

Level II.5 Partial Hospitalization – Child and Adolescent SA

Definition

The following is based on 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.

Partial hospitalization is a non-residential treatment program that is hospital-based. The program provides diagnostic and treatment services on a level of intensity similar to an inpatient program, but on less than a 24-hour basis. These services include therapeutic milieu, nursing, psychiatric evaluation, medication management, group, individual and family therapy. The environment at this level of treatment is highly structured, and there must be a staff-to-patient ratio sufficient to ensure necessary therapeutic services. Partial Hospitalization may be appropriate as a time-limited response to stabilize acute symptoms, transition (step-down from inpatient), or as a stand-alone service to stabilize a deteriorating condition and avert inpatient hospitalization.

Policy

Partial Hospitalization 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

The hospital must be licensed or formally approved as a hospital by the Nebraska Department of Health and Human Services (DHHS), Division of Public Health, or appropriately licensed in the state where the hospital is located. Acute Inpatient services must be accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), enrolled with the NE DHHS Division of Medicaid and Long-Term Care, and be contracted with the Nebraska Managed Care entity.

The hospital must have written policies and procedures related to:

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. Hospitals must develop policies to guide the provision of any service in which they engage clients, and to guide their overall administrative function, and to guide their overall administrative function and to meet the approval of their accrediting body.

Features and Hours

The program has the ability to accept admissions at any time and operates 24 hours a day, 7 days per week. Staff must be available to schedule meetings and sessions at a variety of times including weekends and evenings in order to support family involvement for the youth

Service Expectations

- An initial diagnostic interview by the program psychiatrist (child psychiatrist preferable) within 24 hours of admission
- A history and physical (H&P) is required within 24 hours of admission. If the individual is a direct admission from an acute psychiatric hospital setting, the program may elect to obtain the H&P in lieu of completing a new H&P. In this instance, the program physician's signature indicates the review and acceptance of the document.
- A multidisciplinary bio-psychosocial assessment including a comprehensive substance abuse assessment within 24 hours of admission. If the individual is a direct admission from an acute psychiatric hospital setting, the program may elect to obtain and review this assessment in lieu of completing a new assessment.
- An initial treatment/discharge plan will be developed with the attending physician within 24 hours of admission.
- The multidisciplinary team develops and signs a family centered, outcome focused comprehensive treatment/recovery and discharge plan within 48 hours of admission. The multidisciplinary team consists of the youth, the parent(s), and other caregivers identified by the youth and/or parent(s) caregiver and team members including the psychiatrist.
- Treatment interventions must be outcome focused and based on the comprehensive assessment, treatment goals, culture, expectations, and needs as identified by the youth/family/other caregivers
- Face to face with either the psychiatrist or an APRN at a minimum 5 out of 7 days, however the psychiatrist must see the client 1 out of every 5 days. The APRN, supervised by a psychiatrist, may provide the other 4 out of 5 days face to face. Services cannot be duplicated on the same day.
- The individual treatment/recovery and discharge plan is reviewed by the treatment team as frequently as medically indicated, but at a minimum of every 5 calendar days, and signed by the attending physician and the additional multidisciplinary team members
- Medication management and youth/family education (expected benefits, potential side effects, potential interactions, dosage, obtaining/filling prescriptions, etc.)
- Ancillary service referral as needed by the individual: (dental, optometry, ophthalmology, etc.)
- Partial Hospitalization must have psychological, nursing, dietary, pharmacology, emergency medical, laboratory, recreational, spiritual, and social services. Services will be utilized in accordance with the individual's treatment/recovery plan
- Individual or family therapy daily, and group therapy daily at a minimum
- Recreational therapy and psycho-educational groups daily
- 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 Partial Hospitalization.
- Discharge planning starts at admission and must be part of the treatment plan and all treatment plan reviews. Prior to discharge, the Partial Hospitalization provider must facilitate, confirm, and document that contacts are made with the identified

Special Staff Requirements for Psychiatric Hospitals as per (42 CFR 482.62)

Medical Director/Clinical Director (Boarded or Board eligible Psychiatrist) (Child Psychiatrist preferred)

Additional Psychiatrist (s) and/or Physicians (s), as needed to meet the needs of the program

APRN(s) (if utilized must have a psychiatric specialty, and work in collaboration with a psychiatrist)

Director of Psychiatric Nursing (RN. APRN)

LMHP, LMHP/ LADC, LIMHP (or managed care entity approved provisional licensure)

Psychologist

RN(s) and APRN(s) (psychiatric experience preferable)

Director of Social Work (MSW preferred)

Social Worker(s) (at least one social worker, director or otherwise, holding an MSW degree)

Technicians, HS with JCAHO approved training and competency evaluation. (2 years experience in mental health service preferred)

Medical Director (Boarded or Board eligible Psychiatrist):

A Nebraska licensed physician, working within his/her scope of practice, qualified to insure the medical integrity of, and provide the leadership required for an acute psychiatric treatment program. The psychiatrist physician's personal involvement in all aspects of the patient's care must be documented in the patient's medical record (i.e., physician's orders, progress notes).

Director of Psychiatric Nursing (RN or APRN with psychiatric experience)

The Director of Psychiatric Nursing is licensed in the State of Nebraska, works within his/her scope of practice, and has the psychiatric nursing experience to provide the leadership for the Acute Inpatient program. This position directs, supervises, evaluates, and trains other program staff to implement the nursing and other therapeutic components of the patient's treatment plan.

Director of Social Work (Master's Degree Social Worker preferred)

Monitor and evaluate the quality and appropriateness of social services furnished. If the Director of Social Work is not a Master's Degree Social Worker (MSW), at least one individual in this department needs to be an MSW.

APRN(s) (with psychiatric specialty, in collaboration with a psychiatrist)

Provides services in lieu of, and under the direction of psychiatrist/attending physician

Licensed Mental Health Practitioner, Psychologist, Licensed Independent Mental Health Practitioner:

A sufficient number of fully Nebraska licensed clinicians working within their scope of practice should be available to meet patient needs for psychotherapy services. Dual licensure is preferable for some positions to provide optimum services to patients with co-morbid diagnoses (MH/SA).

RN(s) and APRN(s):

RNs and APRNs must be Nebraska licensed, working within their scope of practice and have experience in developing and carrying out nursing care plans in mental health or substance abuse program service.

community service(s) or treatment provider (if medically necessary), as identified in the discharge plan.

Social Worker:

Social work services in the Partial Hospitalization program are carried out under the direction of a Social Work Services Director preferably possessing a MSW degree from an accredited school of social work, licensed in the State of Nebraska, and working within his/her scope of practice. The Social Worker(s) fulfills responsibilities relating to the specific needs of the individual client and their families in regard to discharge planning, community resources, consulting with other staff and community agencies as needed. This position may also assist in obtaining psychosocial information for use in planning by the treatment team.

Technicians:

Technicians, HS with JCAHO approved training and competency evaluation. (2 years experience in mental health service preferred)

Staffing Ratios

Therapist/Client: 1 to 8 minimum clients

Technician/Client: 1 to 3 minimum clients

RN services are provided in a RN/client ratio sufficient to meet patient care needs

Other positions staffed in sufficient numbers to meet patient and program needs

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 should 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. All staff must be educated and trained in substance abuse and mental health rehabilitation and recovery principles.

Clinical Documentation

The program shall follow the agency's written policy and procedures regarding clinical records. 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 client's medical necessity for this 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 summary progress notes should contain the name and title of the author of the note.

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 a minimum of seven years following the provision of services.

Length of Stay

Length of service is individualized and based on clinical criteria for admission and continuing stay, but considering its time-limited expectations, a period of 14 to 21 days with decreasing attendance hours is typical.

Special Procedures

The Partial Hospitalization program is responsible to follow all Federal, State, and accrediting body guidelines in the use of restraint and seclusion.

For client's who present with co-occurring symptoms and diagnoses, the provider must refer to the Partial Hospitalization Child and Adolescent Mental Health clinical guidelines and service descriptions as well as the clinical guidelines in this service description.

Clinical Guidelines: Level II.5: Partial Hospitalization –Adolescent SA

Admission Guidelines:

1. The child/adolescent is assessed as meeting the diagnostic criteria for a Substance Related disorder or a co-occurring psychiatric disorder as defined in the most recent DSM.
2. Direct **admission** to a Level II.5 program is advisable for the adolescent who meets stability specifications in dimensions 1 (if any withdrawal problems exist) and Dimension 2 (if any biomedical problems exist) as well as the severity specifications of *one* of the Dimensions 1, 3, 4, 5, and 6.
3. **Transfer** to a Level II.5 program is advisable for the child/adolescent who **(a)** has meet the treatment objectives at a more intensive level of care **and (b)** who requires the intensity of services provided in a Level II.5 in at least one dimension.
4. An child/adolescent also may be transferred to a Level II.5 from a Level I or a Level II.1 program when services provided at those levels have proved insufficient to address the adolescent's needs or when Level I or Level II.1 services have consisted of motivational interventions to prepare the adolescent for participation in more intensive levels of care for which he or she now meets admission criteria.

The following six dimensions are criteria that are abbreviated. ***Providers are responsible to refer to the ASAM PPC-2R Adolescent PLACEMENT MANUAL (pages 220-233) for the complete criteria.***

- **DIMENSION 1: ACUTE INTOXICATION AND/OR WITHDRAWAL**

The youth experiencing acute or subacute withdrawal marked by mild symptoms that are diminishing. The adolescent is likely to attend, engage and participate in treatment as evidenced by the following:

The youth is able to tolerate mild withdrawal symptoms;

The youth has made a commitment to sustain treatment and to follow treatment recommendations; and

The youth has external supports as from family and/or court that promote treatment engagement.

- **DIMENSION 2: BIOMEDICAL CONDITIONS AND COMPLICATIONS**

In level II.5, the youth's biomedical conditions and problems, if any, are stable or are being concurrently addressed and will not interfere with treatment at this level of care. The youth's biomedical conditions and problems are severe enough to distract from recovery and treatment at a lower level of care but will not interfere with recovery at Level II.5. The biomedical conditions and problems are being addressed concurrently by a medical treatment provider.

- **DIMENSION 3: EMOTIONAL, BEHAVIORAL OR COGNITIVE CONDITIONS AND COMPLICATIONS**

The adolescent's status at Dimension 3 is characterized by one of the following:

Dangerousness/lethality - The adolescent is at mild risk of behaviors endangering self, others or property and requires frequent monitoring to assure reasonable likelihood of safety during non-treatment hours. However, his or her condition is not severe to require 24-hour supervision.

Interface with addiction recovery efforts - The adolescent's recovery efforts are negatively affected by emotional, behavioral or cognitive problem which causes moderate interference with and requires increased intensity to support treatment participation and/or compliance.

Social functioning - The adolescent's symptoms are causing mild to moderate difficulty in social functioning but not to such a degree that the adolescent is unable to manage the activities of daily living or to fulfill responsibilities at home, school, work or community. Alternatively, the adolescent may be transitioning back to the community in a step-down from an institutional setting.

Ability for self-care - The adolescent is experiencing moderate impairment in the ability to manage activities of daily living and thus requires near daily monitoring and treatment interventions. Problems may involve disorganization and inability to manage the demands of daily self-scheduling, a progressive pattern of promiscuous or unprotected sexual contacts, or poor vocational or pre-vocational skills that require habilitation and training provided by the program.

Course of illness - The adolescent's history and present situation suggest that an emotional, behavioral, or cognitive condition would become unstable without daily or near daily monitoring and maintenance.

- **DIMENSION 4 READINESS TO CHANGE:**

The adolescent status is characterized by:

The adolescent requires structured therapy and programmatic milieu to promote progress through the stages of change as evidenced by the following:

The adolescent demonstrates verbal and behavioral opposition to treatment,

The adolescent is only minimally involved in treatment,

The adolescent demonstrates poor compliance with attendance at outpatient sessions, or

The adolescent's alcohol and drug use is escalating, contributing to school failure, truancy or behaviors leading to suspension from school.

The adolescent's perspective and lack of impulse control inhibits the adolescent's ability to make progress through stages of change. The adolescent thus requires structured therapy and a programmatic milieu. Such interventions are not feasible or likely to succeed in a Level II.1 service. However, the adolescent's resistiveness is not so high as to render treatment ineffective.

• DIMENSION 5 RELAPSE, CONTINUED USE OR CONTINUED PROBLEM POTENTIAL:

The adolescent's status in Dimension 5 is characterized by the following:

The adolescent is at high risk of relapse or continued use without almost daily outpatient monitoring and structured therapeutic services. Treatment at a less intensive level of care has been attempted or given serious consideration and has been judged insufficient to stabilize the adolescent's condition.

The adolescent demonstrates impaired recognition and understanding of relapse issues. The adolescent has such poor skills in coping with, and interrupting substance use problems and avoiding or limiting relapse that the near daily structure afforded by Level II.5 is needed to prevent or arrest significant deterioration in functioning.

• DIMENSION 6 RECOVERY ENVIRONMENT:

The adolescent's status in Dimension 6 is characterized by:

Continued exposure to the adolescent's current school, work or living environment will render recovery unlikely. The adolescent lacks the resources or skills necessary to maintain an adequate level of function without the services of a Level II.5 program. The youth is capable of maintaining an adequate level of functioning between sessions.

The adolescent lacks social contacts or has inappropriate social contacts that jeopardize recovery or has few friends or peers who do not use alcohol or drugs. The adolescent has insufficient resources or skills necessary to maintain an adequate level of functioning without the services of Level II.5 program but is capable of maintaining an adequate level of functioning between sessions.

Family members and/or significant others living with the adolescent are not supportive of his or her recovery goals and/or are passively opposed to treatment. The adolescent requires structured treatment services and relief from the home environment in order to remain focused on recovery but he or she may live at home because there is active opposition to or sabotaging of the recovery effort.

Exclusionary Guidelines:

1. N/A in ASAM. Please refer to admission and continued stay criteria as noted.
2. Treatment for Pervasive Developmental Disorders and/or adaptive limitations from Pervasive Development Disorders is ineligible for Medicaid reimbursement.

Continued Stay Guidelines:

It is appropriate to retain the individual at the present level of care if:

1. The individual is making progress but has not yet achieved the goals articulated in the individualized treatment plan. Continued treatment at this level of care is assessed as necessary to permit the individual to continue to work toward his or her treatment goals.

OR

2. The individual is not yet making progress, but has the capacity to resolve his or her problems. The individual is actively working toward the goals in the individualized treatment plan. Continued treatment at this level of care is assessed as necessary to permit the individual to continue to work toward his or her treatment goals.

AND/OR

3. New problems have been identified that are appropriately treated at this level of care. This level of care is the least intensive level of care at which the individual's new problems can be addressed effectively.

To document and communicate the individual's readiness for discharge or need for transfer to another level of care, each of the six dimensions of the ASAM criteria should be reviewed. If the criteria apply to the individual's existing or new problem(s), he or she should continue in treatment at the present level of care. If not, refer to the Discharge/Transfer Criteria.

Discharge/Transfer Criteria

It is appropriate to transfer or discharge the youth from the present level of care if he or she meets the following criteria:

1. The youth has achieved the goals articulated in his or her individualized treatment plan thus resolving the problem(s) that justified admission to the present level of care and the youth has a comprehensive relapse plan in place which is individualized for his/her specific needs.

OR

2. The youth has been unable to resolve the problem(s) that justified admission to the present level of care, despite amendments to the treatment plan. Treatment at another level of care or type of service is therefore indicated.

OR

3. The youth has demonstrated a lack of capacity to resolve his or her problem(s). Treatment at another level of care or type of service is therefore indicated.

OR

4. The youth has experienced an intensification of his or her problem(s), or has developed a new problem(s), and can be treated effectively only at a more intensive level of care.

To document and communicate the youth's readiness for discharge or need for transfer to another level of care, each of the six dimensions of the ASAM criteria should be

reviewed. If the criteria apply to the existing or new problem(s), the youth should be discharged or transferred, as appropriate.

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