



## *Performance Standards*

### **School-Based Partial Hospitalization Program**

Performance Standards are intended to provide a foundation and serve as a tool to promote continuous quality improvement and progression toward best practice performances, to increase the consistency of service delivery and to improve outcomes for members

**Disclaimer:** These Performance Standards should not be interpreted as regulations. Entities providing services as part of the HealthChoices program must first be enrolled in the Pennsylvania Medical Assistance program as the appropriate provider type. Providers must then comply with all applicable Pennsylvania laws, including Title 55, General Provisions 1101, licensing program requirements and any contractual agreements made with Community Care Behavioral Health Organization in order to be eligible for payment for services.

## PERFORMANCE STANDARDS SCHOOL-BASED PARTIAL HOSPITALIZATION PROGRAMS

Final

Update 06/05

*\* Additions for “enhanced” SBPH supplemental services in bold italics e.g. services provided off site or after hours*

### **DESCRIPTION**

The School-Based Partial Hospital (SBPH) Program provides licensed mental health partial hospital services in an Approved Private School or Private Academic School setting for select children and adolescents with serious emotional and mental health needs. Placement in such settings is normally initiated by the student’s home School District when the District can no longer effectively meet the students education needs within the District’s programs. Students in SBPH programs have Individualized Educational Plans as well as formal mental health treatment plans covering the range of strengths, needs and goals of the programs.

These programs are generally full-time. Exceptions would include transition plans for assisting the student to return to his/her District or the next level of care. Although there may be exceptions, SBPH programs would generally be seen as a stand-alone level of care (that is, students would not, under usual circumstances, also be receiving other levels of mental health care, such as outpatient), while being enrolled in a School-based Partial Hospital program.

## **PERFORMANCE SPECIFICATIONS**

*All SBPH Programs must comply with applicable Pennsylvania laws and regulations (including licensure), CASSP principles, HealthChoices Appendix T mental health medical necessity criteria, and credentialing requirements of Community Care Behavioral Health (CCBH). If provided as part of the Health Choices program, the provider must have enrolled in the Pennsylvania Medical Assistance program and PROMISe system as the appropriate provider type (33) or, under PROMISe, Provider Type 11 (Mental Health/Substance Abuse) as Provider Specialty 113 (Partial Psychiatric Hospital – Child). Programs must maintain their accreditation by the Pennsylvania Department of Education (PDE) as an Approved Private School or Private Academic School.*

*Anticipated length of stay for a student in a SBPH program ranges from one (1) to three (3) school years, based on the child's individual mental health and developmental needs and individual program design, with a plan for treatment in the summer months and scheduled vacation periods. Length of stay may vary based on the availability of less restrictive school placement alternatives with adequate mental health supports available, the child/adolescents history of prior school placements and the length of time spent attempting to transition the child/adolescent to the next level of care and school placement. Treatment plans should be reviewed every twenty (20) treatment days or every 120 calendar days (whichever comes first), and will address measurable goals for the student and his/her family, for example, safety issues, socialization skills, symptom management, medication evaluation and management, and transition plans for discharge to regular education when appropriate. On-going attempts to contact and efforts to involve the family in developing, reviewing and participating in the treatment plan will be documented. Providers are expected to provide education and support to families to participate in all aspects of treatment planning for their child. Providers are expected to consider a family's cultural background and beliefs in engagement, treatment planning and treatment delivery in order to provide culturally relevant and competent services. Families will be invited to attend all treatment team meetings on a regular basis as a partner in the treatment planning process. Providers are expected to encourage family leadership in all aspects of treatment planning. If the family is unable to attend a treatment plan review, a review of the treatment plan will be made by telephone. In addition, one (1) face-to-face meeting per semester with the family to review the treatment plan is the minimum expectation. Meetings will be scheduled at times when it is convenient for the family to attend. Providers are expected to make accommodations to facilitate family participation in treatment planning and review. Providers should offer meeting times and family therapy sessions outside normal school hours, at the family's request. The expectations of attendance, participation, and frequency of meetings must be clearly communicated to families. Reasons for missing a meeting must be clearly documented and an interim meeting should be scheduled. Additional meetings with increased participation on an as needed basis are preferred. At a minimum, providers are expected to include the family/primary caregiver/legal guardian, case manager or other system equivalent (MH/MR/CYF/JPO) and other Behavioral Health providers involved with the child and/or family, when applicable. Providers are expected to participate in other Interagency Team meetings with outside behavioral health providers*

*to coordinate care and ensure consistency in treatment/behavioral interventions across all settings.*

Although this is a relatively intense level of care, placement in a SBPH program is not a crisis-oriented service. Only the hours that the student attends SBPH may be billed. The minimum period of billing must be three (3) hours per day. Treatment of less than three hours per day cannot be billed according to current licensing regulations for Partial Hospitalization. ***\*SBPH providers may request Enhanced School-based Partial Hospitalization for services delivered to children/adolescents during breaks from school and during the transition between home school and SBPH, or alternative level of care, to insure continuity of care.***

### **Physical Facilities**

Services are provided within the structure of an educational setting, providing adequate space for provision of services is available at this level. Space must be accessible to members with physical or other disabilities. Appropriate occupancy permits must be issued and kept up to date (i.e. Department of Labor & Industry (external to Pittsburgh), City Building Inspection (internal to Pittsburgh)).

## **ACCESS STANDARDS**

For Approved Private School Programs, the School District and Pennsylvania Department of Education review processes that govern placement in SBPH programs. Referrals are generally made by school districts and approved by the PDE and the time frame for admission can be variable as a result. To the extent possible within those requirements,

- Families should have a choice of provider within the limitations of what the school district is willing to offer as an educational placement
  - Families, including the student, should have an opportunity to review potential providers in advance of the School District's decision and referral
  - Services should be as accessible to the family as possible
- For the mental health part of the placement, intake assessment and clinical decisions should be completed with seven (7) days of the official authorization by the School District. (Assessment and clinical decisions may be made in advance of this authorization.)
- A completed request for authorization form for mental health services should be received by CCBH within five (5) business days of the member's admission date to the program.
- Within fifteen (15) school days of admission, the member/family should have a comprehensive assessment including a face-to-face psychiatric evaluation, a social history done by master's level staff, and a treatment plan signed by the physician.

## **GENERAL APPROPRIATENESS FOR SERVICES**

Children and adolescents who are appropriate for these programs are generally those who:

- Meet the Pennsylvania criteria for Serious Emotional Disturbance and have an Individualized Education Plan that addresses their behavioral and emotional support needs in school.
- Have an extensive history of inability to function successfully in
  - Mainstream educational placements
  - Emotional support classrooms
- Have been unsuccessfully treated in lower levels of behavioral health treatment (such as outpatient, stand-alone partial hospital, school-based counseling, family based mental health and/or wraparound services.) Occasionally, children/adolescents may be placed in SBPH to avoid placement in more restrictive environments. In some cases, very young children with serious emotional disturbance or Pervasive Developmental Disorder/Autism, SBPH may be deemed to be the least restrictive available alternative.

## **ENGAGEMENT**

Providers are expected to make an on-going, concerted effort to effectively engage not only the student but also his/her family in the treatment of behavioral health disorders. Providers are expected to make every effort to support families to participate in their child's treatment and planning for their child's needs in the program. This may include:

- Accommodation to families' work schedules
- Accommodation for other children in the student's family
- Engagement efforts that are individualized to meet the cultural backgrounds and beliefs of the family.
- Fostering active participation of family members in the formulation of the student's treatment plan which may include development of a treatment/behavior plan and/or specific interventions that the family can implement outside the school setting (e.g. home, community)
- Fostering active participation and leadership of the family and child/adolescent (as clinically appropriate) in the review of the student's progress and subsequent modification to the treatment plan
- Work with the child/adolescent's family as a partner in planning for the treatment needs of their child in the program, as well as assisting the family with planning for their child's long-term education and behavioral health needs.
- Identify strengths and needs of the student and family.
- Make aggressive efforts to engage children who have attendance or performance issues so that they can be actively maintained in the program and progress toward identified educational and mental health treatment goals.

- Offer family therapy/psycho-education sessions to address family system issues which effect school attendance/performance or impact the child/adolescent's adherence to mental health treatment. Providers are expected to offer medication education to families as well as offer education for families about treatment options for their child/adolescent and offer parent skill building training/education in the management of their child's behavioral health needs.

## **ASSESSMENTS**

Competent and comprehensive clinical assessments form the basis of a successful treatment program. Assessments are expected to be in the OMHSAS "Best Practice" format. Assessments must be designed to tease out learning/educational issues from behavioral health symptoms. Assessments are expected to determine what drives a child's behavior, taking into consideration a child's physical health and environmental antecedents that may be influencing/triggering a child's behavior/symptoms.

- A licensed masters level clinician, or masters level clinician with a minimum of two (2) years experience will complete clinical assessments.
- Mental status examination, symptom review, and medication assessment will be done by a board certified or board eligible child psychiatrist.
- The identified patient and family will be included in the assessment process
- Other participants may include but are not limited to:
  - agencies providing services to the child/family including case management
  - foster parents
  - the home school
  - the Office of Children, Youth and Families (CYF)
  - Juvenile Probation Office (JPO)
- Information in the assessment is based on CASSP principles and should include
  - Diagnoses on five (5) axes
  - Identification of appropriate Medical necessity criteria according to Appendix T
  - Medication formulation
  - Treatment plans, including targeted interventions
  - Family functioning, including the roles and functions of key caregivers
  - Social/human services providers
  - Safety issues, including housing
  - Assessment for co-occurring mental health and substance abuse problems for any student considered at risk for developing a substance abuse disorder.

If after the assessment the provider decides that their services will not meet the needs of the child, the child/family will be referred to the appropriate level of care.

## **TREATMENT TEAM MEETINGS**

Treatment/service plans are developed with the family, child/adolescent and the identified treatment team, which, at a minimum, should include the child/adolescent (unless clinically counter-indicated), the family/legal guardian and the SBPH treatment team (psychiatrist, mental health treatment specialist, education specialist). Families may choose to invite any one they wish to attend treatment team or interagency team meetings for their child (e.g. advocates, natural supports, community supports, etc.) SBPH providers are expected to extend invitations to and coordinate care/treatment with any other behavioral health treatment providers working with the child/family and any/all case managers (MH/MR/JPO/CYF). Providers are expected to work as partners with families to coordinate and integrate all behavioral health interventions, supports and services.

Representatives/Special Education Liasons from the child/adolescent's home school district should be included in treatment team meetings relevant to school placement and transition planning for the child/adolescent. Likewise, Individual Education Plan (IEP) meetings should include members of the child/adolescent's SBPH treatment team, as relevant to planning for education needs and transition planning.

### **Treatment/service planning**

Treatment within a school-based partial hospitalization program offers a unique behavioral health service that is integrated within a school/classroom setting. Services and interventions occur within the context of the event or natural school/classroom setting as part of the milieu, whenever possible. SBPH classrooms include both education specialists and mental health treatment specialists.

The treatment/service plan should

- Address and build on the identified strengths and needs of the student
- Address and build on the strengths, needs and cultural background of the student's family, particularly as the families strengths, needs and culture may influence the student's participation in treatment and progress toward identified goals
- Include measurable goals and objectives, and time frames for addressing them
  - These should be related to the identified goals and objectives
- When appropriate, include a contingency plan to address anticipated problems should they arise
  - (for example, if a child/adolescent historically experienced an exacerbation of symptoms in the spring of the year, the service plan should include a plan that anticipates that this is likely to occur)
  - Include a plan for crisis intervention when the student's history or current behaviors indicate this is would be appropriate

- Note other behavioral health and educational services and supports being used by the student. The treatment/service plan should clearly delineate the roles/responsibilities in implementing all aspects of the treatment plan. Whenever possible, providers should work with other behavioral health and educational services to implement an integrated treatment plan for the child that addresses all life domains.
- Include specifics regarding the child/adolescent's access to medical and dental resources
  - This should include access strategies (that is, the child/adolescent has a PCP and the child/adolescent knows how to successfully access the PCP)
  - This should also include strategies for contact with the Special Needs Unit of the child/adolescent's PH-MCO for assistance with any special health care needs, as appropriate
- Include a plan or strategy for working with the student and the family to provider education regarding the management of the illness.
- Include an **individualized** relapse prevention and intervention strategy that includes identification of known antecedents, symptoms and behavioral changes that may be signs of de-compensation or need for immediate intervention.
- Document family involvement as appropriate to this plan
- Document leisure/recreational/community/social supports
- Document plans for service delivery during summer and other vacations
- Document plans for implementing any recommended behavioral health treatment interventions outside the school setting and identify person(s) responsible for implementing the plan outside the school setting (e.g. family, ICM, community support, etc.)

## **SERVICE DELIVERY ELEMENTS**

### **Service and Program Descriptions**

School Based Partial Hospital programs deliver a full range of mental health services in a school setting to children with serious mental health needs. In general, the population served has been referred by individual school districts because of the severe and/or chronic mental health and/or behavioral problems that have interfered with the student's ability to function in regular or less restrictive special education classes. The treatment focuses on behavior and medication management, individual, group, **milieu** and family therapy. In general, treatment and behavioral interventions occur in the setting where the child/adolescent is experiencing difficulty.

Collaboration occurs with community agencies, including CYF and JPO, and the appropriate staff at the student's home school district. Community/cultural activities are also integrated into the treatment component to ensure the progression of the student back to the least restrictive school/community setting.

Staff/patient ratios required a minimum of one FTE clinical staff member for every five students. A program has at least 2 hours of assigned psychiatric time per week for every 5 students. Medications may be administered by the program. Staff must conduct a comprehensive review and update the treatment plan every 20 days or 120 calendar days (whichever occurs first) that is reviewed with parents or guardians. Families should be encouraged to attend treatment plan reviews as scheduled. At a minimum, the family should participate in a treatment plan review at least once each semester. Participation may be in person or via telephone conference. In addition, the plan will be reviewed with all students aged 14 and older.

### **Clinical Services**

Clinical services, including psychiatric services, are available to students at the School Based Partial Hospitalization program. On-site psychiatric coverage is required at a ratio of 2 hours/week for every 5 students according to the program's licensed capacity. For small providers who may not have a psychiatrist on-site during all school hours, providers are expected to provide access to a psychiatrist for on-call for telephone consultation or in response to urgent psychiatric needs of the students. Students are provided with individualized treatment plans within the program, and professional staff is responsible for the delivery of mental health services as outlined in the plan. Crisis plans are part of the service continuum. The student must participate in mental health treatment for a minimum of 3 hours a day. Treatment must include individual, group, milieu and family therapy. Treatment should be based upon the diagnostic evaluation of the medical, psychological, familial, educational, vocational, and developmental aspects of the student's situation, depending on the student's needs and the approved treatment plan. Treatment will be specific and relative to the strengths and needs of the child and the family. Child and family strengths and needs will be identified and addressed in the appropriate treatment modality.

Staffing patterns and clinical leadership of the program are expected to meet the needs of the children/adolescents in served in the program. Treatment is provided by a team of clinical staff and education specialists working together across all settings in the school.

In addition, the attending child/adolescent psychiatrist will be actively involved in the development and oversight of the initial treatment plan, as well as the twenty (20) day reviews. Face-to-face individual, group, milieu and family therapy and medication sessions will be documented in the student's chart. The child psychiatrist should also be available to the staff for consultation on a regular and as needed basis, should a crisis occur.

The program must have a policy covering the dispensation of medications that meets state licensing requirements. The program must also be capable of monitoring the adherence to medication schedules and of potential side effects. Adherence to treatment, including medication, should be a goal. The program must have the capability to

administer medications as ordered at any time during program operations. Medication education should be provided to the family, and child/adolescent when appropriate. Information on the benefits/efficacy, potential side effects and options for treating the child's behavioral health disorder should be provided to the family. On-going medication education should be provided to families whenever medication changes are being considered or occur.

### **Coordination of Care**

Providers must ensure that care is coordinated and service linkage is provided, as needed, to the Physical Health HMO, other mental health and /or drug and alcohol providers, mental retardation services, social service agencies, providers of crisis services, and the student's home school. Contacts with other service providers are documented, including discharge planning, summer plans, and any follow-up treatment plans. School based partial programs are also expected to participate in interagency team meetings with other behavioral health providers and supports to insure coordination of care.

- *Services must be coordinated with CCBH, and information required for authorization is provided in a timely manner, as outlined in Policies and Procedures.*

### **Educational Services**

The Department of Education provides the specialized educational program for students. Although provided at the same site as the SBPHP, the educational component will not be reimbursed by CCBH.

- The School Based Partial Hospital program's role is to provide behavioral health treatment rather than educational services to students, within an approved private school or other designated education setting

### **Crisis Plans**

SBPHP's should have standard crisis plans/procedures developed for the program as well as individualized crisis plans for students. These should be clearly outlined in the clinical record and on file for all staff, as well as communicated to students/parents. These plans may change to reflect particular clinical needs of the student. Individualized crisis plans should be developed with the child/adolescent, their family and other appropriate members of the treatment team and include crisis plans/procedures for the family to follow on days or at times when school is not in session. e.g. weekends, holidays, vacations. Crisis plans must be closely coordinated with community services/supports and/or home school districts to insure coordinated/integrated crisis prevention and intervention planning. *\*Enhanced SBPH providers are available to respond to crisis calls 24/7 during holidays, normal breaks from school and during the transition period between SBPH and return to the home school district.*

### **Credentialing**

All organizations must be assessed and approved through the credentialing process of CCBH.

### **Staffing**

Primary clinical staff must be consistent with regulations and must include licensed behavioral health staff. Staff/child/adolescent ratios should typically be one clinical staff FTE to 5 students. Administrative and treatment staff are representative of the cultural diversity of the community which the program serves. Staffing is available to address special needs of the students and priority population within Health Choices. Staffing must reflect sensitivity to the cultural diversity of children/adolescents and their families and include cultural competency as part of the provider's Quality Improvement Plan.

### **Orientation and training**

Providers must have written policies for supervision and training of all staffs and maintain documentation of regularly scheduled and on-going supervision and training. Training records will reflect issues relevant to the population served e.g. cultural diversity, CASSP principles, confidentiality, internal policies and procedures, priority populations and member rights. (Member rights and responsibilities are posted.) Staff must receive training in areas relevant to the behavioral health needs of the children/adolescents served. Relevant staff training should include, at a minimum, the following:

- Psychiatric disorders
- Data collection
- Behavioral Assessments
- Psycho-pharmacology – including medication education and data collection to determine efficacy
- Behavioral Intervention strategies in the milieu
- Positive reinforcement
- Crisis prevention and intervention
- Relapse prevention
- Cultural Competency

### **Hours of operation**

Program services are generally available during the school year, five days a week, 3 – 6 hours a day. The program must provide after-hours crisis plans for all children. Providers are expected to provide information to families on what to do in the event of a psychiatric emergency during non-school hours. *\*The Enhanced SBPH program must provide for 24-hour access to clinical staff in the event of a student emergency off-hours, during*

*normal breaks from school and during the transition from SBPH to home school district.*

### **Utilization and Quality Management programs**

Providers maintain a clearly defined and ongoing program for utilization and quality management: including tracking, resolution, and reporting on complaints, grievances, and critical incidents, measurement of functional outcomes and satisfaction and a quality improvement plan. Senior level personnel are designated to oversee UM/QM programs, and students and families are involved in the design, development and evaluation of services.

### **Policies and Procedures**

Providers develop and maintain policies and procedures that define adherence with Community Care's performance specifications, CASSP principles and relevant PA laws and regulations. Policies and Procedures are reviewed and revised at a minimum on an annual basis.

### **DISCHARGE PLANNING**

Discharge planning should be inherent in the treatment planning process, but should assume increasing importance in the anticipated final year or semester of attendance in the Approved Private School or private academic schools. Planning for discharge should include:

- Consultation with the family regarding available resources
- Clinical transition planning to support continuity
  - An updated clinical evaluation, with treatment recommendations, should be done prior to the end of the last semester
- Work with the family's school district regarding education and emotional support needs
- Transition to the next school placement should begin as determined to be appropriate for the individual student
- *\*Enhanced SBPH plans should include provisions for additional clinical or behavior management consultation by a skilled mental health clinician after the student has transitioned to the new setting.*
- Because transitions typically take place at the end of a semester, particular attention should be paid to service provision during the period between semesters
- Arrangements for case management services should be noted **as part of the discharge plan**. If a case manager has not been identified, the provider will work with the family to determine case management needs and assist the family with referrals, as needed.

- Direct linkage to the provider(s) of continuing care should be made when there is question of the student's ability to make these transitions successfully.
- Information about crisis management resources should be provided to the student/family/significant others and documented. An individualized crisis prevention and intervention plan will be developed for the family and home school district to assist with a smooth transition to the next level of care and school placement.
  - This should include information on the Telephone and Mobile Crisis Services, and the use of the CACTIS or similar programs, as necessary
- When appropriate, a Transitional Plan, as required by the PDE, should be included.

## **PROVIDER BENCHMARKING**

*In addition to standard provider benchmarking measures, SBPH programs will be monitored on*

- Success in ensuring the family's school district placement in the responsible school district, as documented through continued monitoring of POMS reports. Specifically, improvement in school attendance, school performance and school behavior, as documented on the POMS reports.
- Crisis events (crisis interventions, emergency assessments, unplanned hospitalizations, etc.) during vacation periods
- Utilization of other behavioral health resources during the time of authorizations for School-based Partial Hospital
- Service continuity planning for vacation periods

## **OUTCOMES**

Individual child/adolescent outcomes will be measured by the provider by measuring progress toward individual goals in program. Overall, expected outcomes for SBPH programs include improvement/progress in school performance, school attendance and school behavior as documented on quarterly POMS data collection/reports. Programs are expected to work with the home school district, family and treatment team toward returning the child/adolescent to the least restrictive educational environment that meets both their educational needs and mental health treatment needs.

As with all mental health treatment programs for children/adolescents, expected outcomes include:

- Symptom stabilization
- Improved ability of the family to manage the child/adolescent's behavioral health needs through skill development, education and training.

## **SATISFACTION MEASURES**

*In addition to standard measures, assessment will include*

- Family satisfaction with school placement and behavioral change
- School district satisfaction with communication regarding the student and after-care planning
- Family satisfaction with transition at discharge of after-care mental health services
- Family satisfaction with provider staff performance related to interactions with their child and the family.
- Family satisfaction with the cultural competency of provider staff.

## **CULTURAL COMPETENCE**

Cultural competence, from the perspective of the child/adolescent/family, is monitored by:

- Specific requests made by a member, or on behalf of a member
- Member complaints

The provider will:

- Understand the scope of cultural identity and its impact on the delivery and response to the services provided
- Identify the cultural composition of the population served
- Incorporate methods into the treatment setting that convey a culturally competent and sensitive provider
- Recruit/maintain staff who reflect that cultural diversity of the student population served.