specific Enrollees, including but not limited to consultation and coordination of care with prescribers, including those with whom the practitioner maintains an Affiliation Agreement.

Discharge Planning and Documentation

1. Outpatient Services providers engage the Enrollee in developing and implementing an aftercare

plan when the Enrollee meets the outpatient discharge criteria established in his/her treatment plan. Outpatient Services providers provide the Enrollee with a copy of the plan upon his/her discharge and document these activities in the Enrollee's health record.

2. When the Outpatient Services provider, based on its policies and procedures for managing no-shows and cancellations, determines that it is appropriate and necessary to terminate outpatient services with an Enrollee, the Outpatient Services provider makes best efforts facilitating his/her linkage with other services and supports, as needed. All such activities are documented in the Enrollee's health record.
3. In preparation for discharge, and as clinically indicated, Outpatient Services providers ensure that the Enrollee has a current crisis prevention plan and/or safety plan in place and that he/she has a copy. Outpatient Services providers work with the Enrollee to update the plan he/she had obtained when the Enrollee began treatment, or, if one was not available, develop one with the Enrollee prior to discharge. With Enrollee consent and as clinically indicated, Outpatient Services providers send a copy of the plan to the ESP/MCI director at the Enrollee's local ESP/MCI provider, other providers including the Enrollee's PCC, and family members/significant others, and enter it in the Enrollee's health record.
4. For Enrollees under the age of 21 who are also engaged in the TM or FST service, Outpatient Services providers make best efforts to ensure that these youth have another hub service in place (IHT or ICC) and document these efforts, or document verification that the TM or FST service is no longer medically necessary.
5. For Enrollees under the age of 18, as clinically indicated or with appropriate consent, Outpatient Services providers present treatment findings and recommendations to parents/guardians/caregivers prior to transfer or termination. This consultation is documented in the Enrollee's health record.

Case Consultation

1. Case Consultation is a documented meeting of at least 15 minutes' duration, either in person or by telephone, between the treating provider and other behavioral health/medical clinicians or physician, concerning an Enrollee who is a client of the BH provider.
2. Goals of case consultation are to identify and plan for additional services, coordinate a treatment plan, review the individual's progress, and revise the treatment plan, as required.
3. The scope of required service components provided includes, but is not limited to the following:
    a) Treatment coordination
    b) Treatment planning
    c) Assessment of the appropriateness of additional or alternative treatment
    d) Clinical consultation (which does not include supervision)
    e) Second clinical opinion
    f) Aftercare planning
    g) Termination planning
4. Case Consultation shall not include clinical supervision or consultation with other clinicians who provide the same service at the same agency. The meeting could take place between two

outpatient providers who work for different agencies, between the treating outpatient provider and any behavioral health provider offering services at a different level of care, or between the treating outpatient provider and a representative from a school, state, medical office, CBHI agency, or residential provider.

Family Consultation

1. Family Consultation is a documented meeting of at least 15 minutes' duration, either in person or by telephone, between the treating provider and with family members or others who are significant to the Enrollee and clinically relevant to an Enrollee's treatment.
2. Goals of family consultation are to educate, identify and plan for additional services or resources, coordinate a treatment plan, review the individual's progress, or revise the treatment plan, as required.
3. The scope of required service components provided includes, but is not limited to, the following:
    a) Treatment coordination
    b) Treatment planning with the Enrollee's family or identified supports
    c) Assessment of the appropriateness of additional or alternative treatment
    d) Aftercare planning
    e) Termination planning
    f) Supporting or reinforcing treatment objectives for the Enrollee's care
4. The meeting is between the treating outpatient provider and Enrollee-identified family or supports.

Collateral Contact

1. Collateral Contact is a documented communication of at least 15 minutes' duration, either in-person, by telephone (including voice mails), or by email. These contacts are between a provider and individuals who are involved in the care or treatment of an Enrollee under the age of 21. This would include but is not limited to school and day care personnel, state agency staff, human services agency staff, court appointed personnel, religious or spiritual advisers, and/or other community resources.
2. The scope of required service components provided includes, but is not limited to, the following:
    a) Treatment coordination
    b) Treatment planning with the Enrollee's family or identified supports
    c) Implementation of additional or alternative treatment
    d) Aftercare planning
    e) Termination planning
    f) Supporting or reinforcing treatment objectives for the Enrollee's care
3. The contact is between the outpatient provider and identified individuals involved in the Enrollee's behavioral health or medical care or Enrollee-identified family or supports.

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.