Performance Specifications

Non-24-Hour Diversionary Services
Psychiatric Day Treatment

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. The requirements outlined within these service-specific performance specifications take precedence over those in the General performance specifications.

Psychiatric Day Treatment provides a coordinated set of individualized, integrated, and therapeutic supportive services to Members with psychiatric disorders, who need more active or inclusive treatment than is typically available through traditional outpatient mental health services.

While less-intensive than partial hospitalization, Psychiatric Day Treatment is an intensive, clinical program that includes diagnostic, medical, psychiatric, psychosocial, and adjunctive treatment modalities in a structured setting. Psychiatric Day Treatment programs provide rehabilitative, pre-vocational, educational, and life-skill services to promote recovery and attain adequate community functioning, with focus on peer socialization and group support.

Psychiatric Day Treatment assists Members in beginning the recovery and wellness process and provides supportive transitional services to Members who are no longer acutely ill, require moderate supervision to avoid risk, and/or are not fully able to re-enter the community or the workforce.

Psychiatric Day Treatment offers the Member opportunities and support for involvement in community, social, and leisure time programs, as well as opportunities to pursue personal, ethnic, and cultural interests. Services are provided in a community setting. A goal-directed treatment plan developed with the Member and/or Member’s family guides the course of treatment.

Components of Service

1. The provider provides services at a minimum of five days per week. The provider offers a minimum of 30 hours of active programming per week.
2. Psychiatric Day Treatment provides structured, goal-oriented groups focused on symptom management, understanding the Member’s psychiatric condition(s), improving the Member’s ability to function in a valued role in the community, establishing and maintaining stable interpersonal relations, and practicing health-promoting lifestyles. The program assists Members in identifying and protecting their legal rights, as well as identifying and pursuing vocational, educational, and other community and/or recovery-focused interests.
3. The scope of required service components provided in this level of care includes, but is not limited to, the following:
   a. Behavioral management;
   b. Bio-psychosocial evaluation;
   c. Crisis management;
   d. Development and/or updating of crisis prevention plan or safety plan;
e. Discharge planning/case management;
f. Group therapy;
g. Multi-disciplinary treatment team review;
h. Peer support and recovery-oriented services;
i. Psychiatric and nursing assessment, as indicated;
j. Psycho-education;
k. Substance use disorder assessment and services, as indicated; and
l. Treatment planning.

4. The provider ensures that each Member receives a program orientation at the initiation of services. The information includes the following:
   a. A description of program services;
   b. Hours of operation;
   c. Confidentiality;
   d. Informed consent;
   e. Non-discrimination provisions;
   f. Rights and responsibilities;
   g. Rules of the program; and
   h. Telephone number(s) of the appropriate Emergency Services Program(s)/Mobile Crisis Intervention(s) (ESPs/MCIs).

5. Psychiatric Day Treatment services are accessible to the Member seven days per week, directly or on an on-call basis. 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 requirement.

6. If a Member experiencing a behavioral health crisis 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) refer the Member to their outpatient provider; 2) refer the Member to an ESP/MCI for emergency behavioral health crisis assessment, intervention, and stabilization; and/or 3) implement other 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/safety plan, 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.

### Staffing Requirements

1. The provider utilizes a multi-disciplinary staff that includes a psychiatrist, AND any two of the following licensed clinicians (one of which must be independently licensed):
   a. Psychologist;
   b. Psychiatric nurse mental health clinical specialist (PNMHCS);
   c. Licensed independent clinical social worker (LICSW);
   d. Licensed clinical social worker (LCSW);
   e. Registered nurse (RN);
   f. Licensed occupational therapist (OTR);
   g. Licensed mental health counselor (LMHC);
   h. Licensed marriage and family therapist (LMFT);
   i. Certified rehabilitation counselor (CRC);
   j. Certified addiction counselor (CAC);
k. Certified alcoholism and drug abuse counselor (CADAC);
I. Registered psychiatric rehabilitation practitioner (RPRP);

m. Registered expressive therapists (ATR, MTR, etc.);

n. Registered recreational therapists (RTR); and

o. Additional staffing may include allied health professionals or paraprofessional staff as outlined in 130 CMR 417.423.

2. The program staff participate in regularly scheduled supervision and attend training that promotes skill development in the provision of clinical and rehabilitative services to Members.

Service, Community, and Collateral Linkages

1. Program staff coordinates treatment planning and aftercare with the Member’s primary care practitioner, outpatient, and other community-based providers, involved state agencies, educational system, community supports and family, guardian, and/or significant others when applicable. If consent for such coordination is withheld or refused by the parent or guardian of a minor, then this is documented in the Member’s record.

2. The program ensures that a written aftercare plan is available to the Member at the day of discharge. When consent is given, a copy of the written aftercare plan is forwarded at the time of discharge to the referral source, family/guardian/significant other, outpatient or community-based provider, PCP, school, and other entities and agencies that are significant to the Member’s aftercare.

3. In the case of youth involved with Children’s Behavioral Health Initiative (CBHI) services, the facility social worker or other clinician will collaborate with those providers including, but not limited to, Community Service Agencies (CSAs). The facility will accommodate requests from a CSA to facilitate or attend a team meeting while the Member is at the facility; if a Member is admitted to a 24-hour level of care, they will collaborate with the program.

4. The provider develops and documents organizational and clinical linkages with each of the high-volume referral source ESPs/MCIs and inpatient units, holds regular meetings or has other contacts as necessary, and communicates with the ESPs/MCIs and inpatient units on clinical and administrative issues, as needed, to enhance continuity of care for Members. A Memorandum of Understanding is required with the local ESP/MCI to facilitate collaboration around Members’ crisis prevention/safety plans as well as to access ESP/MCI crisis assessment, intervention, and stabilization for Members enrolled in day treatment when needed. On a Member-specific basis, the provider collaborates with the ESP/MCI upon admission to ensure the ESP’s/MCI’s evaluation and treatment recommendations are received, any existing crisis prevention/safety plan is obtained, and, in preparation for discharge, to develop or update the Member’s crisis prevention/safety plan.

5. For those Members who would benefit from or are currently receiving medication management and monitoring, the provider facilitates the referral to or monitors the Member’s ongoing status with the prescriber.

Quality Management (QM)

1. The facility and/or program will develop and maintain a quality management plan that is consistent and that utilizes appropriate measures to monitor, measure, and improve the activities and services it provides.

2. A continuous quality improvement process is used, and will include outcome measures and satisfaction surveys, to measure and improve the quality of care and service delivered to
Members, including youth and their families.

3. Clinical outcomes data must be made available upon request, and must be consistent with performance standards of this service.

4. All Reportable Adverse Incidents will be reported within one business day of their occurrence per policy and DMH licensing requirements. A Reportable Adverse Incident is an occurrence that represents actual or potential harm to the well-being of a Member, or to others by action of a Member, who is receiving services, or has recently been discharged from services.

5. The facility and/or program will adhere to all reporting requirements of DPH and/or DMH regarding Serious Incidents and all related matters.

**Process Specifications**

**Assessment, Treatment Planning, and Documentation**

1. The provider ensures that for referrals from psychiatric inpatient units, Members are scheduled for an intake appointment within three business days from the date of discharge.

2. Members with routine requests for services are offered an appointment to be scheduled within 10 business days of the date of the request.

3. Upon admission, the provider assigns each Member a primary counselor.

4. The provider ensures that assessments are completed, that a multi-disciplinary treatment team has been assigned to each Member, and that the treatment team has met to review the assessment and initial treatment plan and initial discharge plan within 48 hours of admission.

5. The treatment plan is reviewed by the multi-disciplinary team and the Member after the following:
   a. Every 30 days of attendance or 90 calendar days, whichever comes first;
   b. Any 24-hour behavioral health inpatient admission that necessitates a change in the treatment plan; and
   c. When major clinical changes occur.

6. In collaboration with the provider and in the context of the treatment plan, the Member chooses a daily schedule that is revised on a periodic basis to reflect their needs.

7. If public transportation is not readily available, the provider assists the Member with identifying reasonable transportation alternatives (e.g., public transportation, PT-1 forms, etc.).

**Discharge Planning and Documentation**

1. If the Member does not attend the program as scheduled on a given day, the assigned clinician attempts to contact the Member within 24 hours and documents such effort(s), including unsuccessful attempts, within the Member’s health record.

2. If the Member terminates without notice, every effort is made to contact them and to provide assistance for appropriate follow-up plans (i.e., schedule another appointment or provide appropriate referrals). Such activity is documented in the Member’s health record.

3. Discharge Planning begins on admission to the program, including the identification of potential barriers to discharge.

4. The transition to the providers/caregivers identified in the discharge/aftercare plan begins while the Member is active in the program to ensure greater compliance.

5. All activities and plans are documented in the Member’s chart, including their permission for any outside contact, including coordination of services.