



CENPATICO

# Utilization Management Guidelines for the Iowa Plan

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## Introduction

Cenpatico Behavioral Health, LLC created its Utilization Management Guidelines for use by the Cenpatico clinical staff and clinician consultants as well as Cenpatico's network of providers in making determinations regarding the appropriateness and the level of mental health and substance abuse care. Cenpatico considers consumers' bio-psycho-social needs, including factors that take into consideration their support system, culture, environment and motivation. Upon receipt of the clinical information including the assessment of the consumer's bio-psycho-social needs obtained from a face to face evaluation, Cenpatico clinical staff will make a determination using these standards except when other standards are mandated by State law or contract. For Substance Abuse Disorder determinations, including ambulatory detoxification, Cenpatico utilizes the American Association of Addiction Medicine's 2<sup>nd</sup> Edition-Revised Patient Placement Criteria (ASAM PPC-2R). The determinations will be consistent with Cenpatico clinical practice guidelines and the prevailing standards of care. Cenpatico will then communicate the decision to the consumer, provider, and/or facility. These guidelines are reviewed and revised annually and have been approved by the Cenpatico's corporate oversight committee.

## Guidelines for Providers in Evaluating Psychosocial Necessity in Conjunction with Medical Necessity

Cenpatico is dedicated to the principle that behavioral health and substance abuse services should be provided at the least restrictive level of care while ensuring safety, effectiveness, and a focus on recovery and resiliency.

**Recovery** is defined as the ability to live a fulfilling and productive life despite a history of behavioral health challenges, by reducing or eliminating the impact of the symptoms of mental illness, overcoming behavioral health challenges and developing compensatory life skills.

**Resiliency** is defined as the personal and community qualities that ameliorate the effects of illness, trauma, adversity or other stressors. Using a recovery-oriented philosophy, we train our clinical staff and educate network providers to recognize that using an individual's personal strengths, skills and social supports is essential in helping them achieve and maintain their recovery goals.

Cenpatico's guidelines take into account not only medical necessity, but also psychosocial factors in working with providers and consumers in determining the appropriate care. This requires that providers evaluate and document supporting evidence for both Medical Necessity and Psychosocial Necessity in determining the appropriate level of care and treatment or rehabilitative planning. Psychosocial Necessity is an expansion of the concept of Medical Necessity and shall mean clinical, rehabilitative or supportive mental health treatment or rehabilitative planning. Recovery-oriented treatment and discharge planning is evidenced, at a minimum, by meeting the following guidelines:

- 1) ***A Strengths-Based Assessment (SBA) has been completed and is updated on an ongoing basis.*** There shall be evidence that a discussion of strengths is a central focus of every assessment and treatment or care plan. The SBA is conducted as a collaborative process with the consumer and all assessments are in written form and shared with the consumer during treatment.
- 2) ***Primacy of participation and active engagement of the consumer must be evident in treatment and treatment planning.*** Consumers in treatment, and where appropriate, family members and other natural supports, participate and drive the initial framing of questions or problems to be addressed as well as treatment interventions. The consumer is not referred to, or treated as, a diagnosis, nor a "case" being "managed" by treatment or rehabilitative professionals. The consumer is the driver of his or her own recovery plan with professional interventions agreed upon and contracted for between the consumer and helping professional.

- 3) ***Ensuring continuity of care is vital to recovery.*** Providers demonstrate in treatment planning their understanding that a particular episode of treatment or rehabilitative service needs to be understood within the context of the consumer's treatment and rehabilitative history. The providers must have an understanding of the consumer as a whole person, within a community, with specialized needs and existing supports understood across their recovery history.
- 4) ***An individualized recovery-oriented treatment and discharge plan must be developed.*** All treatment and rehabilitative services and supports to be provided shall be based on an individualized, multi-disciplinary recovery plan developed in partnership with the consumer receiving these services and any others that he or she identifies as supportive of the process. While based on a model of collaboration, significant effort is taken to ensure that the consumer rights to self-determination are respected and that all consumers in treatment are afforded maximum opportunity to exercise choice in the full range of treatment and recovery decisions. The individualized plan will include a comprehensive and culturally sensitive assessment of the person's hopes, assets, strengths, interests and goals and will reflect a holistic understanding of his or her behavioral health conditions, general medical concerns, barriers to recovery and desires to build or maintain a meaningful life in their community.
- 5) ***Identify and address psychosocial factors and barriers that do not support recovery.*** The treatment and discharge plan shall incorporate an understanding of psychosocial factors, the elements and characteristics of the service delivery system and the broader community that may unwittingly contribute to the creation and perpetuation of chronicity and dependency in some consumers with behavioral health disorders. Providers are expected to work with consumers to find and implement strategies that address these barriers to recovery and offer alternative supports that foster the individual's recovery and independence.

## **Descriptions of Levels of Care**

Cenpatico's philosophy of care is centered on consumers receiving individualized, recovery-oriented, quality mental healthcare in the least restrictive setting to meet their needs. To ensure that consumers receive a high standard of care, Cenpatico has defined the following eight levels of care and described the minimum services which are associated with each level of care.

(Note: All levels of care and services are not available as covered benefits for all Enrollees. For example, mental healthcare for children in Psychiatric Mental Institutes for Children is carved out of the Iowa Plan benefit structure.)

### **1. Acute Psychiatric Inpatient**

Acute hospitalization is the highest level of care for psychiatric. This facility based care may occur in a psychiatric unit of a general hospital or at a free standing psychiatric program. Key elements of this level of care are: the facility is licensed as a hospital, 24 hour medical and nursing care is provided, care is supervised by behavioral health specialists, and each consumer must have an individualized recovery-oriented treatment plan that addresses their mental health and substance abuse needs, psychosocial needs, sets discharge standards, identifies barriers to discharge, and ensures that the treatment is the least restrictive option. The consumer cannot be safely treated at a lower level of care and should improve within a reasonable and predictable period of time.

The Acute Psychiatric Inpatient Hospitalization definition also covers 23-hour observation beds or beds that provide an equivalent or greater intensity of nursing and medical care.

Crisis stabilization services provide 24 hour medical and nursing care, and serve as a diversion to acute psychiatric inpatient services. Crisis stabilization services are provided by behavioral health specialists at facilities generally not licensed as hospitals.

2. **Sub-acute Facility**

The Sub-acute Facility is an inpatient level of care but treatment is not narrowly focused only on immediate stabilization of acute conditions. The facilities are licensed and nursing and medical services are required with daily nursing notes and notes by the psychiatrist every two to three days. Each consumer must have an individualized recovery-oriented treatment plan that addresses their mental health and substance abuse needs, psychosocial needs, sets discharge standards, identifies barriers to discharge, and ensures that the treatment is the least restrictive option.

3. **Residential Treatment**

Residential treatment describes a longer term 24 hour program of treatment for consumers with severe mental disorders. Care at a Residential Treatment Center (RTC) is medically monitored, with 24 hour onsite nursing services and medical provider availability. RTC treatment is expected to provide a range and intensity of diagnostic, therapeutic, life skills, rehabilitation and milieu-behavioral health and/or substance abuse services that cannot be provided by a combination of outpatient or community based services. Each consumer must have an individualized recovery-oriented treatment plan that addresses their mental health and substance abuse needs, psychosocial needs, sets discharge standards, identifies barriers to discharge, and ensures that the treatment is the least restrictive option. Family therapy should occur 2-3 times per week as part of the treatment to ensure that the consumer can reintegrate back into their home and community (unless there is an identified valid reason why such a plan is not clinically appropriate or feasible). Goals should be clinically significant and achievable within a reasonable and predictable period of time

4. **Partial Hospitalization**

Partial hospital programs provide services at least 4 hours/day for 3 days/week and typically are initially provided 6 hours/day for 5 days/week. These facility based services are of similar intensity to acute hospital services: on-site nursing, psychiatric and behavioral health services are available as needed by the consumer, but are provided less than 24 hours/day. The consumer is not a resident of the program. Each consumer must have an individualized recovery-oriented treatment plan that addresses their mental health and substance abuse needs, psychosocial needs, sets discharge standards, identifies barriers to discharge, and ensures that the treatment is the least restrictive option. A specific treatment goal of this treatment is improving symptoms and level of functioning, and addressing barriers to recovery which support the consumer's success in participating in a lesser level of care within a reasonable and predictable period of time. Partial hospital programs for children and adolescents are expected to have family therapy sessions at least once a week.

5. **Day Treatment**

Day Treatment Programs can be either free-standing or hospital based and provide frequent behavioral monitoring, and intervention and access to frequent medication management by a behavioral health specialist, when necessary. Consumers at this level of care are unable to be treated by or have not responded to traditional mental health services (i.e. individual/family/group therapy, medication management, etc) and are experiencing an exacerbation of a longstanding psychiatric disorder, are at risk of deteriorating, or cannot reach identified goals due to significant functional impairments associated with the mental health diagnosis and psychosocial factors. The Day Treatment program must provide an integrated program of rehabilitation counseling, education, therapeutic, and/or family services at least 25 hours in a week to address a consumer's mental health and/or substance abuse needs as well as psychosocial needs. Each consumer must have an individualized recovery-oriented treatment plan that addresses their mental health and substance abuse needs, psychosocial needs, sets discharge standards, identifies barriers to discharge, and ensures that the treatment is the least restrictive option. A specific treatment goal of the treatment team is a reduction in severity of symptoms, improvement in level of functioning, and a plan

addressing barriers to recovery sufficient to return the consumer to a lower level of care within a reasonable and predictable period of time

**6. Intensive Outpatient Programs**

Intensive Outpatient Programs must provide an integrated program of rehabilitation, counseling, education, therapeutic, and/or family services of six to nine or more hours per week to address a consumer's mental health and/or substance abuse needs. The minimum number of hours of service is 6 hours per week. Each consumer must have an individualized recovery-oriented treatment plan that addresses their mental health and substance abuse needs, psychosocial needs, sets discharge standards, identifies barriers to discharge, and ensures that the treatment is the least restrictive option. A specific treatment goal of the treatment team is reduction in severity of symptoms, improvement in level of functioning, and a plan addressing barriers to recovery sufficient to return the consumer to outpatient treatment follow-up and/or self-help support groups within a reasonable and predictable period of time

**7. Rehabilitation and Community Support Services**

The primary goal of Rehabilitation and Support Services is to maintain the member in their home, and community. Members who have not regained sufficient stability and function with traditional mental health services (i.e. individual/family/group therapy, and/or medication management, etc) or who have complex needs which require the involvement of multiple providers and agencies can be eligible for this level of care. In all cases, the treatment plan should be individualized, recovery-oriented and use techniques that are time-limited in nature and subordinate to a goal of enhanced autonomy and the least restrictive environment possible. The treatment plan should be updated monthly (every 30 days) and reflect efforts to reduce the frequency of service or clinical documentation for inability to decrease the usage of Rehabilitation and Support Services.

**8. Outpatient Treatment**

Outpatient treatment may be comprised of evaluation services, individual, group, and/or family therapy, and medication management services provided by behavioral health specialists. Each consumer must have an individualized recovery-oriented treatment plan that addresses their mental health and substance abuse needs, psychosocial needs, sets discharge standards, identifies barriers to discharge, and ensures that the treatment is the least restrictive option. The treatment plan should be updated monthly (every 30 days) and reflect efforts at targeting symptom reduction, increase community tenure by addressing barriers to recovery, and enhance independence.

## **Hospitalization, Psychiatric Adult**

### ***Quality of Care Standards***

*Standards must apply for any requested service either at admission or during continued stay.*

The services provided to identify or treat an illness are consistent with the diagnosis and treatment of a condition, and the standards of good medical practice.

#### **I. Admission - Severity of Need**

*A and either B, C, D, E or F must be met to satisfy severity of need.*

- A. The consumer must have a diagnosed or suspected mental illness. Mental illness is defined as a psychiatric disorder that, by accepted medical standards, can be expected to improve significantly through psychosocially necessary and appropriate therapy at this level of care. Presence of the illness(es) must be documented through the assignment of appropriate DSM-IV-TR® codes on all applicable axes (I-V).
- B. The consumer demonstrates a clear and reasonable inference of imminent serious harm to self by (any one of the following):
  - 1. Current plan or intent to imminently and seriously harm self with an available and highly lethal means.
  - 2. A highly lethal recent attempt to harm self with continued imminent risk as demonstrated by poor impulse control or an inability to plan reliably for safety.
  - 3. An acute, severe decompensation in the ability to care adequately for own physical needs demonstrated through disordered, disorganized or bizarre behavior.
  - 4. Other similarly clear and reasonable evidence of imminent serious harm to self.
- C. The consumer demonstrates a clear and reasonable inference of imminent serious harm to others by (any one of the following):
  - 1. Current plan or intent to imminently and seriously harm others with an available and highly lethal means.
  - 2. A highly lethal recent action to harm others with continued imminent risk as demonstrated by poor impulse control or an inability to plan reliably for safety.
  - 3. Violent, unpredictable, or uncontrolled behavior that represents an imminently serious harm to the body or property of others.
  - 4. Other similarly clear and reasonable evidence of imminent serious harm to others.
- D. As a result of potential reasonable complications from an acute psychiatric assessment technique or intervention, there is a high probability of serious, imminent and dangerous deterioration of the consumer's general medical or mental health.
- E. A lower level of care is not available or will not provide the support to prevent deterioration of the consumer's condition or maintain functioning improvement attained through previous treatment.
- F. Psychosocial factors identified (See III. Admission – Psychosocial Factors), prevent the establishment of a viable plan for recovery which would provide the support to prevent the deterioration of the consumer's condition or maintain functioning improvement attained through previous treatment.

#### **II. Admission - Intensity of Service**

*Standards A, B and C must be met to satisfy intensity of service.*

- A. The evaluation and assignment of the mental illness diagnosis must take place in a face-to-face evaluation of the consumer performed by an attending physician prior to, or within 24 hours following the admission.
- B. This care must require an recovery-oriented individual plan of active psychiatric treatment that includes 24-hour need for, and access to, the full spectrum of psychiatric staffing. This psychiatric staffing must provide 24-hour services, including medication monitoring and administration, other therapeutic interventions, quiet room, seclusion, intermittent restraints, and suicidal/homicidal observation and precautions.
- C. A recovery-oriented discharge plan is initially formulated that is directly linked to the behaviors and/or symptoms as well as psychosocial factors that resulted in admission. This plan receives regular review and revisions that includes, as appropriate, timely evaluation of post-hospitalization needs and potential barriers to recovery

### **III. Admission – Psychosocial Factors**

*If Standard A is met, intensity of service is met. Otherwise, a minimum of two of Standards B-H must be met to satisfy intensity of service.*

- A. Due to symptoms of their illness, the consumer is unable to comprehend, engage or participate in a strengths based assessment and in recovery-oriented treatment planning and discharge planning.
- B. Current recovery and living environment is such that the likelihood of a successful recovery oriented treatment plan at a lower level of care is extremely doubtful, e.g., homelessness.
- C. There is a lack of family, friends or other natural supports in their community.
- D. The consumer has experienced a recent traumatic event, e.g., sudden and dangerous deterioration in living arrangements, physical abuse, sexual abuse, sudden loss of a key familial or other natural supports (e.g., death), sudden loss of employment (e.g., firing, job layoff), sudden change in a serious medical condition, etc.
- E. The consumer faces imminent legal risks, such as incarceration, due in significant part to their illness.
- F. Access issues, such as transportation, physical or cognitive or mental disability, lack of other alternative treatment or rehabilitative services in community, prevent the establishment of a viable recovery-oriented treatment plan at a lower level of care.
- G. Due to cultural or linguistic issues, the consumer is unable to comprehend, engage or participate in a strengths based assessment and in recovery-oriented treatment planning and discharge planning.
- H. Stressors and barriers related to primary caretaker responsibilities such as single parent with children at home, elder care, or care of someone at home who is disabled.

### **IV. Continued Stay**

*Standards A, B, C and D, and either E or F must be met to satisfy continued stay.*

- A. Despite therapeutic efforts, clinical evidence indicates the persistence of problems or psychosocial factors that caused the admission to the degree that would necessitate continued hospitalization, or the emergence of additional problems or psychosocial factors consistent with the admission standards and to the degree that would necessitate continued hospitalization.
- B. The current recovery oriented treatment plan should include documentation of diagnosis (DSM-IV-TR®, I-V), a written strength based assessment, a plan for addressing identified barriers to recovery, documentation of the consumer's participation and acceptance of the

treatment and discharge planning, individualized goals of treatment and treatment modalities needed and provided on a 24-hour basis.

- C. The consumer's progress confirms that the presenting, or newly defined problem(s) or psychosocial factors will respond to the current treatment plan.
- D. Daily progress notes, written and signed by the provider, document the treatment received and consumer's response.
- E. There is a severe reaction to medication or need for further monitoring and adjustment of dosage in an inpatient setting. This should be documented in daily progress notes by a physician.
- F. There is clinical evidence that disposition planning, identified psychosocial factors, identified barriers to recovery, progressive increases in hospital privileges and/or attempts at therapeutic re-entry into the community have resulted in, or would result in exacerbation of the psychiatric illness to the degree that would necessitate continued hospitalization.

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## **Hospitalization, Psychiatric, Child and Adolescent**

### ***Quality of Care Standards***

*Standards must apply for any requested service either at admission or during continued stay.*

The services provided to identify or treat an illness are consistent with the diagnosis and treatment of a condition, and the standards of good medical practice.

#### **I. Admission - Severity of Need**

*Standards A and either B, C, D, E or F must be met to satisfy severity of need.*

- A. The child/adolescent must have a diagnosed or suspected mental illness that can be expected to improve significantly. Mental illness is defined as a psychiatric disorder that, by accepted medical standards, can be expected to improve significantly through psychosocially necessary and appropriate therapy at this level of care. Presence of the illness(es) must be documented through the assignment of appropriate DSM-IV-TR® codes on all applicable axes (I-V).
- B. The child/adolescent demonstrates a clear and reasonable inference of imminent serious harm to self by (any one of the following):
  - 1. Current plan or intent to imminently and seriously harm self with an available and highly lethal means.
  - 2. A highly lethal recent attempt to harm self with continued imminent risk as demonstrated by poor impulse control or an inability to plan reliably for safety.
  - 3. An imminently dangerous inability to care adequately for own physical needs through disordered, disorganized or bizarre behavior.
  - 4. Other similarly clear and reasonable evidence of imminent serious harm to self.
- C. Current plan or intent to imminently and seriously harm others with an available and highly lethal means.
  - 1. Current plan or intent to imminently and seriously harm others with an available and highly lethal means.
  - 2. A highly lethal recent action to harm others with continued imminent risk as demonstrated by poor impulse control or an inability to plan reliably for safety.
  - 3. Violent, unpredictable, or uncontrolled behaviors that represents an imminently serious harm to the body or property of others.
  - 4. Other similarly clear and reasonable evidence of imminent serious harm to others.
- D. As a result of potential reasonable complications from an acute psychiatric assessment technique or intervention, there is a high probability of serious, imminent and dangerous deterioration of the child/adolescent's general medical or mental health.
- E. A lower level of care is not available or will not provide the support to prevent deterioration of the child/adolescent's condition or maintain functioning improvement attained through previous treatment.
- F. Psychosocial factors identified (See III. Admission – Psychosocial Factors) prevent the establishment of a viable recovery plan which would provide the support to prevent the deterioration of the child/adolescent's condition or maintain functioning improvement attained through previous treatment.

#### **II. Admission - Intensity of Service**

*Standards A, B and C must be met to satisfy intensity of service.*

- A. The evaluation and assignment of the mental illness diagnosis must take place in a face-to-face evaluation of the child/adolescent performed by an attending physician prior to, or within 24 hours following the admission. Parents/ guardians/ other caretakers should be included in the evaluation process, unless there are specific clinical contraindications for their involvement.
- B. This care must require an recovery oriented individual plan of active psychiatric treatment that includes 24-hour need for, and access to, the full spectrum of psychiatric staffing. This psychiatric staffing must provide 24-hour services, including medication monitoring and administration, other therapeutic interventions, quiet room, seclusion, intermittent restraints, and suicidal/homicidal observation and precautions.
- C. A recovery oriented discharge plan is initially formulated that is directly linked to the behaviors and/or symptoms as well as psychosocial factors that resulted in admission. This plan receives regular review and revision that includes, as appropriate, timely evaluation of post-hospitalization needs and potential barriers to recovery.

### **III. Admission – Psychosocial Factors**

*If Standard A is met, intensity of service is met. Otherwise, a minimum of two of Standards B-I must be met to satisfy intensity of service.*

- A. The child/adolescent and/or custodial guardian is unable to comprehend, engage or participate in a strengths based assessment and in recovery-oriented treatment planning and discharge planning.
- B. Current recovery and living environment is such that the likelihood of a successful recovery oriented treatment plan at a lower level of care is extremely doubtful, e.g., homelessness.
- C. There is a lack of daycare or other responsible adult supervision and support available when needed by the custodial guardian.
- D. The child/adolescent has experienced a recent traumatic event, e.g., sudden and dangerous deterioration in living arrangements, physical abuse, sexual abuse, sudden loss of a key familial or other natural supports (e.g., death), sudden change in a serious medical condition, etc.
- E. The child/adolescent faces imminent legal risks, such as incarceration, due in significant part to their illness.
- F. Access issues, such as transportation, physical or cognitive or mental disability, lack of other alternative treatment or rehabilitative services in the community, prevent the establishment of a viable recovery-oriented treatment plan at a lower level of care.
- G. Due to cultural or linguistic issues, the child/adolescent and/or custodial guardian is unable to comprehend, engage or participate in a strengths based assessment and in recovery-oriented treatment planning and discharge planning.
- H. Due to physical or psychiatric disability, the custodial guardian is unable to comprehend, engage or participate in a strengths based assessment and in recovery-oriented treatment planning and discharge planning.
- I. Significant stressors and barriers related to the custodial guardian's primary caretaker responsibilities such as single parent with children at home, elder care, or care of someone at home who is disabled.

### **IV. Continued Stay**

*Standards A, B, C, D and E, and either F or G must be met to satisfy continued stay.*

- A. Despite therapeutic efforts, clinical evidence indicates the persistence of problems or psychosocial factors that caused the admission to the degree that would necessitate continued

hospitalization, or the emergence of additional problems or psychosocial factors consistent with the admission standards and to the degree that would necessitate continued hospitalization.

- B. The current recovery oriented treatment plan should include documentation of diagnosis (DSM-IV-TR®, I-V), a written strength based assessment, a plan for addressing identified barriers to recovery, documentation of the child/adolescent's and/or custodial guardian's participation and acceptance of the treatment and discharge planning, individualized goals of treatment and treatment modalities needed and provided on a 24-hour basis.
- C. The child/adolescent's progress confirms that the presenting, or newly defined problem(s) or psychosocial factors will respond to the current treatment plan.
- D. Daily progress notes, written and signed by the provider, document the treatment received and consumer's response.
- E. There should be evidence of intensive family involvement occurring several times per week unless the treatment plan specifically indicates a clinical need for less frequent involvement.
- F. There is a severe reaction to medication or need for further monitoring and adjustment of dosage in an inpatient setting. A physician should document this in daily progress notes.
- G. There is clinical evidence that disposition planning, identified psychosocial factors, identified barriers to recovery, progressive increases in hospital privileges and/or attempts at therapeutic re-entry into the community have resulted in, or would result in exacerbation of the psychiatric illness to the degree that would necessitate continued hospitalization.

## **Hospitalization, Psychiatric, Geriatric<sup>1</sup>**

### ***Quality of Care Standards***

*Standards must apply for any requested service either at admission or during continued stay.*

The services provided to identify or treat an illness are consistent with the diagnosis and treatment of a condition, and the standards of good medical practice.

#### **I. Admission - Severity of Need**

*Standards A and either B, C, D, E or F must be met to satisfy severity of need.*

- A. Consumer must have a diagnosed or suspected mental illness. Mental illness is defined as a psychiatric disorder that, by accepted medical standards, can be expected to improve significantly through psychosocially necessary and appropriate therapy at this level of care. Presence of the illness(es) must be documented through the assignment of appropriate DSM-IV-TR® codes on all applicable axes (I-V).
- B. The consumer demonstrates a clear and reasonable inference of imminent serious harm to self by (any one of the following):
  1. Current plan or intent to imminently and seriously harm self with an available and highly lethal means.
  2. A highly lethal recent attempt to harm self with continued imminent risk as demonstrated by poor impulse control or an inability to plan reliably for safety.
  3. An imminently dangerous inability to care adequately for own physical needs through disordered, disorganized or bizarre behavior.
  4. Other similarly clear and reasonable evidence of imminent serious harm to self.
- C. The consumer demonstrates a clear and reasonable inference of imminent serious harm to others by (any one of the following):
  1. Current plan or intent to imminently and seriously harm others with an available and highly lethal means.
  2. A highly lethal recent action to harm others with continued imminent risk as demonstrated by poor impulse control or an inability to plan reliably for safety.
  3. Violent, unpredictable, or uncontrolled behavior that represents an imminently serious harm to the body or property of others.
  4. Other similarly clear and reasonable evidence of imminent serious harm to others.
- D. As a result of potential reasonable complications from an acute psychiatric assessment technique or intervention, there is a high probability of serious, imminent and dangerous deterioration of the consumer's general medical or mental health.
- E. A lower level of care is not available or will not provide the support to prevent deterioration of the consumer's condition or maintain functioning improvement attained through previous treatment.
- F. Psychosocial factors identified (See III. Admission – Psychosocial Factors) prevent the establishment of a viable recovery plan which would provide the support to prevent the deterioration of the consumer's condition or maintain functioning improvement attained through previous treatment.

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<sup>1</sup> These standards apply to those individuals at or over the age of 65.

**II. Admission - Intensity of Service**

*Standards A, B, C and D must be met to satisfy intensity of service.*

- A. The evaluation and assignment of the mental illness diagnosis must take place in a face-to-face evaluation of the consumer performed by an Attending Physician prior to, or within 24 hours following the admission.
- B. This care must require an recovery-oriented individual plan of active psychiatric treatment that includes 24-hour need for, and access to, the full spectrum of psychiatric staffing. In addition to skilled nursing care for activities of daily living and supervision required for structure and redirection of behavior, the psychiatric staffing must provide 24-hour services, including medication monitoring and administration, other therapeutic interventions, quiet room, seclusion, intermittent restraints, and suicidal/homicidal observation and precautions.
- C. For those consumers whose co-morbid medical conditions may contribute to their mental status, there must be the availability of an appropriate initial medical assessment and ongoing medical management.
- D. A recovery oriented discharge plan is initially formulated that is directly linked to the behaviors and/or symptoms as well as psychosocial factors that resulted in admission. This plan receives regular review and revision that includes, as appropriate, timely evaluation of post-hospitalization needs and potential barriers to recovery.

**III. Admission – Psychosocial Factors**

*If Standard A is met, intensity of service is met. Otherwise, a minimum of two of Standards B-G must be met to satisfy intensity of service.*

- A. Due to symptoms of their illness, the consumer is unable to comprehend, engage or participate in a strengths based assessment and in recovery-oriented treatment planning and discharge planning.
- B. Current recovery and living environment is such that the likelihood of a successful recovery oriented treatment plan at a lower level of care is extremely doubtful, e.g., homelessness, lack of residential facility support and care, lack of support and proper care by caretakers in the consumer's home, current living arrangements do not foster and support non-institutional living, etc.
- C. There is a lack of family, friends or other natural supports in their community.
- D. The consumer has experienced a recent traumatic event, e.g., sudden and dangerous deterioration in living arrangements, physical abuse, sexual abuse, sudden loss of a key familial or other natural supports (e.g., death), sudden change in a serious medical condition, etc.
- E. Access issues, such as transportation, physical or cognitive or mental disability, lack of other alternative treatment or rehabilitative services in community, prevent the establishment of a recovery-oriented treatment plan at a lower level of care.
- F. Due to cultural or linguistic issues, the consumer is unable to comprehend, engage or participate in a strengths based assessment and in recovery-oriented treatment planning and discharge planning.
- G. Stressors and barriers related to primary caretaker responsibilities such as single parent with children at home, elder care, or care of someone at home who is disabled.

**IV. Continued Stay**

*Standards A, B, C, D and E, and either F or G must be met to satisfy continued stay.*

- A. Despite therapeutic efforts, clinical evidence indicates the persistence of problems or psychosocial factors that caused the admission to the degree that would necessitate continued hospitalization, or the emergence of additional problems or psychosocial factors consistent with the admission standards and to the degree that would necessitate continued hospitalization.
- B. The current recovery oriented treatment plan should include documentation of diagnosis (DSM-IV-TR®, axes I-V), a written strength based assessment, a plan for addressing identified barriers to recovery, documentation of the consumer's participation and acceptance of the treatment and discharge planning, individualized goals of treatment and treatment modalities needed and provided on a 24-hour basis.
- C. The consumer's progress confirms that the presenting or newly defined problem(s) or psychosocial factors will respond to the current treatment plan.
- D. Daily progress notes, written and signed by the provider, document the treatment received and consumer's response.
- E. There should be evidence that disposition planning includes ongoing contact with facility of residence, personal caretakers and medical caretakers.
- F. There is a severe reaction to medication or need for further monitoring and adjustment of dosage in an inpatient setting. A physician should document this in daily progress notes.
- G. There is clinical evidence that disposition planning, identified psychosocial factors, identified barriers to recovery, progressive increases in hospital privileges and/or attempts at therapeutic re-entry into the community have resulted in, or would result in exacerbation of the psychiatric illness to the degree that would necessitate continued hospitalization

## Hospitalization, Eating Disorders<sup>2</sup>

### *Quality of Care Standards*

*Standards must apply for any requested service either at admission or during continued stay.*

The services provided to identify or treat an illness are consistent with the diagnosis and treatment of a condition, and the standards of good medical practice.

#### **I. Admission - Severity of Need**

*Standard A and one of standards B, C, D, E or F must be met to satisfy severity of need.*

- A. Consumers must have a *primary* diagnosis of Anorexia Nervosa, Bulimia Nervosa, or Eating Disorder Not Otherwise Specified. The illness can be expected to improve significantly through psychosocially necessary and appropriate therapy at this level of care. Consumers hospitalized because of another primary psychiatric disorder who have a coexisting Eating Disorder should be reviewed according to the standards below *only* if the primary psychiatric disorder no longer requires hospitalization.
- B. Body weight less than 75% of Ideal Body Weight (IBW) or Body Mass Index (BMI) of 16 or below. If body weight is greater than 75% of IBW (or BMI > 16), this criterion can be met if there is evidence of weight loss of >15% in one month or weight loss associated with physiologic instability unexplained by any other medical condition. This criterion may be satisfied in children and adolescents who have a body weight between 75-85% of ideal, based upon height, during a period of rapid growth.
- C. Medical consequences of the eating disordered behavior that present the potential for imminent harm such that immediate medical and psychiatric stabilization is necessary before ambulatory or residential management can be considered safe or effective. Such medical consequences would include severe malnutrition, emaciation, significant electrolyte or fluid imbalance, cardiac arrhythmias, hypotension, impaired renal function, intestinal atony or obstruction, pancreatitis, gastric dilatation, esophagitis or esophageal tears, and colitis.
- D. In bulimia, immediate interruption of the binge/purge cycle is required to avoid imminent, serious harm, due to the presence of a co-morbid medical or psychiatric condition (e.g. pregnancy, uncontrolled diabetes, severe depression with suicidal ideation, etc.), with the need to ensure adequate nutrition and absorption of pharmaceuticals.
- E. Failure to respond to an adequate therapeutic trial of treatment in a less restrictive setting (partial hospital). An adequate therapeutic trial would, at a minimum, consist of treatment several times per week with twice weekly individual and/or family therapy, either professional group therapy or self-help group involvement, nutritional counseling, and medication if indicated.

To meet this criterion, the consumer must have significant weight loss (<85% IBW), significant impairment in social or occupational functioning, and be uncooperative with treatment (or cooperative only in a highly structured environment) despite having insight and motivation to recover. If consumer has failed to improve in an acute program, there must be evidence to suggest that necessary changes in the treatment plan cannot be implemented in an outpatient setting or that inpatient hospitalization is required due to medical co-morbidity or need for special feeding.

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<sup>2</sup> Because of the severity of co-existing medical disorders, the principle or primary treatment of some eating disorders may be medical/surgical. In these instances, medical/surgical benefits and standards for appropriateness of care will apply.

- G. A lower level of care is not available or will not provide the support to prevent deterioration of the consumer's condition or maintain functioning improvement attained through previous treatment.

## **II. Admission - Intensity of Service**

*Standards A, B and C must be met to satisfy intensity of service.*

- A. The evaluation and assignment of the mental illness diagnosis must take place in a face-to-face evaluation of the consumer performed by an Attending Physician prior to, or within 24 hours following the admission. For child and adolescents, parents/ guardians/ other caretakers should be included in the evaluation process, unless there are specific clinical contraindications for their involvement.
- B. This care must require an individual plan of active psychiatric treatment that includes 24-hour need for, and access to, the full spectrum of psychiatric staffing. This psychiatric staffing must provide 24-hour services, including medication monitoring and administration, other therapeutic interventions, quiet room, seclusion, intermittent restraints, and suicidal/homicidal observation and precautions.
- C. A recovery-oriented discharge plan is initially formulated that is directly linked to the behaviors and/or symptoms as well as psychosocial factors that resulted in admission. This plan receives regular review and revision that includes, as appropriate, timely evaluation of post-hospitalization needs and potential barriers to recovery.

## **III. Admission – Psychosocial Factors**

*If Standard A is met, intensity of service is met. Otherwise, a minimum of two of Standards B-H must be met to satisfy intensity of service.*

- A. Due to symptoms of the eating disorder, the consumer and/or custodial guardian is unable to comprehend, engage or participate in a strengths based assessment and in recovery-oriented treatment planning and discharge planning.
- B. Current recovery and living environment is such that the likelihood of a successful recovery oriented treatment plan at a lower level of care is extremely doubtful, e.g., inability to follow a nutrition plan.
- C. There is a lack of daycare or other responsible adult supervision and support available when needed by the custodial guardian.
- D. The consumer has experienced a recent traumatic event, e.g., sudden and dangerous deterioration in living arrangements, physical abuse, sexual abuse, sudden loss of a key familial or other natural supports (e.g., death), sudden change in a serious medical condition, etc.
- E. Access issues, such as transportation, physical or cognitive or mental disability, lack of other alternative treatment or rehabilitative services in community, prevent the establishment of a recovery-oriented treatment plan at a lower level of care.
- F. Due to cultural or linguistic issues, the consumer and/or custodial guardian is unable to comprehend, engage or participate in a strengths based assessment and in recovery-oriented treatment planning and discharge planning.
- G. Due to physical or psychiatric disability, the Enrollee is unable to comprehend, engage or participate in a strengths based assessment and in recovery-oriented treatment planning and discharge planning.
- H. Significant stressors and barriers related to the Enrollee's primary caretaker responsibilities such as single parent with children at home, elder care, or care of someone at home who is disabled.

**IV. Continued Stay**

*Standards A, B, C, D and E, and either one of F, G, H, I, J or K, must be met to satisfy continued stay.*

- A. Despite therapeutic efforts, clinical evidence indicates the persistence of problems or psychosocial factors that caused the admission to the degree that would necessitate continued hospitalization, or the emergence of additional problems or psychosocial factors consistent with the admission standards and to the degree that would necessitate continued hospitalization.
- B. The current recovery oriented treatment plan should include documentation of diagnosis (DSM-IV-TR®, axes I-V), a written strength based assessment, a plan for addressing identified barriers to recovery, documentation of the consumer's participation and acceptance of the treatment and discharge planning, individualized goals of treatment and treatment modalities needed and provided on a 24-hour basis.
- C. The consumer's progress confirms that the presenting or newly defined problem(s) or psychosocial factors will respond to the current treatment plan.
- D. Daily progress notes, written and signed by the provider, document the treatment received and consumer's response.
- E. There should be evidence of intensive family involvement occurring several times per week unless the treatment plan specifically indicates a clinical need for less frequent involvement.
- F. The consumer's weight remains <85% of IBW and he/she fails to achieve a reasonable and expected weight gain despite provision of adequate caloric intake.
- G. Continued inability to adhere to a meal plan and maintain control over urges to binge/purge such that continued supervision during and after meals and/or in bathrooms is required. In order to satisfy this criterion, there must be evidence that consumer is unable to participate in ambulatory treatment, lacks significant insight into the symptoms of his/her illness, *and* has regressed in response to progressive increases in privilege level.
- H. The consumer continues to meet Admission Standards I-C with the need for ongoing medical monitoring of medical consequences of the eating disorder.
- I. There is a severe reaction to medication or need for further monitoring and adjustment of dosage in an inpatient setting. A physician should document this in daily progress notes.
- J. There is clinical evidence that disposition planning, progressive increases in hospital privileges and/or attempts at therapeutic re-entry into the community have resulted in, or would result in exacerbation of the psychiatric illness to the degree that would necessitate continued hospitalization.
- K. Unique circumstances exist which may impact the accessibility or appropriateness of particular services for an individual consumer (e.g., living situation is not able to continue the feeding plan developed in the inpatient setting, availability of transportation, lack of natural supports including a place to live, etc.).

## **Sub-acute Facility**

### ***Quality of Care Standards***

*Standards must apply for any requested service either at admission or during continued stay.*

The services provided to identify or treat an illness are consistent with the diagnosis and treatment of a condition, and the standards of good medical practice.

#### **I. Admission - Severity of Need**

*A and either B, C, D or E must be met to satisfy severity of need.*

- A. The consumer must have a diagnosed or suspected mental illness. Mental illness is defined as a psychiatric disorder that, by accepted medical standards, can be expected to improve significantly through psychosocially necessary and appropriate therapy at this level of care. Presence of the illness(es) must be documented through the assignment of appropriate DSM-IV-TR® codes on all applicable axes (I-V).
- B. The consumer demonstrates a clear and reasonable inference of imminent serious harm to self by (any one of the following):
  1. Current plan or intent to imminently and seriously harm self with an available and highly lethal means.
  2. A highly lethal recent attempt to harm self with continued imminent risk as demonstrated by poor impulse control or an inability to plan reliably for safety.
  3. An acute, severe decompensation in the ability to care adequately for own physical needs demonstrated through disordered, disorganized or bizarre behavior.
  4. Other similarly clear and reasonable evidence of imminent serious harm to self.
- C. The consumer demonstrates a clear and reasonable inference of imminent serious harm to others by (any one of the following):
  1. Current plan or intent to imminently and seriously harm others with an available and highly lethal means.
  2. A highly lethal recent action to harm others with continued imminent risk as demonstrated by poor impulse control or an inability to plan reliably for safety.
  3. Violent, unpredictable, or uncontrolled behavior that represents an imminently serious harm to the body or property of others.
  4. Other similarly clear and reasonable evidence of imminent serious harm to others.
- D. As a result of potential reasonable complications from an acute psychiatric assessment technique or intervention, there is a high probability of serious, imminent and dangerous deterioration of the consumer's general medical or mental health.
- E. A lower level of care is not available or will not provide the support to prevent deterioration of the consumer's condition or maintain functioning improvement attained through previous treatment.

#### **II. Admission - Intensity of Service**

*Standards A, B and C must be met to satisfy intensity of service.*

- A. The evaluation and assignment of the mental illness diagnosis must take place in a face-to-face evaluation of the consumer performed by an attending physician prior to, or within 24 hours following the admission.

- B. This care must require an individualized recovery-oriented plan of active psychiatric treatment that includes 24-hour need for, and access to, the full spectrum of psychiatric staffing. This psychiatric staffing must provide 24-hour services, including medication monitoring and administration, other therapeutic interventions, quiet room, seclusion, intermittent restraints, and suicidal/homicidal observation and precautions.
- C. A discharge plan is initially formulated that is directly linked to the behaviors and/or symptoms as well as psychosocial factors that resulted in admission. This plan receives regular review and revision that includes, as appropriate, timely evaluation of post-hospitalization needs and potential barriers to recovery.

### **III. Admission – Psychosocial Factors**

*If Standard A is met, intensity of service is met. Otherwise, a minimum of two of Standards B-H must be met to satisfy intensity of service.*

- A. Due to symptoms of their illness, the consumer is unable to comprehend, engage or participate in a strengths based assessment and in recovery-oriented treatment planning and discharge planning.
- B. Current recovery and living environment is such that the likelihood of a successful recovery oriented treatment plan at a lower level of care is extremely doubtful, e.g., homelessness.
- C. There is a lack of family, friends or other natural supports in their community.
- D. The consumer has experienced a recent traumatic event, e.g., sudden and dangerous deterioration in living arrangements, physical abuse, sexual abuse, sudden loss of a key familial or other natural supports (e.g., death), sudden loss of employment (e.g., firing, job layoff), sudden change in a serious medical condition, etc.
- E. The consumer faces imminent legal risks, such as incarceration, due in significant part to their illness.
- F. Access issues, such as transportation, physical or cognitive or mental disability, lack of other alternative treatment or rehabilitative services in community, prevent the establishment of a recovery-oriented treatment plan at a lower level of care.
- G. Due to cultural or linguistic issues, the consumer is unable to comprehend, engage or participate in a strengths based assessment and in recovery-oriented treatment planning and discharge planning.
- H. Significant stressors and barriers related to primary caretaker responsibilities such as single parent with children at home, elder care, or care of someone at home who is disabled.

### **IV. Continued Stay**

*Standards A, B, C and D, and either E or F or G must be met to satisfy continued stay.*

- A. Despite therapeutic efforts, clinical evidence indicates the persistence of problems that caused the admission to the degree that would necessitate continued hospitalization, or the emergence of additional problems or psychosocial factors consistent with the admission standards and to the degree that would necessitate continued hospitalization.
- B. The current recovery oriented treatment plan should include documentation of diagnosis (DSM-IV-TR®, axes I-V), a written strength based assessment, a plan for addressing identified barriers to recovery, documentation of the consumer's participation and acceptance of the treatment and discharge planning, individualized goals of treatment and treatment modalities needed and provided on a 24-hour basis. The consumer's progress confirms that the presenting or newly defined problem(s) and psychosocial factors will respond to the current treatment plan.

- C. The consumer's progress confirms that the presenting, or newly defined problem(s) or psychosocial factors will respond to the current recovery-oriented treatment plan.
- D. Daily progress notes, written and signed by the provider, document the treatment received and consumer's response.
- E. There is a severe reaction to medication or need for further monitoring and adjustment of dosage in an inpatient setting. This should be documented in daily progress notes by a physician.
- F. There is clinical evidence that disposition planning, progressive increases in hospital privileges and/or attempts at therapeutic re-entry into the community have resulted in, or would result in exacerbation of the psychiatric illness to the degree that would necessitate continued sub-acute stay.
- G. Unique circumstances exist which may impact the accessibility or appropriateness of particular services for an individual consumer (e.g., availability of transportation, lack of natural supports including a place to live, inability to follow the treatment plan developed in the sub acute facility due to the need for a higher level of support than is available in the sub-acute facility or other less restrictive setting, etc.).

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## **Residential Treatment Center (RTC), Psychiatric**

### ***Quality of Care Standards***

*Standards must apply for any requested service either at admission or during continued stay.*

The services provided to identify or treat an illness are consistent with the diagnosis and treatment of a condition, and the standards of good medical practice.

#### **I. Admission – Severity of Need**

*Standards A, B, C and D must be met to satisfy severity of need.*

- A. The consumer must have a diagnosed or suspected mental illness that can be expected to improve significantly. Mental illness is defined as a psychiatric disorder that, by accepted medical standards, can be expected to improve significantly through psychosocially necessary and appropriate therapy at this level of care. Presence of the illness(es) must be documented through the assignment of appropriate DSM-IV-TR® codes on all applicable axes (I-V).
- B. Due to the psychiatric disorder, the consumer exhibits an inability to adequately care for his/her own physical needs, representing potential serious harm to self and/or others. The family and/or other non-residential community support systems are unable to safely fulfill these needs.
- C. The consumer requires supervision 7 days per week/24 hours per day to develop skills necessary for daily living, to assist with planning and arranging access to a range of educational, therapeutic and aftercare services, and to develop the adaptive and functional behavior that will allow him/her to live outside of a residential setting.
- D. Psychosocial factors identified (See III. Admission – Psychosocial Factors) prevent the establishment of a viable recovery plan which would provide the support to prevent the deterioration of the consumer's condition or maintain functioning improvement attained through previous treatment.

#### **II. Admission – Intensity of Service**

*Standards A, B, and C must be met to satisfy for intensity of service.*

- A. The evaluation and assignment of a diagnosis must result from a face-to-face psychiatric evaluation.
- B. The program provides supervision 7 days per week/24 hours per day to assist with the development of skills necessary for daily living, to assist with planning and arranging access to a range of educational, therapeutic and aftercare services, and to assist with the development of the adaptive and functional behavior that will allow the consumer to live outside of a residential setting.
- C. An individualized recovery-oriented plan of active psychiatric treatment and residential living support is provided. This plan must include evaluation for individual and/or family treatment. This plan must include weekly family and/or supportive person involvement or identify valid reasons why such a plan is not clinically appropriate.

#### **III. Admission - Psychosocial Factors**

*If Standard A is met, intensity of service is met. Otherwise, a minimum of two of Standards B-G must be met to satisfy intensity of service.*

- A. The consumer and/or custodial guardian is unable to comprehend, engage or participate in a strengths based assessment and in recovery-oriented treatment planning and discharge planning.

- B. Current recovery and living environment is such that the likelihood of a successful recovery oriented treatment plan at a lower level of care is extremely doubtful, e.g., support system is not engaged in the therapeutic process and will be unlikely to supervise the consumer.
- C. The consumer has experienced a recent traumatic event, e.g., sudden and dangerous deterioration in living arrangements, physical abuse, sexual abuse, sudden loss of a key familial or other natural supports (e.g., death), sudden change in a serious medical condition, etc.
- D. Access issues, such as transportation, physical or cognitive or mental disability, lack of other alternative treatment or rehabilitative services in community, prevent the establishment of a recovery-oriented treatment plan at a lower level of care.
- E. Due to cultural or linguistic issues, the consumer and/or custodial guardian is unable to comprehend, engage or participate in a strengths based assessment and in recovery-oriented treatment planning and discharge planning.
- F. Due to physical or psychiatric disability, the custodial guardian is unable to comprehend, engage or participate in a strengths based assessment and in recovery-oriented treatment planning and discharge planning.
- G. Significant stressors and barriers related to the custodial guardian's primary caretaker responsibilities such as single parent with children at home, elder care, or care of someone at home who is disabled.

**IV. Continued Stay**

*Standards A, B, C, (D for children and adolescents), and E, must be met to satisfy continued stay.*

- A. Despite reasonable therapeutic efforts, clinical evidence indicates the persistence of problems that caused the admission to a degree that continues to meet the admission standards, or the emergence of additional problems that meet the admission standards.
- B. The current recovery oriented treatment plan should include documentation of diagnosis (DSM-IV-TR®, I-V), a written strength based assessment, a plan for addressing identified barriers to recovery, documentation of the consumer's and/or custodial guardian's participation and acceptance of the treatment and discharge planning, individualized goals of treatment and treatment modalities needed and provided on a 24-hour basis. There is evidence that treatment plan is focused on the alleviation of psychiatric symptoms that are interfering with the consumer's ability to return to a less intensive level of care.
- C. Unique circumstances exist which may impact the accessibility or appropriateness of particular services for an individual consumer (e.g., availability of transportation, lack of natural supports including a place to live, inability to follow the treatment plan developed in the sub acute facility due to the need for a higher level of support than is available in the partial hospital less restrictive setting, etc.).
- D. For Children and Adolescents, there is evidence of intensive family involvement occurring several times per week (unless there is an identified valid reason why such a plan is not clinically appropriate or feasible).
- E. The consumer's progress confirms that the presenting, or newly defined problem(s) and psychosocial factors will respond to the current treatment plan, and this is documented in weekly progress notes, written and signed by the provider.

## **Partial Hospitalization, Psychiatric, Adult**

### ***Quality of Care Standards***

*Standards must apply for any requested service either at admission or during continued stay.*

The services provided to identify or treat an illness are consistent with the diagnosis and treatment of a condition, and the standards of good medical practice.

#### **I. Admission – Severity of Need**

*Standards A, B, C, D and E must be met to satisfy severity of need.*

- A. The consumer must have a diagnosed or suspected mental illness. Mental illness is defined as a psychiatric disorder that, by accepted medical standards, can be expected to improve significantly through psychosocially necessary and appropriate therapy at this level of care. Presence of the illness(es) must be documented through the assignment of appropriate DSM-IV-TR® codes on all applicable axes (I-V).
- B. There is clinical evidence that a less intensive setting is not appropriate at this time and/or a partial hospital program can safely substitute for, or shorten, a hospital stay.
- C. Either:
  - 1. There is clinical evidence that the consumer would be at risk to self or others if he/she were not in a partial hospitalization program; or
  - 2. As a result of the consumer's mental disorder there is an inability to adequately care for one's physical needs, representing potential serious harm to self.
- D. Additionally, either:
  - 1. The consumer can reliably plan for safety in a structured environment under clinical supervision for part of the day and has a suitable support system for the rest of the time; or
  - 2. The consumer is believed to be capable of maintaining safety and/or seeking professional assistance or other supports when not in the partial hospital setting.
- E. Psychosocial factors identified (See III. Admission – Psychosocial Factors) prevent the establishment of a viable recovery plan which would provide the support to prevent the deterioration of the consumer's condition or maintain functioning improvement attained through previous treatment.

#### **II. Admission – Intensity of Service**

*Standards A, B, C and D must be met to satisfy intensity of service.*

- A. In order for a partial hospital program to be safe and therapeutic for a consumer, professional and/or social supports must be identified and available to the consumer outside of program hours, and the consumer must be capable of seeking them as needed.
- B. The consumer's condition must require a structured program with nursing and medical supervision, intervention and/or treatment for at least 4 hours per day.
- C. The individualized recovery-oriented plan of treatment for partial hospitalization requires treatment by a multidisciplinary team. A specific treatment goal of this team is improving symptoms, level of functioning and having a viable plan to address barriers to recovery so that the consumer is able to participate effectively in a lesser level of care.
- D. A discharge plan is initially formulated that is directly linked to the behaviors, symptoms, and/or psychosocial factors that resulted in admission. This plan receives regular review and

revision that includes, as appropriate, timely evaluation of post-partial hospitalization needs as well as potential barriers to recovery.

### **III. Admission – Psychosocial Factors**

*A minimum of two of Standards A-F must be met to satisfy intensity of service.*

- A. Current recovery and living environment is such that the likelihood of a successful recovery oriented treatment plan at a lower level of care is extremely doubtful, e.g., inability to engage in a recovery-oriented treatment plan.
- B. There is a lack of family, friends or other natural supports in their community.
- C. The consumer has experienced a recent traumatic event, e.g., sudden and dangerous deterioration in living arrangements, physical abuse, sexual abuse, sudden loss of a key familial or other natural supports (e.g., death), sudden loss of employment (e.g., firing, job layoff), sudden change in a serious medical condition, etc.
- D. Access issues, such as transportation, physical or cognitive or mental disability, lack of other alternative treatment or rehabilitative services in community, prevent the establishment of a recovery-oriented treatment plan at a lower level of care.
- E. Due to cultural or linguistic issues, the consumer is unable to comprehend, engage or participate in a strengths based assessment and in recovery-oriented treatment planning and discharge planning.
- F. Significant stressors and barriers related to primary caretaker responsibilities such as single parent with children at home, elder care, or care of someone at home who is disabled during the hours of treatment at the Partial Hospital level of care.

### **IV. - Continued Stay**

*Standards A and B, and either C or D must be met to satisfy continued stay.*

- A. Despite therapeutic efforts, clinical evidence indicates the persistence of problems or psychosocial factors that caused the admission to the degree that would necessitate continued partial hospitalization, or the emergence of additional problems or psychosocial factors consistent with the admission standards and to the degree that would necessitate continued partial hospitalization.
- B. The current recovery oriented treatment plan should include documentation of diagnosis (DSM-IV-TR®, I-V), a written strength based assessment, a plan for addressing identified barriers to recovery, documentation of the consumer's participation and acceptance of the treatment and discharge planning, individualized goals of treatment and treatment modalities needed and provided on a 24-hour basis.
- C. The consumer's progress confirms that the presenting, or newly defined problem(s) or psychosocial factors will respond to the current treatment plan.
- D. There is clinical evidence that disposition planning, identified psychosocial factors, identified barriers to recovery and/or attempts at therapeutic re-entry into the community have resulted in, or would result in exacerbation of the psychiatric illness to the degree that would necessitate continued partial hospitalization.

## **Partial Hospitalization, Psychiatric, Child and Adolescent**

### ***Quality of Care Standards***

*Standards must apply for any requested service either at admission or during continued stay.*

The services provided to identify or treat an illness are consistent with the diagnosis and treatment of a condition, and the standards of good medical practice.

#### **I. Admission – Severity of Need**

*Standards A, B, C and D must be met to satisfy severity of need.*

- A. The child/adolescent must have a diagnosed or suspected mental illness. Mental illness is defined as a psychiatric disorder that, by accepted medical standards, can be expected to improve significantly through psychosocially necessary and appropriate therapy at this level of care. Presence of the illness(es) must be documented through the assignment of appropriate DSM-IV-TR® codes on all applicable axes (I-V).
- B. There is clinical evidence that a less intensive setting is not appropriate at this time and/or a partial hospital program can safely substitute for, or shorten, a hospital stay.
- C. Either:
  - 1. There is clinical evidence that the child/adolescent would be at risk to self or others if he/she were not in a partial hospitalization program; or
  - 2. 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.
- D. Additionally, either:
  - 1. The child/adolescent can reliably plan for safety in a structured environment under clinical supervision for part of the day and has a suitable environment for the rest of the time; or
  - 2. The child/adolescent is believed to be capable of maintaining safety and/or seeking professional assistance or other support when not in the partial hospital setting.

#### **II. Admission – Intensity of Need**

*Standards A, B, C and D must be met to satisfy intensity of service.*

- A. In order for a partial hospital program to be safe and therapeutic for an individual consumer, professional and/or social supports must be identified and available to the child/adolescent outside of program hours, and the child/adolescent must be capable of seeking them as needed.
- B. The child/adolescent's condition must require a structured program with nursing and medical supervision, intervention, treatment, and/or family services for at least 4 hours per day.
- C. The individualized recovery-oriented plan of treatment for partial hospitalization requires treatment by a multidisciplinary team. A specific treatment goal of this team is improving symptoms, level of functioning and removal of potential barriers to recovery enough to return the child/adolescent to a lesser level of care and to develop psychosocial supports that foster recovery.
- D. A discharge plan is initially formulated that is directly linked to the behaviors, symptoms, and psychosocial factors that resulted in admission. This plan receives regular review and revision that includes, as appropriate, timely evaluation of post-partial hospitalization supports and potential barriers to recovery.

#### **III. Admission – Psychosocial Factors**

*A minimum of two of Standards A-F must be met to satisfy intensity of service.*

- A. Current recovery and living environment is such that the likelihood of a successful recovery oriented treatment plan at a lower level of care is extremely doubtful, e.g., family and/or guardian has a past history compliance with outpatient treatment.
- B. There is a lack of family, friends or other natural supports in their community.
- C. The consumer has experienced a recent traumatic event, e.g., sudden and dangerous deterioration in living arrangements, physical abuse, sexual abuse, sudden loss of a key familial or other natural supports (e.g., death), sudden loss of employment (e.g., firing, job layoff), sudden change in a serious medical condition, etc.
- D. Access issues, such as transportation, physical or cognitive or mental disability, lack of other alternative treatment or rehabilitative services in community, prevent the establishment of a recovery-oriented treatment plan at a lower level of care.
- E. Due to cultural or linguistic issues, the consumer is unable to comprehend, engage or participate in a strengths based assessment and in recovery-oriented treatment planning and discharge planning.
- F. Significant stressors and barriers related to primary caretaker responsibilities such as single parent with children at home, elder care, or care of someone at home who is disabled during the hours of treatment at the partial hospital level of care.

**IV. Continued Stay**

*Standards A, B, C, D and E, and either F or G must be met to satisfy continued stay.*

- A. Despite therapeutic efforts, clinical evidence indicates the persistence of problems or psychosocial factors that caused the admission to the degree that would necessitate continued partial hospitalization, or the emergence of additional problems or psychosocial factors consistent with the admission standards.
- B. The current recovery oriented treatment plan should include documentation of diagnosis (DSM-IV-TR®, I-V), a written strength based assessment, a plan for addressing identified barriers to recovery, documentation of the child/adolescent's and/or custodial guardian's participation and acceptance of the treatment and discharge planning, individualized goals of treatment and treatment modalities needed and provided on a 24-hour basis.
- C. The child/adolescent's progress confirms that the presenting or newly defined problem(s) will respond to the current treatment plan.
- D. Daily progress notes, written and signed by the provider, document the treatment received and the child/adolescent's response.
- E. There should be evidence of intensive family involvement occurring several times per week unless the treatment plan specifically indicates a clinical need for less frequent involvement.
- F. There is a severe reaction to medication or need for further monitoring and adjustment of dosage in an inpatient setting. A physician should document this in daily progress notes.
- G. There is clinical evidence that disposition planning, identified psychosocial factors, identified barriers to recovery, and/or attempts at therapeutic re-entry into the community have resulted in, or would result in exacerbation of the psychiatric illness to the degree that would necessitate continued partial hospitalization.

## **Day Treatment**

### ***Quality of Care Standards***

*Standards must be applied for any requested service either at admission or during continued stay.*

The services provided to identify or treat an illness are consistent with the diagnosis and treatment of a condition and the standards of good medical practice.

#### **I. Admission Standards (all must be met):**

- A. The consumer has received a psychological or psychiatric evaluation that includes a DSM-IV-TR®, axes I-V. The consumer demonstrates symptoms that require interventions that cannot adequately be provided in a lower level of care.
- B. The consumer has a longstanding psychiatric disorder and is experiencing a worsening of symptoms of that disorder (behaviors, mood, psychotic thinking) and there is significant functional impairment.
- C. Traditional mental health services have been attempted (i.e. individual/group/family therapy, medication management, rehabilitation and support services) and are inadequate to prevent the functional deterioration.
- D. A clear individualized recovery-oriented treatment plan is established including specific behavioral based and objective goals. Amount, scope, and duration as well as specific interventions must be documented in the treatment plan and progress notes.
- E. The consumer demonstrates the capability of developing more complex personal and interpersonal life skills including problem solving, self advocacy and the appropriate use of community resources.
- F. Psychosocial factors identified (See II. Admission – Psychosocial Factors) prevent the establishment of a viable recovery plan which would provide the support to prevent the deterioration of the consumer's condition or maintain functioning improvement attained through previous treatment.

#### **II. Admission – Psychosocial Factors**

*A minimum of two of Standards A-F must be met to satisfy intensity of service.*

- A. Current recovery and living environment is such that the likelihood of a successful recovery oriented treatment plan at a lower level of care is extremely doubtful, e.g., homelessness.
- B. There is a lack of family, friends or other natural supports in their community.
- C. The consumer has experienced a recent traumatic event, e.g., sudden and dangerous deterioration in living arrangements, physical abuse, sudden loss of a key familial or other natural supports (e.g., death), sudden loss of employment (e.g., firing, job layoff), sudden change in a serious medical condition, etc.
- D. Access issues, such as physical or cognitive or mental disability, lack of other alternative treatment or rehabilitative services in community, prevent the establishment of a recovery-oriented treatment plan at a lower level of care.
- E. Due to cultural or linguistic issues, the consumer is unable to comprehend, engage or participate in a strengths based assessment and in recovery-oriented treatment planning and discharge planning.
- F. Significant stressors and barriers related to primary caretaker responsibilities such as single parent with children at home, elder care, or care of someone at home who is disabled during the hours of day treatment.

**III. Continued Stay Standards (all must be met):**

- A. Validated DSM-IV diagnosis which continues to have a broad and persistent negative effect on the consumer's functioning.
- B. The recovery-oriented treatment plan is regularly updated and documents the consumer's functional status changes and documents modifications to the treatment plan in response to changing functional status or lack of progress.
- C. The consumer is making progress toward treatment goals as evidenced by a lessening of symptoms, resolution of psychosocial factors and stabilization of functioning, but goals of treatment have not yet been achieved or there are barriers to fostering recovery in a less restrictive setting.
- D. Discharge planning and coordination is documented.
- E. Services provided are time-limited in nature and tailored to assist in developing autonomy in the least restrictive environment with the consideration of rehabilitation and supports not utilized previously.
- F. There is clinical evidence that disposition planning, identified psychosocial factors, identified barriers to recovery, progressive increases in hospital privileges and/or attempts at therapeutic re-entry into the community have resulted in, or would result in exacerbation of the psychiatric illness to the degree that would necessitate continued day treatment.

## **Intensive Outpatient Treatment, Psychiatric, Adult**

### ***Quality of Care Standards***

*Standards must apply for any requested service either at admission or during continued stay.*

The services provided to identify or treat an illness are consistent with the diagnosis and treatment of a condition, and the standards of good medical practice.

#### **I. Admission – Severity of Need**

*Standards A, B and C must be met to satisfy severity of need.*

- A. The clinical evaluation indicates that the consumer has a primary DSM-IV-TR®, IV diagnosis or severe emotional disturbance that is the cause of significant psychological, personal care, vocational, educational, and/or social impairment. The consumer's disorder can be expected to improve significantly through psychosocially necessary and appropriate therapy at this level of care. The consumer is sufficiently competent, and behaviorally and cognitively stable, to benefit from admission to an intensive outpatient program.
- B. The impairment results in at least one of the following:
  - 1. A clear, current threat to the consumer's ability to live in his/her customary setting for a consumer who, without that setting and the supports of that setting, would then meet the standards for a higher level of care, e.g., inpatient care, etc.
  - 2. A clear, current threat to the consumer's ability to be employed, attend school, attend vocational training, etc.
  - 3. An emerging/impending risk to the safety or property of the consumer or of others.
- C. Either:
  - 1. For consumers with persistent or recurrent disorders, the consumer's past history indicates that when the consumer has experienced similar clinical circumstances, less intensive treatment was not sufficient to prevent clinical deterioration, address psychosocial factors, stabilize the disorder, support effective rehabilitation, or avert the need for a more intensive level of care due to increasing risks to the consumer or others; or
  - 2. For consumers with an acute disorder, crisis, or those transitioning from an inpatient to a community setting, there is clinical evidence that less intensive treatment will not be sufficient to prevent clinical deterioration, resolve psychosocial factors, stabilize the disorder, support effective rehabilitation or avert the need to initiate or continue a more intensive level of care due to current risk to the consumer or others.

#### **II. Admission – Intensity of Service**

*Standards A, B and C must be met to satisfy intensity of service.*

- A. In order for intensive outpatient services to be safe and therapeutic for a consumer, professional and/or social supports must be identified and available to the consumer outside of program hours, and the consumer must be capable of seeking them as needed when not attending the program.
- B. The consumer's condition must require an integrated program of rehabilitation counseling, education, therapeutic, and/or family services at least 2 hours/day or for 6 hours in a week.
- C. The individual recovery-oriented treatment plan for intensive outpatient requires that a multidisciplinary team of professional and supervised support staff provide the services. A specific treatment goal of the treatment team is reduction in severity of symptoms,

improvement in level of functioning and resolution of psychosocial factors sufficient to return the consumer to outpatient treatment follow-up and/or self-help support groups.

**III. Admission – Psychosocial Factors**

*A minimum of two of Standards A-D must be met to satisfy intensity of service.*

- A. There is a lack of family, friends or other natural supports in their community.
- B. The consumer has experienced a recent traumatic event, e.g., sudden and dangerous deterioration in living arrangements, physical abuse, sexual abuse, sudden loss of a key familial or other natural supports (e.g., death), sudden loss of employment (e.g., firing, job layoff), sudden change in a serious medical condition, etc.
- C. Access issues, such as transportation, physical or cognitive or mental disability, lack of other alternative treatment or rehabilitative services in community, prevent the establishment of a recovery-oriented treatment plan at a lower level of care..
- D. Due to cultural or linguistic issues, the consumer is unable to comprehend, engage or participate in a strengths based assessment and in recovery-oriented treatment planning and discharge planning.

**IV. Continued Stay**

*Standards A, B, C and D or E must be met to satisfy continued stay.*

- A. Despite treatment efforts, clinical evidence indicates the persistence of the problems and psychosocial factors that necessitated the admission to the intensive outpatient program, or the emergence of additional problems and psychosocial factors consistent with the admission standards.
- B. There are progress notes for each day that consumer is in intensive outpatient services documenting the provider's treatment, and the consumer's response to treatment.
- C. The consumer's progress confirms that the presenting, or newly defined problem(s) and psychosocial factors will respond to the current treatment plan.
- D. Clinical evidence indicates that attempts at therapeutic re-entry into a less intensive level of care have or would result in exacerbation of the psychiatric illness to the degree that would warrant the continued need for intensive outpatient services.
- E. There is clinical evidence that disposition planning, identified psychosocial factors, identified barriers to recovery, and/or attempts at therapeutic re-entry into the community have resulted in, or would result in exacerbation of the psychiatric illness to the degree that would necessitate continued intensive outpatient treatment.

## **Intensive Outpatient Treatment, Psychiatric, Child and Adolescent**

### ***Quality of Care Standards***

*Standards must apply for any requested service either at admission or during continued stay.*

The services provided to identify or treat an illness are consistent with the diagnosis and treatment of a condition, and the standards of good medical practice.

#### **I. Admission - Severity of Need**

*Standards A, B and C must be met to satisfy severity of need.*

- A. The clinical evaluation indicates that the consumer has a primary DSM-IV-TR®, IV diagnosis or severe emotional disturbance that is the cause of significant psychological, personal care, vocational, educational, and/or social impairment. The child/adolescent's disorder can be expected to improve significantly through psychosocially necessary and appropriate therapy at this level of care. The child/adolescent is sufficiently competent, and behaviorally and cognitively stable, to benefit from admission to an intensive outpatient program.
- B. The impairment results in at least one of the following:
  - 1. A clear, current threat to the child/adolescent's ability to live in his/her customary setting for a consumer who, without that setting and the supports of that setting, would then meet the standards for a higher level of care, e.g., inpatient care.
  - 2. A clear, current threat to the child/adolescent's ability to be employed or attend school.
  - 3. An emerging/impending risk to the safety or property of the child/adolescent or of others.
- C. Either:
  - 1. For child/adolescent with persistent or recurrent disorders, the consumer's past history indicates that when the child/adolescent has experienced similar clinical circumstances, less intensive treatment was not sufficient to prevent clinical deterioration, stabilize the disorder, resolve psychosocial factors, support effective rehabilitation, or avert the need for a more intensive level of care due to increasing risks to the child/adolescent or others; or
  - 2. For a child or adolescent with an acute disorder, crisis, or those transitioning from an inpatient to a community setting, there is clinical evidence that less intensive treatment will not be sufficient to prevent clinical deterioration, stabilize the disorder, resolve psychosocial factors, support effective rehabilitation or avert the need to initiate or continue a more intensive level of care due to current risk to the child/adolescent or others.

#### **II. Admission – Intensity of Service**

*Standards A, B and C must be met to satisfy intensity of service.*

- A. In order for intensive outpatient services to be safe and therapeutic for a child/adolescent, professional and/or social supports must be identified and available to the consumer outside of program hours, and the child/adolescent must be capable of seeking them as needed when not attending the program.
- B. The child/adolescent's condition must require an integrated program of rehabilitation counseling, education, therapeutic, and/or family services at least 2 hours/day or for 6 hours in a week.
- C. The individual recovery-oriented treatment plan for intensive outpatient requires that a multidisciplinary team of professional and supervised support staff provide the services. A specific treatment goal of the treatment team is reduction in severity of symptoms, resolution

of psychosocial factors and improvement in level of functioning sufficient to return the child/adolescent to outpatient treatment follow-up and/or self-help support groups.

**III. Admission – Psychosocial Factors**

*A minimum of two of Standards A-C must be met to satisfy intensity of service.*

- A. There is a lack of family or other natural supports in their community.
- B. The child/adolescent has experienced a recent traumatic event, e.g., sudden and dangerous deterioration in living arrangements, physical abuse, sudden loss of a key familial or other natural supports (e.g., death), sudden loss of employment (e.g., firing, job layoff), sudden change in a serious medical condition, etc.
- C. Due to cultural or linguistic issues, the child/adolescent is unable to comprehend, engage or participate in a strengths based assessment and in recovery-oriented treatment planning and discharge planning.

**IV. Continued Stay**

*Standards A, B, C, and D or E must be met to satisfy continued stay.*

- A. Despite treatment efforts, clinical evidence indicates the persistence of the problems and psychosocial factors that necessitated the admission to the intensive outpatient program, or the emergence of additional problems and psychosocial factors consistent with the admission standards.
- B. There are progress notes for each day that child/adolescent is in intensive outpatient services documenting the provider's treatment, and the consumer's response to treatment.
- C. The child/adolescent's progress confirms that the presenting or newly defined problem and psychosocial factors will respond to the current treatment plan.
- D. Clinical evidence indicates that attempts at therapeutic re-entry into a less intensive level of care have or would result in exacerbation of the psychiatric illness to the degree that would warrant the continued need for intensive outpatient services.
- E. There is clinical evidence that disposition planning, identified psychosocial factors, identified barriers to recovery, progressive increases in hospital privileges and/or attempts at therapeutic re-entry into the community have resulted in, or would result in exacerbation of the psychiatric illness to the degree that would necessitate continued intensive outpatient treatment.

## **Rehabilitation and Community Support Services, Child and Adolescent**

### **Services covered by this guideline:**

1. Community Psychiatric Supportive Treatment
2. Personal Care Services
3. Mental Health Attendant Care
4. Child & Adolescent Psychosocial Group
5. Child and Adolescent Day Supports
6. Psychosocial Rehabilitation Group
7. Targeted Case Management
8. Crisis Intervention and Management
9. Activity Therapy (within the milieu of placement, not as a stand alone service)
10. Assertive Community Treatment
11. Residential Rehabilitative Supports
12. Intensive Family Intervention
13. Respite Care

### **Intensity Guidelines:** (three (3) elements are evaluated):

- A. Severity of the psychosocial impairment
- B. Appropriate intensity of services
- C. Least restrictive or intrusive services necessary

### **I. Admission Guidelines (all must be met):**

- A. The child/adolescent has an emotional or behavioral problem that is of a severity that functioning in the home or community requires rehabilitation and support services.
- B. Traditional mental health services have been attempted (i.e. individual/family/group therapy, medication management, etc) and are inadequate to prevent the youth from deteriorating or to reach identified goals.
- C. Services are supervised by a qualified licensed mental health professional.
- D. At least one adult member of the child's family agrees to participate in the service (unless this is not available).
- E. A clear individualized recovery-oriented treatment plan is established including specific behavioral and psychosocial objective goals. Amount, scope and duration as well as specific interventions must be documented in the treatment plan and supported by progress notes.
- F. The child/adolescent and/or family demonstrates the capability of developing more complex personal and interpersonal life skills including problem solving, self advocacy, and the appropriate use of community resources.

### **II. Admission – Psychosocial Factors**

*Two of Standards A-C must be met to satisfy intensity of service.*

- A. There is a lack of family or other natural supports in their community and the education and social development of the child/adolescent is at risk.

- B. The consumer has experienced a recent traumatic event, e.g., sudden and dangerous deterioration in living arrangements, physical abuse, sexual abuse, sudden loss of a key familial or other natural supports (e.g., death), sudden change in a serious medical condition, etc.
- C. Due to cultural or linguistic issues, the consumer is unable to comprehend, engage or participate in a strengths based assessment and in recovery-oriented treatment planning and discharge planning.

**IV. Continued Stay Guidelines (all must be met):**

- A. The emotional and behavioral problems of the child/adolescent continue to have a broad and persistent effect on the child's ability to remain in the home/community.
- B. Child/adolescent and/or family is making adequate progress toward treatment goals as evidenced by lessening of symptoms over time and stabilization of psychosocial functioning through treatment planning and involvement but would not be able to progress without the services provided by the Rehabilitation and Community Support Services.
- C. The treatment plan is updated monthly (30 days) and reflects effort to reduce the frequency of service or clinical documentation for inability to decrease the usage of community based services.
- D. Techniques are employed in treatment that are time-limited in nature and subordinate to a goal of enhanced autonomy, maintaining treatment progress and placement in the least restrictive environment available.

**V. Discharge Standards:**

- A. Child/adolescent no longer meets continued stay standards.
- B. Child/adolescent has progressed to the extent rehabilitation and community based services are no longer necessary.
- C. Severity of illness or deterioration of psychosocial factors requires a higher level of care.

## **Rehabilitation and Community Support Services, Adult**

### **Services covered by this guideline:**

1. Community Psychiatric Supportive Treatment
2. Personal Care Services
3. Mental Health Attendant Care
4. Psychosocial Rehabilitation Group
5. Targeted Case Management
6. Crisis Intervention and Management
7. Assertive Community Treatment
8. Residential Rehabilitative Supports
9. Peer Supports
10. Skills Training
11. Respite Care

### **Intensity Guidelines:** all three (3) elements are evaluated

- A. Severity of the functional impairment
- B. Appropriate intensity of services
- C. Least restrictive or intrusive services necessary

### **I. Admission Guidelines (all must be met):**

- A. The consumer has an emotional or behavioral problem that is of a severity that functioning in the home or community requires rehabilitation and support services..
- B. The consumer demonstrates an exacerbation of longstanding symptoms (e.g. thought disorder, mood disorder) which result in significant functional impairments.
- C. Traditional mental health services have been attempted (i.e. individual/family/group therapy, medication management, etc) and are inadequate to prevent the consumer from deteriorating or to reach identified goals.
- D. Services are supervised by a qualified licensed mental health professional.
- E. At least one member of the family or other natural support agrees to participate in the service (if available).
- F. A clear individualized recovery-oriented treatment plan is established including specific behavioral and psychosocial objective goals. Amount, scope and duration as well as specific interventions must be documented in the treatment plan and supported by progress notes.
- G. The consumer demonstrates the capability of developing more complex personal and interpersonal life skills including problem solving, self advocacy, and the appropriate use of community resources.

### **II. Admission – Psychosocial Factors:**

*Two of Standards A-C must be met to satisfy intensity of service.*

- A. There is a lack of family, friends or other natural supports in their community.
- B. The consumer has experienced a recent traumatic event, e.g., sudden and dangerous deterioration in living arrangements, physical abuse, sexual abuse, sudden loss of a key

familial or other natural supports (e.g., death), sudden loss of employment (e.g., firing, job layoff), sudden change in a serious medical condition, etc.

- C. Due to cultural or linguistic issues, the consumer is unable to comprehend, engage or participate in a strengths based assessment and in recovery-oriented treatment planning and discharge planning.

**III. Continued Stay Guidelines (all must be met):**

- A. The emotional and behavioral problems continue to have a broad and persistent effect on the consumer's ability to remain in the home/community.
- B. The consumer is making adequate progress toward treatment goals as evidenced by lessening of symptoms over time and stabilization of psychosocial functioning through treatment planning and involvement but would not be able to progress without the services provided by the Rehabilitation and Community Support Services.
- C. The treatment plan is updated monthly (30 days) and reflects effort to reduce the frequency of service or clinical documentation for inability to decrease the usage of community based services.
- D. Techniques are employed in treatment that are time-limited in nature and subordinate to a goal of enhanced autonomy, maintaining treatment progress and placement in the least restrictive environment available.

**V. Discharge Standards:**

- A. Consumer no longer meets continued stay standards.
- B. Consumer has progressed to the extent Rehabilitation and Community Support Services are no longer necessary.
- C. Severity of illness or deterioration of psychosocial factors requires higher level of care.

## **Outpatient Treatment, Psychiatric**

### ***Quality of Care Standards***

*Standards must apply for any requested service either at admission or during continued stay.*

The services provided to identify or treat an illness are consistent with the diagnosis and treatment of a condition, and the standards of good medical practice.

#### **I. Initial Review - Severity of Need**

*Standards A, B, C, and D must be met to satisfy severity of need.*

- A. A DSM-IV-TR® diagnosis on Axis I and/or Axis II.
- B. Completed assessments on Axes III, IV and V.
- C. A description of DSM-IV-TR®, IV psychiatric symptoms, intrapsychic conflict, behavioral and/or cognitive dysfunction consistent with the diagnoses on Axes I and II.
- D. Either 1, 2, or 3 below must be met to satisfy standard D.
  1. At least mild symptomatic distress and/or impairment in functioning due to psychiatric symptoms and/or behavior in at least one of the three spheres of functioning (occupational, scholastic, or social), that are the direct result of an Axis I or Axis II disorder.
  2. The consumer has a persistent DSM-IV illness for which maintenance treatment is required to maintain optimal symptom relief and/or functioning.
  3. There is evidence that therapy is required to support the consumer, although the consumer no longer has symptomatic distress or impairment in functioning. The factors considered in making a determination about the continued psychosocial necessity of outpatient treatment is the prevention of relapse of symptoms or discomfort, the level of current stressors, and other relevant indicators including consumer choice.

#### **II. Initial review - Intensity of Service**

*Standards A and B must be met to satisfy intensity of service.*

- A. A psychosocially necessary and appropriate treatment plan, or its update, specific to the consumer's impairment in functioning and DSM-IV-TR®, IV psychiatric symptoms, behavior, cognitive dysfunctions, and/or psychodynamic conflicts. The treatment plan is expected to be effective in either:
  1. Alleviating the consumer's distress and/or dysfunction, or
  2. Achieving appropriate maintenance goals for a persistent illness, or
  3. Supporting recovery.
- B. The treatment plan must identify (1-6) to satisfy standard B:
  1. The status of target-specific DSM-IV-TR®, IV psychiatric symptoms, behavior, and cognitive dysfunction being treated.
  2. The current or anticipated modifications in, biologic, behavioral, psychodynamic or psychosocial framework(s) of treatment for each psychiatric symptom/cluster and/or behavior.
  3. The status of specific and measurable goals for treatment specified in terms of symptom alleviation, behavioral change, cognitive alteration, psychodynamic change, or improvement in social, occupational, or scholastic functioning.

4. The current, or anticipated modifications in, treatment methods in terms of:
  - a. Treatment framework or orientation
  - b. Treatment modality
  - c. Treatment frequency
  - d. Estimate of treatment duration
5. Status of measurable, target standards used to identify both interim treatment goals and end of treatment goals (unless this is a maintenance treatment) to substantiate that: a) treatment is progressing, and/or b) goals have been met and treatment is no longer needed.
6. An alternative plan to be implemented if the consumer does not make substantial progress toward the given goals in a specified period of time. Examples of an alternative plan are a second opinion or introduction of adjunctive or alternative therapies or supports.

### **III. Continued Stay**

*Standards A, B, C and D must be met to satisfy continued outpatient treatment.*

- A. Intensity of Service Standard for the Initial Treatment Review must be met.
- B. A DSM-IV-TR®, IV diagnosis on Axis I and/or a personality disorder diagnosis on Axis II.
- C. A description of -IV-TR®, IV psychiatric symptoms, intrapsychic conflict, cognitive dysfunction, or behavior consistent with the diagnoses given.
- D. Either 1, 2, or 3 must be met to satisfy standard D.
  1. There is the persistence of, or recurrence of at least mild symptomatic distress and/or impairment in functioning due to these psychiatric symptoms and/or behavior.
  2. The consumer has a persistent DSM-IV-TR®, IV illness for which maintenance treatment is required to maintain optimal symptom relief and/or functioning.
  3. There is clinical evidence that further therapy is required to support termination of therapy, although the consumer no longer has symptomatic distress or impairment in functioning.

## **Psychological Testing & Neuro Psychological Testing**

### ***Quality of Care Standards***

*Standards must be applied for any requested service.*

The services provided to identify or treat an illness are consistent with the diagnosis and treatment of a condition and the standards of good medical practice.

#### **I. Severity of Need:**

- A. Testing may be required if the consumer's diagnosis is unclear and cannot be determined from standard interviews and assessment procedures and if the testing results will significantly impact the outcome of treatment.
- B. Testing may be required if the consumer has a poor or no response to standard therapies and the explanation for the failure is unclear and the testing results may significantly impact the outcome of treatment.

#### **II. Intensity:**

*Standards A and B must be met:*

- A. A licensed doctoral-level psychologist (Ph.D., Psy.D or Ed.D.), or other qualified provider as permitted by applicable state and/or federal law, who is credentialed by and contracted with Cenpatico, administers the tests.
- B. Requested tests must be valid and reliable, and the most recent version of the test must be used. The instrument must be age-appropriate and meet the consumer's developmental, linguistics, and cultural requirements.

#### **III. Exclusion Standard:**

- A. Testing primarily for educational or vocational purposes.
- B. Testing using measures that have no standardized norms or documented validity.
- C. Testing primarily for cognitive rehabilitation.
- D. Testing is primarily for legal purposes.
- E. The time requested to administer the testing exceeds established time parameters.

## **Electroconvulsive Therapy**

### ***Quality of Care Standards***

*Standards must apply for any requested service either at initiation or during continued treatment for both inpatient and outpatient electroconvulsive therapy (ECT).*

It should be noted that this standard set is abstracted from the Task Force Report of the American Psychiatric Association, *The Practice of Electroconvulsive Therapy, Recommendations for Treatment, Training, and Privileging, Second Edition, 2001*. It should also be noted that various states have enacted laws relating to ECT and those laws will supersede Cenpatico standards for those states.

### **General Principles of ECT:**

- A. The total number of treatments depends upon the treatment response and severity of adverse effects.
- B. An ECT course usually consists of 6 to 12 treatments for Major Depression and is generally performed every other day. For the newer technique of ultra brief pulse ECT, there may be a need for up to 15 treatments. Initially, in severe cases, the treatment may be performed on a daily basis for severe risk posed by the underlying condition. Larger numbers of treatments may be required for Schizophrenia.
- C. ECT is usually ended or tapered when the maximum response has been achieved.
- D. In the absence of significant clinical improvement after 6 to 10 treatments, the indication for continued ECT should be reassessed.
- E. Repeated courses of ECT are sometimes necessary. Also, some consumers benefit from maintenance ECT when medications alone are not effective.

### **I. Severity of Need**

*Standards A B, C and D must be met to satisfy severity of need.*

- A. The consumer must have a diagnosed mental illness that can be expected to improve significantly from psychosocially necessary and appropriate ECT. The diagnoses include, but are not limited to: Major Depression, Bipolar Disorder and acute Mania, Mood Disorder, Schizoaffective Disorder, Schizophrenia, and Mental Disorders due to medical conditions.
- B. The severity of the consumer's symptoms requires a definitive intervention for reasons such as, but not limited to, high risk of suicide, extreme agitation, catatonia, and/or marked impairment and inability to function.
- C. There is evidence of at least one of the following:
  - 1. The consumer has been a poor responder to adequate trials of medications or combinations of medications; *or*
  - 2. The consumer is unable to tolerate adverse side effects of medications; *or*
  - 3. The consumer has a history of a positive response to ECT for previous episodes of the illness; *or*
  - 4. The consumer is pregnant or has another co-morbid medical condition where providing ECT is favorable to providing no treatment.
- D. The consumer has had a thorough medical evaluation and has no condition that might be a risk with ECT. Examples include, but are not limited to, increased intracranial pressure, risk for hemorrhagic cerebrovascular events, unstable cardiovascular disease, severe electrolyte imbalance, severe pulmonary disease, untreated glaucoma, and recent or evolving retinal detachment. If the medical risk has been contained, ETC may be appropriate.

## **II. Intensity of Service**

*Standards A, B and C must be met to satisfy intensity of service.*

- A. The evaluation and assignment of the mental illness diagnosis must take place in a face-to-face evaluation of the consumer performed by a physician who is credentialed by the facility to provide ECT services. This should include a full psychiatric (including response to past ECT) and a medical history, review of recent physical examination and evaluation of pertinent laboratory tests and procedures.
- B. There should be a individualized recovery-oriented treatment plan or update of a previous treatment plan that documents the reasons for ECT and the course planned for the consumer including anesthesia evaluation.
- C. There is availability of proper medical monitoring prior to, during, and after the administration of anesthesia and ECT.

## **III. Continued Treatments**

*Standards A, B, and C must be met to satisfy continued care.*

- A. Despite therapeutic efforts, clinical evidence indicates the persistence of problems that caused the initiation of ECT.
- B. The consumer's progress confirms that the presenting or newly defined problem will respond to the current treatment plan.
- C. The treatment plan meets the intensity of Intensity of Service standards found above in section II.

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DRAFT