



# Performance Standards

## School Based Outpatient

Performance Standards are intended to provide a foundation and serve as a tool to promote continuous quality improvement and progression toward best practice performances, to increase the consistency of service delivery and to improve outcomes for members

**Disclaimer:** These Performance Standards should not be interpreted as regulations. Entities providing services as part of the HealthChoices program must first be enrolled in the Pennsylvania Medical Assistance program as the appropriate provider type. Providers must then comply with all applicable Pennsylvania laws, including Title 55, General Provisions 1101, licensing program requirements and any contractual agreements made with Community Care Behavioral Health Organization in order to be eligible for payment for services.

## SCHOOL BASED OUTPATIENT

### PERFORMANCE STANDARDS

School based outpatient services include a range of services that include short term and long term treatments that vary with the diagnosis and severity of illness, as well as the coping skills and support systems available to the member. These services are provided in a manner consistent with the principles articulated by the Community Support Program (CSP), the Child and Adolescent Service System Program (CASSP), the Bureau of Drug and Alcohol Programs (BDAP), the Department of Health standards, recovery principles, mental illness/substance abuse (MISA) principles, and relevant Medical Necessity Criteria (MNC).

These standards represent an effort to build on the work of the Department of Public Welfare (DPW), the CSP, BDAP, and CASSP program, MISA principles, recovery principles, and input from member and family stakeholders and providers to emphasize the importance of implementing “best practice” treatment methods, to increase the consistency of services and to improve member outcomes. As with all performance standards developed by Community Care, these standards are intended to define the parameters of desired care for most members. To that end, these should NOT be interpreted as regulations, or as requirements for specific interventions for specific individuals. All individuals receiving services should have treatment plans developed to address their individual strengths and needs.

### Program Description

Outpatient services are provided in an approved setting. For Medical Assistance (MA) members, these settings require appropriate licensure. In some instances, when clinically appropriate, these services may be held in other settings dependent upon the member’s clinical need. For example, a member who is unable to leave his/her home to attend outpatient appointments due to physical or mental disabilities may be seen at home.

All treatments should be guided by the use of recovery based approaches and supports. This approach includes implementation of the most promising approaches for a member who is diagnosed with a behavioral health illness. The member’s potential for growth and recovery should be emphasized. Intervention strategies should attempt to improve the member’s quality of life as well as alleviate his/her symptoms. The goals of the member should drive the treatment plan.

These services are provided by a behavioral health professional. **Independent practitioners** must be licensed. Independent practitioners must have a referral mechanism in place for psychiatric consultations that meet approved access standards. **Facility based practices** should be delivered by a licensed, certified, or, at minimum, a master’s prepared individual as per facility policy. This clinician is deemed, by the facility, as competent to provide these services. They will be supervised in their practice

by senior clinicians or psychiatrists or other appropriately trained clinicians. The facility is expected to have a policy and procedure outlining appropriate clinical supervision frequency as well as content and substance of the supervision. The facility is expected to maintain ongoing training and supervision records for clinicians who are employed as outlined in the facility policy. All clinicians must have Act 33 (Pennsylvania Child Abuse History Clearance), Act 34 (Pennsylvania State Police Criminal Record Check), and FBI Background Check prior to the provision of services. The facility must also have a policy in place that requires Act 33/34 clearances and FBI Background Check for employees working with children ages 18 years and under.

All providers of outpatient care have an emergency management protocol for afterhours coverage and crisis intervention. This protocol must include an answering service, pager, or voice mail message that provides clear direction for the member in active outpatient treatment about how to reach an active clinician within one hour for non-life threatening emergencies. A voice mail message must also include, for life threatening emergencies, a way to immediately contact the clinician, the phone number of the county crisis service, or information that the member may go to the nearest emergency department for immediate attention.

### **Access Standards**

Although a member always has a choice of providers; there is often only one provider in a specific school. Member calls to Community Care for a provider referral will acknowledge school based outpatient as a choice as well as facility based outpatient services. A member/family will be given a minimum of two providers to call. The member is advised that they may call Community Care if the providers are not able to accommodate his/her request. Members may also seek an outpatient provider without a referral.

### **New requests for Outpatient Services**

Members should be scheduled for their first clinical appointment within seven calendar days of their request to be seen. If the provider is unable to accommodate this request within the seven day timeframe in the school based clinic or the facility outpatient clinic, the provider should call Community Care to gain another referral for the member and to advise Community Care that they are at a maximum capacity. Providers are expected to offer appointment times that will meet the member's needs, including evening and/or weekend appointment times to accommodate those who work, attend school, or are otherwise unable to attend appointments offered during traditional office hours. School based clinics may offer these appointments at the school and/or the facility based outpatient clinic. If the outpatient provider believes that they cannot accommodate the clinical treatment needs of or the appointment times for this member, they are to immediately call Community Care so that Community Care can follow up with the member to refer them to another provider. If the member requests an appointment outside of the seven day offered appointment, the provider should document this

information in the clinical record. The first appointment must be offered within the first days.

It is recognized that all providers may not be able to see a new member who is in clinical need of treatment on an outpatient basis within emergent or urgent standards. This may be due to the provider status as a solo practitioner, office hour availability, or other practice limitations.

Other issues that must be considered by school based outpatient services include:

- Management of privacy issues in the school setting may present unique challenges.
- Optimal location of services may minimize the stigma of mental health treatment, e.g. the school nurses office.
- Education of school personnel may increase referrals for this service.
- Increasing the awareness of the parent/caregiver regarding school based outpatient services may improve the likelihood that his/her child will obtain needed treatment in this setting.
- The internal referral mechanism for school based outpatient varies across schools. Typically the Student Assistant Program (SAP) makes referrals. However, in some schools this process is less efficient than others.

While non-therapy services, such as helping the school handle crisis situations and assessment of dangerousness, may not be a routine part of the school based clinician's responsibility, some school based outpatient programs have obtained funding from the schools to assist in such processes.

### **Members in Treatment**

Providers are expected to see (or provide coverage for) a current member within emergent or urgent standards for ongoing clinical crises. It is expected that providers will see or contact members with emergent needs within one hour, and urgent needs within 24 hours.

The Member/primary support/caregiver(s) that are being treated in an outpatient setting should assist with the development of a crisis plan through the treatment planning process. Crisis plans should inform the member, family, school personnel, and treatment team members as to how to handle a crisis, should one arise, while the member is being treated in a school based outpatient level of care.

### **Post Hospital Follow Up**

It is clinically important to quickly assess a member who has recently been discharged from acute levels of care. Post hospital follow up should occur within three to seven days. For this high-risk group, psychiatric reassessment for medication management should occur within three to 14 days of discharge from an acute setting, or sooner if the member indicates concerns regarding their medication regime. Most Psychiatric evaluations for children receiving school based outpatient treatment are provided at outpatient facilities rather than the school. In general, the role of the school based

clinician should involve regular communication as well as coordination between the school and the psychiatrist, both prior to the initial evaluation, and during the member's treatment.

## **Assessments**

The assessment process is a collaborative process between the member, the family, and the provider. Information from the school and other involved child serving systems should also inform the assessor as permitted by release. The family should be included in the child's assessment and ongoing treatment when clinically indicated and with the member's consent and agreement as per Act 147. The school based clinician should also communicate treatment expectations to family members, when indicated, and with the consent of the individual member. It is also understood that for a member who presents with family situations where domestic violence or other physical or sexual abuse may be occurring, the clinician will use their best clinical judgment when involving the family, and will discuss high risk family situations with the member.

It is expected that the member and family receive education and information about the member's illness. The member and family should be provided with information in order to assist the member and his/her family in the management of symptoms and behaviors that may occur with behavioral health disorders. When indicated, the school based clinician should also provide meaningful educational materials to school personnel, to assist them in better understanding of the member's needs.

A comprehensive assessment should be completed during the evaluation, to include relevant information provided by the member, caregivers, and teaching staff. The assessment should be strengths based and recovery focused. The assessment should include the presenting problem, developmental, family, legal, medical, social, vocational, educational, substance use/abuse, trauma history, and psychiatric history. It should also include a mental status examination that assesses appearance, speech, mood, affect, the absence or presence of suicidal and homicidal ideation, the absence or presence of psychotic thoughts, and cognition. The evaluation should conclude with a review of treatment objectives, a discharge plan, anticipated length of treatment, and options for linkage with community resources including peer support and/or family support and education. The assessment should also detail the specific recommended responsibilities of all those providing support to the member, including the teaching staff, caregivers, SAP, and clinician. There should be documented evidence that a mental illness/substance abuse (MISA) screening has been completed and indication of the presence or absence of a co-occurring disorder. Consistent with the 1999 MISA Consortium Report, the MISA screening process is to be conducted by appropriately trained individuals and is to identify:

- 1) Alcohol and other drug issues
  - a) Substances used and intensity of use
  - b) Likelihood and severity of withdrawal
  - c) Medical and behavioral risk secondary to intoxication
- 2) Mental health issues

- a) Suicidal, homicidal ideation/intentions/plans/history
- b) Impairment of function and/or judgment
- 3) Medical issues
  - a) Pregnancy
  - b) Conditions posing an immediate risk of harm to self or others
  - c) Current medications and recent ingestions of any non-prescribed drugs or alcohol
- 4) Special needs
  - d) Barriers to access
  - e) Environmental risks

It is also expected that a diagnostic impression will be formulated on five Axes. Diagnosis must be based on the *DSM IV-TR*.

Providers are expected to encourage the member to permit communication with primary care physicians (PCPs) and other behavioral health providers. It is expected that a release of information will be obtained from the member for both the PCP and other behavioral health providers who may be co-treating the member. It is expected that there will be documented evidence of this discussion in the treatment record and of client refusal if this action is not completed.

At a minimum, it is expected that a child under the age of 18 and the member with a serious mental illness will have a family session offered within the first 15 days of initial treatment since the family tends to be the primary support/caregiver in these instances. If the family refuses to participate in family treatment the provider should document this in the clinical record. If the primary support/caregiver is unwilling or unable to attend sessions at the school, sessions should be offered at the primary outpatient facility. The Family should be involved whenever possible to promote healthy social and living environments. If the family cannot be available in person, it is expected that the clinician will attempt to talk with the primary support/caregiver via telephone on at least a monthly basis. All attempts to engage the family, as well as actual phone contacts, should be documented in the child's chart. The provider should also determine if the family could benefit from community or other referrals for support and/or education, e.g., NAMI, CHADD, peer support, Al-Anon, Nar-Anon.

The member is to be referred for a psychiatric evaluation according to outpatient licensure requirements, or in the absence of licensure (for independent practitioners) if the member presents with a diagnostic picture that might benefit from medication intervention or if the member presents with significant diagnostic complexity to support a psychiatric evaluation. It is expected that this evaluation will occur within the first six weeks of treatment unless refused by the member and that such refusal is documented in the medical record.

## Treatment and Treatment Planning

Treatment services should be delivered within models supported as evidence based practices in behavioral health literature. Community Care encourages clinicians to use modalities that have the strongest possible scientific support, e.g., time limited interpersonal or cognitive behavioral therapy or medications for the treatment of major depressive disorder, family psychoeducational programs and medications for the treatment of schizophrenia, motivational interviewing and motivational enhancement therapy for the treatment of substance abuse disorders, etc. The member is an active participant in the model, and the primary support/caregiver should be considered as an active participant as well, unless their participation is refused by the member. Treatment should meet the relevant MNC and is expected to focus on mental health and drug and alcohol conditions.

A defined treatment plan should be developed within the first two sessions with the member, taking into account the input from parents, school personnel, and others who will be involved in the child's treatment. Treatment planning should include behavioral and measurable objectives, with clearly defined discharge criteria outlined within the treatment plan. Treatment objectives should be based upon a recovery and strengths based model. Treatment plans should also include the expectations of parent(s)/caregiver(s) relevant to their involvement and the use of or referral to community support and education services for both the child and his/her parent(s)/caregiver(s) as appropriate, e.g. NAMI, CHADD, Al-Anon. It is expected that the child as well as the family will have choices in the development of the treatment plan and that the therapist will foster this involvement, and attempt to motivate involvement in the process. It is expected that the child and family will receive a copy of the treatment plan and will sign the treatment plan as acknowledgement of their involvement and acceptance of the terms of treatment. In the event of a diagnosis of a chemical dependency co-occurring disorder, it is expected that utilization of community resources, e.g., AA or NA, be encouraged and concurrent referrals be implemented if indicated. It is also expected that other mental health or drug and alcohol treatment interventions are considered, documented, and discussed with the member.

The member should continue to receive outpatient treatment during school holidays and summer vacation. In some instances schools permit the school based outpatient provider to continue to deliver services in the school during these time periods. If not, continued treatment is expected either in the primary outpatient facility or via other comparable means such as the child attending a summer therapeutic activities program (STAP) during the summer months. If the child is receiving services via another provider or level of mental health care, coordination of services is expected.

Alternative levels of care should be considered if improvement is not seen within a clinically appropriate timeframe, or if the member's mental status deteriorates to a point that the member cannot be safely managed in an outpatient setting.

Treatment should be focused and may require more intense interventions earlier in treatment, during periods of crisis, and during symptom exacerbation. Outpatient treatment may utilize a variety of modalities including individual, group, or family sessions, depending on clinical need and member readiness and choice. Time limited interventions should be utilized whenever clinically appropriate.

All service providers involved in treatment, care, or other supportive services for a specific member should have a working knowledge of the treatment plan for each service being delivered to the member, e.g., residential providers or rehabilitation providers. This sharing of information must be supported by documentation in the clinical record along with appropriate releases of information. For a member having case management (ICM or RC) services, the case manager should be viewed in a leadership role as a participant in the treatment team in order to develop and maintain linkages, coordinate services, and ensure continuity of care. The ICM or RC should be informed of the treatment plan either by verbal communication or by receipt of a copy of the treatment plan.

The outpatient provider is responsible for promoting a recovery environment for members receiving behavioral health services and recovery principles should be an integral part of all aspects of care. The provider must demonstrate how recovery principles are incorporated into all aspects of care. Examples of how this may be demonstrated include the following:

- The member/primary support/caregiver must be informed of their rights and responsibilities at the time of admission to outpatient care. Providers are expected to review member rights and responsibilities as part of the on-going course of treatment and provide this information in a manner that is easily understood by the member. Providers are expected to assess each member's level of understanding through open discussion with the member and adapt methods to meet the individual's needs. Providers are encouraged to use written, verbal, pictorial, and/or other methods of communication to assist the member in understanding his/her rights and responsibilities.
- The member/primary support/caregiver must be instructed in how to report dissatisfaction with care. Member rights should be provided in writing to the member/primary support/caregiver at the time of admission, in addition to being posted in a clearly visible location.
- The member must be invited to participate in the development of his/her treatment plan. Providers must demonstrate methods by which they will engage the member/primary support/caregiver in the development of the treatment plan. Whenever possible, and with the member's consent, the primary support/caregiver should be included in the development of the treatment plan, particularly related to the need for primary support/caregiver to support the member in his/her continued recovery in the community.
- Services should meet the member's cultural needs whenever possible. The members/primary support/caregiver should be encouraged to exercise their right to choose based on their specific cultural needs.

- The member/primary support/caregiver should be given contact information for advocacy services, peer and family support services, and educational materials related to mental illness and substance abuse.

### **Linkages and Coordination of Care**

The outpatient provider must ensure linkage with the member's PCP, other behavioral health providers including ICM/RCs, community treatment team (CTT), prescribing physician, school, and other community support services. It is expected that when a member has targeted case management services, that the targeted case manager will be the linkage point with all other levels of care. Housing stability must be considered when treating the member at any level of care, and appropriate referral to support systems outside of the behavioral health system may need to occur if housing is inappropriate or at risk. Referral to peer support groups or drop in centers should be considered, as well as a referral to NAMI for family support and education.

### **Discharge**

The member must have a clearly stated discharge plan. If the member continues to need community supports and medication management, the provider is expected to solidify plans for those activities. The member/primary support/caregiver should be informed of crisis services or how to reengage in outpatient services if the member believes there might be a need in the future. If the member has targeted case management services, the targeted case manager should solidify plans for post discharge services and supports for the member.

### **Comprehensive Provider Evaluation Process (CPEP)**

Community Care provides an annual report that includes several indicators related to outpatient services such as length of treatment, utilization, use of appropriate outpatient service codes, complaints, and significant member incidents. Providers are asked to comment on these indicators if their measurement varies significantly from the network average and to provide either corrective action plans when indicated or to provide education to other service providers on successful implemented techniques. Providers are encouraged to collect and utilize data to assess the outcome of treatment rendered. Providers are also encouraged to document their contact with the teacher or other relevant school personnel at least once per school term (semester), and to document whether the child is also receiving services through an individualized education program (IEP).

### **Practice Guidelines**

For those members aged 18 or older who present with major depressive disorder or substance abuse disorder, it is expected that providers reference the American Psychiatric Association's Clinical Practice Guidelines, or the National Institute for Drug Abuse (NIDA) guidelines, respectively. Provider performance will be measured, from a

quality perspective, on compliance with two quality indicators that have been derived from each practice guideline.

### **Cultural Competency**

Treatment should be provided within a culturally competent and culturally sensitive environment. Every effort should be made to meet the cultural needs of the individual member and their primary support/caregiver and to attempt to accommodate those needs whenever possible. If a provider is unable to meet the cultural needs of the member, the provider must offer the member referrals to other, culturally relevant providers. Evidence of culturally sensitive office settings and clinician demeanor will be monitored through the complaint process, personnel reviews as part of the credentialing/re-credentialing process, site visits during quality record reviews and compliance audits and during provider service visits through Community Care.

### **Documentation**

Documentation must meet all licensure standards, MA regulations, and HIPAA regulations. Providers must have a documented policy of how they will ensure that access to medical charts of school based clients are restricted to appropriate personnel. Documentation must demonstrate industry standard practices.