Intensive Outpatient Program (IOP)

An intensive outpatient program (IOP) is a freestanding or hospital-based program that maintains hours of service for at least 3 hours per day, 2 or more days per week. It may be used as an initial point of entry into care, as a step up from routine outpatient services, or as a step down from acute inpatient, residential care or a partial hospital program.

An IOP can be used to treat mental health conditions or can specialize in the treatment of co-occurring mental health and substance use disorders. These criteria are used for mental health and co-occuring mental health disorders. However, ASAM Criteria are used for substance use disorders.

When supported by the benefit plan, coverage may be available for intensive outpatient programs that are provided with less intensity to members who are recovering from severe and persistent mental health conditions.

Any ONE of the following criteria must be met:

1. The member's psychosocial functioning has become impaired by moderate-severe symptoms of a mental health condition, and treatment cannot be adequately managed in a lower level of care; or
2. The member's mood, affect or cognition has deteriorated to the extent that a higher level of care will likely be needed if intensive outpatient treatment is not provided; or
3. The member has completed inpatient, residential treatment or a partial hospital/day treatment program, and requires the structure and monitoring available in an intensive outpatient program; or
4. The member has a non-supportive living situation creating an environment in which the member's mental health condition is likely to worsen without the structure and support of the intensive outpatient program.

And all of the following:

1. The member is not at imminent risk of serious harm to self or others.
2. Co-occurring medical conditions, if present, can be safely managed in an outpatient setting.
3. Co-occurring substance use disorders, if present, can be treated in a dual diagnosis program, or can be safely managed at this level of care.
4. The member is not at risk for severe withdrawal or delirium tremens.
5. The member and/or his/her family/social support system understand and can comply with the requirements of an IOP, or the member is likely to participate in treatment with

the structure and supervision afforded by an IOP.

6. Within the first 3 days of treatment, the following should occur:
    a. A psychiatrist completes a comprehensive evaluation of the member when the member has been directly admitted to the intensive outpatient program from an inpatient setting.
    b. The provider and, whenever possible, the member does the following:
        i. Develop a treatment plan; ii. Project a discharge date; and iii. Develop an initial discharge plan.
    c. The provider does the following within 48 hours of admission with the member's documented consent:
        i. Contacts the member's family/social supports to discuss participating in treatment and discharge planning when such participation is essential and clinically appropriate.
        ii. Contacts the member's most recent provider to obtain information about the member's presenting condition and response to treatment.
7. After admission, the program shall ensure that:
    a. A psychiatrist continues to see the member at least weekly when the member has been directly admitted from an inpatient setting.
    b. Services are coordinated with other behavioral health or medical providers who are providing concurrent care, as well as with agencies and programs such as the school or court system with which the member is involved with the members documented consent.
8. The provider and, whenever possible, the member collaborate to update the treatment plan every 3 to 5 treatment days in response to changes in the member's condition or provide compelling evidence that continued treatment in the current level of care is required to prevent acute deterioration or exacerbation of the member's current condition.
9. The provider and, whenever possible, the member collaborate to update the initial discharge plan in response to changes in the member's condition so that an appropriate discharge plan is in place prior to discharge. Whenever possible, the provider should review the discharge plan with the provider at the next level of care prior to discharge. The final discharge plan should be provided to the Care Advocate at least 24 hours prior to the anticipated date of discharge.
10. The discharge plan must include ALL of the following:
    a. The anticipated discharge date.
    b. The level and modalities of post-discharge care including the following:
        i. The next level of care, its location, and the name(s) of the provider(s) who will deliver treatment;
        ii. The rationale for the referral;
        iii. The date and time of the first appointment for treatment as

well as the first follow-up psychiatric assessment;
1. The first appointment should be within 7 days of discharge;

iv. The recommended modalities of post-discharge care and the frequency of each modality;
v. The names, dosages and frequencies of each medication and a schedule for appropriate lab tests if pharmacotherapy is a modality of post-discharge care.
vi. Linkages with peer services and other community resources.
vii. A crisis plan to help the member address re-emergence of referral symptoms or the emergence of new symptoms that require services.

c. The plan to communicate all pertinent clinical information to the provider(s) responsible for post-discharge care, as well as to the member's primary care provider as appropriate.
d. The plan to coordinate discharge with agencies and programs such as the school or court system with which the member has been involved when appropriate and with the member's documented consent.
e. A prescription for a supply of medication sufficient to bridge the time between discharge and the scheduled follow-up psychiatric assessment.
f. Confirmation that the member or authorized representative understands the discharge plan.
g. Confirmation that the member was provided with written instruction for what to do in the event that a crisis arises prior to the first follow-up appointment.

Continuation of Stay

ALL of the following criteria must be met.
1. The criteria for the current level of care continue to be met.
2. The treatment plan continues to include evidence-based treatments which are aimed at achieving specific and realistic goals, and are of sufficient intensity to address the member's specific and realistic goals, and are of sufficient intensity to address the member's condition and support the member's recovery/resiliency. When the diagnosis is a co-occurring substance use disorder, referral to an age-appropriate sobriety support group and use of an accountability partner such as a sponsor have been considered.
3. When clinically indicated, the provider and the member assess the need to create or update the member's advance directive.
4. When clinically indicated, the member's family/social supports actively participate in the member's treatment.
   a. The member's documented consent is required when the member is of legal age or status.

5. There continues to be evidence that the member is receiving active treatment, and there continues to be a reasonable expectation that the member's condition will improve further. Lack of progress is being addressed by an appropriate change in the member's treatment plan, and/or an intervention to engage the member in treatment.
6. The member's current symptoms and/or history provide evidence that relapse or a significant deterioration in functioning would be imminent if the member was transitioned to a lower level of care or, in the case of outpatient care, was discharged.