

Intensive Outpatient –Adolescent MH

Definition

Intensive Outpatient Programs (IOP) for children and adolescents provide, multidisciplinary, multi-modal, structured treatment in an outpatient setting. Services are based on the individual's medical need. Such programs are less intensive than partial hospital and day treatment programs but significantly more intensive than traditional outpatient psychotherapy and/or medication management. This level of care is used to intervene in complex and refractory clinical presentations. Clinical interventions should include modalities that utilize structured, evidence informed, culturally competent approach, or one approved by the managed care entity and Medicaid as part of the IOP service. Mandatory interventions include: individual, group and family psychotherapy, and psycho-educational services. Some evidenced-based practices might not include group psychotherapy, and may be enrolled according to their evidence-based program description, approved through the Managed Care Entity. IOP programs may be developed with a particular focus such as those prepared to treat a mental health and other, co-occurring diagnoses such as substance abuse or eating disorders, or dysfunctions such as sexual offending. IOP's could also fill special, focused needs for transition age (17-20) youth diagnosed with a mental health and/or other disorder, focusing specifically on the youth's additional need to develop independent living skills. Family involvement from the beginning of treatment is extremely important and, unless contraindicated, should occur at least once weekly. Coordination of school performance is an important component of treatment planning as is involvement with school personnel to monitor the ongoing impact of treatment and facilitate constructive ways of working with children/adolescents.

Policy

Mental health/substance abuse intensive outpatient services are available to youth aged 20 and younger.

Program Requirements

Refer to the program standards common to all levels of care for general requirements.

Licensing/Accreditation

Accreditation is not required for this service. The agency must be credentialed by the managed care entity. Each individual staff member required or suggested to provide this service must be licensed as defined by the Department of Health and Human Services Division of Public Health Licensure Unit.

The agency must have written policies and procedures related to:

The agency must have written policies and procedures related to the provision of Intensive Outpatient Treatment Services. Refer to "Standards Common to all Levels of Care" for a potential list of policies generally related to the provision of mental health and substance abuse treatment. Agencies must develop policies to guide the provision of any service in which they engage clients, and to guide their overall administrative function.

Features/Hours

This service may be available 7 days/week after school, evenings and weekends. Intensive Outpatient Treatment may be provided up to 15 hours per week depending on individual need. These services must be provided by licensed clinicians. The service must be available to meet the needs of the youth and their family. The provider must identify their scheduled service hours in their program description. The service must provide or otherwise demonstrate that youth and family have on-call access to a licensed mental health provider on a 24-hour, seven-day per week basis.

Service Expectations

- A pre-treatment assessment (Biopsychosocial Assessment and Initial Diagnostic Interview) that identified IOP as the recommended treatment service must be obtained by the IOP provider prior to the initiation of IOP.
- An initial plan will be developed with the multidisciplinary treatment team within the second day of treatment following admission, which includes the youth and their family, based on the referring practitioner's comprehensive assessment until the Supervising Practitioner can complete the face to face diagnostic interview and the treatment plan and discharge plan is developed.
- The Supervising Practitioner for the program must complete a face-to-face, Initial Diagnostic Interview within 7 calendar days of admission and a face-to-face treatment intervention with the client at least every 30 calendar days after the Initial Diagnostic Interview
- Complete additional assessments and screenings as determined by the supervising practitioner. Assessment must take place as an ongoing activity throughout the treatment episode.
- Multidisciplinary team which includes the youth and their family develops and signs a family centered, outcome focused comprehensive treatment and discharge plan within 10 calendar days of admission.
- The multidisciplinary team consists of the youth, family, therapist/licensed clinician, supervising practitioner and other supportive individuals identified by the youth and their family
- Treatment interventions should be outcome focused based on the comprehensive assessment, treatment goals, culture, expectations, and needs as identified by the youth and their family.
- The individual treatment/recovery and discharge plan is reviewed by the treatment team as frequently as medically indicated, but at a minimum of every 30 calendar days, and signed by the supervising practitioner and the additional multidisciplinary team members
- Medication management and youth/family education (expected benefits, potential side effects, potential interactions, dosage, obtaining/filling prescriptions, etc.)
- The following mandatory interventions must include: ongoing assessment, individual, group and family psychotherapy, psycho-educational services
- Adjunctive therapies such as life skills, community support building, leisure skill building, time management, pre-vocational skill building, and health education (nutrition, hygiene, medications, personal wellness, etc) may also be a part of the treatment program.
- Family interventions must relate to the youth's treatment plan and includes skill building regarding mental health and substance abuse symptom management. This may include: de-escalation techniques, behavioral management techniques, coping skills, assisting the

youth with social and life skills development, child development, medication compliance, and relapse prevention.

- Awareness and skill development for youth and/or family in regards to accessing community resources and natural supports that could be used to help facilitate youth/family efficacy and increase youth function without the support of ongoing Intensive Outpatient Therapy
- Consultation and/or referral for general medical, psychiatric, psychological, vocational, educational services and psychopharmacology needs
- It is the provider's responsibility to coordinate with other treating professionals
- Discharge planning starts at admission and must be included in the treatment plan and all treatment plan reviews. Prior to discharge the IOP staff must facilitate, confirm, and document that contacts are made with the identified community service or treatment provider as identified in the discharge plan.

Staffing

Staff, licensed to practice in the State of Nebraska, enrolled with Nebraska Medicaid, contracted and credentialed with the Managed Care Entity, and acting within their scope may provide this service and include:

- Licensed Mental Health Practitioner (LMHP)
- Provisionally Licensed Mental Health Practitioner (PLMHP)
- Licensed Independent Mental Health Practitioner (LIMHP)
- Licensed Psychologist
- Provisionally Licensed Psychologist
- Psychiatrist
- Advanced Practice Registered Nurse (APRN) (if utilized must have a psychiatric specialty, and work in collaboration with a psychiatrist)

Staffing Requirements

Supervising Practitioner: (Psychiatrist, Licensed Psychologist, Licensed Independent Mental Health Practitioner (LIMHP))

The responsibilities of the Supervising Practitioner include but are not limited to the following:

- Assume accountability to direct the care of the client at the time of admission
- Provides guidance in the development of the treatment/discharge plan
- Provide face-to-face service to the client at least every 30 days (or as medically necessary) to include a diagnostic assessment or a review the effectiveness of the treatment plan
- Attend treatment planning meetings at a minimum of every 30 days to provide supervision and direction to the treatment team
- Provide supervision and direction with crisis situations

Program/Clinical Director: (LMHP, Psychiatric RN, APRN, LIMHP, Licensed Psychologist, Dual Licensure (e.g. LMHP/LADC or LMHP/PLADC) is required for Dual IOP (MH/SA) programs)

A clinician fully licensed by the State of Nebraska, who is providing services within his/her scope of practice and licensure, and has two years of professional experience in the psychiatric treatment of children and adolescents. This clinician has professional experience in a treatment setting similar to that for which the clinician is providing services of the program director.

The responsibilities of the Program/Clinical Director include but are not limited to the following:

- Oversees, implements, and coordinates all treatment services and activities provided within the program.
- Continually incorporates new clinical information and best practices into the program to assure program effectiveness and viability.
- Oversees the process to identify, respond to, and report crisis situations on a 24 hour per day, 7 day per week basis.
- Responsible in conjunction with a supervising practitioner for the program's clinical management
- Assures quality organization and management of clinical records, other program documentation, and confidentiality.

Therapist/licensed clinician: (LMHP, LIMHP, PLMHP, LADC, Licensed Psychologist, Provisionally Licensed Psychologist, APRN, Licensed Psychiatrist)

The clinician(s) providing MH/SA services for youth in the treatment program must be operating within their scope of practice and meeting program requirements.

The role and responsibilities of the therapist include but are not limited to the following:

- Reports to the Program/Clinical Director and Supervising Practitioner for clinical and non-clinical guidance and direction
- Communicates treatment issues to supervising practitioner as needed
- Provides individual, group, family psychotherapy, and/or substance abuse counseling
- Assists to develop and update treatment plans for individuals in their care in conjunction with the multidisciplinary team
- Provides input to the multidisciplinary team and attends treatment team meetings
- Provides continuous and ongoing assessment to assure the clinical needs of the youth and family are met. This includes transitioning of youth to other treatment and care settings, or other types of supports as necessary.

Staff Ratios

All staffing must be adequate to meet the individualized treatment needs of the client and meet the responsibilities of each staff position as outlined in the Staffing Requirements section to include:

- Supervising Practitioner: adequate to provide necessary services to admitted youth
- Program/Clinical Director: adequate to fulfill the expectations of this position
- Therapist/Licensed Clinician to individual served: 1 to 15 maximum clients

Training

Refer to “Standards Common to all Treatment Services” for a list of potential training topics related to the provision of mental health and substance abuse treatment. Agencies must provide adequate pre-service and ongoing training to enhance the capability of all staff to treat the individuals they serve and provide the maximum levels of safety for themselves and others.

Clinical Documentation

The program shall follow the agency’s written policy and procedures regarding clinical records that meet the accreditation body, Medicaid guidelines and the Managed Care Handbook. The agency’s policies must include specifics about timely record entry by all professionals and paraprofessionals providing services in the program.

The clinical record must provide information that fully discloses the extent and outcome of treatment services provided to the client. The clinical record must contain sufficient documentation to justify the Medicaid Managed Care service that was specifically delivered by the staff person, who it was delivered to and the frequency/duration of the service.

The record must be organized with complete legible documents. When reviewing a clinical record, a clinician not familiar with the client or the program must be able to review, understand and evaluate the mental health and substance abuse treatment for the client. The clinical record must record the date, time, and complete name and title of the facilitator of any treatment service provided to the client. All progress notes should contain the name and title of the author of the note including signature and when appropriate the signature of the Supervising Practitioner.

In order to maintain one complete, organized clinical record for each client served, the agency must have continuous oversight of the condition of the clinical record. The provider shall make the clinical record available upon Medicaid and/or the managed care entity’s request to review or receive a copy of the complete record. All clinical records must be maintained for seven years following the provision of services.

Length of Services

Length of service is individualized and based on clinical criteria for admission and continuing stay. Frequency and duration is expected to be adjusted based upon the symptoms and acuity of the mental health/substance abuse diagnoses for which they were admitted. As clients make progress toward treatment goals, frequency and duration of the service is expected to decrease. If progress is not being made and client stability is not increasing, the treatment plan must be adjusted to promote progress.

Special Procedures

None Allowed.

For client’s who present with co-occurring mental health and substance abuse symptoms and diagnoses, the provider must refer to the Youth Criteria of the Patient Placement Criteria for the Treatment of Substance-Related Disorders of the American Society of Addiction Medicine, Second Edition Revised (ASAM PPC-2R or current version) pages 217-233. Providers are responsible to refer to the ASAM

PPC-2R Youth Placement Manual for complete criteria. The provider must also adhere to the service descriptions and clinical guidelines for SA Intensive Outpatient Level II.1 as well as the clinical guidelines identified in this service description.

Clinical Guidelines: Intensive Outpatient –Adolescent MH

Admission Guidelines

All of the following Guidelines are necessary for admission to this level of care:

1. The child/adolescent demonstrates symptomology consistent with a DSM (current edition) diagnosis which requires, and can reasonably be expected to respond to, the proposed Intensive Outpatient treatment services.
2. There are significant symptoms that currently interfere with the child/adolescent's ability to function in more than one life area.
3. There is an expectation that the child/adolescent has the developmental level and/or capacity to make significant progress toward treatment goals in the IOP setting.
4. There is an expectation that the child/adolescent will show significant progress toward treatment goals within the specified time frames as dictated by the focus of the program.
5. The child/adolescent's condition requires a coordinated, community-based treatment plan of services that may require various modalities and/or clinical disciplines for progress to occur.

In addition, one of the following Guidelines is necessary for admission to this level of care:

6. Complex family dysfunction interferes with the child/adolescent's ability to benefit from traditional outpatient treatment without this level of intensity and family involvement, *or*
7. Non-participation has made outpatient individual psychotherapy treatment ineffective without team interventions and structure.

Exclusion Guidelines

Any of the following Guidelines is sufficient for exclusion from this level of care:

1. The child/adolescent requires a level of structure and supervision beyond the scope of IOP services.
2. The child/adolescent has a medical condition or impairment that warrants a medical/surgical setting for treatment.
3. The primary problem is social, educational, or economic (i.e. family conflict, need for a special school program, housing, etc.), one of physical health without concurrent major psychiatric episode, or treatment is being used as an alternative to incarceration.
4. Treatment goals are educational or supportive in nature or are intended to address issues other than currently active symptoms of a DSM diagnosis causing significant functional impairments.
5. Treatment for Pervasive Developmental Disorders and/or adaptive limitations from Pervasive Development Disorders is ineligible for Medicaid reimbursement.

Continued Stay Guidelines

All of the following Guidelines are necessary for continuing treatment at this level of care:

1. The child/adolescent's condition continues to meet Admission Guidelines for this level of care.
2. The child/adolescent's treatment continues to require the current level of care. A less intensive level of care would not be adequate for continued progress and a more intensive level of care does not appear to be necessary for continued progress to occur.
3. Treatment planning is individualized and appropriate to the child/adolescent's changing condition, with realistic and specific goals and objectives clearly stated and progress on each goal documented.
4. The treatment plan is carefully structured to achieve optimum results in the most time efficient manner possible, consistent with sound clinical practice.
5. Progress in relation to the DSM disorder symptoms is clearly evident and is described in objective terms.
6. Goals of treatment have not yet been fully achieved and adjustments in the treatment plan to address lack of progress are documented.
7. Care is rendered in a clinically appropriate manner and focused on the child/adolescent's objective functional outcomes as described in the treatment plan.
8. When appropriate, the child/adolescent is referred for psychopharmacological evaluation and intervention, and, when necessary, for re-evaluation. Collaboration with the prescriber should include regularly reporting information about side effects, compliance and effectiveness.
9. There is active discharge planning documented.
10. The child/adolescent is motivated for continued treatment as evidenced by compliance with program rules and procedures.

Discharge Guidelines

Any one of the following guidelines is sufficient for discharge from this level of care:

1. The child/adolescent no longer meets Continued Stay Guidelines, or meets Guidelines for a less, or more, intensive level of care.
2. The child/adolescent's and/or family's documented treatment plan goals and objectives have been substantially met.
3. In spite of documented attempts to address non compliance, the child/adolescent's attendance is at a level that renders continued IOP ineffective.
4. Consent for treatment is withdrawn by the parent or legal guardian.

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