

## **Partial Hospitalization – Child and Adolescent MH (Managed Medicaid only Service)**

### **Definition**

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 within 24 hours of admission including alcohol and drug screening. A full substance abuse evaluation is required if alcohol and drug screening indicates the need. 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 psychotherapy daily, and group psychotherapy 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 community service(s) or treatment provider (if medically necessary), as identified in the discharge plan.

## **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 an 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 or provisionally 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 psychiatric service programs.

### 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 patient 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 maximum clients

Technician/Client: 1 to 3 maximum 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 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 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 Partial Hospitalization Level II.5 as well as the clinical guidelines identified in this service description.**

Clinical Guidelines: Partial Hospitalization – Child and Adolescent MH (Managed Medicaid only Service)

### Admission Guidelines

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

1. The child/adolescent demonstrates symptomatology consistent with a DSM (current edition) diagnosis which requires, and can reasonably be expected to respond to, the structured milieu of the proposed Partial Hospitalization.
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 using Partial Hospitalization.
4. The patient's condition requires a structured program with frequent supervision intervention and or treatments which cannot be provided in a less intensive outpatient setting at this time, and/or Partial Hospitalization can safely substitute for, or shorten, a potential hospital stay.
5. The child/adolescent has a suitable environment for the time outside of the Partial Hospitalization program and is believed to be capable of controlling the behavior and/or to seek appropriate support when not in the Partial Hospital setting.

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

6. There is clinical evidence that the child/adolescent would be at risk to self or others if he or she were not in a Partial Hospitalization program, *or*

7. As a result of the child/adolescent's mental disorder, there is an inability to adequately care for one's physical needs, representing potential serious harm to self.

### Exclusion Guidelines

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

1. The child/adolescent's safety needs cannot be adequately met outside of an inpatient setting or their treatment requires 24/7 availability of psychiatric medical and nursing interventions.
2. The child/adolescent requires a level of structure and supervision beyond the scope of Partial Hospital services.
3. The child/adolescent has a medical condition or impairment that warrants a medical/surgical setting for treatment.
4. 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 meeting, or treatment is being used as an alternative to incarceration.
5. 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.
6. 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 Partial Hospitalization ineffective.
4. Consent for treatment is withdrawn by the parent or legal guardian.

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