

Day Treatment Mental Health – Adult

Definition

Day Treatment provides a community based, coordinated set of individualized treatment services to individuals with psychiatric disorders who are not able to function full-time in a normal school, work, and/or home environment and need the additional structured activities of this level of care. While less intensive than hospital based day treatment, this service includes diagnostic, medical, psychiatric, psychosocial, and adjunctive treatment modalities in a structured setting. Day Treatment programs typically are less medically “involved” than Hospital Based Day Treatment programs. Day Treatment should not be confused with custodial and social rehabilitation programs. Day Treatment leads to the attainment of specific goals through specific therapeutic interventions and allows for transition of the patient to an outpatient level of care.

Policy

Day Treatment mental health services are available to Medicaid Managed Care eligible adult members, age 21 and over.

Program Requirements

Refer to general “Facility and Program Standards” for additional requirements

Licensing/Accreditation

Licensed as a Adult Day Service.

The agency 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. 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

May be available 7 days/week with a minimum availability of 5 days /week including days, evenings and weekends

Service Expectations

- An initial diagnostic interview by the program psychiatrist within 24 hours of admission
- Multidisciplinary bio-psychosocial assessment within 24 hours of admission including alcohol and drug screening and assessment as needed
- A history and physical present in the client’s record within 30 days of admission
- A treatment/recovery plan developed by the multidisciplinary team integrating individual strengths & needs, considering community, family and other supports, stating measurable goals, that includes a documented discharge and relapse prevention plan completed within 72 hours of admission

- The individual treatment plan is reviewed at least bimonthly and more often as necessary, updated as medically indicated, and signed by the supervising practitioner and other treatment team members, including the individual being served
- Medication management
- Consultation services available for general medical, pharmacology, psychological, dietary, pastoral, emergency medical, recreation therapy, laboratory, dietary if meals are served, and other diagnostic services
- Ancillary service referral as needed: (dental, optometry, ophthalmology, other mental health and/or social services, etc.)
- Individual, group, and family therapy services
- Recreation and social services
- Access to community based rehabilitation/social services that can be used to help the individual transition to the community
- Face-to-face psychiatrist/APRN visits 1X weekly

Staffing

- Supervising Practitioner (psychiatrist)
- Clinical Director (APRN, RN, LMHP, LIMHP, or licensed Psychologist).
- Nursing (APRN, RN) (psychiatric experience preferred)
- Therapist (Psychiatrist, APRN, LMHP, PLMHP, LIMHP, Psychologist, Provisionally Licensed Psychologist)
- All staff must be Nebraska licensed and working within their scope of practice as required.
- Direct care staff, holding a BS degree or higher in psychology, sociology, or a related human service field are preferred, but two years of course work in a human services field, and two years experience/training with demonstrated skills and competencies in treatment with individuals with a MH diagnoses is acceptable.

Supervising Practitioner (psychiatrist):

A Nebraska licensed physician, working within his/her scope of practice, to provide medical oversight to the program. The supervising practitioner's personal involvement in aspects of the individual's care must be documented in the individual's medical record. The psychiatrist must be available, in person or by telephone, to provide assistance and direction to the program as needed.

Clinical Director:

APRN, RN, LMHP, LIMHP, or licensed Psychologist) working with the program to provide clinical supervision, consultation and support to staff and the individuals they serve, continually incorporating new clinical information and best practices into the program to assure program effectiveness and viability, and assure quality organization and management of clinical records, and other program documentation. Depending on the size of the program more than one Clinical Director may be needed to meet these expectations.

Therapist:

A sufficient number of Nebraska licensed or provisionally licensed mental health practitioners working with their scope of practice should be available to meet the needs of individuals served. Dual licensure is preferable for some positions to provide optimum services to patients with co-occurring diagnoses (MH/SA).

Nursing:

RN's should be Nebraska licensed, working within their scope of practice and have experience in assessment as well as developing and carrying out nursing care plans for individuals with a MH diagnosis.

Direct Care:

Direct care staff holding a BS degree or higher in psychology, sociology, or a related human service field are preferred, but two years of course work in a human services field, and two years experience/training with demonstrated skills and competencies in treatment of individuals with a MH diagnoses is acceptable.

Staff Ratios

- Clinical Director to direct care staff ratio as needed to meet all responsibilities
Therapist/Individual
- 1 to 12; Care Worker/Individual: 1 to 6

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/trained in 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 Medicaid Managed Care participation.

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.

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 ASO'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, but considering its time-limited expectations, a period of 21-90 days with decreasing days in attendance is typical.

Special Procedures

None allowed.

Clinical Guidelines: Day Treatment MH - Adult

Admission Guidelines

Valid principal DSM (most current version) Axis I or II diagnosis AND All of the following:

1. The client is unable to maintain an adequate level of functioning outside the treatment program due to a mental health disorder as evidenced by:
 - a. Severe psychiatric symptoms that require medical stabilization.
 - b. Inability to perform the activities of daily living.
 - c. Significant interference in at least one functional area (Social, vocational/educational, etc.)
 - d. Failure of social/occupational functioning or failure and/or absence of social support resources.

The treatment necessary to reverse or stabilize the client's condition requires the frequency, intensity and duration of contact

Exclusionary Guidelines

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

1. The individual is an active or potential danger to self or others or sufficient impairment exists that a more intense level of service is required.
2. The individual has medical conditions or impairments that warrant a medical/surgical setting for treatment.

3. The individual requires a level of structure and supervision beyond the scope of the program.
4. The individual can be safely maintained and effectively treated at a less intensive level of care.
5. The primary problem is social, economic (i.e. housing, family conflict, etc.) or one of physical health without a concurrent major
6. psychiatric episode meeting guidelines for this level of care, or admission is being used as an alternative to incarceration.

Continued Stay Guidelines

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

1. The individual's condition continues to meet admission guidelines for this level of care.
2. The individual does not require a more intensive level of care, and no less intensive level of care would be appropriate.
3. There is reasonable likelihood of substantial benefit as a result of active continuation in the therapeutic program, as demonstrated
4. by objective behavioral measurements of improvement.
5. The consumer is making progress toward goals and is actively participating in the interventions.
6. Treatment planning is individualized and appropriate to the individual's changing condition with realistic and specific goals and
7. objectives stated.
8. All services and treatment are carefully structured to achieve optimum results in the most time efficient manner consistent with
9. sound clinical practice, including evaluating and/or prescribing appropriate psychopharmacological intervention.
10. There is documented active discharge planning, including relapse and crisis prevention planning.

Discharge Guidelines

Any of the following may be sufficient for discharge from this level of care:

1. The individual's documented treatment plan, goals and objectives have been substantially met.
2. The individual no longer meets Continued Stay Guidelines, or meets Guidelines for a less or more restrictive level of care.
3. Symptoms are stabilized.
4. Support systems that allow the individual to be maintained in a less restrictive treatment environment have been secured.