Clinical Performance Standards:

Acute Partial Hospital Program (APHP) – Child, Adolescent, and Adults

Updated May 2, 2023

C·B·H
Community Behavioral Health
A DIVISION OF DBHIDS | CBHPHILLY.ORG

Member Services Hotline
888.545.2600
888.436.7482 *(TTY)*

Mental Health
Delegate Hotline
215.685.6440

TABLE OF CONTENTS

1. PURPOSE

The Acute Partial Hospital Program (APHP) Performance Standards describe expectations for quality in service delivery for children, adolescents and adults whose services are funded through Community Behavioral Health (CBH). They are intended as a guide for providers to design and monitor their programs and for CBH to evaluate these services. Providers entering the CBH Network following the time of publication of this document will be expected to meet the Standards prior to their program start date. Existing providers will be expected to implement the Standards over time, prior to their enforcement through CBH Oversight and monitoring processes.

The goal for the APHP Performance Standards is to standardize quality expectations across the CBH network of APHP programs, ensuring that all providers have the capacity to treat and stabilize youth and adults in the community and successfully transition them back to school and/or employment setting to less restrictive community-based services. An additional aim of these Standards is to support APHP programming that leads to successful, sustained community reintegration for all members post-discharge from APHP programming. This calls for APHPs to operationalize state-of-the art best practices through all components of programming and with all levels of staff, as described in these Performance Standards. The Standards support resilience and sustained family and community reintegration through comprehensive assessment, individualized treatment planning, mobilization of supports, and comprehensive discharge planning.

The APHP Performance Standards reflect the core values and principles of the **DBHIDS Philadelphia Behavioral Health Services Transformation Practice Guidelines for Recovery and Resilience Oriented Treatment**, the **Child and Adolescent Service System Program (CASSP) principles**, and The **Network Inclusion Criteria Standards for Excellence**. The Standards aim to describe foundational standards, promote continuous quality improvement and best practices, increase consistency in service delivery, and improve outcomes for all members in this level of care. The Standards support resilience and sustained family and community reintegration through comprehensive assessment, individualized treatment planning, mobilization of supports, and comprehensive discharge planning.

2. CULTURAL COMPETENCE

All APHP providers are expected to support the development of cultural competence regarding gender, age, race, ethnicity, spirituality/ religion, gender identity and sexual orientation within their programs through:

- Ongoing staff training
- Open, respectful communication to the member and family/caregiver, where applicable, about culturally based values and belief systems that need to be considered when intervening with a member
- Programming that recognizes the extent of cultural diversity among members
- Respecting the wishes of members and familial traditions in the celebration of holidays, special social activities and gift giving

- Maintaining documentation of all initiatives to further develop the cultural competence and sensitivity of staff and interventions to improve the overall equitability of their programs

As noted, APHPs must be able to accept and accommodate the needs of all LGBTQIA members; including treatment considerations that respect and account for gender and sexual identity, ensures medical needs are met specific to members who are transgender, and ensures use of selected names and pronouns, when applicable.

3. SCOPE OF SERVICES

APHPs provide clinically enhanced day programming in a clinical or hospital-based setting to members experiencing acute behavioral health symptoms that do not require acute inpatient hospitalization. Members are considered safe to remain in the community, but require intensive, interdisciplinary treatment management and intervention. This setting provides the opportunity for intensive treatment, re-assessment, and skill-building individualized to the needs of every member and family (where applicable) to remain stable and/or progress in the resolution of symptoms following an inpatient stay, or from the community or lower level of care with the goal of treating symptoms for the goal of diversion from acute psychiatric inpatient units or to shorten the length of stay, or for the purpose of crisis stabilization and treatment of chronically ill patients who require more intensive services for some period of time than is provided in outpatient programs. The targeted length of stay is no more than 20 days, with the expectation of daily participation in treatment. The APHP license requirements can also be reviewed in the **PA Code, Title 55, Chapter 5210**.

4. ADMISSIONS REQUIREMENTS

All members must meet the Medical Necessity Criteria (MNC) requirement for admission. MNC are a group of medical criteria used to determine if a member's situation meets the need for a type of service. As indicated, the MNC for admission to APHP are based on HealthChoices Appendix T and can be found on the **CBH Medical Necessity Criteria webpage**.

Members who are recommended for APHP must present with acute psychiatric illness, or an acute exacerbation of chronic psychiatric illness and are marginally functional in the community. For children/adolescents, this includes behavioral and/or emotional disturbance in the school setting even with the addition of community-based supports. Members considered for referral may also be safely diverted from Acute Inpatient admissions for stabilization or are referred as a step down from Acute Inpatient admissions for continued stabilization before full time reintegration into a community setting. Adult APHP programs may treat adolescents 15 years of age and older when clinically appropriate.

Once a member is admitted to acute partial hospitalization, an initial authorization will be provided for 20 business days, not including holidays or weekends, with corresponding units.

5. CONSENT

The informed consent process should be viewed as an opportunity to engage the member, involved natural supports and/or systems partners to offer education about the goals of APHP treatment and emphasize their involvement as a predictor of success in treatment. A staff member who is knowledgeable about the consent forms and processes should assist members and natural supports with review and signing of consent documentation. Consent forms should be culturally and linguistically appropriate, and all releases of information must include names of individuals/agency, what information will be shared, and the date the consent was signed. Signatures on consent forms for treatment and releases of information should be obtained at the time of intake. Additionally, once medication is recommended, medication informed consent should be pursued daily to ensure the member begins receiving necessary treatment in a timely manner. Consent should be obtained in accordance with state policy for age and guardian consent. For minors, verification of legal guardianship (e.g., court order) should be obtained for youth residing in out-of-home placements, for e.g., through the Philadelphia Department of Human Services/ Community Umbrella Agencies (DHS/CUA).

6. ENGAGEMENT

6.1. Linkages/Coordination of Care – Children/Adolescents

6.1.1. Educational Services

Supporting the continued educational needs of the member should be integrated into member daily programming and continued outreach and collaboration with the member's educational institution should be ongoing. Upon admission, outreach to the assigned school guidance counselor and Prevention and Intervention (P&I) liaison is necessary to initiate collaboration and coordinate transition planning back to the school setting. School staff can provide a perspective on a child's needs and behaviors, thus facilitating more individualized, targeted interventions. School teams should be included in interagency meetings for close collaboration, when deemed necessary. A transition plan should be developed to support reintegration and promote success upon return to the school community. This is especially important for children with primary behavioral challenges in school and/or experienced a traumatic event at school (see details in discharge planning). The APHP team will assist with developing a plan to administer medications for youth in need during school hours. Additionally, schools must be consulted when planning appropriate therapeutic interventions to be utilized during academic hours.

6.1.2. Cross Systems Collaboration

Strong collaboration with collateral providers/supports is essential to tailoring Acute Partial Hospitalization treatment and discharge recommendations to the individual child/adolescent. All outreach to collateral contacts should begin at admission and be documented; CBH Member Services, Provider Relations and/or Clinical Care Management should be consulted when contacts do not respond to outreach.

6.1.3. Current and/or Previous Behavioral Health Providers

Contact with other treatment providers is critical to providing effective treatment. Providers should consult current and past providers to determine previous interventions and their impact. Collaboration among

Providers helps the Acute Partial team to continue effective interventions or introduce new ones when needed, thus increasing the likelihood of engagement from a child/family who may otherwise be experiencing "treatment fatigue" or discouragement. Partnering with a provider who will resume treatment after discharge helps to ensure consistency in treatment approaches.

6.1.4. Other Involved Systems

CBH expects providers to identify any other significant collaborators in a child's life including child welfare, juvenile justice, etc. For many children, this will include DHS/CUA case managers. Acute Partial Hospital providers should maintain communication with DHS/CUA beyond the initial consent process. DHS/CUA should be consulted for perspectives on the child and family, including placement histories and settings where the child has experienced the most success. System partners are better able to contribute to successful and sustained discharge when providers have educated them about child/adolescent needs.

6.2. Linkages/Coordination of Care – Adults

APHP programs require a close relationship with acute inpatient service providers. Cross communication should occur about the availability of these services to members. APHPs should also assure linkages with other appropriate treatment and rehabilitative services including Crisis Response Centers, outpatient services and vocational rehabilitation programs.

Strong cross-system collaboration with collateral providers/supports is essential to tailoring APHP treatment and for discharge planning. All outreach to collateral contacts should begin at admission and be documented for the purpose of coordinating care; CBH member services, provider relations and/or clinical care management should be consulted when contacts do not respond to outreach.

Contact with current and/or previous behavioral health providers is critical to providing effective treatment. Providers should consult current and past providers to determine previous interventions and their impact. Collaboration among Providers helps the Acute Partial team to continue effective interventions or introduce new ones when needed. Partnering with a provider who will resume treatment after discharge helps to ensure consistency in treatment approaches.

7. ASSESSMENT

An integrative assessment that addresses behavioral and physical health, substance use, educational history, family history, trauma, and all other social determinants of health should be performed during the admission process. Assessment should emphasize wellness, in addition to symptom reduction.

The assessment process should include a comprehensive review of the member's current treatment from the referring provider, where applicable. It should consider a holistic view of the member including their individual and family personal strengths and community supports.

The psychiatrist must assess each member on-site within 24 hours of entering the program. This should include obtaining a full history, performing a mental status exam, providing provisional diagnoses and an initial treatment plan and formulation of the case.

Within one week of entering the program, the physician should have reviewed current treatment and medication regimen and outreach should occur with referring provider physician. The psychiatrist is expected to speak with the member's guardian where applicable as well.

The psychiatrist must meet with each member at least once per week to complete a mental status exam and to assess for stabilization. Additional visits should be provided on an as needed basis, such as if a member is in crisis or is having side effects to medication.

8. LABORATORY TESTING

APHP program providers must be able to provide basic health screening and laboratory testing for pregnancy, HIV, hepatitis, tuberculosis, and other common conditions. In addition, a protocol to obtain appropriate urine or oral drug testing to assess recovery progress must be established. This protocol must ensure that there is a documented rationale for the frequency and content of such testing, as well as documented review of such results by the treatment team and incorporation of results into treatment planning. Repeated positive results must be accompanied by a documented discussion of how they will be addressed, including consideration for a higher Level of Care (LOC). A multidisciplinary case conference is the ideal format but not required.

9. RESILIENCY/TREATMENT PLANNING

APHP treatment should be comprehensive, trauma-informed, member-driven, and tailored to individual needs and preferences. Treatment planning should be based upon diagnostic evaluation and monitored by the treating physician which includes examination of the medical, psychological, social, cultural, behavioral, familial, educational, vocational and developmental aspects of the member's presentation. Treatment objectives should be clearly defined and prescriptive of an integrated program of therapies, activities, experiences and appropriate education designed to meet these objectives. Wellness should be emphasized in addition to symptom reduction, with an aim for timely discharge to the most appropriate, least restrictive setting. Evidence-based practices should be utilized across treatment modalities. Treatment plans should be developed within the first 5 days of service and reviewed by the treatment team a minimum of once every 10 days of service to the individual and modified as appropriate.

10. TREATMENT PROVISIONS

10.1. Clinical Services

10.1.1. Individual Therapy

Specialized individual therapy is to be provided at minimum once per week to address individualized treatment goals that are developed through the initial assessment process factoring in trauma, risk behaviors, or other challenges that surpass what can be addressed by the traditional milieu approaches. Evidence-based treatments are particularly encouraged during individual therapy sessions. Provider must adhere to all internal policies required by CBH surrounding creation and maintenance of evidence-based treatment (e.g., CBT, DBT, trauma informed treatment, etc.) linkage policy.

10.1.2. Group Therapy

Allied and psychotherapy groups are to be held daily and include activities tailored to the member's interests and strengths, including, but not limited to, conflict resolution, anger management, emotional regulation, art, dance movement, athletics, music, relaxation, occupational therapy, etc. Providers should regularly evaluate and update programming and staff to provide members with a variety of outlets for healing. Group therapy should include evidence-based or empirically supported programming tailored to the treatment needs of members in acute partial hospitalization. Groups may address challenges related to communication, anger/affect regulation, trauma, and social skills. Group therapy can't exceed 12 members.

10.1.3. Family Therapy

Required for members 17 and under, highly encouraged for members 18+

Family treatment is a critical component of acute partial hospitalization. Family therapy allows for skill building, relationship building and acquisition through real-life enactments, increasing the likelihood of positive and sustained progress upon discharge. In addition, family sessions provide opportunities for family members to voice their desire for next level of care/service, and for providers and families to consider and address any anticipated barriers to a successful return home. Family sessions must be prioritized in treatment planning and delivery, with any barriers to consistent meetings addressed. Providers are encouraged to accommodate the schedules of family members, providing supportive and consistent outreach via phone calls/ letters, and offering transportation assistance. Face-to-face sessions are preferred family treatment modalities. However, telephonic or video sessions should be offered, as needed. For members ages 17 and under, family sessions must occur at a minimum of once per week, and all outreach efforts and missed appointments must be documented.

11. MEDICATION MANAGEMENT AND ONGOING MONITORING

11.1. Medication Management

The psychiatrist should assess each member regarding the need for pharmacotherapy. This should occur within the first five days of the program. The psychiatrist is expected to obtain necessary medication consents from the member's legal guardian (if applicable) and order all necessary lab work in a timely fashion. The psychiatrist should assess for medication response and possible side effects during each visit and make any needed adjustments. This information must be communicated to the member (or guardian if 13 and under) by the psychiatrist or nurse. The psychiatrist is expected to collaborate regarding medication planning with the inpatient psychiatrist if member is stepped down from a hospital or with member's outpatient psychiatrist and other key medical practitioners if member is returning to their care upon discharge. It is expected that the psychiatrist will complete all necessary prior authorizations for medications prior to the member's discharge to prevent any delays in members receiving their medication.

11.2. Aftercare Planning

11.2.1. Discharge Planning Meeting

The discharge plan should be an individual plan that is both member specific and strength based, utilizing supports in place and/or referring to additional treatment services to assist in building and maintaining resiliency. Discharge plan should be formulated as a comprehensive plan including the member, legal guardian/school (if applicable), treatment provider/s and any additional supports identified by the individual member. The discharge plan should be reviewed with all active parties prior to discharge. There should be a scheduled discharge planning meeting prior to discharge to ensure that all parties are aware of next steps and identified community and/or in-home supports. Triggers, coping skills and successful interventions should be included in the aftercare plan and provided to the next treating provider or other relevant stakeholders.

The full continuum of services, including evidence-based practices should be considered when planning next services. Interagency meetings are used to facilitate consensus about recommendations. Providers must engage member and natural supports to include their voice in the decision-making process and clinical considerations when formulating the aftercare plan. Research shows evidence that the subsequent two weeks following discharge is a critical period for risk of recidivism, thus the first appointment with the next provider must be scheduled for a date no more than seven days after discharge. If there are any challenges with scheduling an appointment for the next level of care, providers should follow-up with a CBH clinical care manager as soon as possible. Discharge plans should be given to the member, natural supports and all other relevant stakeholders. Ideally, APHPs can facilitate warm handoffs to the next level of care for continuity.

11.2.2. Psychiatric Evaluation

The psychiatrist is expected to drive treatment recommendations for aftercare by integrating information provided by the treatment team members, the member's natural supports (if applicable), and outside providers. Once a recommendation is identified for a level of care requiring prior authorization, a psychiatric evaluation should be completed and submitted to CBH within 5 business days. The psychiatrist must complete the mental status examination, discharge diagnoses, and recommendations sections of the evaluation and review and integrate all other information provided by treatment team members. The evaluation is expected to be strength-based.

11.2.3. Prescriptions/Prior Authorizations

Providers should have a working knowledge of insurer's policies and procedures regarding prior authorizations. Providers' internal policies and resources must address external authorization challenges to prevent access issues post discharge. Upon consent to medication, provider should immediately complete prior authorization process to ensure timely access to medications (if applicable); families and/or next providers should be given labs to facilitate authorizations as needed. Members must discharge with a prescription to last at least until their next medication management appointment, which should be scheduled, by the provider, for a date no more than 30 days following discharge.

11.2.4. School Transition Plan

For members still enrolled in school, coordination with schools is an essential component of discharge planning. Providers must relay discharge recommendations to school guidance counselors, particularly

sharing interventions that should be used in the school setting to keep the child/adolescent stable and to prevent re-hospitalization. Providers, along with school counselors should also determine whether there is a need for the child/adolescent to have school transition days prior to discharge. Providers should make every effort to include schools in discharge planning meetings, documenting outreach efforts (phone calls/e mail) and contacting CBH regarding barriers to communication. Providers should be aware that the schools cannot refuse a child's readmission, and CBH and other liaisons should be contacted in these cases.

12. STAFFING

12.1. Psychiatric Services

The acute partial hospitalization program must have a licensed, board-certified or board-eligible psychiatrist. For children, the individual must be trained and certified to treat children/adolescents. The psychiatrist is an integral leadership role as part of the interdisciplinary treatment team during program hours, preferably on-site. If the psychiatrist is on-site part time, he/she or a covering psychiatrist must be able to come into the program on short notice or be available by telephone to address urgent matters which arise. The absence of the psychiatrist shall not impede the essential functions of the program including but not limited to performing assessments/intakes, assessing need for step up to inpatient hospitalization, and prescribing and adjusting medications. The psychiatrist is expected to participate in treatment team meetings, CBH provider meetings, and interagency meetings. The psychiatrist should also be available to participate in family sessions if clinically indicated.

13. MONITORING OF STANDARDS

The Standards emphasize the importance of communication and collaboration with families, behavioral health providers, systems partners, schools (if applicable), etc., to ensure robust discharge planning occurs to promote community tenure upon completion of treatment. Performance Measurements that will be monitored are listed in the table below. Failure to meet these metrics may result in a provider being placed on a CBH Quality Performance Improvement Plan, implementation of additional CBH Clinical Care Management interventions, and/or financial risks.

Standard	*Metric*	*Denominator*	*Numerator*	*Target/Benchmark*
Community Tenure	30-day readmission rates to APHP Admission rate to bed-based level of care within 30 days post discharge	Number of discharges within the measurement period	Number of discharges with no claims for APHP or bed-based level of care 30 days post discharge from APHP	Benchmarked against provider network weighted mean and standard deviation
Discharge Planning	30-day post-discharge follow-up	Number of discharges within the measurement period	Number of discharges with no claims for a community-based service within 30 days post discharge from APHP	Benchmarked against provider network weighted mean and standard deviation

14. SUMMARY OF KEY PERFORMANCE INDICATORS

Key Performance Indicators (KPIs) will be assessed on a quarterly basis by the CBH Quality Department's Performance Evaluation Unit. KPIs are well-defined performance measurements that are used to monitor, analyze and optimize all relevant processes to increase member satisfaction and member safety. For the Acute Partial Hospital Program level of care the indicators assessed are as follows: Medicine Errors, Overturned Complaints, Against Medical Advice and Administrative Discharge, Physical Restraints, and Suicide Attempts with Medical Attention. CBH will monitor these metrics through a variety of contacts, including Quality Indicator (QI) and Utilization Management (UM) data. Providers identified as outliers are reviewed with the CBH Quality Management (QM) Medical Director and Senior Director of QM to determine further actions as appropriate. Further actions can include items such as a root cause analysis due from the provider, phone consultation with the provider, or a plan to continue to monitor the provider for another quarter. When identified as an outlier within their level of care, providers can expect to be notified during a regularly scheduled meeting with CBH or via email. Providers who continue to be identified as outliers and do not engage in quality improvement activities may be at risk for termination from the network.

Measure	*Description*	*Numerator*	*Denominator*	*Responsible Party*
Medicine Errors	Errors related to dispensing medication. Provider may have failed to follow a particular policy or procedure.	Total number of medicine errors in the acute partial hospital on a quarterly basis	Total number of medicine errors in acute partial hospitalization level of care on a quarterly basis	CBH Performance Evaluation Team
Overturned Complaints	Complaints supported in favor of the member. Provider may have failed to follow a particular policy or procedure.	Total number of overturned complaints in the acute partial hospital on a quarterly basis	Total number of overturned complaints in acute partial hospitalization level of care on a quarterly basis	CBH Performance Evaluation Team
Against Medical Advice (AMA) discharge	A member leaves the facility against the advice of their clinician.	Total number of times AMA discharge occurs with members in the acute partial hospital on a quarterly basis	Total number of AMA discharges in the acute partial hospitalization level of care on a quarterly basis	CBH Performance Evaluation Team
Administrative Discharge	Discharge of a member initiated by the facility	Total number of times administrative discharge occurs with members in the acute partial hospital on a quarterly basis	Total number of administrative discharges in the acute partial hospitalization level of care on a quarterly basis	CBH Performance Evaluation Team

Measure	*Description*	*Numerator*	*Denominator*	*Responsible Party*
Physical Restraints	Any action or procedure that prevents a person's free body movement to a position of choice and/or normal access to his/her body by the use of any method, attached or adjacent to a person's body that he/she cannot control or remove easily	Total number of times physical restraints occurs with members in the acute partial hospital on a quarterly basis	Total number of physical restraints in the acute partial hospitalization level of care on a quarterly basis	CBH Performance Evaluation Team
Suicide Attempts with Medical Attention	Suicide attempt of a member that requires medical attention	Total number of times suicide attempts with medical attention occurs with members in the acute partial hospital on a quarterly basis	Total number of suicide attempts with medical attention in the acute partial hospitalization level of care on a quarterly basis	CBH Performance Evaluation Team

CBH's Complaints and Grievances department will review and address member grievances in real time as they occur.