Intensive Outpatient Psychiatric (IOP) Services Performance Specifications

These performance specifications apply to the following Tufts Health Plan products:

- ☐ Tufts Health Plan Commercial (including Tufts Health Freedom Plan)[1]
- ☐ Tufts Medicare Preferred HMO (a Medicare Advantage product)[2]
- ☒ Tufts Health Plan Senior Care Options (SCO) (a dual-eligible product)[2]

These performance specifications apply to the following Tufts Health Public Plans products:

- ☐ Tufts Health Direct (a Massachusetts Qualified Health Plan (QHP) (a commercial product)
- ☒ Tufts Health Together (a MassHealth MCO Plan and Accountable Care Partnership Plans)
- ☐ Tufts Health RITogether (a Rhode Island Medicaid Plan)
- ☒ Tufts Health Unify (OneCare Plan; a dual-eligible product)

Providers contracted for this level of care or service will be expected to comply with all applicable regulations set forth in the Code of Massachusetts Regulations and requirements of these service-specific performance specifications, in addition to the General Behavioral Health Performance Specifications. All Performance specifications are located in the Provider Resource Center.

DEFINITION

Intensive outpatient programs (IOP) are similar to partial hospitalization programs (PHPs), offering short-term day or evening programming consisting of intensive treatment within a stable therapeutic milieu. For adults, the IOP must be available seven (7) days per week. For children and adolescents, the IOP must be available at least five (5) days per week, though seven (7) days are preferable. IOPs are required to provide daily management and active treatment comparable to that provided by a partial hospitalization program setting, with each daily session being equal to ½ day of services. Length of stay generally ranges between one to three (1-3) weeks, declining in intensity as the Member establishes community supports and resumes normal daily activities.

IOPs may be provided by either hospital-based or freestanding outpatient programs to Members who are experiencing symptoms of such intensity that they are unable to be safely treated in a less intense setting and would otherwise require admission to a PHP. In either case, the Member's living environment, however compromised, offers enough psychosocial stability to warrant intensive outpatient treatment, and their biomedical condition is stable enough to be managed in an outpatient setting.

COMPONENTS OF SERVICE

1. The Member will be evaluated/assessed within one day of referral if the program is identified as a diversion from a higher level of care and within two days of referral if the program is to serve as a step-down level of care.
2. The Member will be admitted into the program within 24 hours of the initial evaluation.
3. Programs have the capacity to treat and stabilize the Member if they present in crisis or if their mental status deteriorates, unless the individual is a danger to self and/or others or sufficient impairments exist, which indicate that a more intensive level of service is required.
4. IOP Services are designed to provide flexible treatment that provides stabilization within the community, divert an inpatient admission, or facilitate a rapid and stable reintegration into the community as a step down from an inpatient admission.

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[1] Commercial products include HMO, POS, PPO, Tufts Health Freedom Plan, and CareLink℠ when Tufts Health Plan is the primary administrator.

[2] Tufts Medicare Preferred and Tufts Health Plan SCO are collectively referred to in this payment policy as Senior Products.

5. The IOP provides individually customized, time-limited, comprehensive and coordinated multidisciplinary treatment plans, which include multiple services and modalities delivered in an outpatient setting.
6. A multidisciplinary team, with the consent of the Member and as clinically appropriate, coordinates with the Member's providers to develop an integrated treatment and discharge plan.
7. Programming emphasizes a solution-focused approach to increase the Member's ability to function in the community and utilize a more traditional outpatient model.
8. Though variable, based on the individual treatment plan, services will generally range from 3-7 units per week in any combination of modalities.
9. Services available should meet the needs of Members who demonstrate symptomatology consistent with a DSM-V diagnosis. Psychiatric, substance abuse or dual diagnoses which require intensive structured interventions may be served through IOP services.
10. The IOP psychiatrist will review each admission to assess the medical, psychiatric and pharmacological treatment needs of the Member.
11. Program must have an affiliation with a contracting ESP provider for coverage of emergency evaluations for members, and provisions for after-hours and weekend coverage 24 hours per day, 7 days per week, 365 days per year.

STAFFING REQUIREMENTS

1. The provider follows formal procedures for credentialing, periodic re-credentialing, supervision, orientation to provider's policies and procedures, and training of all staff. The facility/provider will have a psychiatrist specifically assigned to the members being served in the IOP program.
2. Facility is responsible for providing staffing and supervision in accordance with Tufts Health Plan General Behavioral Health Performance Specifications, and Department of Public Health (DPH) and Bureau of Substance Addiction Services (BSAS) licensing requirements.
3. The provider ensures access to qualified clinicians able to meet the cultural, linguistic and ethnic needs of all members served within their local community.
4. The provider has a sufficient array of staff with appropriate credentials and training required to deliver the varied modalities and/or disciplines required by the members and to ensure a multidisciplinary approach.
5. Multidisciplinary staffing shall consist of, but not be limited to: independently licensed clinician and/or other clinical master's degree staff, RN and psychiatrist.
6. The provider will ensure appropriate and adequately trained staff to maintain the capacity to serve members with special needs.
7. The clinician who works primarily with children and adolescents must demonstrate competence through the provider's credentialing program to work with children and adolescents.
8. Providers build and maintain a treatment model designed to serve Members with serious and persistent mental illness. The model includes approaches and information that support and facilitate members' recovery from serious and persistent mental illness and linkage with appropriate DMH personnel.
9. Staffing should reflect the cultural, gender and linguistic needs of the community it serves.

SERVICE, COMMUNITY AND COLLATERAL LINKAGES

1. Facility/provider staff coordinates treatment planning and aftercare with the member's primary care clinician, 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 facility/provider ensures that a written aftercare plan is available to the member on 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, appropriate state agency, 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 children or youth involved with CBHI services, the facility social worker or other clinician will collaborate with those providers, including but not limited to, community service agencies (CSA). The facility will accommodate requests from a CSA to facilitate or attend a team meeting while the member is at the facility.
4. Facility/provider will actively coordinate and promote member access to peer and self-help group services as appropriate or requested by the member.

5. The facility/provider has wellness, self-help, and recovery information and resources, including but not limited to: written consumer/survivor accounts of recovery experiences, a listing of other self-help groups (i.e. Alcoholics Anonymous or other 12-step models, and other groups with local and statewide Members), and a listing of advocacy and wellness organizations statewide (i.e., National Alliance for the Mentally Ill, PAL, Independent Living Centers, etc.).

QUALITY MANAGEMENT (QM)

1. The facility will develop and maintain a quality management plan that is consistent with that of Tufts Health Plan 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 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 to Tufts Health Plan upon request and must be consistent with Tufts Health Plan's performance standard for intensive outpatient services.
4. All Reportable Adverse Incidents will be reported to Tufts Health Plan within 1 business day of their occurrence per Tufts Health Plan 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 managed by Tufts Health Plan or has recently been discharged from services managed by Tufts Health Plan.
5. The facility/program will adhere to all reporting requirements of DPH and/or DMH regarding Serious Incidents and all related matters.

PROCESS SPECIFICATIONS

Treatment Planning and Documentation

1. The facility/provider will ensure that an individualized, comprehensive bio-psychosocial written assessment is completed for any Member entering treatment.
2. The facility/provider will ensure that assessments are conducted, and include but are not limited to, review and assessment of:
    - History of presenting problem
    - Chief complaints and symptoms
    - Past BH/SUD history
    - Past medical history
    - Family, social history and linguistic cultural background
    - Current substance abuse
    - Mental status exam
    - Previous medication trials, current medications and any allergies
    - Diagnosis and clinical formulation
    - Level of functioning
    - The individual's strengths, and for children and adolescents, family strengths
    - Name of PCP
3. The provider will assign a multidisciplinary treatment team to each Member within 24 hours of admission.
4. The provider will develop treatment plans that are in writing and include, at a minimum:
    - A description of all services needed during the course of treatment
    - Goals, expected outcomes, and time frames for achieving the goals. Goals should be in behavioral terms and should be measurable and solution focused.
    - Indication of the strengths of the individual and his/her family as identified in the assessment
    - When appropriate, indication of the need for involvement of a state agency
5. Members of the multidisciplinary team must be cross functional and cross disciplined though the specific disciplines may vary depending on the needs of the Members, and there must be a minimum of 2, with at least 1 being independently licensed.
6. Providers document treatment provision with goal-oriented progress notes reflecting implementation of the treatment plan and the Member's response to the plan.
7. Progress notes must be written, at a minimum, after each contact with the Member or collateral, reflect progress on goals and become a permanent part of the treatment record.
8. Treatment plans must incorporate a detailed discharge and aftercare plan for the Member. Discharging planning should begin at the onset of treatment and include the member's input and signature.

Discharge Planning and Documentation

1. Discharge is a planned process beginning upon initiation of services and continuing throughout treatment.
2. Components of discharge planning incorporate Member's identified concerns, including but not limited to: housing, finances, health care, transportation, familial, occupational, educational and social supports.
3. The treatment team staff member who is responsible for implementing a Member's discharge plan documents in the medical record all of the discharge-related activities that have occurred while the Member is in the facility, and this reflects Member participation in its development.
4. The completed discharge form, including referral to any agency, is available to and given to the Member, and when appropriate, the Member's family or guardian at the time of discharge, which includes, but is not limited to, appointments, medication information and emergency/crises information.
5. The provider will develop linkages and policies that create smooth, clinically sound transitions of a Member's care from the IOP to the next service, including transition to services provided by state agencies.
6. At least 1 initial aftercare appointment is scheduled not more than 7 days from the Member's discharge from the facility, and this is clearly documented in the Member's medical record.
7. For those Member's discharged on medications, at least one psychiatric medication monitoring appointment is scheduled no more than 14 days after discharge.
8. Discharge plans must include the necessary community supports, including community agencies, and family members/significant others, when Member consent is given.

DOCUMENT HISTORY

- August 2020: Template updates