OUTPATIENT SERVICES

Providers contracted for this level of care or service are expected to comply with all 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, located at the beginning of the performance specifications section of the Provider Manual, found at www.masspartnership.com. The requirements outlined within these service-specific performance specifications take precedence over those in the General performance specifications.

The Outpatient Services performance specifications contained within 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
- Dialectical Behavioral Therapy (DBT)
- Assessment for Safe and Appropriate Placement (ASAP)

Please refer to these performance specifications attachments for these specialty services.

Outpatient Services are behavioral health services that are rendered in an ambulatory care setting, such as an office, clinic environment, a Member’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 a Member’s optimal level of functioning, and the alleviation or amelioration of significant and debilitating symptoms impacting at least one area of the Member’s life domains (e.g., family, social, occupational, educational). The goals, frequency, intensity, and length of treatment vary according to the needs of the Member 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.

Components of Service

1. Outpatient Services providers comply with all provisions of the corresponding section in the General performance specifications.
2. The scope of required service components provided in this level of care includes, but is not limited to, the following. Please refer to the per diem/service definition which is all-inclusive and includes the components covered in the rate for this service, found at www.masspartnership.com.
   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 (diagnostic evaluation for outpatient therapy including individual counseling, group counseling, and couples/family counseling) are provided to Members under age 21, with the exception of 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:
   • Diagnostic evaluation
   • Individual, couples, group and family therapy, including short-term, solution-focused outpatient therapy
   • Case and family consultation; collateral contacts

3. Outpatient Services providers provide the following directly, or ensure access through an official Memorandum of Understanding (MOU) or Affiliation Agreement with another provider for same Psychopharmacology (including medication evaluation and ongoing medication monitoring and management)
   Psychological testing

4. Outpatient Services providers provide initial crisis response 24 hours per day, seven days per week, to all Members enrolled in the outpatient program/clinic/practice. These crisis responses are intended to be the first level of crisis intervention whenever needed by the Member.
   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 Members with a telephone number that allows them to access a clinician either directly or via an answering service. That is, a live person must answer the phone number at all times.
   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 Member, 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.

5. Outpatient Services providers ensure that each Member receives a
program orientation describing the process of care, including after-hours emergency coverage, at the initiation of services.

6. Outpatient Services providers have documented policies and procedures, including those specific to the particular 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 Member notification, outreach, and discharge.

7. Outpatient Services providers make best efforts to develop and maintain the capacity to serve Members 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 Members directly.

8. Outpatient Services providers that serve Members 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 Members’ recovery-oriented principles and practices as well as linkages and coordination with a Member’s PCC, appropriate state agencies, consumer-operated and recovery-oriented services and supports, and natural resources.

9. 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 (FS&T). The outpatient treatment plan must incorporate goals specific to TM skill-building needs, IHBS target behaviors, and FS&T 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.

10. Outpatient Services providers educate Members 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 a Member begins to utilize psychopharmacology services through the Outpatient Services provider’s organization, the Outpatient Services provider engages in a medication reconciliation process in order to avoid inadvertent inconsistencies in medication prescribing that may occur, particularly in transition of a Member’s prescribing from one provider or care setting to another. The Outpatient Services provider does this by reviewing with the Member, and, with Member consent, other treatment providers, the Member’s complete medication regimen when the Member 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 in order to avoid medication errors. This involves:

- Develop a list of current medications, i.e., those the Member was prescribed prior to beginning treatment at the Outpatient Services provider’s organization;
- Developing a list of medications to be prescribed in the Outpatient Services provider’s organization;
- Comparing the medications on the two lists;
- Making clinical decisions based on the comparison and, when indicated, in coordination with the Member’s PCC; and
- Communicating the new list to the Member and, with consent, to appropriate caregivers, the Member’s PCC and other treatment providers.

All related activities are documented in the Member’s health record.

### Staffing Requirements

1. Outpatient Services providers comply with all provisions of the corresponding section in the General performance specifications.

2. Outpatient Services providers comply with the staffing requirements of the applicable licensing body, the staffing requirements in the MBHP service-specific performance specifications, and the credentialing criteria outlined in the MBHP Provider Manual, Volume I, as referenced at [www.masspartnership.com](http://www.masspartnership.com).

3. Facility-based Outpatient Services providers make available to all Members 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):

   - Psychologist (PhD, PsyD, EdD)
   - Licensed Independent Clinical Social Worker (LICSW)
   - Licensed Clinical Social Worker (LCSW)
   - 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)

4. 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 MBHP 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.

5. Outpatient Services providers provide all staff with supervision in compliance with MBHP’s credentialing criteria.

6. Supervisory clinical staff must be available for consultation to staff during all hours of operation. Staff also have access to a psychiatrist, or a PNMHCS, for consultation as needed during operating hours.

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**Process Specifications**

**Access**

1. Outpatient Services providers comply with all provisions of the corresponding section in the General performance specifications.

2. Members 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 Members are also given the Outpatient Services after-hours telephone number with appropriate emergency instructions.

3. Members with routine requests for outpatient services are offered an outpatient therapy appointment within 10 business days of the request.

4. Members 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.

5. Members 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.

6. Outpatient Services providers are proactive and make best efforts to facilitate Member attendance at initial and ongoing appointments, such as via outreach and follow-up, reminder telephone calls or mailed notices, assistance with transportation arrangements, etc.
7. If the Member 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.

8. Outpatient Services providers make best efforts to offer operating hours that are responsive to the needs of Members and their families, including a range of appointment days and hours, and offer evening and weekend appointments as possible and appropriate.

<table>
<thead>
<tr>
<th>Assessment, Treatment Planning, and Documentation</th>
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<tbody>
<tr>
<td>1. Outpatient Services providers comply with all provisions of the corresponding section in the General performance specifications.</td>
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<tr>
<td>2. When a newly referred Member, or a Member 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 a Member is discharged from a 24-hour level of care, the Outpatient Services provider, with appropriate Member consent:</td>
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<td>a. Receives and returns phone calls from these providers as soon as possible and no later than within one business day;</td>
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<td>b. Provides information (including the most recent CANS assessment, if applicable) and consultation in order to inform the assessment of the Member by the ESP/MCI program and/or 24-hour level of care;</td>
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<td>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;</td>
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<td>d. Provides bridge consultations for Members admitted to, or in the process of discharging from, 24-hour levels of care whenever possible;</td>
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<tr>
<td>e. Facilitates the aftercare plan by ensuring access to outpatient therapy and psychopharmacology appointments that meet the access standards outlined above;</td>
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<tr>
<td>f. Supports the Member in implementing his/her aftercare plan; and</td>
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<td>g. Documents all such activities in the Member’s health record.</td>
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<td>3. Outpatient Services providers collaborate with the Member, the Member’s local ESP/MCI provider, and other clinical service providers such as discharging inpatient providers, to obtain the Member’s crisis prevention plan and/or safety plan, as clinically indicated. Outpatient Services providers collaborate with the Member and these entities to update the plan if needed, or to develop one if the Member does not yet have one. The crisis prevention plan and/or safety plan is included in the Member’s health record.</td>
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<tr>
<td>4. For Members 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 90 days</td>
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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. A copy of the CANS is maintained in the Member’s health record. With parent/guardian/caregiver consent, the provider enters into the CANS IT System the information gathered 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).

5. 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.

6. For Facility-based Providers, each Member’s treatment plan is updated, and the treatment plan and progress is 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 Member’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 Member’s health record.

7. Group Practices and Individually Contracted Practitioners ensure that treatment plans are reviewed and updated at least annually, and are documented in the Member’s health record. The frequency of reviewing and updating a given Member’s treatment plan is based upon the Member’s current problems, specific and concrete goals, and treatment.

8. Group Practices document in the Member’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.

9. Individual Practitioners document in the Member’s health record evidence of clinical consultation as needed in treating specific Members, 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 comply with all provisions of the corresponding section in the General performance specifications.  
2. Outpatient Services providers engage the Member in developing and implementing an aftercare plan when the Member meets the outpatient discharge criteria established in his/her treatment plan. Outpatient Services providers provide the Member with a copy of the plan upon his/her discharge, and document these activities in |

*Effective November 4, 2014*
the Member’s health record.
3. 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 a Member, the Outpatient Services provider makes best efforts to initiate a thoughtful process, inclusive of the Member, aimed at facilitating his/her linkage with other services and supports, as needed. All such activities are documented in the Member’s health record.
4. In preparation for discharge, and as clinically indicated, Outpatient Services providers ensure that the Member has a current crisis prevention plan and/or safety plan in place and that he/she has a copy of it. Outpatient Services providers work with the Member to update the plan he/she had obtained when the Member began treatment, or, if one was not available, develop one with the Member prior to discharge. With Member consent and as clinically indicated, Outpatient Services providers send a copy of the plan to the ESP/MCI Director at the Member’s local ESP/MCI provider, other providers including the Member’s PCC, and family members/significant others, and enter it in the Member’s health record.
5. For Members under the age of 21 who are also engaged in the TM or FS&T 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 FS&T service is no longer medically necessary.
6. For Members 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 Member’s health record.

### Service, Community, and Collateral Linkages

1. Outpatient Services providers comply with all provisions of the corresponding section in the General performance specifications.
2. To facilitate continuity of care, Outpatient Services providers develop linkages and working relationships with other service providers frequently utilized by Members 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
| Members. On a Member-specific basis, Outpatient Services providers collaborate with the ESP/MCI when a Member 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 Members’ health records.  

3. Outpatient Services providers utilize case consultation, family consultation, and collateral contacts to involve parents/guardians/caregivers in the planning, assessment, and treatment for Members, as clinically indicated, and to educate them on mental health and substance use disorder treatment and relevant recovery issues. Additionally, with Member 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 Members. All such activities are documented in the Member’s health record. |