

HEALTHCHOICES BEHAVIORAL HEALTH SERVICES
GUIDELINES for MENTAL HEALTH MEDICAL NECESSITY CRITERIA

ADULT

PSYCHIATRIC INPATIENT SERVICES

Admission (must meet criteria I, II, and III):

A physician has conducted an evaluation and has determined that:

- I. The person has a psychiatric diagnosis or provisional psychiatric diagnosis, excluding mental retardation, substance abuse or senility, unless these conditions coexist with another psychiatric diagnosis or provisional psychiatric diagnosis,

and
- II. The person cannot be appropriately treated at a less intense level of care because of the need for:
 - * 24 hour availability of services for diagnosis, continuous monitoring and assessment of the person's response to treatment,
 - * availability of a physician 24 hours a day to make timely and necessary changes in the treatment plan,
 - * the involvement of a psychiatrist in the development and management of the treatment program, and
 - * 24 hour availability of professional nursing care to implement the treatment plan and monitor/assess the person's condition and response to treatment.
 - * 24 hour clinical management and supervision,

and
- III. The severity of the illness presented by the person meets one or more of the following:
 - * The person poses a significant risk of harm to self or others, or to the destruction of property.
 - * The person has a medical condition or illness which cannot be managed in a less

intensive level of care because the psychiatric and medical conditions so compound one another that there is a significant risk of medical crisis or instability.

- * The person's judgment or functional capacity and capability has decreased to such a degree that self-maintenance, occupational, or social functioning are severely threatened.
- * The person requires treatment which may be medically unsafe if administered at a less intense level of care.
- * There is an increase in the severity of symptoms such that continuation at a less intense level of care cannot offer an expectation of improvement or the prevention of deterioration, resulting in danger to self, others, or property.

Continued stay (must meet criteria I and II):

I. The severity of the illness presented by the person meets one or more of the following:

- * persistence of symptoms which meet admission criteria; or
- * development of new symptoms during the person's stay which meet admission criteria; or
- * there is an adverse reaction to medication, procedures, or therapies requiring continued hospitalization; or
- * there is a reasonable expectation based on the person's current condition and past history, that withdrawal of inpatient treatment will impede improvement or result in rapid decompensation or the re-occurrence of symptoms or behaviors which cannot be managed in a treatment setting of lesser intensity.

and

II. The person continues to need the intensity of treatment defined under Admission Criterion II; and

- * a physical examination is conducted within 24 hours after admission; and
- * a psychiatrist conducts a psychiatric examination within 24 hours after admission; and
- * the person participates in treatment and discharge planning; and
- * treatment planning and subsequent therapeutic orders reflect appropriate, adequate and timely implementation of all treatment approaches in response to the person's changing needs.

Discharge Indicators (must meet I or II):

I. The person no longer needs the inpatient level of care because:

- * The symptoms, functional impairments and/or coexisting medical conditions that necessitated admission or continued stay have diminished in severity and the person's treatment can now be managed at a less intensive level of care; and
- * The improvement in symptoms, functional capacity and/or medical condition has been stabilized and will not be compromised with treatment being given at a less intensive level of care; and
- * The person does not pose a significant risk of harm to self or others, or destruction of property; and
- * There is a viable discharge plan which includes living arrangements and follow-up care

or

II. Inpatient psychiatric treatment is discontinued because:

- * A diagnostic evaluation and/or a medical treatment has been completed when one of these constitutes the reason for admission; or
- * The person withdraws from treatment against advice and does not meet criteria for involuntary commitment; or
- * The person is transferred to another facility/unit for continued inpatient care.

PARTIAL HOSPITALIZATION

Admission (must meet criteria I, II, and III):

I. A mental health professional, as defined in Chapter 5210.3 of the Partial Hospitalization regulations, has conducted an evaluation and has determined that the person meets one of the following:

- * The person has an established history of a psychiatric disorder, excluding mental retardation, substance abuse or senility, unless these conditions co-exist with other psychiatric symptomatology, and is presenting symptoms which require this level of care; or
- * The person does not have an established psychiatric history, but a psychiatrist, or physician, or a licensed clinical psychologist has been consulted and has confirmed the presence of a psychiatric disorder that requires this level of care; or
- * The person has had an evaluation by a psychiatrist, a physician, or a licensed clinical psychologist at another mental health treatment facility, (e.g., inpatient, outpatient or crisis intervention) and is being directly referred to this level of care; or

- * The person needs a diagnostic evaluation that cannot be performed at a lesser level of care.

and

II. The partial hospital level of care is appropriate because:

- * The person has the capacity to participate in the partial hospitalization level of care; and
- * The person has a community based network of support that enables him/her to participate in the partial hospitalization level of care; and
- * The person exhibits sufficient control over his/her behavior such that he/she is judged not to be an imminent danger to self, others or property.

and

III. The severity of the symptoms presented by the person meets one or more of the following:

- * The person's judgment or functional capacity and capability is compromised to such a degree that self-maintenance, occupational, educational or social functioning are significantly impaired, and the severity of the presenting symptoms is such that the success of treatment at a less intense level of care is unlikely; or
- * The person requires treatment which may be unsafe if administered at a less intense level of care; or
- * Sufficient clinical gains have not been made within a less intensive level of care, and the severity of presenting symptoms is such that the success of treatment at a less intense level of care is unlikely; or
- * Co-existing, non-psychiatric medical conditions preclude treatment at a less intensive level of care because the psychiatric and medical conditions so compound one another that there is a significant risk of medical crisis or instability.

Continued Stay Criteria (must meet criteria I and II)

I. One or more of the symptoms or conditions which necessitated admission persist, or new symptoms develop which meet admission criteria, and the person meets one or more of the following:

- * The person has not completed the goals and objectives of the Individualized Treatment Plan that are necessary to warrant transition to a less intensive level of care; or

- * The person demonstrates a current or historical inability to sustain/maintain gains without a comprehensive program of treatment services provided by the partial hospital program; or
- * Attempts to reduce the intensity and structure of the therapeutic program have resulted in, or are likely to result in, exacerbation of the psychiatric illness as manifested by regression of behavior and/or the worsening of presenting symptomatology; or
- * Attempts to increase the person's level of functioning or role performance in the areas of interpersonal, occupational or self-management functioning have resulted in exacerbation of psychiatric illness as manifested by regression of behavior and/or the worsening of presenting symptomatology; or
- * An adverse reaction to medication, procedures or therapies requires frequent monitoring which cannot be managed at a less intensive level of care.

and

II. The partial hospital program provides the following service elements:

- * The person is receiving active treatment within the framework of a multi-disciplinary individualized treatment plan approach; and
- * There is the involvement of a psychiatrist in the development and management of the treatment program and discharge plan; and
- * The treatment plan includes a discharge plan and is reviewed and modified, as appropriate, by the treatment team to respond to changes in the person's clinical presentation or lack of progress; and
- * The person is an active participant in treatment and discharge planning; and
- * Where clinically appropriate, and with the person's informed consent, timely attempts are made by the treatment team, and documented in the treatment plan, to involve the family and other components of the person's community support network in treatment planning and discharge planning.

Discharge Indicators (must meet I or II):

I. The person no longer needs the partial hospital level of care because:

- * The symptoms, functional impairments and/or coexisting medical conditions that necessitated admission or continued stay have diminished in severity and the person's treatment can now be managed at a less intensive level of care; and
- * The improvement in symptoms, functional capacity and/or medical condition has been stabilized and will not be compromised with treatment being given at a less intensive level of care; and

- * There is a viable discharge plan with which service and care providers identified for after-care treatment, if needed, and support have concurred.

or

II. The partial hospital level of care is discontinued because:

- * The diagnostic evaluation has been completed when this constitutes the reason for admission; or
- * The person withdraws from treatment against advice and does not meet criteria for involuntary commitment; or
- * The person is transferred to another facility/unit for continued care.

Admission (must meet criteria I and II):

I. A mental health professional determines that the outpatient level of care is appropriate and there is the potential for the person to benefit from outpatient care. The person must meet at least one of the following condition elements:

- * The person has a psychiatric illness exhibited by reduced levels of functioning and/or subjective distress in response to an acute precipitating event; or
- * The person is exhibiting signs or symptoms of a psychiatric illness, associated with reduced levels of functioning and/or subjective distress; or
- * The person has a history of psychiatric illness and presents in remission or with a residual state of a psychiatric illness, and without treatment there is significant potential for serious regression,

and

II. A comprehensive diagnostic evaluation, including an assessment of the psychiatric, medical, psychological, social, vocational and educational factors important to the person, is conducted.

Continued Stay (must meet criteria I, II and III):

I. The person has a current psychiatric diagnosis or provisional psychiatric diagnosis.

and

II. The treatment team determines that:

- * The person continues to exhibit one or more signs or symptoms that necessitated admission and can be expected to benefit from the outpatient level of care; or
- * The person has developed new signs or symptoms that meet admission criteria and could be expected to benefit from the outpatient level of care; or
- * There is a reasonable expectation based on the person's clinical history that withdrawal of treatment will result in decompensation or recurrence of signs or symptoms.

III. The services provided to the person meet the following criteria:

- * The person is an active participant in treatment and discharge planning; and
- * A psychiatrist reviews and approves the treatment plan; and
- * The treatment plan includes a discharge plan and is reviewed and modified, as appropriate, by the treatment team to address changes in the person's clinical presentation and response to treatment; and
- * The person is receiving treatment within the framework of a multidisciplinary individualized treatment plan approach.

Discharge Indicators

- * The person no longer meets continued stay criteria; or
- * The person withdraws from treatment against advice and does not meet criteria for involuntary treatment.

**Appendix T
Part A**

**HEALTHCHOICES BEHAVIORAL HEALTH SERVICES
GUIDELINES for MENTAL HEALTH SERVICE NECESSITY CRITERIA**

ADULT

TARGETED CASE MANAGEMENT SERVICES

Admission Criteria

An individual who meets the minimum staff requirements for an Intensive Case Manager as defined by Chapter 5221, Mental Health Intensive Case Management; a Resource Coordinator as defined by Mental Health Bulletin OMH-93-09 —Resource Coordination: Implementation; or a Blended Case Manager as defined by Office of Mental Health and Substance Abuse Bulletin OMHSAS-10-03 Blended Case Management (BCM) - Revised and has received training on the use of the environmental matrix has conducted an evaluation and has determined that:

- I. The person meets either the eligibility criteria for Resource Coordination Services as defined by Mental Health Bulletin OMH-93-09 —Resource Coordination: Implementation; Intensive Case Management Services as defined by Chapter 5221, Mental Health Intensive Case Management; or Blended Case Management as defined by Office of Mental Health and Substance Abuse Bulletin OMHSAS-10-03 Blended Case Management (BCM) - Revised;

or

- II. The person meets the criteria for serious mental illness (SMI) as described in *Federal Register Volume 58 No. 96, May 20, 1993, pages 29422-29425*; and cited in OMH-94-04: p. 1;

and

- III. The person is in need of Targeted Case Management Services as indicated by the evaluation of the functional level through utilization of the Targeted Case Management-Adult Environmental Matrix, and in

conjunction with clinical information and the professional judgement of the reviewer.

Continued Stay and/or Change of Level of Need

The consumer must be reassessed at the point of concurrent review, but no less frequently than six month intervals, and when there are significant changes in the individual's situation that warrants a change in level of TCM services.

- I. The consumer continues to meet either I or II of part A Admission Criteria.

and
- II. The person is in need of Targeted Case Management Services as indicated by the evaluation of the functional level through utilization of the Targeted Case Management-Adult Environmental Matrix and in conjunction with clinical information and the professional judgement of the reviewer.

Discharge Indicators

Targeted Case Management may be terminated when one of the following criteria is met:

- A. The consumer receiving the service determines that Targeted Case Management is no longer needed or wanted and the consumer no longer meets the continued stay criteria; or
- B. Determination by the targeted case manager in consultation with his/her supervisor or the director of targeted case management, and with written concurrence by the county administrator that targeted case management is no longer necessary or appropriate for the adult receiving the service and the consumer no longer meets the continued stay criteria; or
- C. The consumer receiving the service determines that Targeted Case Management is no longer wanted, however, the consumer does meet continued stay criteria; or
- D. The consumer has moved outside of the current geographical service area (e.g., county, state, country); or

-
- E. The consumer is undergoing long-term incarceration and/or long-term hospitalization or long-term skilled-nursing care without a discharge or anticipated discharge date.

TCM ENVIRONMENTAL MATRIX — ADULTS INSTRUCTIONS

The Environmental Matrix - Adults is a scale that evaluates the functional level of consumers on the six activities identified by regulation as Targeted Case Management activities. Cultural competency will be recognized throughout the entire evaluation process and the entire document. Individuals must be assessed in the following areas, in a face-to-face interview with the evaluator. Individuals should be reassessed as needed, but no less than every six months.

1. Assessment and Service Planning
2. Informal Support and Network Building
3. Use of Community Resources
4. Linking and Accessing Services
5. Monitoring of Service Delivery
6. Problem Resolution

The scale has a range from 0 to 5 with the following values for each activity:

0	1	2	3	4	5
No assistance Needed	Minimal assistance needed		Needs Moderate assistance in this area		Needs Significant assistance in this area

All six activities are ranked on the above scale. The evaluator must complete the environmental matrix in a face- to – face, strengths - based assessment interview with the consumer. Evaluators should incorporate in their assessment a recognition/determination of cultural strengths (i.e., extended family, allocation of family resources, the decision making process, values, etc.). The evaluator should consider the individual’s strengths and needs in the following life domains for each assessment area in order to produce a score that reflects the full dimension of need:

- . Housing/living situation
- . Education/vocation
- . Income/benefits/financial management
- . Mental Health treatment
- . Alcohol and other drug use.
- . Socialization/support
- . Activities of daily living

- . Medical treatment
- . Legal situation
- . Transportation issues
- . Criminal justice system involvement

Each area is defined at the “1”, “ 3 ”, and “ 5 ” levels (See attached Environmental Matrix) and the subtotal score is divided by 6 to obtain the EM Score (when scoring the individual, refer to the Environmental Matrix TCM Service Scoring Grid which identifies the expected frequency of TCM contact needed for the individual for that particular assessment area). Scoring levels on individual assessment areas may be gradated to the 0.5 level only; this allows for minor differentiation of consumer need without compromising the integrity of the scale.

Looking at the behavior, inclusive of the lowest level of functioning, of the consumer during the last ninety (90) days, rate the consumer’s functional level in each of the six areas. Please note that the rating for each area should be made in whole numbers; in cases where there are extraordinary factors that make the assignment of whole numbers extremely difficult, if not impossible, 0.5 points may be added to or subtracted from the base scores. The sum of the six (6) scores should then be taken and divided by 6 and the resulting subtotal score should be reviewed and compared to other known factors that may affect the consumer’s need for service. This should be noted on the scoring sheet. If after averaging the scores, the average is lower by at least 2 points than any one value given in any one assessment area (e.g., if a person’s average is 2 and he/she received a score of 4 in any one area), the evaluator must provide written justification for assignment to the level that corresponds to the average, rather than the higher value.

The Environmental Matrix score, your *professional judgement* *, and other information (e.g., cultural factors, records of past treatment, psychiatric evaluations, psychosocial summaries) that impacts on the consumer’s level of need should then be considered and the Recommended Level of TCM service should be entered on the recommended level of TCM line of the Scoring Sheet. (These levels are consistent with minimum levels of contact as defined in *Chapter 5221, Intensive Case Management* regulations and Bulletin *OMH-93-09, Resource Coordination: Implementation*.) If the recommended level of TCM service differs from the Environmental Matrix score, the difference must be justified with professional judgement in “Other Factors/Issues Affecting Score” section of the scoring sheet. **Note: The level of service indicated by the assessment represents the individual’s needs at the time of assessment. Service intensity could change as an individual’s needs and/or desires for service change.**

**ENVIRONMENTAL MATRIX
TCM SERVICE SCORING GRID**

MATRIX LEVEL	NEED LEVEL	INTENSITY OF CARE
4.0 –5.0	ICM	At least 1 contact every 14 days (Face to face contact strongly recommended).
1.5 – 3.9	RC	At least 1 face to face contact every two months
0.0 - 1.4	NO TCM NEEDED	Alternative services may be needed and if necessary, referrals should be made.

* **professional judgement:** opinion based on a thorough and ethical analysis of facts, data, history, and issues in accordance with one's training and experience.

ASSESSMENT & SERVICE PLANNING

The consumer is able to provide meaningful and accurate information regarding own mental health status and needs. The consumer, with possible assistance from the targeted case manager, identifies, formulates, and expresses personal goals and objectives and can correlate these into concrete service needs and activities. The TCM should take into consideration that the behavioral health system may pose a number of barriers which serve as obstacles to service planning (i.e., language, perceived/actual institutional racism/discrimination, etc.)

0		3	5
	Needs minimal assistance in this area	Needs moderate assistance in this area	Needs significant assistance in this area

- 0= Consumer does not need/or request assistance in this area.
- 1= Consumer is able to provide meaningful/relevant/accurate information regarding own mental health status. Consumer is able to identify and formulate and express personal goals and objectives with minimal assistance from others. Consumer is able to translate/correlate these goals and objectives, with minimal direction, into concrete service needs and activities.
- 3= Consumer needs and/or requests moderate assistance in identifying and conveying information regarding own mental health status/problems. Consumer needs and/or requests moderate assistance from others in order to identify, formulate, and express personal goals and objectives. Consumer needs and/or requests moderate assistance from others to translate/correlate needs and goals into concrete service needs and activities.
- 5= Consumer needs and/or requests significant assistance from others to provide any meaningful information regarding own mental health status and/or needs. Consumer is unable to express personal goals nor objectives without assistance. Consumer needs and/or requests significant assistance from others to design/formulate service plan and activities.

USE OF COMMUNITY RESOURCES

The consumer is able to identify, understand, and articulate daily living needs as well as those community/neighborhood resources that may be needed to meet these needs. The consumer may need additional support from the targeted case manager in utilizing the services that may go beyond the realm of traditional mental health/substance abuse services. TCM must recognize cultural and linguistic needs as an important element in articulating daily living needs and resources. Many services may not be available in the immediate community and be less effective if located outside the community.

0	1	2	3	4	5
	Needs minimal assistance in this area		Needs moderate assistance in this area		Needs significant assistance in this area

- 0= Consumer does not need/or request assistance in this area.

- 1= Consumer is able, when encouraged, to identify and articulate daily living needs. Consumer is able to access, navigate, and utilize community/neighborhood resources with minimal assistance. Consumer’s needs may be fulfilled through the use of existing community resources such as social/religious groups, libraries, stores, directories, and public transportation and consumer is able to utilize these with minimal assistance.

- 3= Consumer needs and/or requests moderate assistance in identifying daily living needs as well as those community resources needed to meet these needs. When directed to community resources such as social/religious groups, libraries, stores, directories, and public transportation, the consumer may require and/or request moderate assistance to access and utilize these resources in order to accomplish a planned task.

- 5= Consumer is unable to identify nor understand daily living needs. Consumer is not familiar with community/neighborhood resources and has had very few, if any, positive experiences while living in the community. Consumer needs and/or requests significant assistance to access, navigate, or utilize existing community resources.

INFORMAL SUPPORT NETWORK BUILDING

The consumer identifies, communicates, and interacts with family, friends, significant others, and community groups from whom the consumer may gain informal support. The TCM should recognize that service system barriers may impede the consumer from interacting with family, friends, significant others and community groups. The consumer may need the assistance of the targeted case manager and/or others to identify, enhance and/or maintain existing relationships and the encouragement to develop new ones.

0	1	2	3	4	5
	Needs minimal assistance in this area		Needs moderate assistance in this area		Needs significant assistance in this area

- 0= Consumer does not need/or request assistance in this area.

- 1= Consumer is able to identify and provide meaningful/accurate/relevant information about family, friends, significant others, and social/religious groups with whom consumer interacts and from whom consumer may gain informal support. Consumer is able, with minimal assistance, to access and maintain positive relationships with these people and groups who provide personal social support and/or companionship.

- 3= Consumer needs and/or requests moderate assistance in identifying and communicating with family, friends, significant others, and social/religious groups from whom consumer may gain informal support. Consumer needs and/or requests moderate assistance from others in order to enhance and/or maintain existing relationships and to develop new ones.

- 5= Consumer is unable to identify nor interact with family, friends, significant others, and/or social/religious groups who may serve as personal supports. Consumer has few, if any, personal or familial relationships and is unable/unwilling to interact positively, if at all, with these persons or groups. Consumer needs and/or requests significant assistance from others to elicit information and support on his/her behalf.

LINKING AND ACCESSING SERVICES

The consumer is able to locate, gain access, and maintain contact and services with the service providers that have been identified as needed in the treatment or service plan. The treatment or service plan must recognize the cultural and linguistic needs of the consumer. At times, the targeted case manager may be needed to provide assistance in nontraditional and/or assertive ways to successfully gain and maintain these resources.

0	1	2	3	4	5
	Needs minimal assistance in this area		Needs moderate assistance in this area		Needs significant assistance in this area

0= Consumer does not need/or request assistance in this area.

- 1= Consumer is able, with minimal assistance from others, to locate and gain access to services identified in the treatment or service plan. Consumer is able, when encouraged, to establish and maintain appointments/services with appropriate service providers with minimal assistance. Consumer needs and/or requests minimal assistance by others to successfully gain access to and to maintain contact with community resources and services.

- 3= Consumer needs and/or requests moderate assistance in locating and gaining access to services identified in the treatment or service plan. Consumer may require and/or request moderate assistance, often in nontraditional ways, to access, establish, and maintain contact and services with the identified service providers.

- 5= Consumer is unable and/or unwilling to locate or gain access to services identified in the treatment or service plan. Consumer’s identified needs are so immense or so unusual that assertive and creative efforts outside of the usual and normal practice must be employed in order to help the person gain the resources and services identified. Consumer needs and/or requests significant (frequent and continual) assistance by others to successfully gain access to and to maintain contact with community resources and services.

MONITORING OF SERVICE DELIVERY

The consumer gauges and communicates her/his satisfaction with the progress that has been made and with the services offered/delivered by the service providers identified in the treatment plan. The consumer suggests possible needed revisions and/or additions to the treatment/service plan. The TCM should recognize that language and culture has much to do with expressions of satisfaction/dissatisfaction and be prepared to assist the consumer in suggesting changes in the treatment plan/service plan or actual provider.

0	1	2	3	4	5
	Needs minimal assistance in this area		Needs moderate assistance in this area		Needs significant assistance in this area

0= Consumer does not need/or request assistance in this area.

- 1= Consumer is able to communicate, when encouraged, his/her opinion of the progress and satisfaction with the service provider and/or the delivered services as well as the need for revisions to the treatment/service plan. Consumer is able and willing to participate in intra- and inter-agency as well as cross-systems reviews of the need for and appropriateness of the specific services delivered. Minimal assistance from others is needed and/or requested to ensure that the consumer is satisfied with the services received.

- 3= Consumer needs and/or requests moderate assistance in determining and communicating his/her satisfaction with the service provider and with the services delivered. Consumer needs and/or requests moderate assistance in identifying what progress has been made and the possible need for revisions to the treatment/service plan.

- 5= Consumer is almost totally dependent on others to see that progress is being made and to suggest needed revisions to the treatment/service plan. Consumer needs and/or requests significant assistance to communicate effectively and realistically about her/his progress and satisfaction with the service provider and/or the services delivered.

PROBLEM RESOLUTION

The consumer is able to resolve issues and overcome barriers, including those that are cultural and linguistic in nature, that prevent her/him from receiving needed treatment, rehabilitation, and/or support services as well as entitlements. The consumer is aware of and able to utilize complaint/grievance procedures as well as additional appropriate advocacy supports. The targeted case manager, when requested and or needed, may be called upon to not only help the consumer with these tasks but also to provide information to the County Office of Mental Health and/or the BHMCO in order to overcome barriers and to assist the consumer in obtaining needed services.

0	1	2	3	4	5
	Needs minimal assistance in this area		Needs moderate assistance in this area		Needs significant assistance in this area

- 0=** Consumer does not need/or request assistance in this area.
- 1=** Consumer needs and/or requests minimal assistance to resolve issues and overcome barriers that prevent him/her from receiving treatment, rehabilitation and/or support services.
- 3=** Consumer is able, with moderate assistance and encouragement, to identify issues that need to be resolved but is unable, without direct assistance from others, to formulate steps or implement actions that would overcome barriers that prevent him/her from receiving treatment, rehabilitation and/or support services.
- 5=** Consumer needs and/or requests significant assistance, to identify and resolve issues that prevent him/her from receiving treatment, rehabilitation and/or support services. Consumer is totally dependent on others to recognize and to take steps to overcome these barriers. Resolution may require the intervention of the County Office of Mental Health and/or the modification of existing services or the development of new services.

**TARGETED CASE MANAGEMENT
ENVIRONMENTAL MATRIX - ADULT**

Agency

County

CONSUMER INFORMATION:

Name :

(Last)

(First)

(MI)

Parent/Guardian Name:

Identifying Number(s):

Date of Birth: / /
(MM)/(DD)/(YYYY)

Social Security Number: - -

CIS/BSU/MCO Number:

PHMCO:

BHMCO:

Form Completed by:

Date Completed:

The purpose of this form is to assess what environmental and cultural factors help to determine an individual's need for the various levels of case management services. Please complete this form utilizing the individual's behavior during the last ninety days as a basis for scoring each indicator. Please see the *Scoring Sheet* for additional information on determining the Environmental Matrix Score and its meaning for level of care assignments.

ENVIRONMENTAL MATRIX ADULT SCORING SHEET

CONSUMER NAME: _____

ID#(SOCIAL SECURITY/CIS/BSU): _____

SCORES:

- | | | |
|----|-----------------------------------|--------------|
| 1. | Assessment and Service Planning | _____ |
| 2. | Use of Community Resources | _____ |
| 3. | Informal Support Network Building | _____ |
| 4. | Linking and Assessing Services | _____ |
| 5. | Monitoring of Service Delivery | _____ |
| 6. | Problem Resolution | _____ |
| | SUBTOTAL | _____ |

ENVIRONMENTAL MATRIX SCORE = SUBTOTAL ÷ 6= _____

OTHER FACTORS/ISSUES AFFECTING SCORE:

**ENVIRONMENTAL MATRIX
TCM SERVICE SCORING GRID**

MATRIX LEVEL	NEED LEVEL	INTENSITY OF CARE
4.0 –5.0	ICM	At least 1 contact every 14 days (Face to face contact strongly recommended).
1.5 – 3.9	RC	At least 1 face to face contact every two months
0.0 - 1.4	NO TCM NEEDED	Alternative services may be needed and if necessary, referrals should be made.

** professional judgement: opinion based on a thorough and ethical analysis of facts, data, history, and issues in accordance with one's training and experience.*

RECOMMENDED LEVEL OF TARGETED CASE MANAGEMENT SERVICE: _____

CONSUMER: _____ **DATE:** _____

PERSON COMPLETING THE FORM: _____ **DATE:** _____

APPROVED LEVEL OF TARGETED CASE MANAGEMENT SERVICE: _____

REVIEWER _____ **DATE:** _____

**HEALTHCHOICES BEHAVIORAL HEALTH SERVICES
GUIDELINES for MENTAL HEALTH MEDICAL NECESSITY CRITERIA**

CHILDREN AND ADOLESCENTS

**PSYCHIATRIC INPATIENT HOSPITALIZATION
RESIDENTIAL TREATMENT
PSYCHIATRIC PARTIAL HOSPITALIZATION PROGRAMS
PSYCHIATRIC OUTPATIENT TREATMENT**

Purpose

The purpose of this document is to provide decision-making criteria for the admission of children and adolescents to four (4) treatment environments under regulation. This document provides a clear interpretive framework, in accordance with Office of Mental Health and Substance Abuse Services (OMHSAS) program, and Office of Medical Assistance Programs (OMAP) payment regulations, for deciding when to treat, continue or discontinue treatment, and refer elsewhere for other services. These criteria will serve the basis for decision-making for Managed Care Organizations (MCOs), county Mental Health/Mental Retardation/Intellectual Disabilities (MH/MR/ID) offices, and prescribers of children's mental health services in general, as well as for providers delivering their respective services to children qualifying for Medical Assistance (MA) coverage. This document provides a common set of criteria for reference by all the decision-makers in a child's care. These four (4) sets of criteria are intended to further consistency between the child's treatment needs and the broader philosophy of individualized service delivery in the most appropriate and least restrictive setting as guided, respectively, by the principles of the Child and Adolescent Service System Program (CASSP) and the Community Service Program (CSP).

Background

The Office of Mental Health and Substance Abuse Services (OMHSAS) produced Title 55 PA Code Chapters 5100, 5300, 4210, 5200, 5310, and 5210 to regulate the general delivery of services in community psychiatric inpatient, outpatient, residential, and partial hospitalization settings, while OMAP produced Title 55 PA Code, Chapters 1151 and 1153 to regulate M.A.

payment for these services. Additional clarity for psychiatric residential treatment is provided in OMHSAS's proposed Chapter 5215 regulations. However, as more mental health services are developed for delivery in the home and community, in conjunction with a growing emphasis on providing services in the least restrictive environments necessary, greater clarity is required for mental health providers, case managers, interagency teams, and third party payers, including Managed Care Organizations and their sub-contractors, to make coordinated treatment determinations concerning appropriateness of admissions, continued stay, and discharge planning. It is for this reason that the criteria provided below have been developed.

Presented in the opening section which precede the criteria, is a summary outline of the major aspects of service delivery, including: CASSP principles, the function of each of the four (4) treatment environments, and the importance of prescribing the least restrictive setting necessary. More detail is provided by the addenda in the document. Following the introduction are the individual "Admission Criteria" for each service. Each set of criteria is divided into three (3) sections, the first for determining "Admission", the second for determining the appropriateness of "Continued Stay," and the third for identifying "Discharge Criteria."

For ease of reading in the following text, "child(ren) and adolescent(s)" shall be commonly referred to as "child(ren)," unless otherwise indicated.

Introduction

The mental health system has undergone substantial structural change from an emphasis on community segregation and maintenance of children with emotional disorders, to one of community integration and fostering increasing independence of individuals (see Mental Health/Mental Retardation Act of 1966 and the Mental Health Procedures Act of 1976 with subsequent amendments). These changes are further reflected in the development of the Child and Adolescent Service System Program (CASSP) and its philosophy. The OMHSAS summary representation of CASSP, is provided below:

The CASSP philosophy of collaborative service delivery to children, adolescents and their families undergirds all treatment methods. CASSP involves all child-serving systems including mental health, mental retardation, education, special education, children and youth services, drug and alcohol, juvenile justice, health care, and vocational rehabilitation. It should also include informal community supports and organizations. This philosophy is essential to making decisions to provide treatment for children. It is also the foundation for the development of these criteria. These principles are represented in the following six summary statements:

- (1) Child-centered - Services are planned to meet the individual needs of the child, rather than to fit the child into an existing service. Services should be developmentally appropriate and child-specific, and should also build on the strengths of the child and family to meet the mental health, social and physical needs of the child.
- (2) Family-focused - Services recognize that the family is the primary support system for the child. The family participates as a full partner in all stages of the decision-making and treatment planning process, including implementation, monitoring and evaluation. A family may include biological, adoptive and foster parents, siblings, grandparents and other relatives, and other adults who are committed to the child. The development of mental health policy at state and local levels should include family representation.
- (3) Community-based - Whenever possible, services should be delivered in the child's home community, drawing on formal and informal resources to promote the child's successful participation in the community. Community resources include not only mental health professionals and provider agencies, but also social, religious and cultural organizations and other natural community support networks.
- (4) Multi-system - Services should be planned in collaboration with all the child-serving systems involved in the child's life. Representatives from all these systems and the family should collaborate to define the goals for the child, develop a service plan, develop the necessary resources to implement the plan, and provide appropriate support to the child and family.
- (5) Culturally competent - Culture determines our world view and provides a general design for living and patterns for interpreting reality that are reflected in our behavior. Therefore, services that are culturally competent are provided by individuals who have the skills to recognize and respect the behavior, ideas, attitudes, values, beliefs, customs, language, rituals, ceremonies and practices characteristic of a particular group of people.

Note: Pennsylvania's cultural competence initiative has focused specifically on African Americans, Latinos, Asian Americans and Native Americans who have historically not received culturally appropriate services.

- (6) Least restrictive/least intrusive - Services should take place in settings that are the most appropriate and natural for the child and family and

are the least restrictive and intrusive available to meet the needs of the child.

These principles encompass not only the psychological, but the physical, cognitive, and socio-cultural development of children, which include the child's dependency on family, community, and environmental influences in general. From these principles, the four services for which "Admission Criteria" are provided below, can be understood as components within a wider network of service options.

Severity of Symptoms

The child's expression of impairment in any of the following should be considered in the design of the individual's treatment: judgement, thought, mood, affect, impulse control, psychosocial, psychomotor retardation/excitation, physiological functioning and/or cognitive/perceptual abilities. Challenging behaviors closely associated with social contexts such as family, school, or other community activities must also be considered when determining an appropriate treatment design, and the concomitant discharge planning.

Intensity of Treatment

The intensity and range of treatment varies for each of the four services. Psychiatric Inpatient and Residential Treatment are out of home services which provide highly intensive treatment for the purpose of returning children home, or to a homelike setting. Partial Hospitalization and Psychiatric Outpatient provide services of varying intensity depending on the child's need for therapeutic support to remain home. The therapeutic function and emphasis of each of the four services to return a child home, or to prevent out-of-home placements, depends strongly on the interaction between the therapist, the parents/guardians, and the child, for the effectiveness of the treatment plan developed.

Psychiatric Inpatient hospitalization provides the most restrictive level of care. The setting is locked and highly focused toward the delivery of intensive, short term treatment. It serves as an appropriate placement for children expressing the sudden onset of acute symptoms, and/or requiring treatment which cannot be managed outside of a 24 hour, secure setting.

Residential Treatment facilities provide a stable, open, community living setting for the delivery of comprehensive mental health treatment with 24 hour monitoring and a strong supportive environment from which the child is able to reenter the community. This is a longer term treatment option for children who

require the comprehensive treatment and professional support of this setting to prevent a need for inpatient hospitalization.

Partial hospitalization lies between the most restrictive and community-based levels of care. A partial hospitalization treatment program offers a wide range of treatment in a setting segregated from the child's natural setting for part of the day. Effective treatment and stabilization of the child must be possible within the partial hospital program hours prescribed in the treatment plan. Partial hospitalization provides an opportunity to observe a child's behavior and the effects of treatment, for the purpose of developing and confirming a proper course of treatment designed for the effective reintegration of the child into the community.

Outpatient treatment is for children and their families who are seeking help and believe there is a need for mental health services. Services and treatment approaches include, diagnostic testing, crisis intervention services, behavior therapy, individual, group and family psychotherapy, medication, and similar services. The child should be able to maintain sufficient stability in his/her existing support network, to be treated effectively within the hours of outpatient treatment prescribed in the treatment plan. Treatment and services should be directed toward helping the child to remain integrated with his/her natural community and work to prevent the necessity of a more restrictive or intrusive service.

Least Restriction

The four services addressed in this bulletin are presented in descending order of restrictiveness and in increasing order of community integration. The need for greater or lesser restrictiveness must be adjusted to the individual's need for active treatment as reflected in the treatment plan. Increased restrictiveness of setting improves the convenience and opportunity for immediate intervention in the delivery of treatment. However, less restrictive environments should be considered to prevent the removal of children from their families, peers, and normalized settings in the community. Each service provides treatment with the object of helping a child with acute behavioral problems or serious emotional disturbance to increase his or her functional capacity, in order to increase his/her ability to reintegrate into the community. Therefore, the goals of treatment may be summarized by the following:

- amelioration of symptoms such that less restrictive and/or less intrusive services can be planned and introduced;

- stabilization of medical regimen for children requiring psychotropic medication so they may remain in the least restrictive setting possible;
- prevention of regression/recidivism by improving the child's level of functioning and ability for self maintenance;
- coordination of the treatment and discharge plan on an ongoing basis with the family and the appropriate agencies to provide the necessary community based supports, including wraparound services; and
- increase in the age-appropriate interactiveness in a variety of settings [see Community Integration Attachment in Appendix C].

Psychiatric Inpatient Hospitalization

Admission of a child for psychiatric inpatient treatment is most appropriately based on a diagnosis by a certified child and adolescent psychiatrist. In the absence of a child and adolescent psychiatrist, a diagnosis may be appropriately provided by a Board Certified psychiatrist. When a certified psychiatrist is not available, a diagnosis may be provided by a Board eligible psychiatrist or a licensed physician contingent on confirmation by a Board Certified psychiatrist within forty-eight (48) hours of admission, or as indicated by the regulations governing this service. However, any time the most appropriate specializing physician is unavailable to perform the necessary diagnostic services, this should be documented and explained.

Diagnostic references for the purpose of the documentation below must conform to the most current edition of the Diagnostic and Statistical Manual (DSM).

ADMISSION CRITERIA

(Must meet I and II)

I. DIAGNOSTIC EVALUATION AND DOCUMENTATION

- A. Presenting illness is diagnosed on DSM IV Axis I or Axis II, as part of a complete multi-axial, face-to-face diagnostic examination (MR or D&A cannot stand alone) and in accordance to ICD-9 codes, by a licensed physician¹ contingent on confirmation by a child and adolescent psychiatrist or Board Certified psychiatrist within forty-eight (48) hours of admission.

AND

- B. Psychiatric Inpatient Treatment is prescribed by the diagnosing psychiatrist, and/or as required by Pennsylvania regulation, indicating that this is the most appropriate, and least restrictive service to meet the mental health needs of the child;

AND

- C. Documentation in the current psychiatric evaluation that the treatment, 24-hour supervision, and observation, provided in the Psychiatric Inpatient setting, are necessary as a result of:

¹ Diagnosis by a resident physician with training license must receive confirmation within 24 hours.

- severe mental illness or emotional disorder, *and/or*
 - behavioral disorder indicating a risk for safety to self/others;
- AND

D. Based on the patient's current condition and current history, reasonable, documented treatment within a less restrictive setting has been provided by a mental health professional, *and/or* careful consideration of treatment within an environment less restrictive than that of a Psychiatric Inpatient Hospitalization, *and* the direct reasons for its rejection, have been documented;

AND

E. A complete strengths-based evaluation, including identifying the strengths of child's family, community, and cultural resources, must be completed prior to admission, or within 120 hours in the event of an emergency admission.

II. SEVERITY OF SYMPTOMS

A. Significant risk of danger is assessed for any of the following,

1. child HARMING HIM/HERSELF
2. child HARMING OTHERS
3. DESTRUCTION TO PROPERTY which is:
 - a. life-threatening, *OR*
 - b. in combination with "B", "C", or "D" below;

OR

B. There is an acute occurrence or exacerbation of impaired judgement or functional capacity and capability, for the child's developmental level, that interpersonal skills, and/or self-maintenance in home/school/community is/are severely compromised;

OR

C. There are endangering complications in *either* of the following:

1. *complications* of the child's psychiatric illness or treatment would seriously threaten the child's health safety due to a lack of capacity for self-care; *OR*
2. due to a *coexisting medical condition* where the child has a medical condition or illness which, as a result of a psychiatric condition, cannot be managed in a less intensive level of care without significant risk of medical crisis or instability;

OR

- D. The severity of the child's symptoms are such that continuation in a less intense level of care cannot offer either an expectation of improvement, or prevention of deterioration, as identified in the above three categories of "II."

Requirements for Continued Stay

(Must meet I and II. Complete documentation for each is required, and additional documentation as indicated in Appendix B.)

I. DIAGNOSTIC EVALUATION AND DOCUMENTATION

- A. The initial evaluation and diagnosis is updated and revised as a result of a face-to-face diagnostic examination by the treating psychiatrist;
AND
- B. Continued Psychiatric Inpatient Treatment is prescribed by the diagnosing psychiatrist, and/or as required by Pennsylvania regulation, indicating and documenting that this is the least restrictive, appropriate service to meet the mental health needs of the child, and the discharge implementation plan;

II. SEVERITY OF SYMPTOMS

- A. Severity of illness indicators and updated treatment plan support the likelihood that: *substantial benefit* is expected as a result of continued active intervention in a psychiatric inpatient setting, without which there is *great risk of a recurrence of symptoms*; *OR severity is such that treatment cannot be safely delivered at a lesser level of care, necessitating hospitalization*;
AND
- B. Although child is making *progress toward goals* in the expected treatment process, further progress must occur before transition to a lesser level of care is advisable. The necessary changes must be identified in an updated treatment plan, and the treatment team review must recommend continued stay;
OR
- C. The symptoms or behaviors that required admission, *continue with sufficient acuity* that a less intensive level of care would be insufficient to stabilize the child's condition;
OR
- D. Appearance of *new symptoms* meeting admission criteria.

III. DISCHARGE CRITERIA

A child not meeting criteria as established in Section II, SEVERITY OF SYMPTOMS, of the CONTINUED STAY CRITERIA, must be discharged.

Residential Treatment Facilities

Admission of a child to a JCAHO Accredited Residential Treatment Facility is most appropriately based on a diagnosis by a certified child and adolescent psychiatrist. In the absence of a child psychiatrist a diagnosis may be appropriately provided by a Board Certified psychiatrist. However, any time the most appropriate specializing physician is unavailable to perform the necessary diagnostic services, this should be documented and explained. Admission to a Non-JCAHO Accredited Residential Treatment Facility is most appropriately based on a diagnosis as described above for JCAHO accredited facilities, or by a licensed psychologist specializing in treatment for children and adolescents.

Diagnostic references for the purpose of the documentation below must conform to the most current edition of the Diagnostic and Statistical Manual (DSM).

ADMISSION CRITERIA

(Must meet I *and* II or III)

I. DIAGNOSTIC EVALUATION AND DOCUMENTATION

- A. Diagnosis on DSM IV Axis I or Axis II, as part of a complete multi-axial, face-to-face diagnostic examination (MR or D&A cannot stand alone) and in accordance to ICD-9 codes, by a psychiatrist (as defined in Chapter 5200.3 of the Pennsylvania Code) for JCAHO accredited facilities, or by a psychiatrist or a licensed psychologist for Non JCAHO accredited facilities;

AND

- B. Residential Treatment service is prescribed by the diagnosing psychiatrist or psychologist, as appropriate to the accreditation of the facility, indicating that this is the most appropriate, least restrictive service to meet the mental health needs of the child;

AND

- C. Documentation in the current psychiatric/psychological evaluation² that the treatment, 24-hour supervision, and observation, provided in the Residential Treatment setting, are necessary as a result of:
- severe mental illness or emotional disorder, *and/or*
 - behavioral disorder indicating a risk for safety to self/others;
- AND
- D. Reasonable, documented treatment within a less restrictive setting has been provided by a mental health professional, *and/or* careful consideration of treatment within a less restrictive environment than that of a Residential Treatment Facility, *and* the direct reasons for its rejection, have been documented;
- AND
- E. Placement in a Residential Treatment Facility must be recommended as the least restrictive and most clinically appropriate service for the child, by an interagency service planning team as currently required by the OMHSAS and OMAP. Following PA School Code, Sections 1306-1309 and 2561, when a child is removed from the school setting for the purpose of receiving mental health treatment, it is expected that the appropriate school system will be involved in the child's educational planning and the interagency team. In the event that conditions prevent the possibility of parental or child involvement, attempts to involve the child and parents *and/or* reasons explaining their non-involvement must be fully documented and presented to an interagency team;
- AND
- F. A complete strengths-based evaluation, including identifying the strengths of child's family, community, and cultural resources, must be completed prior to admission.

II. SEVERITY OF SYMPTOMS

The child's problematic behavior *and/or* severe functional impairment discussed in the presenting history and psychiatric/psychological examination must include at least one (1) of the following:

² A current psychiatric/psychological evaluation is one which has been conducted within sixty (60) days prior to admission to the program. A psychiatric/psychological evaluation for a child placed on a waiting list during which time the thirty (30) day maximum has passed, shall continue to be "current" for an additional thirty (30) days.
(updated 9/10/09)

- A. Suicidal/homicidal ideation
- B. Impulsivity and/or aggression
- C. Psycho-physiological condition (i.e.- bulimia, anorexia nervosa)
- D. Psychomotor retardation or excitation.
- E. Affect/Function impairment (i.e.- withdrawn, reclusive, labile, reactivity)
- F. Psychosocial functional impairment
- G. Thought Impairment
- H. Cognitive Impairment

III. OBSERVATION

The child's problematic behavior *and/or* severe functional impairment discussed in the presenting history and psychiatric/psychological examination requires further observation for clarification under section II. Allowable for up to fifteen (15) calendar days within which time the examining psychiatrist/psychologist must clarify the criteria for admission under II *AND/OR* recommend development of a discharge plan. Should it be found that the child does not fit the criteria for admission, an appropriate discharge plan is to be developed with the interagency team, and the child discharged under the provisions of that plan.

- A. Troubling symptoms of the child which have been described by members of the family (and/or representatives of the community or school), persist but,
 - they are not observed on a psychiatric inpatient unit, *or*
 - they are denied by the child in outpatient or partial hospitalization treatment,*such that* the residential treatment milieu provides an ideal opportunity to observe and treat the child;

OR

- B. Child's symptoms have not sufficiently improved despite responsible comprehensive treatment at a lower level of care, which has involved the participation of an interagency team.

REQUIREMENTS FOR CONTINUED STAY

(Must meet I and II)

I. DIAGNOSTIC EVALUATION AND DOCUMENTATION (see also, Appendix A)

- A. The initial evaluation and diagnosis is updated and revised as a result of a face-to-face diagnostic examination by the appropriate treating psychiatrist or psychologist;

AND

- B. Less restrictive treatment environments have been considered in consultation with the Interagency Service Planning Team;

AND

- C. There is the clinically determined likelihood of substantial benefit as a result of continued active intervention in the Residential Treatment setting, without which there is great risk of a recurrence of symptoms;

AND

- D. Any other clinical reasons supporting the rejection of other alternative services in favor of continuing Residential Treatment;

AND

- E. Residential Treatment service is prescribed by the diagnosing psychiatrist/psychologist following a current face-to-face psychiatric evaluation, indicating and documenting that this is the least restrictive, appropriate service to meet the mental health needs of the child, and the discharge implementation plan.

II. SEVERITY OF SYMPTOMS

- A. Severity of illness indicators and updated treatment plan support the likelihood that: *substantial benefit* is expected as a result of continued active intervention in a psychiatric residential treatment setting, without which there is *great risk of a recurrence of symptoms*; *OR severity is such that treatment cannot be safely delivered at a lesser level of care*;

AND

- B. The treatment team review recommends continued stay, documenting the need for the child's further improvement, with the corresponding modifications in both treatment plan and the discharge goals;

AND

C. Although child is making *progress toward goals* in the expected treatment process, further progress must occur before transition to a lesser level of care is advisable. The necessary changes must be identified in an updated treatment plan, and the treatment team review, in conjunction with an interagency team, must recommend continued stay;

OR

D. The symptoms or behaviors that required admission, *continue with sufficient acuity* that a less intensive level of care would be insufficient to stabilize the child's condition;

OR

E. Appearance of *new symptoms* meeting admission criteria.

III. DISCHARGE CRITERIA

A. A child admitted under Sections I and III only, of the **ADMISSION CRITERIA** must be discharged within fifteen (15) calendar days of admission, unless a subsequent face-to-face psychiatric evaluation clarifies child's eligibility under Section II.

B. A child not meeting criteria as established in Section II, **SEVERITY OF SYMPTOMS**, of the **CONTINUED STAY CRITERIA**, must be discharged.

Partial Hospitalization Programs

Admission of a child to a Partial Hospitalization Program is most appropriately based on a diagnosis by a certified child and adolescent psychiatrist. In the absence of a child and adolescent psychiatrist, a diagnosis may be appropriately provided by a Board Certified psychiatrist. A diagnosis may otherwise be provided as indicated by the regulations governing this service. However, any time the most appropriate specializing physician is unavailable to perform the necessary diagnostic services, this should be documented and explained.

Diagnostic references for the purpose of the documentation below must conform to the most current edition of the Diagnostic and Statistical Manual (DSM).

ADMISSION CRITERIA

(Must meet I *and* II or III)

I. DIAGNOSTIC EVALUATION AND DOCUMENTATION

- A. Diagnosis on DSM IV Axis I or Axis II as part of a complete multi-axial diagnostic examination (MR or D&A cannot stand alone) by a psychiatrist or psychologist (as defined in Chapter 5200.3 of the Pennsylvania Code);
AND
- B. Behaviors which indicate a risk for safety to self/others, and/or decreased functioning for the child's developmental level, such that:
1. this behavioral disturbance requires regular observation and treatment, but does not require 24-hour supervision, *and*
 2. reasonable treatment within a less restrictive setting has been attempted by a mental health professional, *or* treatment in a less restrictive setting has been considered and documented, but is rejected directly in favor of partial hospital treatment;
AND
- C. Partial hospitalization must be recommended as the most clinically appropriate and least restrictive service available for the child, by the *treatment team* [as described in PA 55 §5100.2.] to also include: child, parent/guardian and/or caretaker, and case manager;
AND

D. Removal of a child from his/her regular classroom for all or part of the school day necessitates the incorporation of an interagency planning team (in accordance with Chapter 5210.24,(b), except when partial provides acute hospital diversion. [The interagency planning team must include the appropriate representative from the child's local school in compliance with PA School Code, Sections 1306-1309 and 2561, and establish that the child's mental health needs cannot be otherwise met with appropriate supports in a school setting];

AND

E. A treatment plan [See PA 55 §5210.35], to include a complete strengths-based assessment of the child, including identifying the strengths of child's family, community, and cultural resources, can be completed prior to admission or within five (5) days of service in the partial hospitalization program;

AND

F. In the event that conditions prevent the possibility of parental or child involvement, attempts to involve the child and parents, and/or reasons explaining their non-involvement, must be fully documented and presented to the interagency team.

II. SEVERITY OF SYMPTOMS

The child's problematic behavior and/or severe functional impairment discussed in the presenting history and psychiatric examination must include at least one (1) of the criterion in A through F with a severity level as indicated in "B" above.

A. Suicidal/homicidal ideation

B. Impulsivity and/or aggression

C. Psycho-physiological condition (i.e.- bulimia, anorexia nervosa)

E. Affect/Function impairment (i.e.- withdrawn, reclusive, labile, reactivity)

F. Psychosocial functional impairment

G. Thought Impairment

H. Cognitive Impairment

III. OBSERVATION

The child's problematic behavior *and/or* severe functional impairment discussed in the presenting history and psychiatric examination requires further observation for clarification under section II. Allowable for up to fifteen (15) calendar days within which time the examining psychiatrist must clarify the criteria for admission under II *AND/OR* recommend development of a transition plan. Should it be found that the child does not fit the criteria for admission, an appropriate transition plan is to be developed with the interagency team, and the child discharged under the provisions of that plan.

- A. Troubling symptoms of the child which have been described by members of the family (and/or representatives of the community or school), persist but,
- they are not observed on a psychiatric inpatient unit, *or*
 - they are denied by the child in outpatient treatment,
- such that* the day treatment milieu and return to home environment daily, provides an ideal opportunity to observe and treat the child;
- OR
- B. Child's symptoms have not sufficiently improved despite responsible comprehensive treatment at a lower level of care, which has involved the participation of an interagency team in planning, coordinating and providing this treatment, and the interagency team currently recommends this level of treatment.

REQUIREMENTS FOR CONTINUED STAY

(Must meet I and II)

- I. DIAGNOSTIC EVALUATION AND DOCUMENTATION (see also, Appendix A)
- A. The initial evaluation and diagnosis is updated and revised as a result of a current face-to-face diagnostic examination by the treating psychologist or psychiatrist;
- AND
- B. Less restrictive treatment modalities have been considered;
- AND
- C. There is the clinically determined likelihood of substantial benefit as a result of continued active intervention in the Partial Hospitalization Program, without which there is great risk of a recurrence of symptoms;
- AND

- D. Any other reasons supporting the rejection of other alternative services in favor of continuing Partial Hospitalization;

II. SEVERITY OF SYMPTOMS

- A. Severity of illness indicators and updated treatment plan support the likelihood that: *substantial benefit* is expected as a result of continued active intervention in a partial hospitalization program, without which there is *great risk of a recurrence of symptoms*; *OR severity is such that treatment cannot be safely delivered at a lesser level of care*;

- B. The treatment team review recommends continued stay, documenting the need for the child's further improvement, with the corresponding modifications in both treatment plan and the discharge goals;

AND

- C. Child is making *progress toward treatment goals* in the expected treatment process as evidenced by reductions in the problematic signs, symptoms, and/or behaviors the child presented upon admission; and the treatment team or interagency team review recommends continued stay, documenting the need for further improvement and the corresponding modifications in both treatment plan and the discharge goals;

OR

- D. The symptoms or behaviors that required admission, *continue with sufficient acuity* that a less intensive level of care would be insufficient to stabilize the child's condition;

OR

- E. The appearance of *new problems, symptoms, or behaviors* meet the admission criteria.

III. DISCHARGE CRITERIA

- A. A child admitted under Sections I and III only, of the ADMISSION CRITERIA must be discharged within fifteen (15) calendar days of admission, unless a subsequent face-to-face psychiatric evaluation clarifies child's eligibility under Section II.

- B. A child not meeting criteria as established in Section II, SEVERITY OF SYMPTOMS, of the CONTINUED STAY CRITERIA, must be discharged.

Psychiatric Outpatient Treatment (Clinics)

Admission of a child for Psychiatric Outpatient Treatment (clinic) is most appropriately based on a diagnosis by a certified child and adolescent psychiatrist. In the absence of a child and adolescent psychiatrist, a diagnosis may be appropriately provided by a Board Certified psychiatrist. A diagnosis may otherwise be provided by a developmental pediatrician or otherwise as indicated by the regulations governing this service. However, any time the most appropriate specializing physician is unavailable to perform the necessary diagnostic services, this should be documented and explained.

Diagnostic references for the purpose of the documentation below must be from the most current edition of the Diagnostic and Statistical Manual (DSM).

ADMISSION CRITERIA

(Must meet I and II)

I. DIAGNOSTIC EVALUATION AND DOCUMENTATION

- A. Diagnosis on DSM IV Axis I or Axis II, as part of a complete multi-axial, face-to-face assessment (MR or D&A cannot stand alone), by a Mental Health Professional (see Title 55. Public Welfare § 5200.3) as reviewed and approved by a psychiatrist or licensed psychologist (see Title 55. Public Welfare § 5200.22(d) and § 5200.31);

AND

- B. Behaviors indicate *minimal* risk for safety to self/others and child must not require inpatient treatment or a psychiatric residential treatment facility.

II. SEVERITY OF SYMPTOMS

- A. Service must be recommended as the most clinically appropriate and least restrictive service available for the child, by the *treatment team director* [described in PA 55 §5100.2], as informed by the *treatment team* [described in PA 55 §5210.34]. Parent(s)/guardian(s), and/or caretaker, as appropriate, case manager (when one is assigned) and the child must be involved in the planning

process. Where a parent or the child are not or cannot be involved, the attempts to involve either or both and the reasons for non-involvement must be documented. *The treatment team should otherwise recommend the most appropriate alternatives should treatment at an outpatient clinic not be recommended;*

AND

- B. There is serious and/or persistent impairment of developmental progression and/or psychosocial functioning due to a psychiatric disorder, requiring treatment to alleviate acute existing symptoms and/or behaviors; or to prevent relapse in the child with symptoms and/or behaviors which are in partial or complete remission;

OR

- C. Significant psychosocial stressors and/or medical condition increasing the risk that the child's functioning will decrease for his/her developmental level;

OR

- D. Symptoms improve in response to comprehensive treatment at a higher level of care, but child is still in need of outpatient treatment to sustain and reinforce stability;

OR

- E. Requires prescription and monitoring of medications to mitigate the effects of the child's symptoms.

REQUIREMENTS FOR CONTINUED STAY

(Must meet I and II)

I. DIAGNOSTIC EVALUATION AND DOCUMENTATION

- A. Revised and updated diagnosis by a Mental Health Professional (see Title 55. Public Welfare § 5200.3) as reviewed and approved by a psychiatrist or licensed psychologist (see Title 55. Public Welfare § 5200.31);

AND

- B. There is significant family (including the child) cooperation and involvement in the treatment process, except where the involvement of family members other than the child would be clinically counter-productive or legally prohibited.

II. SEVERITY OF SYMPTOMS

A. Child is making progress toward goals, and the treatment team review recommends continued stay;

OR

B. The presenting conditions, symptoms or behaviors continue such that natural community supports alone are insufficient to stabilize the child's condition;

OR

C. The appearance of new problems, symptoms, or behaviors meet the admission criteria.

III. DISCHARGE CRITERIA

A child not meeting criteria as established in Section II, SEVERITY OF SYMPTOMS, of the CONTINUED STAY CRITERIA, must be discharged.

FUNCTION OF THE FOUR SERVICES

Inpatient Hospitalization:

- Inpatient hospitalization provides a locked setting for the delivery of acute care.
- Inpatient hospitalization combines security and restrictiveness with intensive treatment, for the purpose of ameliorating symptoms and reducing the need for such intensity of service by establishing within the child the self-control *and/or* capacity for constructive expression and more adaptive interpersonal skills necessary to continue treatment in a more natural and less restrictive setting.
- Inpatient hospitalization provides service for children with serious mental and/or serious emotional or behavioral problems who require the coordinated, intensive and comprehensive treatment available from a multi-disciplinary team within a secure setting.
- The inpatient hospitalization process and treatment must meet the conditions set forth in the MH/MR Act of 1966 and the MH Procedures Act of 1976.
- Treatment components include: major diagnostic assessments, medical and psychiatric treatment, and psychosocial rehabilitation (to include educational components, as appropriate to the child's development).

Residential Treatment Facilities:

- Residential Treatment Facilities provide a safe environment within a restrictive setting for the delivery of psychiatric treatment and care. However, it is an unlocked, and otherwise, less restrictive, more flexible alternative than inpatient hospitalization for the delivery of acute care and for the provision of transitional care from an acute inpatient setting.
- Residential Treatment Facilities offer the comprehensive and intense services needed for the purpose of ameliorating symptoms, by establishing within the child the self-control, the capacity for constructive expression, and the adaptive interpersonal skills necessary to continue in a more natural and less restrictive setting.
- Residential Treatment Facilities provide service for children with serious mental and/or serious emotional or behavioral problems who require the coordinated, intensive and comprehensive treatment available from a multi-disciplinary team within a structured, residential setting.
- Treatment components include: major diagnostic assessments, psychiatric and other medical treatment, and psychosocial rehabilitation. Psychosocial rehabilitation is an

important vehicle through which psychiatric residential treatment facilities provide culturally competent service. These services provide the child with community linkages and the real world competency necessary for his/her successful return to the community.

- Residential Treatment Facilities must collaborate with the school district of residency, and, if different, the school district where the child in treatment is enrolled, to ensure the child receives educational instruction in the least restrictive setting appropriate to meet their needs while accommodating their behavioral and psychiatric difficulties (see Commonwealth of Pennsylvania, OMH-95-07; BEC 19-93; OCYF).
- Parents/guardians are actively involved in the treatment planning process and provided the opportunity to address the treatment of the child in the broader context of the family system. They may receive other additional supports necessary to develop the therapeutic environment the child needs to return home or to other community settings, including training and family therapy. Also, parents/guardians are to be informed of the appropriate parent support and advocacy groups available [see addendum], or any other involvement consistent with the applicable regulations.

Partial Hospitalization Programs:

- Partial hospitalization provides a less restrictive, more flexible alternative than inpatient hospitalization for the delivery of acute care, *by providing* transitional and diversionary care from an acute inpatient setting.
- Partial hospitalization provides a short-term, intensive outpatient treatment as a transition to Outpatient Clinic services. Its purpose is to reduce the child's need for restrictive therapeutic settings for treatment, and help the child develop the necessary self-control *and/or* capacity for constructive expression, including more adaptive interpersonal skills, to make the transition to interacting more fully in family and community environments.
- Partial hospitalization provides service for children with serious mental and/or psychosocial disorders who require the coordinated, intensive and comprehensive treatment available from a multi-disciplinary team within a single setting (see "**Settings**" below).
- Partial hospitalization provides day, after school, weekend, and evening service for children with mental and/or psychosocial disorders, so that :
 - the child receives the additional support necessary to interact effectively and cooperatively with family members, thereby helping to insure the family bond;
 - parents/guardians can receive family therapy/treatment consistent with the treatment of their child.

- Partial hospitalization uses group approaches to the treatment of children with serious mental and/or psychosocial disorders.
- Treatment components include: major diagnostic assessments, medical and psychiatric treatment, psychosocial rehabilitation (to include educational and prevocational components, as appropriate to the child's development), individual and group therapies and opportunities for family therapy. Recognizing the responsibility of the school districts to provide an educational program for all children, full day or school day partial hospitalization programs must collaborate with the school district of residency and the school district where the child in treatment is enrolled, to incorporate an educational program within the therapeutic milieu.

Program Range- Partial hospitalization programs vary in the intensity and purpose of the services offered. The range of programs includes, on the one end, those serving a more acute population as a step-down from inpatient treatment, or as a preventive for a more restrictive treatment setting. On the other end are programs serving those with more long standing impairments, where clinical judgement suggests that partial hospitalization is therapeutically necessary to return the child or maintain the child in a stable condition while providing effective treatment.

Settings- Child partial hospitalization programs serve a range of age groups from pre- school to late teens, and they also occur in a variety of settings. Typical settings may be characterized individually or in combination by place, such as, school settings, clinics, and free-standing units; by specified time of service, such as, morning, afternoon, all day, after-school, and evening, and some have 24 hour emergency phone service; and by established age categories, such as, pre-school, children, and adolescents. In those provided in public and private school settings serving the general population, the school system and the mental health system collaborate closely in meeting the educational and mental health needs of the child. Many facilities described as "free-standing" are designed specifically for those children who require a secure setting for mental health treatment, and the coordination of education and treatment in the same setting. In other settings, such as a mental health agency, the educational component must be designed and developed to meet the child's needs in collaboration with the mental health agency.

Outpatient Treatment:

- Provision of services which are less restrictive, more flexible yet effective supports for patients discharged from in-patient or partial hospitalization. In this way outpatient services provide for the delivery of transitional care from a more restrictive setting.
- Prevent the need for more intense services, or accompany more enhanced or community based services, to help the child develop the necessary self-control, *and/or* capacity for constructive expression, including cultivating more adaptive interpersonal skills for effective participation in the child's natural setting.
- Provision of service for children with mental and/or psychosocial disorders who require the periodic support provided by this treatment, to remain stable and ensure the effectiveness of a treatment plan.
- Provision of after school service for children with mental and/or psychosocial disorders, so that :
 - parents/guardians can receive the additional support necessary to maintain a therapeutic environment for the child;
 - parents/guardians can receive family therapy consistent with the treatment of their child.Should service require removing the child during regular school hours, this service, and any subsequent plan to continue service during this time, must be documented with an explanation of the child's condition which necessitates such intervention.
- Treatment components include: major diagnostic assessments, medical and psychiatric treatment. Recognizing the responsibility of the Department of Education to provide an educational program for all children, the therapist must collaborate with the school or school district, but only when appropriate and as necessary to assist in the child's Individualized Education Plan when one has been or should be developed. Where such collaboration is problematic, the reasons must be clearly documented.

Treatment Range- Outpatient treatment varies in both intensity and purpose. Intensity may be reflected in the number and length of visits as well as the duration and types of service offered. The range of service provides support for a more acute population and for those without long standing impairments, where clinical judgement suggests that outpatient treatment is therapeutically necessary to return the child to or maintain the child in a stable condition. Outpatient treatment may serve as a step-down from inpatient treatment and partial hospitalization, and to prevent the need for a more restrictive treatment setting. It also serves children, and their families, experiencing distress who may need the support of short term services to ameliorate the presiding condition or

stress.

Outpatient treatment is clearly identified by the setting from which it is offered. In concordance with Title 55 Public Welfare, Chapter 5200 *Psychiatric Outpatient Clinics*, the domain of this level of treatment for the scope of this document is the clinic, exclusive of partial hospitalization and other day-treatment programs.

Continued Stay Service Documentation

The following list of information should be documented for all four services.

1. Routine assessments and treatment updates chart child's progress.
2. The establishment and documentation of active treatment must include, the implementation of the treatment plan, the therapy provided, documentation of the family's participation and interagency collaboration, cultural competency, and active discharge planning.
3. Current active treatment is focused upon stabilizing or reversing symptoms necessitating admission.
4. Current active treatment is focused on ameliorating symptoms and increasing the child's level of functioning.
5. The level of professional expertise and intervention are appropriate to address the child's current condition(s).
6. The initial discharge criteria formulated for the child have been reviewed and revised, as necessary in the course of developing the discharge plan.
7. The treatment plan and strengths-based evaluation has been updated to reflect the child's progress, medication status, continuing needs and the provider's efforts to meet the identified needs. The treatment plan addresses any necessary supports for the child's successful transition into the community, including mental health and other community-based services, and the natural resources of the family. It incorporates a plan to form appropriate transitional linkages in preparation for discharge to a less restrictive setting.
8. The treatment team programmatically reduces intensity of treatment as the child progresses toward the expected date of discharge, and forms linkages with community and family supports.
9. Type, duration and frequency of services provided to the child, and the outcome of each service must be well documented, i.e.- individual, group and family therapy; education, training and community involvement; family participation in treatment; any special activities; and medication administration and monitoring.

10. As the child improves clinically, active treatment facilitates and increases contact of the child with the community (including home and school) to which the child will return.
11. The provision of services supports the child's involvement in age appropriate activities and interests.
12. In special programs where the child does not attend the local school, there must be a current Individualized Education Plan *and/or* plan to provide the child an educational program in collaboration with the local school or school district on record at the PRTF.
13. Family (parent, guardian or custodian) is actively involved in the treatment planning and/or process. Should conditions prevent the possibility of such involvement, attempts to involve parents and/or reasons explaining their non-involvement must be fully documented and presented to an interagency team.
14. Continued inpatient hospitalization **must** be recommended by the treatment team (to also include child, parent/guardian, case manager [when one is assigned], current treating or evaluating therapist).
15. All appropriate documentation follows the child as the child makes the transition to other therapeutic services, be they more or less intense.

Community Integration Questionnaire

1. Are the **child's interest areas?** and **strengths?** documented, with a plan to **explore new interests and strength's** for the child?
2. Have the **child's community and family support network, and cultural resources** been explored for the purpose of involving the child in his/her own community, and recorded?
3. Has there been **recruitment of family members, or other significant individuals,** to participate as designated support persons
4. Do you have a list of the **available services, events and activities** in the community? [Both the child's home community and the community surrounding the therapeutic center, if different].
5. What activities has the child been **involved in** over the past two months? Is there a plan to **continue** this involvement?
6. Does the **treatment plan** include community integrative activities, such as:
 - planned parental supervised activities?
 - age appropriate, child independent participation in planned community activities [such as: Traditional events; school sponsored clubs and gatherings; extra-curricular classes (ie. dance, music, martial arts, etc); church or community center picnic, etc.]?
 - opportunity for child-peer interaction in the community [such as: visits to neighborhood friends (including overnight visits); participation in peer group activities [such as: neighborhood "hoops", stick ball, parties and informal gatherings].
 - [other activities- specify in treatment plan].

OR, for children who may be more severely impaired:

 - staff oversight of planned parental supervised activities?
 - staff supervised activities for parent/child interaction?
for child/community peer interaction?
 - staff supervised activities in the community?
 - planned reentry into the regular classroom (independently, or with a therapeutic staff support)?
7. Do you have a **plan of reinforcement** for a child's successful participation outside of the treatment setting? and a **crisis intervention plan** for the child while outside of the

treatment setting?

8. Do the **progress notes** detail the outcome of the home/community integrative activity?
9. Do you have a data gathering form or instrument to **measure the outcome** of a child's participation in a home/community activity?
10. Do you have a **plan to expand** the child's home/community/cultural participation?

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HEALTHCHOICES BEHAVIORAL HEALTH SERVICES
GUIDELINES for BEHAVIORAL HEALTH MEDICAL NECESSITY CRITERIA

CHILDREN AND ADOLESCENTS

**Behavioral Health Rehabilitation
Services Under EPSDT:
Home/Community Services
(2nd Edition)**

- ⊙ **Serious Emotional Disturbance**
- ⊙ **Intellectual Disabilities**

INTRODUCTION:

Generally absent in both regulation and the literature on behavioral health, are admission guidelines for behavioral health services delivered to children in their homes, schools, and daily community activities. The availability of these services is required under the federal ruling titled the Omnibus Budget Reconciliation Act of 1989 (Public Law 101-239) as specifically described in the section called Early and Periodic Screening, Diagnosis and Treatment (EPSDT). Implementation of OBRA '89 in Pennsylvania was established through the Medical Assistance Bulletin 1241-90-02 of October 15, 1990. While there has been a strong focus on development and expansion of needed services to respond to children with behavioral health treatment needs in multiple child serving systems, more work is required to regulate use of services. Clearly, with concerns about containing cost while enhancing the efficacy of treatment affecting decisions on service delivery, guidelines are needed to bridge the purpose, function, and expectations of these services with actual service delivery. Up to now, the primary connection has been the determination of medical necessity, in combination with the application of the Child and Adolescent Service System Program (CASSP) principles, and a variously applied understanding of the "Wraparound" philosophy of care. The guidelines and classification system presented in this document and subsequent revisions, provide a basis for admitting children and adolescents to behavioral health services delivered in the home, and school, or elsewhere in the community, under EPSDT, and within the context of multiple child serving systems. For ease of reading in the text which follows "child" will refer to both child and adolescent unless otherwise stated.

CASSP principles and the Wraparound philosophy of care provide the foundation supporting the effort to provide mental and behavioral health services to children in their homes and communities. It is understood here that home/community delivered services are not simply intended to be a replacement for all other clinic and hospital based services. These relatively new services are to address the increasingly complex needs of children receiving services in multiple child serving systems (i.e.- child welfare, juvenile justice, education, intellectual

disabilities, and drug & alcohol) and offer an alternative to some of the functions clinic/hospital based services have previously played, because home/community delivered services are considered more appropriate to specific tasks of directed treatment.

Home/community delivered behavioral health services are specifically appropriate for children and adolescents who require intervention at the sites where their problematic behaviors occur. This eliminates the necessity to understand and treat problems, behaviors, or activities in an abstract form dissociated from their actual occurrence, and allows direct intervention. In this way the clinician observes and learns directly from the child's behavior in the natural context, but it also allows the child and clinician to formulate together the language and symbolic references to the problem and the strategies for resolution. Thus the interaction between the child and clinician is not dependent on first understanding an abstract expression of the problem, and allows the child to firmly establish the practicality of the therapeutic intervention. The clinician is not solely dependent on informants and the child receiving treatment for information, nor does the child need to transfer change which occurs in the clinic or institutional setting to the family or community setting where the problem primarily manifests.

The purpose for any recommended service must be justified and clearly stated whether they are clinic or home based. Also, the recommendation for services must carefully consider not only treatment for an identified problem, but the child's multi-system involvement, willingness to engage in treatment, the confidentiality concerns of both the child and family, and whether safety issues require a certain level of restrictiveness in the treatment planning for a particular child or adolescent. Making the decision for the type and level of service is not always easy, but the rationale for the decision made is necessary. Building the rationale requires the appropriate diagnostic and life domain assessments, treatment and interagency team involvement, and the spirit of building a cooperative effort to enhance the intervention in order to achieve the goals of treatment.

Home/Community Services

The behavioral health system has undergone substantial structural change from an emphasis on community segregation and maintenance of children with emotional disorders, to one of community integration and skill development essential in fostering increasing independence of individuals and families (see Mental Health/Mental Retardation Act of 1966 and the Mental Health Procedures Act of 1976 with subsequent amendments). The change in emphasis from providing service to children exclusively in established sites, such as clinics and hospitals, and residential and day treatment centers, to serving children individually where they live, learn and play in the community is reflective of this overall change. These changes are supportive of the wraparound philosophy of care to the extent that these community delivered services are often identified as "wraparound services." Wraparound is a philosophy which promotes developmentally appropriate behavior, activities, skills, and social skills for the child in his/her natural context through focusing on his/her individualized strengths and needs. More broadly, it promotes the opportunity for family independence from professional treatment and therapeutic

supports. Family autonomy in the care of children with special needs may be fostered through skill development and assisting the family in the development of their informal support network. An understanding of the social contexts of the child or adolescent, including school and community as well as home, is essential to determining the appropriate sites for interventions and the resources available. When professional services provide a necessary treatment, the service(s) must be focused on accomplishing a set of goals, and incorporate into the planning the appropriate tapering of the service or the replacement of the service with informal and other non-behavioral health therapeutic supports.

The Office of Mental Health and Substance Abuse Services (OMHSAS) has promoted the development of expanded behavioral health services in response to the need for services delivered to children in natural community settings. In Pennsylvania these services have multiple references including, "EPSDT mental health services", "expanded mental health services," "psychosocial rehabilitative services" and "'wraparound' mental health services". However, EPSDT refers to more than the services considered in the Level of Care protocols to follow, "enhanced" is a term relative to the services currently offered and therefore not necessarily restricted to community based services, and "wraparound" is a philosophy of care and implementation within which professional services may play a role. For clarity in this paper, the services are called simply by their association with home and community. Other psychosocial rehabilitative services which are offered on provider-site, such as therapeutic summer programs and after-school programs are not incorporated into the protocol for home/community services. It is in the application that home/community services must be medically necessary, adhere to the requirement of EPSDT service provision, and should be consistent with the wraparound process.

Treatment objectives may be characterized in at least three ways, individualized, generalized, and service specific. Individualized objectives for the child and family must be created as part of a treatment process which is strengths-based and developmentally appropriate. The generalized objectives reflected in the admission guidelines for clinic and hospital based services are as follows: ameliorate symptoms such that less restrictive and/or less intrusive services can be planned and introduced; stabilization of medical regimen for children requiring psychotropic medication which helps them to effectively receive the least restrictive/least intrusive services possible; promotion of psychosocial growth and development and prevention of regression/recidivism by improving the child's level of functioning and ability for self maintenance; coordination of the treatment and discharge plan on an ongoing basis with the appropriate agencies to provide the necessary natural community based supports; and increase in age-appropriate interactivity in a variety of settings [see "Community Integration Questionnaire" in Reference Form D (p. 27)]. Some objectives more specific to the home/community services have been mentioned above, such as: development and practice of interpersonal skills as necessary to enhance parent/child, child/adult, and child/peer relations; identification of personal, family and community resources and exploring their usage; and directly relating therapeutic aims with social contexts and laying the groundwork for treatment which references the problem (a higher level of abstraction) such as occurs in clinic based treatment.

Home and community services are developed and tailored specifically to meet individualized child and family needs (see Table 2). Specialized therapeutic services on the Medical Assistance fee schedule are: Mobile Therapy, Behavioral Specialist Consultant (Doctoral Level), Behavioral Specialist Consultant (Master's Level), Therapeutic Staff Support (TSS), and Summer Therapeutic Activities Program. Each of the first four services is distinct and described in Medical Assistance Bulletin 01-94-01, issued January 11, 1994 on "Outpatient Psychiatric Services for Children Under 21 Years of Age." The last is a new program which is described in Medical Assistance Bulletin 50-96-03, issued April 25, 1996. All of these services are provided for the purpose of improving and developing the capacity of the treated child or adolescent, and the family, thereby contributing toward the independence of the family as a unit. The need for these services will vary according to the severity of the child's problems and the richness of the resources of the child, the family, and the community.

In this edition of the guidelines for behavioral health home/community services, guidelines for the delivery of home and community behavioral health services to children with intellectual disabilities have been added. The Office of Developmental Programs supports the provision of services in homes and communities. These behavioral health services provide discrete short term, goal oriented rehabilitative interventions to children with intellectual disabilities. The availability of these services helps to ensure that children with intellectual disabilities receiving services have access to additional therapeutic interventions when medically necessary and to assist them remain in their communities.

The structural changes in the behavioral health system are reflected in the development of the Child and Adolescent Service System Program (CASSP) and its philosophy. Within the body of this Bulletin is emphasized the importance of consistency in the services with the CASSP principles. The OMHSAS summary representation of the CASSP principles, is provided below.

CASSP Principles

The CASSP philosophy of collaborative service delivery to children, adolescents and their families undergirds all treatment methods. CASSP involves all child-serving systems including mental health, intellectual disabilities, education, special education, children and youth services, drug and alcohol, juvenile justice, health care, and vocational rehabilitation. It should also include informal community supports and organizations. This philosophy is essential to making decisions to provide treatment for children. It is also the foundation that motivates the development of these guidelines. These principles are represented in the following six summary statements:

- (1) Child-centered - Services are planned to meet the individual needs of the child, rather than to fit the child into an existing service. Services should be developmentally appropriate and child-specific, and should also build on the strengths of the child and family to meet the mental health, social and physical needs of the child.

- (2) Family-focused - Services recognize that the family is the primary support system for the child. The family participates as a full partner in all stages of the decision-making and treatment planning process, including implementation, monitoring and evaluation. A family may include biological, adoptive and foster parents, siblings, grandparents and other relatives, and other adults who are committed to the child. The development of mental health policy at state and local levels should include family representation.
- (3) Community-based - Whenever possible, services should be delivered in the child's home community, drawing on formal and informal resources to promote the child's successful participation in the community. Community resources include not only mental health professionals and provider agencies, but also social, religious and cultural organizations and other natural community support networks.
- (4) Multi-system - Services should be planned in collaboration with all the child- serving systems involved in the child's life. Representatives from all these systems and the family should collaborate to define the goals for the child, develop a service plan, develop the necessary resources to implement the plan, and provide appropriate support to the child and family.
- (5) Culturally competent - Culture determines our world view and provides a general design for living and patterns for interpreting reality that are reflected in our behavior. Therefore, services that are culturally competent are provided by individuals who have the skills to recognize and respect the behavior, ideas, attitudes, values, beliefs, customs, language, rituals, ceremonies and practices characteristic of a particular group of people.

Note: Pennsylvania's cultural competence initiative has focused specifically on African Americans, Latinos, Asian Americans and Native Americans who have historically not received culturally appropriate services.

- (6) Least restrictive/least intrusive - Services should take place in settings that are the most appropriate and natural for the child and family and are the least restrictive and intrusive available to meet the needs of the child.

These principles encompass not only the psychological, but the physical, cognitive, and socio-cultural development of children, which include the child's dependency on family, community, and environmental influences in general. From these principles, the home/ community delivered services for which "Admission Guidelines" are provided below, can be understood as components within a wider network of service options.

CLASSIFICATION SYSTEM:

Because the collective of home/community behavioral health services is appropriate to treat

the full range of symptom severity, an organizational system for associating intensity of service with severity of need is essential. This is different from the current clinic and hospital based services which associate the individual service with the severity of need, such that inpatient hospitalization is associated with higher severity of symptoms than that of partial or outpatient. By dividing the community delivered services into four levels of intensity from least to most, these services roughly parallel the four traditional categories of clinic and hospital based services: Outpatient; Partial Hospitalization; Residential Treatment; and Inpatient Hospitalization. Services are further divided into two types: treatment and therapeutic support. With intensity of service defined by the amount of time the service is provided, as related to the type of service provided, the four levels of home/community delivered services may be identified as contiguous segments along a continuum of intensity.

The first of the four levels describes the criteria for the children with the least severe need who are eligible for the service. Each of the successive levels represents an increase in the severity level for which it is designed. Criteria for children with intellectual disabilities are identified in the first two levels only with the recognition that if these children display greater severity in their symptomatology they may receive an axis I diagnosis. Because all of the home/community delivered services are available for each of the levels, the variation in intensity must be ranked by how much service is delivered. Time is selected as a general measure of quantity for each of the levels, because it is already used in this way to determine payment when a rate is assigned to the service. At this writing, the range of hours for each of the levels is not identified, however the levels represent a proportional relationship between both, the identified levels of severity and the range of services within each.

There are a maximum of four components to each of the levels. In order of presentation in the guidelines and the table: the first part identifies the type and extent of the emotional and behavioral disturbance, including the degree of endangerment; the second requires assurance that the child or adolescent and the family is amenable to treatment in community settings; while the third assures that there is the professional opinion that the service necessary is at this level of intensity. The fourth level applies only to the two least intensive levels and tends to serve the purpose of observation based on an initial assessment of need which needs greater clarity. As the two highest levels involve a higher severity of symptoms, "observation" for the purpose of determining the problem does not apply. Differentiation between the levels rests primarily with the severity of the problem, and the ability to treat in the community but it also includes the risk of endangerment allowed. More care is required of the assessment of endangerment, but the other categories solicit the psychiatrist or psychologist to elaborate their justification. The usual process for determining improvement or relapse and identifying service and therapeutic support needs, should guide the use of the services.

Using a continuum of severity expresses schematically the importance of allowing children to flow from one category to another as indicated by the child's needs (see Table 2, below). However, suggesting discrete categories with fixed ranges may be interpreted in a manner contradictory to the value of a continuum in providing fluidity. The association of fixed ranges

of time with each level is complicated by the potential mix in the available array of services such as clinic based services, services from other child serving systems, or the inclusion of informal family and community supports. These issues beg the question of whether the severity levels may be so firmly attached to the hours of service that a child associated with one level must "officially" be reduced to another level, in order to reduce the hours of home/community based services; though the "true" severity level is higher, and the child, in truth continues to receive a high number of hours of service, but from other sources. Ideally, each severity level would have a range of hours for serving a child in each of three categories: clinic/hospital services; home/community services; and the service inherent in the personal support network. However, the usual application of admission guidelines is to structure the use of a specific service or service category, and that is the exercise here. The establishment of a recommended range of hours for the delivery of home/community services is not addressed, except to suggest an adjustable range of times depending on the other services used or functions served by family members, and that there is a proportional increase in the expectation of the maximum amount of service within each category.

For the purpose of establishing a reasonable framework, it will be assumed that the hours assigned do not consider the complicating factors of other services and other therapeutic supports, or temporary reductions of service to assess progress. The next task will be to set up a system of values for any additional services and therapeutic supports which can be used as weights to identify a child with the appropriate level.

GUIDELINE FORMATION:

Working toward furthering consistency between children's treatment needs and the broader philosophy of individualized service delivery in the most appropriate manner, is a complex task. Generalizing work such as, the principles of the Child and Adolescent Service System Program (CASSP), the values presented in a variety of CASSP publications, and the wraparound philosophy of care, provide a theoretical basis, and though this body of work has much room to grow, it is time to develop the tools of implementation. The work of admission guidelines for home/community based services is an important beginning to provide a unified basis for decision-making. It is one of the essential instruments needed for behavioral health providers, case managers, interagency teams, and third party payers (including Managed Care Organizations and their sub-contractors), to coordinate service determinations among themselves and with families (including friends and community services as appropriate). Such coordination is vital to foster confidence in the appropriateness of admissions to any of the recommended treatment modalities, as well as continued stay, and appropriate discharge planning.

Inherent in these guidelines is a framework for implementing the wraparound concept in service delivery and developing discrete individualized service programs. Individualized treatment plans may coordinate a number of services but importantly, the functions of the services must be identified so that they build upon actual strengths, actual needs are addressed by the services. It is also important to help develop family and community resources to meet these

needs. Traditional outpatient and partial hospitalization services are examples of other services which may be coordinated with home/community delivered services when medically necessary. Home/community treatment is for children who: may be effectively treated at home; who require comprehensive wraparound planning for transition from a more restrictive setting back to the home and community; who may require a treatment support system while in the community until an effective family and community support network can be activated. These services provide a full range of intensity to the child in his/her natural setting, depending on the evaluated need of the child. In considering the intensity of home/community service, delivery involves three basic elements of consideration: severity of presenting problem, appropriate intensity of service, and the least restrictive and/or intrusive service necessary. These elements are considered separately below.

Severity of Symptoms

Symptom severity is often more apparent to the clinician than it is easy to describe. Levels with identifiable indicators can make the process of assessing severity easier. Additional descriptive information remains important to provide clarifying documentation in the child or adolescent's record. Each of the four levels represented in these guidelines requires an assessment of the child's expression of emotional and behavioral disturbance in any of the following categories for consideration in the design of the individual's treatment: judgement, thought, mood, affect, impulse control, psychosocial, psychomotor retardation/ excitation, physiological functioning and/or cognitive/perceptual abilities. Also important is an assessment of the impact of any disturbance on social skill development and the relationship between them. Gauging the severity of any of these presenting symptoms is ultimately left to the judgement of the clinician in his or her review. If severity is otherwise linked to endangerment or imminent risk of out-of-home or out-of-school placement, descriptors may be crafted to indicate relative severity. Challenging behaviors closely associated with social contexts such as family, school, or other community activities must be considered when determining an appropriate treatment design involving home/community services, or any combination of home/community and the more conventional services. The severity of presentation determines the extent of service need. The severity of expression for a child with intellectual disabilities must be evaluated in relation to the individual child's behavioral norm or "baseline." The design of the treatment plan must also consider the concomitant discharge planning.

Intensity of Treatment

The intensity and range of treatment varies for each of the home/community services available for children (see Table 1). But because different treatment plans call for different combinations of services to treat a variety of children or adolescents who could be assessed at the same level of severity, intensity is associated with a multiplicity of service options and gauged by the amount of total service time needed. However, one division has been made, establishing two tiers of service based on the professional level of the service. The first is "home/community professional behavioral health services," such as Mobile Therapy and Behavioral Specialist

Consultant, and the second is "home/community behavioral health implementation-therapeutic support services," such as Therapeutic Staff Support (TSS) and Therapeutic Staff Support Aid (TSSA). The professional services are those performed by highly credentialed individuals who also play a critical role in the development of the treatment plan. Therapeutic support services require personnel who have specific training and a Bachelor's degree or, for TSSAs, a High School diploma. Their role is to assist the child or adolescent, and the family, in the follow-through of the treatment plan.

Of the four severity levels, the last two listed are intended to divert the child or adolescent from out-of-home services, or serve as a step down following the child's discharge from any inpatient or out-of-home placement. Highly intensive community delivered treatment is often needed to prevent out-of-home placement, and/or to help children to return to their natural home, school, and community from an out-of-home placement. This works by directly associating the therapeutic process of treatment with effective adaptation to the social environment. The first two severity levels allow a lower range of service intensity to assist the child and family. All the levels provide treatment, but they also encourage the family's developmental process in unassisted interaction. The therapeutic function and emphasis of each of the four service levels depends strongly on the cohesiveness of the interagency and treatment teams and the interaction between the behavioral health staff, the parents/custodians, and the child, for the effectiveness of the treatment plan developed.

Least Restrictive/Least Intrusive

Structural differences between the two kinds of services allow each to be scaled differently along the CASSP principle of providing the least restrictive and least intrusive services necessary. The site-based services, clinics and hospitals, may be scaled on a continuum of restrictiveness from more to less. Restrictiveness essentially refers to the degree the child or person is separated from the general community and integrated into a treatment community. For off-site delivery of services, or those delivered to individuals in their homes, schools, or other community settings, scaling restrictiveness does not apply. However, these services may be scaled on a continuum of intrusiveness, if intrusiveness is to be understood as the degree to which service is integrated into the natural setting and the lifestyle of the individual(s) served. It is through this understanding that it may be asserted that mental and behavioral health services in the lives of clients are not "natural," but an intervention intended to be time-limited. Of course, depending on the severity of the problem, the network of inclusion/ support and the other environmental/ecological factors, the time required for individuals' successful treatment will vary. It is these last three elements which are used to formulate the classification system in the guideline.

Home/community services are generally regarded as the least restrictive service options for children who need intensive behavioral health services. However, by delivering services to children in their homes and communities these services may potentially be the most intrusive. Traditionally, intensive behavioral health services were designed to provide treatment in settings

separate from the community, such as inpatient and partial hospitalization settings, residential treatment facilities, and outpatient clinics. This segregation of children from greater community involvement for the period of treatment has become the defining characteristic of restrictiveness and allows consideration of these services on a continuum from least restrictive to more restrictive. Home/community services parallel the intensity available in the traditional services, but because these services engage the child in family and community activities home/community services are not easily characterized as restrictive. However, they may be identified with intrusiveness due to their close involvement with, and presence in the daily activities of the child receiving treatment, and the family.

The four levels for the delivery of the home and community addressed in this bulletin, are presented in ascending order of service intensity and professional intervention. The need for greater or lesser intensity of service must be adjusted to the individual's need for active treatment as reflected in the evaluation and the treatment plan. Increased intensity of service may improve the effectiveness of treatment by providing convenience and opportunity for more responsive intervention. Reducing levels of intervention is a necessary element of therapy directed toward fostering and developing independence in the relationship formations of children with their families, peers, and functioning in normalized settings in the community. Also, care must be taken to avoid the development of a dependency relationship between any family members and behavioral health professionals which result in a non-therapeutic alliance. Each service level provides treatment with the object of helping children with acute behavioral problems or serious emotional disturbance to increase their ability to integrate into the community and culture of their respective families by increasing his or her capacity for self control.

ADMISSION GUIDELINES:

Criteria for each level of Home/community service is based on the individual severity indicators. In the admission guidelines described below is a process for deciding when to treat, continue, or discontinue treatment and refer elsewhere for other services. However, the concept of tapering, or systematically reducing the intensity of the services delivered has been added here. The guideline is divided into five (5) sections: I- Diagnostic Evaluation and Documentation; II- Severity Levels and Service Correlates; III- Therapeutic Support Criteria; IV- Continued Care; and V- Discharge and Service Transition. The first three include the evaluation and documentation criteria for Admission, the fourth and fifth are for determining the appropriateness of continuing, tapering, and discontinuing care.

As these guidelines are written, it is assumed that any child or adolescent receiving services has a case manager, that children with intellectual disabilities have a county MH/MR/ID case manager, and that all children with multiple systems involvement have incorporated into the planning process an interagency team. Concerning the structure of Section II which associates the severity of the presenting problem with four contiguous levels, each level proposes corresponding ranges of hours for both professional behavioral health services and behavioral

health therapeutic support services. For the purpose of clarity in the structure, the hours proposed assume there are no other services provided to the individual in treatment. Nor do they carry any presumption of the richness of the home/community therapeutic supports available to the child or adolescent in treatment. However, both the system and community therapeutic supports are critical to the appropriate determination of service hours to be delivered. It is for this reason that Table 2 has been included. This table provides two matrices, one for reviewing the problems of the child and the other for the strengths of the child, family and community. Each lists the possible domains and settings affected. The matrices are designed to help in the decision-making process when determining the appropriate mix of services, and the appropriate adjustment for the amount of the services in each severity level in Section II below. Such determinations should be used and documented as an adjustment of time within the severity level selected, and it is expected that this is a natural part of any interagency or treatment team process.

Home/Community Services
Admission Guidelines
(Must meet I, II, and III)

Admission of a child for Home/Community Behavioral Health Treatment is most appropriately based on a face-to-face assessment and diagnosis by the prescribing Board Certified or Board eligible child and adolescent psychiatrist, developmental pediatrician, or licensed psychologist specializing in children or adolescents. In the absence of these prescribers, a diagnosis may be appropriately provided by any Board Certified or Board eligible psychiatrist or a licensed psychologist. Any time a child or adolescent specialist is unavailable to perform the necessary diagnostic services, this should be documented and explained. As part of the assessment process and the development of treatment recommendations, the prescriber addresses the concerns and recommendations of the case manager and the interagency team.

Diagnostic references for the purpose of the documentation below must be from the most current edition of the Diagnostic and Statistical Manual (DSM). The most current edition in use at this writing is the DSM IV; for ease of reading, the text following will reflect this edition. For further convenience in reading, "child and adolescent" will follow the form of "child", unless otherwise indicated.

I. DIAGNOSTIC EVALUATION AND DOCUMENTATION

A. Mental Health

1. Diagnosis on DSM IV Axis I or Axis II, as part of a complete multi-axial, face-to-face evaluation (MR or D&A cannot stand alone);

AND

2. Evaluation indicates:

- a. child has, or is at serious risk of developing, an emotional or behavioral disturbance, or mental illness; *and*
- b. clinic based treatment is not sufficient or appropriate to effectively serve the child/family; *and*
- c. behaviors indicate manageable risk for safety to self/others while in the community, and child must not require inpatient treatment or a psychiatric residential treatment facility; *and/or*
- d. the child needs home/community mental health treatment as a result of documented emotional and behavioral disturbance of functioning:
 - 1) within the family or other community-based residential setting, *or*
 - 2) in the school setting, *or*
 - 3) resulting in limitations in social and community interactions;*or*
- e. a combination of mental health needs that cannot be met without treatment delivered to the child in the community by mental/behavioral health professionals.

OR

B. Intellectual Disabilities

1. Diagnosis on DSM IV Axis II and Axis IV, as part of a complete multi-axial, face-to-face evaluation (ID cannot stand alone), without a diagnosis on Axis I;

AND

2. Evaluation indicates:

- a. an onset of remarkable or crisis behavior(s) in a child or adolescent with intellectual disabilities; *and/or*
- b. a notable adverse change in the baseline behavior of a child or adolescent with intellectual disabilities; *and*
- c. a medical condition has been ruled out; *and*
- d. existing intellectual disability services are no longer sufficient or appropriate to effectively serve the child/family; *and*
- e. behaviors indicate manageable risk for safety to self/others while in the community, and child must not require inpatient treatment or a residential treatment facility; *and/or*
- f. the child needs home/community behavioral health treatment as a result of a documented behavioral disturbance functioning:

- 1) within the family, foster care, family living or other community-based setting,
or
 - 2) due to behavior which results in limitations in social and community interactions; *or*
- g. a combination of behavioral health needs that cannot be met by existing intellectual disability services without treatment delivered to the child in the community by additional behavioral health professionals.

AND

C. Parent(s)/guardian(s), and/or care giver as appropriate, a lead case manager and the child to his/her fullest ability must be involved in the planning process. Where a parent (or legal guardian) or the child are not or cannot be involved, the attempts to involve either or both and the reasons for non-involvement must be documented. The interagency team should otherwise recommend the most appropriate alternatives should home/community service alone be insufficient to serve the child's needs;

AND

D. There is:

1. serious and/or persistent impairment of developmental progression not attributable to intellectual disabilities and/or psychosocial functioning due to a serious emotional disturbance or psychiatric disorder;

OR

2. an onset of remarkable or crisis behavior(s) in a child or adolescent with intellectual disabilities;

AND/OR

3. a notable adverse change in the baseline behavior a child or adolescent with intellectual disabilities resulting in significant measurable reduction in psychosocial functioning with respect to the existing developmental disorder, requiring treatment to alleviate acute existing symptoms and/or behaviors; or to prevent relapse in the child with symptoms and/or behaviors which are in partial or complete remission;

OR

E. Significant psychosocial stressors and/or medical condition increasing the risk that the child's functioning will decrease for his/her developmental level when developmental level is unrelated to intellectual disabilities;

OR

F. Behaviors or symptoms improve in response to comprehensive treatment at a higher level of care, but child needs home/community treatment to sustain and reinforce stability;

OR

G. Requires medication, and time limited monitoring of the medications is needed to mitigate the effects of the child's symptoms until the child and/or family can assume this role.

II. SEVERITY LEVELS and SERVICE CORRELATES

(See also Table 1)

Service volume and intensity must be recommended as the most clinically appropriate and least intrusive necessary for the child, by the prescriber, as informed by the interagency team.

(Must meet A or B or C or D)

A. MH - Level 1 (Least) - DSM IV Axis I/ II diagnosis

(MR or D&A cannot stand alone)

Home/Community Professional Mental Health Services

Home/Community Mental Health Therapeutic Support Services

(Must meet 1, 2, and 3; **OR** 4)

1. Service must be recommended as the most clinically appropriate service available for the child, by the prescriber as informed by the case manager and interagency team, *and*
 - a. There is serious and/or persistent impairment of developmental progression and/or psychosocial functioning due to a psychiatric disorder other than intellectual disabilities, requiring treatment to alleviate acute existing symptoms and/or behaviors; or to prevent relapse in the child for the prescribed period of time to allow the therapeutic process to hold its effectiveness with symptoms and/or behaviors which are in partial or complete remission; *or*
 - b. Significant psychosocial stressors and/or medical condition increasing the risk that the child's functioning will decrease for his/her developmental level, require home/community based intervention to develop resources within the child and/or family to provide the balance to these stressors needed to continue the child in remission and/or to promote effective adaptation; *or*
 - c. Symptoms improve in response to comprehensive treatment at a higher level of care, but child is still in need of direct home/community based treatment to reinforce stability; *or*
 - d. Requires medication and home/community based monitoring of medications to help the child (and family) understand the importance of adhering to the therapy recommended to mitigate the effects of the child's symptoms, and establish a pattern of following the prescription;

AND

2. Child's behavior is assessed to be manageable in the home/community setting, child is assessed to be responsive to the implementation of a community-based treatment plan in the professional judgment of the appropriate behavioral health professional, as a result of:
 - a. the delivery of the professional care required to serve the child's specific treatment occurring on site; *and*
 - b. documented commitment by the primary care givers(usually parent/guardian) to the treatment plan;

AND

3. The severity and expression of the child's symptoms are such that:
 - a. continuation with a less intense level of care cannot offer either an expectation of improvement, or prevention of deterioration, as identified above; *and*
 - b. on-site intervention in the home or community offers a more effective preventive to longer term consequences.

OR

4. OBSERVATION

The child's problematic behavior and/or severe functional impairment discussed in the presenting history *and* psychiatric examination requires further observation for clarification under Section II. Allowable for up to fifteen (15) days within which time the examining psychiatrist must clarify the child's eligibility for admission under Section II *AND/OR* recommend development of a transition plan. Should it be found that the child does not fit the guidelines for admission, an appropriate transition plan is to be developed with the interagency team, and the child discharged under the provisions of that plan.

- a. Troubling symptoms of the child which have been described by members of the family, persist (and/or representatives of the community or school) but,
 - they are not observed on a psychiatric inpatient unit, or they are denied by the child in outpatient or partial hospitalization treatment, such that observation of the child in natural settings provides an ideal opportunity to observe and treat the child; *or*
- b. Child's symptoms have not sufficiently improved despite well-planned comprehensive treatment in site-based levels of care, which has involved the participation of an interagency team.

A. MR- Level 1 - DSM IV Axis II/IV diagnosis

(MR cannot stand alone)

Home/Community Professional Behavioral Health Services

Home/Community Behavioral Health Therapeutic Support Services

(Must meet 1, 2, and 3)

1. Service must be recommended as the most clinically appropriate service available for the child, by the prescriber as informed by the lead case manager and interagency team, *and*
 - a. There is significant change or amplification in exhibited behaviors as indicated by an increase in frequency (average number of events per day), duration (after first day, the increase in number of consecutive days), and/or locations; *and*
 - b. Behavior presents serious risk of self injury, or injury to others, or destruction of environment; *and*
 - c. Significant psychosocial stressors are present affecting a decrease in the child's functioning; *and/or*
 - d. Requires medication and home/community based monitoring of medications to help the child (and family) understand the importance of adhering to the therapy recommended to mitigate the effects of the child's symptoms, and establish a pattern of following the prescription;

AND
2. Child's behavior is assessed to be manageable in the home/community setting, child is assessed to be responsive to the implementation of a community-based treatment plan in the professional judgment of the appropriate behavioral health professional, as a result of:
 - a. the delivery of the professional care required to serve the child's specific treatment occurring on site; *and*
 - b. there is documented commitment by the primary care givers(usually parent/guardian) to the treatment plan;

AND
3. The severity and expression of the child's behaviors are such that:
 - a. continuation with a less intense level of care cannot offer either an expectation of improvement, or prevention of deterioration, as identified above; *and*
 - b. on-site intervention in the home or community offers a more effective preventive approach to longer term consequences.

B. MH - Level 2 - DSM IV Axis I/ II diagnosis

(MR or D&A cannot stand alone)

Home/Community Professional Mental Health Services
Home/Community Mental Health Therapeutic Support Services
(Must meet 1, 2, and 3; or 4)

1. Risk of child harming him/herself or others, or causing destruction to property, is assessed low in the child's current problematic behavioral or functional impairment; presenting history and psychiatric examination, **and**

a. Must include at least one (1) of the criterion below:

- 1) Suicidal/homicidal ideation
- 2) Impulsivity and/or aggression
- 3) Psycho-physiological condition (i.e.- bulimia, anorexia nervosa)
- 4) Psychomotor retardation or excitation
- 5) Affect/Function impairment (i.e.- withdrawn, reclusive, labile, reactivity)
- 6) Psychosocial functional impairment
- 7) Thought Impairment (i.e.- psychosis)
- 8) Cognitive Impairment; **and/or**

b. Presence of very impaired judgement or functional capacity and capability, for the child's developmental level which is not attributable to intellectual disabilities such that interpersonal skills, and/or self-maintenance in home/school/community is/are highly compromised;

AND

2. Behavior is assessed to be manageable in the home/community setting, and degree of risk is assessed to be responsive to, and effectively reduced by the implementation of a treatment plan in the professional judgment of the advising physician or mental health professional , as a result of:

- a. the delivery of the professional care required to serve the child's specific treatment occurring on site; **and**
- b. documented commitment by the primary care givers usually parent/guardian to the therapeutic plan;

AND

3. The severity and expression of the child's symptoms are such that:

- a. continuation with a less intense level of care cannot offer either an expectation of improvement, or prevention of deterioration, as identified above; **and**
- b. on-site intervention in the home or community offers a more effective preventive to longer term consequences.

OR

4. OBSERVATION:

The child's problematic behavior *and/or* severe functional impairment discussed in the presenting history and psychiatric examination requires further observation for clarification under Section II. Allowable for up to fifteen (15) days within which time the examining psychiatrist must clarify the child's eligibility for admission under Section II *AND/OR* recommend development of a transition plan. Should it be found that the child does not meet the guidelines for admission, an appropriate transition plan is to be developed with the interagency team, and the child discharged under the provisions of that plan.

- a. Troubling symptoms of the child which have been described by members of the family, persist (and/or representatives of the community or school) but,
 - they are not observed on a psychiatric inpatient unit, or they are denied by the child in outpatient or partial hospitalization treatment, such that observation of the child in natural settings provides an ideal opportunity to observe and treat the child; *or*
- b. Child's symptoms have not sufficiently improved despite well planned comprehensive treatment in site-based levels of care, which has involved the participation of an interagency team.

MR - Level 2 - DSM IV Axis II/IV diagnosis

(MR cannot stand alone)

Home/Community Professional Behavioral Health Services
Home/Community Behavioral Health Therapeutic Support Services
(Must meet 1, 2, and 3)

1. Service must be recommended as the most clinically appropriate service available for the child, by the prescriber as informed by the lead case manager and interagency team, *and*
 - a. There is significant change or amplification in exhibited behaviors as indicated by an increase in frequency (average number of events per day), duration (after first day, the increase in number of consecutive days), and/or locations; *and*
 - b. Behavior has resulted in self-injury, or injury to others, or destruction to environment; *and*
 - c. Significant psychosocial stressors are present affecting a decrease in the child's

- functioning or an escalation of the child's symptoms; *and/or*
 - d. Requires medication and home/community based monitoring of medications to help the child (and family) understand the importance of adhering to the therapy recommended to mitigate the effects of the child's symptoms, and establish a pattern of following the prescription;
 - AND
2. Child's behavior is assessed to be manageable in the home/community setting, child is assessed to be responsive to the implementation of a community-based treatment plan in the professional judgment of the appropriate behavioral health professional, as a result of:
 - a. the delivery of the professional care required to serve the child's specific treatment needs occurs on site; *and*
 - b. there is documented commitment by the primary care givers(usually parent/guardian) to the treatment plan;
 - AND
 3. The severity and expression of the child's behaviors are such that:
 - a. continuation with a less intense level of care cannot offer either an expectation of improvement, or prevention of deterioration, as identified above; *and*
 - b. on-site intervention in the home or community offers a more effective preventive approach to longer term consequences.

C. MH - Level 3 (Intensive)

Home/Community Professional Mental Health Services
 Home/Community Mental Health Therapeutic Support Services
 (Must meet 1, 2, and 3)

1. Severe functional impairment discussed in the presenting history and psychiatric examination, is assessed in the child's problematic behavior in home, school or community, and there is risk of an out-of-home or out-of-school placement. In addition, there may be risk of danger in child harming him/herself, harming others, and/or demonstrated destruction to property; *and*
 - a. Must include at least one (1) of the criterion below:
 - 1) Suicidal/homicidal threats or intensive ideation
 - 2) Impulsivity and/or aggression
 - 3) Psycho-physiological condition (i.e.- bulimia, anorexia nervosa)
 - 4) Psychomotor retardation or excitation.

- 5) Affect/Function impairment (i.e.- withdrawn, reclusive, labile, reactivity)
- 6) Psychosocial functional impairment
- 7) Thought Impairment (i.e.- psychosis)
- 8) Cognitive Impairment; *and/or*,

- b. There is an exacerbation of severely impaired judgement or functional capacity and capability for the child's developmental level, which is not attributable to intellectual disabilities, such that interpersonal skills, and/or self-maintenance in home/school/community is/are severely compromised;

AND

- 2. Behavior is assessed to be manageable in the home/community setting, and degree of risk is assessed to be responsive to, and effectively reduced by the implementation of a treatment plan in the professional judgment of the advising physician or mental health professional, as a result of:

- a. the delivery of the professional care required to serve the child's specific treatment occurring on site; *and*
- b. documented commitment by the primary care givers (usually parent/guardian) to the treatment plan; *and*
- c. if endangerment/destruction is a relevant feature of the presenting problem, both adolescent and primary care giver develop a safety plan which at least the care giver signs;

AND

- 3. The severity and expression of the child's symptoms are such that:

- a. continuation with a less intense level of care cannot offer either an expectation of improvement, or prevention of deterioration, as identified above; *and*
- b. on-site intervention in the home or community offers a more effective preventive to longer term consequences.

D. MH - Level 4 (Highly Intensive)

Home/Community Professional Mental Health Services
 Home/Community Mental Health Therapeutic Support Services
 (Must meet 1, 2, & 3)

- 1) The severe functional impairment discussed in the presenting history and psychiatric examination is assessed in the child's problematic behavior in home, school or community and there is a high risk of an out-of-home or out-of-school placement, or a resumption of out-of-home/school placement for a child transitioning back to

home or school. In addition, there may be demonstrated risk of endangerment involving child harming self or others, or destruction to property, due to emotional or behavioral problems, or mental illness;

a. Must include at least one (1) of the criterion below:

- 1) Suicidal/homicidal threatening behavior or intensive ideation
- 2) Impulsivity and/or aggression
- 3) Psycho-physiological condition (i.e.- bulimia, anorexia nervosa)
- 4) Psychomotor retardation or excitation.
- 5) Affect/Function impairment (i.e.- withdrawn, reclusive, labile, reactivity)
- 6) Psychosocial functional impairment
- 7) Thought Impairment (i.e.- psychosis)
- 8) Cognitive Impairment; **and**

b. There is an exacerbation of severely impaired judgement or functional capacity and capability for the child's developmental level, which is not attributable to intellectual disabilities, such that interpersonal skills, and/or self-maintenance in home/school/community is/are severely compromised;

AND

2. Behavior is assessed to be manageable in the home/community setting, and degree of risk is assessed to be responsive to, and effectively reduced by the implementation of a treatment plan in the professional judgment of the advising physician or mental health professional , as a result of:

- a. the delivery of the professional care required to serve the child's specific treatment needs occurs on site; **and**
- b. there is documented commitment by the primary care givers (usually parent/guardian) to the therapeutic plan; **and**
- c. if endangerment/destruction is a relevant feature of the presenting problem, both adolescent and primary care giver develop a safety plan which, at least the care giver signs;

AND

3. The severity and expression of the child's symptoms are such that:

- a. continuation with a less intense level of care cannot offer either an expectation of improvement, or prevention of deterioration, as identified above; **and**
- b. on-site intervention in the home or community offers a more effective

preventive to longer term consequences.

III. SUPPORT CRITERIA

The on-site clinical expertise necessary must be available as appropriate to the SEVERITY OF SYMPTOMS or BEHAVIORS. There must be family commitment to the treatment process of the child or adolescent. The treatment must support community integrative objectives including development of the child/adolescent's network of personal, family, and community support.

IV. CONTINUED CARE

- A. Child must be reevaluated *and* continue to meet criteria for admission (Section I);
AND
- B. Child shows:
 - 1. measured improvement *and/or* begins to demonstrate alternative/replacement behaviors (show indicators in the evaluation);
or
 - 2. increased *or* continued behavioral disturbance with continued expectation for improvement (show rationale in the treatment plan);
AND
- C. Treatment plan is addressing the behavior within the context of the psychosocial stressor(s)/event(s);
AND
- D. Interagency service plan recommends continuation of care.

The child/adolescent must meet Admission Criteria for Section II, Level 3 or lesser levels of severity. Whenever service is provided for a term greater than three (3) months, there must be a quarterly review of the child being served which clarifies the child's progress, progress toward developing community linkages, and the necessity for continuing Home/community service rather than another service appropriate to the child's needs or discharge from behavioral health services altogether. The Interagency Service Plan must be updated and attached to the Treatment

Plan.

V. DISCHARGE AND SERVICE TRANSITION GUIDELINES

A. Mental Health

Prescriber, with the participation of the interagency team, determines that home/community service:

1. results in an expected level of stability and treatment goal attainment such that no additional home/community services are necessary and discharge occurs;

OR

2. should be maintained as follows:
 - a. continued at the current level; *or*
 - b. continued with a reduced number of hours as a result of the child's improvement, and/or the child's network of family and friends, and/or the activity of community members and services; *or*
 - c. increased due to changes in the context and/or adjustments in the treatment plan;

OR

3. ceases to be effective, requiring reassessment of services and alternative planning prior to authorization of any further home/community mental health services;

OR

4. interferes with the development of a service-independent lifestyle, requiring reassessment of the treatment plan and careful analysis of the benefits derived in light of the potential for problems created;

OR

5. A child admitted under Section IIB only, of the ADMISSION Guidelines must be discharged within fifteen (15) days of admission, unless a subsequent face-to-face psychiatric evaluation clarifies child's eligibility under Section IIA;

OR

B. Intellectual Disabilities

Prescriber, with the participation of the interagency team, determines that home/community service:

1. results in an expected level of stability and treatment goal attainment for the intervention such that the child meets:
 - a. baseline behavior, *or*
 - b. expected positive behavioral response, *and/or*
 - c. that no additional home/community services are necessary;

OR

2. should be:
 - a. discontinued because it ceases to be effective, requiring reassessment of services and alternative planning prior to authorization of any further home/community behavioral health services; *or*

- b. continued with a reduced number of hours as a result of the child's improvement, and/or the child's network of family and friends, and/or the activity of community members and services; *or*
- c. increased due to changes in the context and/or adjustments in the treatment plan;

OR

- 3. the services provided create a service dependency interfering with the development of the child's progress toward his/her highest functional level, requiring reassessment of the treatment plan and careful analysis of the benefits derived in light of the potential for problems created;

OR

C. The parent/guardian (or other legally responsible care giver if applicable) or adolescent, 14 years old or older, requests reduction in service or termination of the service.

TABLE 1

BEHAVIORAL HEALTH REHABILITATION SERVICES UNDER EPSDT:
Home/Community Services

**TABLE OF SECTION II SEVERITY LEVELS AND SERVICE CORRELATES WITH
CORRESPONDING PROPORTIONAL ORDERING OF TREATMENT HOURS**
(All Services Are to Be Determined On an Individual Basis for the Child or Adolescent)

(Table does not represent EPSDT psychosocial rehabilitative services provided on provider sites, such as After-school and Summer Therapeutic Activities Programs)

<u>Level 1 (Least)</u>	<u>Level 2 (Moderate)</u>	<u>Level 3 (Intensive)</u>	<u>Level 4 (Highly Intensive)</u>
(Must meet A, B, & C; OR D)	(Must meet A, B, & C; OR D)	(Must meet A, B, and C)	(Must meet A, B, and C)
I. & II. [Combined] DIAGNOSTIC INDICATORS BY LEVEL			
<p>A. Service must be recommended as the most clinically appropriate for the child, by the <i>prescriber</i>, as informed by the <i>interagency team</i>, and</p>	<p>A. Risk of harming [self, others, or property] is assessed low in the child's current problematic behavior or functional impairment and presenting history; and psychiatric or psychological examination must include:</p>	<p>A. Severe functional impairment is assessed in the child's problematic behavior in the home, school, or community; there is risk of an out-of-home or out-of-school placement; may be risk of danger of child harming him/herself, others, and/or demonstrated destruction to property; and</p>	<p>A. High risk of out of home placement, or demonstrated risk of endangerment, involving child harming self or others, or destruction to property, due to emotional or behavioral problems, or mental illness; and/or the severe functional impairment in the home, school, or community, and</p>
1. Children with a Diagnostic Indicator on AXIS I			
<p>a. There is serious and/or persistent impairment of developmental progression and/or psychosocial functioning due to a serious emotional disturbance or</p>	<p>a. Assessment of at least one (1) of the following: 1. Suicidal/homicidal ideation 2. Impulsivity and/or aggression</p>	<p>a. Assessment of at least one (1) of the following: 1. Suicidal/homicidal threats or intensive ideation 2. Impulsivity and/or aggression</p>	<p>a. Assessment of at least one (1) of the following: 1. Suicidal/homicidal threatening behavior or intensive ideation 2. Impulsivity and/or aggression</p>

TABLE 1

<u>Level 1 (Least)</u>	<u>Level 2 (Moderate)</u>	<u>Level 3 (Intensive)</u>	<u>Level 4 (Highly Intensive)</u>
<p>psychiatric disorder, requiring treatment to alleviate acute existing symptoms <u>and/or</u> behaviors;</p> <p>or to prevent relapse in the child for the prescribed period of time to allow the therapeutic process to hold its effectiveness with symptoms <u>and/or</u> behaviors which are in partial or complete remission;</p> <p>or</p> <p>b. Significant psychosocial stressors <u>and/or</u> medical condition increasing the risk that the child's functioning will decrease for his/her developmental level require home/community based intervention to develop resources within the child and/or family to provide the balance to these stressors needed to continue the child in remission;</p> <p>or</p> <p>c. Symptoms improve in response to comprehensive treatment at a higher level of care, but child is still in need of direct home/community based treatment to reinforce stability; or</p>	<p>3. Psycho-physiological condition (i.e.- bulimia, anorexia nervosa)</p> <p>4. Psychomotor retardation or excitation</p> <p>5. Affect/Function impairment (i.e.- withdrawn, reclusive, labile, reactivity)</p> <p>6. Psychosocial functional impairment</p> <p>7. Thought Impairment</p> <p>8. Cognitive Impairment</p> <p>and/or</p> <p>b. Presence of very impaired judgement or functional capacity and capability, for the child's developmental level, such that interpersonal skills, and/or self-maintenance in home/school/community is/are highly compromised, are not attributable to intellectual disabilities;</p>	<p>3. Psycho-physiological condition (i.e.- bulimia, anorexia nervosa)</p> <p>4. Psychomotor retardation or excitation.</p> <p>5. Affect/Function impairment (i.e.- withdrawn, reclusive, labile, reactivity)</p> <p>6. Psychosocial functional impairment</p> <p>7. Thought Impairment</p> <p>8. Cognitive Impairment</p> <p>and/or</p> <p>b. There is an exacerbation of severely impaired judgement or functional capacity and capability, for the child's developmental level, such that interpersonal skills, and/or self-maintenance in home/school /community is/are severely compromised, are not attributable to intellectual disabilities;</p>	<p>3. Psycho-physiological condition (i.e.- bulimia, anorexia nervosa)</p> <p>4. Psychomotor retardation or excitation.</p> <p>5. Affect/Function impairment (i.e.- withdrawn, reclusive, labile, reactivity)</p> <p>6. Psychosocial functional impairment</p> <p>7. Thought Impairment</p> <p>8. Cognitive Impairment</p> <p>and</p> <p>b. There is an exacerbation of severely impaired judgement or functional capacity and capability, for the child's developmental level, such that interpersonal skills, and/or self-maintenance in home/school /community is/are severely compromised, are not attributable to intellectual disabilities;</p>

TABLE 1

<u>Level 1 (Least)</u>	<u>Level 2 (Moderate)</u>	<u>Level 3 (Intensive)</u>	<u>Level 4 (Highly Intensive)</u>
<p>d. Requires medication and home/community based monitoring of medications to help the child (and family) understand the importance of adhering to the therapy recommended to mitigate the effects of the child's symptoms, and establish a pattern of following the prescription;</p>			
AND/OR	AND/OR		
<p>2.Children with a Diagnostic Indicator on AXIS II (without a diagnosis on Axis I)</p>			
<p>a. There is an onset of remarkable behaviors which could escalate to a crisis</p>	<p>a. There is an onset of remarkable or crisis behaviors.</p>		
<p>b. Behavior presents serious risk of self injury, or injury to others, or destruction of environment; <i>and</i></p>	<p>b. Behavior has resulted in self-injury, or injury to others, or destruction to environment; <i>and</i></p>		
<p>c. There is significant change from baseline behavior, or amplification in exhibited behaviors, as indicated by the frequency, intensity, duration, of the behavior(s), and/or locations where the behavior(s) occur(s); <i>and/or</i></p>			
<p>d. Requires medication and home/community based monitoring of medications to help the family, and the child, consistent with the child's age and cognitive abilities, to understand the importance of adhering to the therapy recommended to mitigate the effects of the child's symptoms, and establish a</p>			

TABLE 1

<u>Level 1 (Least)</u>	<u>Level 2 (Moderate)</u>	<u>Level 3 (Intensive)</u>	<u>Level 4 (Highly Intensive)</u>
<p>pattern of following the prescription;</p> <p>B. Behavior is assessed to be manageable in the home/community setting, and degree of risk is assessed to be responsive to, and effectively reduced by the implementation of a behavior management plan in the professional judgment of the advising physician or mental health professional, as a result of:</p>			
<p>1. the delivery of the professional care required to serve the child's specific treatment needs occurs on site; <i>and</i></p>			
<p>2. there is documented commitment by the primary care givers (usually parent/guardian) to the therapeutic plan.</p>	<i>and</i>		
	<p>3. if endangerment/destruction is a relevant feature of the presenting problem, both adolescent and primary care giver develop a safety plan which, at least the care giver signs.</p>	<p>3. if endangerment/destruction is a relevant feature of the presenting problem, both child or adolescent and primary care giver develop a safety plan which, at least the care giver signs.</p>	
AND			
<p>C. The severity and expression of the child's symptoms are such that::</p> <p>1. continuation with a less intense level of care cannot offer either an expectation of improvement, or prevention of deterioration, as identified above; <i>and</i></p> <p>2. on-site intervention in the home or community offers a more effective preventive to longer term consequences.</p> <p>D. OBSERVATION- 15 days</p> <p>1. Troubling symptoms of the child (described by family/ school/ others) persist though</p> <ul style="list-style-type: none"> - not observed on a psychiatric inpatient unit, <i>or</i> - they are denied by the child in outpatient or partial hospitalization treatment, <p>such that observation of the child in natural settings provides the opportunity to assess and treat the child; OR</p>			

TABLE 1

<u>Level 1 (Least)</u>	<u>Level 2 (Moderate)</u>	<u>Level 3 (Intensive)</u>	<u>Level 4 (Highly Intensive)</u>
<p>2. Child's symptoms have not sufficiently improved despite responsible comprehensive treatment in other levels of care, involving the interagency team.</p>			
<p>III. SUPPORT CRITERIA The on-site clinical expertise necessary must be available as appropriate to the SEVERITY OF BEHAVIORS. There must be family commitment to the treatment process of the child or adolescent. The treatment must support community integration objectives including development of the child/adolescent's network of personal, family, and community support.</p>			
<p>IV. CONTINUED CARE Whenever service is provided for a term greater than three (3) months, there must be at least a quarterly review of the child being served which clarifies the child's progress, progress toward developing community linkages, and the necessity for continuing home/community service.</p>			
<p>1. Child must be reevaluated <i>and</i> continue to meet criteria for admission (I); <i>and</i></p> <p>2. Child shows:</p> <p>a) measured improvement <i>and/or</i> begins to demonstrate alternative/replacement behaviors (show indicators in the evaluation); <i>or</i></p> <p>b) increased <i>or</i> continued behavioral or emotional disturbance with continued expectation for improvement (show rationale in the treatment plan); <i>and</i></p> <p>3. Review includes consideration/evaluation of alternative Levels of Care, therapeutic approaches, informal approaches, and resources.</p> <p>4. Treatment plan must be updated addressing the presenting problem within the context of the psychosocial stressor(s)/event(s); indicating that service should be:</p> <p>a) continued with a reduced number of hours as a result of the amelioration of original indication for service, <i>and/or</i> activity of community members and services, and/or the child's network of family and friends; <i>or</i></p> <p>b) increased due to changes in the context and/or adjustments in the treatment plan; <i>and</i></p> <p>5. Interagency service plan must be updated to reflect the recommendation to continue care and be attached to the treatment plan</p>			

TABLE 1

<p>V. DISCHARGE CRITERIA</p> <p>A. Prescriber, with the participation of the interagency team, determines that home/community service:</p> <ul style="list-style-type: none">1.results in an expected level of stability and treatment goal attainment for the intervention such that the child meets:<ul style="list-style-type: none">a. baseline behavior, <i>or</i>b. expected positive behavioral response, <i>and/or</i>c. that no additional home/community services are necessary; <p style="text-align: center;">OR</p> <ul style="list-style-type: none">2.should be discontinued because it <i>ceases to be effective</i>, requiring reassessment of services and alternative planning prior to authorization of any further home/community behavioral health services; <p style="text-align: center;">OR</p> <ul style="list-style-type: none">3.the services provided <i>create a service dependency interfering with the development of the child's progress toward his/her highest functional level</i>, requiring reassessment of the treatment plan and careful analysis of the benefits derived in light of the potential for problems created;
<p>B. The parent/guardian (or other legally responsible care giver if applicable) or adolescent, 14 years old or older, requests reduction in service or termination of the service.</p>

**MATRICES OF
CURRENT PROBLEMS AND CURRENT STRENGTHS
BY DOMAIN AND SETTING**

Matrix of Current Problems

Domain	Setting		
	Home	School	Community
Medical			
Behavioral			
Emotional			
Cognitive/Learning			
Interpersonal			
Leisure			
Unique/Other			

Matrix of Current Strengths

Domain	Setting		
	Home	School	Community
Medical			
Behavioral			
Emotional			
Cognitive/Learning			
Interpersonal			
Leisure			
Unique/Other			

REFERENCE FORM A

Expectations for All Individualized Community Based Enhanced Mental Health Services:

Individualized community based enhanced mental health services can be used in the home, community, or school, separately or in combination, as medically necessary. The child's emotional or behavioral disturbance should be carefully evaluated along the following parameters: thought, mood, affect, judgement, insight, impulse control, psychomotor retardation /excitation, physiological functioning, cognitive/perceptual abilities, psychosocial functioning as manifested in interpersonal and social skills, and motivation. Social contexts, such as home, school, and neighborhood/community must be understood in order to determine the appropriate sites of services as well as the resources within each context. Service planning determines the unique combination of individualized community based enhanced mental health services, other child serving systems and/or traditional mental health services.

The following represent specific expectations regarding the utilization of all individualized, community based enhanced mental health services subject to this document. Treatment and its documentation should be consistent with the following:

- Nature of emotional or behavioral disturbance, mental illness, or serious at-risk status is clear and is clearly demonstrated.
- Each proposed or utilized mental health service has a clearly documented rationale, with a specific role in addressing the child's medically necessary needs. Services, separably and in combination, constitute the least restrictive and least intrusive services which are medically necessary.
- Service decisions are substantially determined by an interagency process based on child-driven needs.
- Proposed treatment is demonstrated to meet identified, individualized needs and strengths, addressing child's development in multiple life domains.
- Ongoing efforts are being made to utilize community resources, whenever possible.
- Parents and guardians have requested or otherwise support the use of proposed services.
- Proposed treatment involves a plan, and subsequent demonstrated efforts to implement plan with active participation by parents, guardians, and other responsible adults.
- Treatment involves teaching and support of efforts by parents, guardians, and other responsible adults, and those activities specifically identified within the treatment plan as appropriate for involved mental health staff, rather than substitute care.
- Treatment involves ongoing integrated and supervised efforts by all service providers, which includes a lead case manager.

- Potential medication needs are being addressed or considered.
- Lack of improvement within a level of care is subject to careful clinical and systemic analysis by the team prior to either an increase or decrease of services or change in level of services.
- Exceptions to any of the above are clearly identified with explanation or rationale, and discussed with the interagency team.

REFERENCE FORM B

Function of Home/Community Services

- Provision of services which are less restrictive, more flexible yet effectively provides therapeutic supports for patients discharged from in-patient, residential treatment facilities, or partial hospitalization. In this way home/community services provide for the delivery of transitional care from a more restrictive setting.

- Prevent the need for more restrictive or higher level of services. To help the child develop the necessary self-control, *and/or* capacity for constructive expression, including cultivating more adaptive interpersonal skills for effective participation in the child's natural setting.

- Provision of service for children with mental and/or psychosocial disorders who require treatment directly in the setting where symptoms typically manifest, to remain stable and ensure the effectiveness of a treatment plan.

- Provision of after-school service for children with mental and/or psychosocial disorders, so that :
 - parents/guardians can develop the behavioral patterns necessary to provide the additional support necessary to maintain a therapeutic environment for the child;
 - parents/guardians can receive family therapy consistent with the treatment of their child.

- Should service involve a child removed from school during regular school hours, this service, and any subsequent plan to continue service during this time, must be documented with an explanation of the child's condition which necessitates such intervention.

- Treatment components include: major diagnostic evaluations, medical and psychiatric treatment, and psychosocial rehabilitation. Recognizing the responsibility of the Department of Education to provide an educational program for all children, the therapist must collaborate with the school or school district, but only when appropriate and as necessary to assist in the child's Individualized Education Plan when one has been or should be developed. Where such collaboration is desired but not possible the reasons must be clearly documented.

Treatment Range- Home/community treatment varies in intensity, duration and purpose. Intensity may be reflected in the number and length of visits as well as the professional level of the service. The duration and types of service offered will vary according to the severity of the child's symptomatology and the complexity of the intervention required as described in the treatment plan. The range of service includes therapeutic support identified in four levels corresponding with the levels of severity established for Severe (but Inpatient Treatment not required), Residential Treatment Facility, Partial Hospitalization, and Outpatient Treatment, where clinical judgement suggests that outpatient treatment is therapeutically necessary to return the child to, or maintain the child in a stable condition. Home/community treatment may serve as a step-down from inpatient treatment, a residential treatment facility, and partial hospitalization, and to prevent the need for a more restrictive treatment setting. It also serves children, and their families, experiencing distress who may need the therapeutic support of short term services to ameliorate the presiding condition or stress.

REFERENCE FORM C

Continued Stay Service Documentation **For Mental Health Services**

The following list of information should be documented for the four service levels.

1. Routine evaluations and treatment updates chart child's progress.
2. The establishment and documentation of active treatment must include, the implementation of the treatment plan, the therapy provided, documentation of the family's participation and interagency collaboration, cultural competency, and active discharge planning.
3. Current active treatment is focused upon stabilizing or reversing symptoms necessitating admission.
4. Current active treatment is focused on ameliorating symptoms and increasing the child's level of functioning.
5. The level of professional expertise and intervention are appropriate to address the child's current condition(s).
6. The initial discharge guidelines formulated for the child have been reviewed and revised, as necessary in the course of developing the discharge plan.
7. The treatment plan and strengths-based evaluation has been updated to reflect the child's progress, medication status, continuing needs and the provider's efforts to meet the identified needs. The treatment plan addresses any necessary therapeutic supports for the child's successful transition into the community, including mental health, substance abuse, intellectual disabilities and other community-based services, and the natural resources of the family. It incorporates a plan to form appropriate transitional linkages in preparation for discharge to less intrusive and non-restrictive services.
8. The treatment team programmatically reduces intensity of treatment as the child progresses toward the expected date of discharge, and through working with an interagency team forms linkages with community and family supports.
9. Type, duration and frequency of services provided to the child, and the outcome of each service must be well documented, i.e.- individual, group and family therapy; education, training and community involvement; family participation in treatment; any special activities; and medication administration and monitoring.
10. As the child improves clinically, active treatment facilitates and increases contact of the child with the community (including home and school) to which the child will return.

11. The provision of services supports the child's involvement in age appropriate activities and interests as outlined in the treatment plan.
12. In special programs where the child does not attend the local school, there must be a current Individualized Education Plan *and/or* plan to provide the child an educational program in collaboration with the local school or school district on record at the PRTF.
13. Family (parent, guardian or custodian) is actively involved in the treatment planning and/or process. Should conditions prevent the possibility of such involvement, attempts to involve parents and/or reasons explaining their non-involvement must be fully documented and presented to an interagency team.
14. Continued inpatient hospitalization **must** be recommended by the treatment team (to also include child, parent/guardian, case manager [when one is assigned], current treating or evaluating therapist).
15. All appropriate documentation follows the child as the child makes the transition to other therapeutic services, be they more or less intense.

REFERENCE FORM D

Community Integration Questionnaire

1. Are the **child's interest areas?** and **strengths?** documented, with a plan to **explore new interests and strength's** for the child?
 2. Have the **child's community and family support network, and cultural resources** been explored for the purpose of involving the child in his/her own community, and recorded?
 3. Has there been **recruitment of family members, or other significant individuals,** to participate as designated support persons
 4. Do you have a list of the **available services, events and activities** in the community? [Both the child's home community and the community surrounding the therapeutic center, if different].
 5. What activities has the child been **involved in** over the past two months? Is there a plan to **continue** this involvement?
 6. Does the **treatment plan** include community integrative activities, such as:
 - planned parental supervised activities?
 - age appropriate, child independent participation in planned community activities [such as: Traditional events/celebrations; school sponsored clubs and gatherings; extra-curricular classes (i.e. dance, music, martial arts, etc); church/community center/playground activities, etc.]?
 - opportunity for child-peer interaction in the community [such as: visits to neighborhood friends (including overnight visits); participation in peer group activities (such as: neighborhood "hoops", stick ball, parties and informal gatherings).
 - [other activities- specify in treatment plan].
- OR**, for children who may be more severely impaired:
- staff oversight of planned parental supervised activities?
 - staff supervised activities for parent/child interaction?
for child/community peer interaction?
 - staff supervised activities in the community?
 - planned reentry into the regular classroom (independently, or with a therapeutic staff support
7. Do you have a **plan of reinforcement** for a child's successful participation outside of the treatment setting? and a **crisis intervention plan** for the child while outside of the treatment setting?
 8. Do the **progress notes** detail the outcome of the home/community integrative activity?

9. Do you have a data gathering form or instrument to **measure the outcome** of a child's participation in a home/community activity?

10. Do you have a **plan to expand** the child's home/community/cultural participation?

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HEALTHCHOICES BEHAVIORAL HEALTH SERVICES
GUIDELINES for BEHAVIORAL HEALTH MEDICAL NECESSITY CRITERIA

CHILDREN AND ADOLESCENTS

The Family Based
Mental Health Services Program
(1st Edition)

INTRODUCTION:

The Family Based Mental Health Services Program (FBMHS) represents an important option within the array of services for children and adolescents up to age 21, and their families. Utilization of the FBMHS program occurs following referral for this service and the subsequent determination by the FBMHS treatment team that the service is clinically appropriate. FBMHS is available to children who are at risk for out-of-home placement due to a severe emotional or behavioral disorder, or due to a severe mental illness. FBMHS is also used as a step-down for children returning to their family, which may include natural or substitute care families, following out-of-home placement.

These Family Based Mental Health Services Program guidelines for medical necessity (and its subsequent revisions) provide a basis for the referral of children and their families for this service. [See FBMHS program standards in State Plan Under Title XIX of the Social Security Act, Amendment, Effective Date July 1, 1990 Attachment 3.1A, Section 13.(d)(I), available in the HealthChoices Proposers' Library].

PROGRAM PHILOSOPHY & ORGANIZATION:

Consistent with the CASSP principles and philosophy, the guiding tenets of FBMHS are that children grow-up best in their own home, that the family is a resource and partner in the treatment process, that treatment utilizes strengths in addressing areas of need and concern, and

that coordination among other human service systems and with the community is essential. In addition, while the child receives treatment, services also work to enhance the family role as a resource and partner in the treatment process.

The Family Based Mental Health Services Program is a discrete service provided by a team composed of either two child mental health professionals or one child mental health professional and a child mental health worker, which is comprehensive in scope, incorporating intensive home therapy, casework services, family support services and 24 hour, 7 day availability for crisis stabilization. Each team maintains a caseload of up to eight (8) families to ensure the intensity of service and team availability to the families they serve. Team members receive supervision together as an integral part of an ongoing program for the families served. In addition, there is an ongoing training curriculum that extends over a three year period designed specifically for Family Based Mental Health Service Team members.

The service is broadly conceived for flexible use in the home and community. The specific frequency and schedule of face-to-face contacts are developed collaboratively with the family, based on needs at that time. This allows the team to provide for individual family needs when they are closely associated with the child's treatment, such as time for family education/training regarding therapeutic components and skill building for the child and family. The team also works with the family to identify resources available to them. Teams are available to provide 24 hour service, and they also work with other systems when they are involved with the child and family, such as Drug and Alcohol Services, Children and Youth, Juvenile Justice, special education, etc. Clinical treatment within FBMHS is guided by the recognition of the normal growth and development of children at different ages, and supports family caretaking and functioning through collaborative, conjoint family meetings, which can include different combinations of family members and community members as indicated. Due to its commitment to support both the development of children and the integrity of the family, FBMHS, while primarily treatment, also serves a preventive function. The needs of all the children within a family, not just the child in response to whom services were initiated, are actively considered and included as part of the treatment process.

Services offered by the FBMHS program include formal individual and family therapy sessions with the child and/or family. In addition, program service requirements include the following:

- Crisis intervention and stabilization;
- Emergency availability;

- Ongoing information-gathering in support of active treatment;
- Collaborative development and modification of the treatment plan;
- Clinical intervention by each team member with the child in attaining identified treatment goals and objectives within the treatment plan, including: remediation of child's symptoms (i.e. behavioral, affective, cognitive, thought impairments, etc.), improvement of family relationships, community integration, and other aspects of psychosocial competence and skill development in the home, school, or community;
- Support for the parents in implementing effective behavior management and parenting approaches specific to the presenting problems of their child;
- School-based consultation and intervention as needed;
- Referral, coordination, and linkage to other agencies, social services, and community services, as appropriate;
- Assistance in obtaining relief services such as babysitters, homemakers, respite care and supportive services such as transportation and recreation, and developing a network in order to receive these services.

The Family Support Service (FSS) is a requirement in the Family Based Mental Health Services Program under Health Choices. Family-Based Family Support Services (FBMHS) are formal and informal services or tangible goods which are needed to enable a family to care for and live with a child who has a serious emotional disturbance. FBMHS/FSS include supportive services and tangible goods, which facilitate achievement of the child's treatment goals. If a child is in temporary out-of-home placement, FBMHS/FSS should be used to facilitate the return of the child to the natural family and in this instance should be available to both the natural family as well as the foster family.

A cost component for FBMH/FSS is built into the HealthChoices capitation rate. As such, it is recommended that the provider and the BH-MCO agree to a method for setting aside an appropriate percentage of the FBMHS provider fee for the purchase of services or goods needed to further the child's treatment goals.

The FBMHS budget identifies administrative and program costs which include family support services.

- The FBMHS unit of service is billed for activities or direct services which are provided by the Family-Based team members using existing procedure codes. Only such FBMHS units are reported as encounter data.
- There is no separate reporting requirement for FBMH Family Support Services.
- The provider must have an accounting system that identifies revenue sources and expenditures.

ADMISSION CRITERIA

(Must meet I and II)

I. DIAGNOSTIC EVALUATION AND DOCUMENTATION

A. Diagnosis on DSM IV Axis I or Axis II, as part of a complete multi-axial, face-to-face assessment (MR or D&A cannot stand alone), by a Mental Health Professional (see Title 55. Public Welfare § 5200.3). A psychiatrist, physician or licensed psychologist determines that the child is eligible and recommends the FBMHS program (State Plan Under Title XIX of the Social Security Act, Amendment, Effective Date July 1, 1990 Attachment 3.1A, Section 13.(d)(I));

AND

B. Other less restrictive, less intrusive services have been provided and continuation in this less intensive level of care cannot offer either an expectation of improvement or prevention of deterioration of the child's and the family's condition;

OR

Child has been discharged from an Inpatient Hospitalization or a Residential Treatment Facility, and other less restrictive, less intrusive services cannot offer either an expectation of improvement or prevention of deterioration of the child's and the family's condition;

AND

C. Behaviors indicate manageable risk for safety to self/others and child must not require treatment in an inpatient setting or a psychiatric residential treatment facility.

II. SEVERITY OF SYMPTOMS

A. Treatment is determined by the treatment team to be necessary in the context of the family in order to effectively treat the child,

AND

1. the family recognizes the child's risk of out of home placement and the problem of maintaining their child at home without intensive therapeutic interventions in the context of the family;

AND/OR

2. the child is returning home and FBMHS is needed as a step down from an out-of-home placement;

AND

B. The child's problematic behavior and/or severe functional impairment discussed in the presenting history and psychiatric/psychological examination must include at least one (1) of the following:

1. Suicidal/homicidal ideation
2. Impulsivity and/or aggression
3. Psycho-physiological condition (i.e.- bulimia, anorexia nervosa)
4. Psychomotor retardation or excitation.
5. Affect/Function impairment (i.e.- withdrawn, reclusive, labile, reactivity)
6. Psychosocial functional impairment
7. Thought Impairment
8. Cognitive Impairment

AND

C. Following referral, service must be recommended as the most clinically appropriate and least restrictive service available for the child, by the FBMHS treatment team. Parent(s)/guardian(s), and/or caretaker, as appropriate, case manager (when assigned) and the child must be involved in the planning process;

AND

D. There is serious and/or persistent impairment of developmental progression and/or psychosocial functioning due to a psychiatric disorder or serious emotional disturbance, requiring treatment in the home and family involvement to alleviate acute existing symptoms and/or behaviors; or to prevent relapse in the child with symptoms and/or behaviors which are in partial or tentative remission;

OR

E. There is an exacerbation of severely impaired judgement or functional capacity and capability, for the child's developmental level, such that interpersonal skills, and/or self-maintenance in the home is severely compromised, and intervention involving the child and family is necessary;

OR

F. Significant psychosocial stressors are affecting the child and the family as a whole, increase the risk that the child's functioning will decrease for his/her developmental level;

OR

G. Symptoms improve in response to comprehensive treatment at a higher level of care, but child needs FBMHS to sustain and reinforce stability while completing the transition back to home and community.

REQUIREMENTS FOR CONTINUED CARE

(Must meet I and II)

I. DIAGNOSTIC EVALUATION AND RECOMMENDATION

A. Recommendation to continue FBMHS must occur:

1. by the treatment team every 30 days through an updated and revised treatment plan, and
2. by a psychiatrist, licensed psychologist, or physician at the end of 32 weeks, with an updated diagnosis;

AND

B. There is significant family (including the child) cooperation and involvement in the treatment process.

AND

- C. An updated treatment plan by the treatment team indicates child's progress toward goals, the progress of the child and family as a unit, and revision of goals to reflect documented changes, and the child and family involvement in the treatment planning process.

II. SEVERITY OF SYMPTOMS

- A. Child and the family are making progress toward goals, and the treatment team review recommends continued stay;

OR

- B. The presenting conditions, symptoms or behaviors continue, such that family and natural community supports alone are insufficient to stabilize the child's condition;

OR

- C. The appearance of new conditions, symptoms or behaviors meeting the admission criteria.

III. SUPPORT CRITERIA

The on-site clinical expertise necessary must be available as appropriate to the SEVERITY OF BEHAVIORS. There must be family commitment to the treatment process of the child or adolescent. The treatment must support community integrative objectives including development of the child/adolescent's network of personal, family, and community support.

IV. CONTINUED CARE DOCUMENTATION

- A. Child must be reevaluated every 30 days for the purpose of updating the treatment plan and continue to meet Requirements for Continued Care.

- 1. The review of the child being served must:

- a) clarify the child's progress within the family context and progress toward developing community linkages; and
 - 1) clarify the goals in continuing FBMHS; and
 - 2) the need for continuing FBMHS if continuation beyond 32 weeks is recommended; and

- b) whenever FBMHS service is considered for a term greater than 32 weeks:

- 1) a psychiatrist, licensed psychologist, or physician must update the diagnosis; and
- 2) review includes consideration/evaluation of alternative Levels of Care, therapeutic approaches, informal approaches, and resources; and

B. Child demonstrates:

1. measured improvement *and/or* begins to demonstrate alternative/replacement behaviors (document indicators in the evaluation); *or*
2. increased *or* continued behavioral disturbance with continued expectation for improvement (indicate rationale in the treatment plan);
and

C. Treatment plan is addressing the behavior within the context of the child's problem and/or contributing psychosocial stressor(s)/event(s);
and

D. Treatment plan is updated to reflect recommendation to continue care.

V. DISCHARGE AND SERVICE TRANSITION GUIDELINES

A. The treatment team, determines that FBMHS:

1. up to 32 weeks of FBMHS services has been completed; and/or
2. the service results in an expected level of stability and treatment goal attainment for the intervention such the child meets:
 - a) expected behavioral response, and/or
 - b) the FBMHS program is no longer necessary in favor of a reduced level of support provided by other services, or
3. FBMHS should be discontinued because it ceases to be effective, requiring reassessment of services and alternative planning prior to offering further FBMHS; or
4. creates a service dependency interfering with the family-child development and the development of the child's progress toward his/her highest functional level; requiring reassessment of the treatment plan and careful analysis of the benefits derived in light of the potential for problems created;

OR

B. The parent/guardian (or other legally responsible care giver if applicable) or adolescent (14 years old or older) requests a reduction in service or complete termination of the service.

TABLE OF FAMILY BASED MENTAL HEALTH SERVICES PROGRAM ADMISSION CRITERIA

<p>Family Based Mental Health Services (Must meet I/II and III)</p>	
<p>I. & II. [Combined] DIAGNOSTIC INDICATORS [Axis I or Axis II; D&A on Axis I, and MR on Axis II do not stand alone] (Must meet A, B, C & D)</p>	<p>A. Service must be recommended as the most clinically appropriate for the child, by the prescriber, as informed by the treatment team as an alternative to out-of-home placement or as a step down from inpatient hospitalization or Residential Treatment, or as a result of little or no progress in a less restrictive/intrusive service,</p>
<p>AND</p>	
<p>B. Severe functional impairment is assessed in the child’s presenting behavior. The intensity of service is determined on an individualized basis according to the following parameters: severity of functional impairments, risk of out-of-home placement, and risk of endangerment to self, others or property.</p>	<p>1. There is serious <u>and/or</u> persistent impairment of developmental progression <u>and/or</u> psychosocial functioning due to a psychiatric disorder or serious emotional disturbance, requiring treatment to alleviate acute existing symptoms <u>and/or</u> behaviors; or to prevent relapse in the child for the prescribed period of time to allow the therapeutic process to hold its effectiveness with symptoms <u>and/or</u> behaviors which are in partial or complete remission; and</p> <p>2. Treatment is determined by the treatment team to be necessary in the context of the family in order to effectively treat the child, and</p> <p>a. the family recognizes the child's risk of out-of-home placement and the problem of maintaining their child at home without intensive therapeutic interventions in the context of the family; and/or</p>

Family Based Mental Health Services

(Must meet I/II and III)

b. the child is returning home and FBMHS is needed as a step down from an out-of-home placement; and

3. Presence of at least one (1) of the following:

- a. Suicidal/homicidal threatening behavior or intensive ideation
- b. Impulsivity and/or aggression
- c. Psycho-physiological condition (i.e.- bulimia, anorexia nervosa)
- d. Psychomotor retardation or excitation.
- e. Affect/Function impairment (i.e.- withdrawn, reclusive, labile, reactivity)
- f. Psychosocial functional impairment
- g. Thought Impairment
- h. Cognitive Impairment

and

4. There is an exacerbation of severely impaired judgement or functional capacity and capability, for the child's developmental level, such that interpersonal skills, and/or self-maintenance in home/school /community is/are severely compromised; and

5. Following referral, service must be recommended as the most clinically appropriate and least restrictive service available for the child, by the FBMHS treatment team. Parent(s)/guardian(s), and/or caretaker, as appropriate, case manager (when assigned) and the child must be involved in the planning process; and

6. Significant psychosocial stressors are affecting the child and the family as a whole, increase the risk that the child's functioning will decrease for his/her developmental level;

Family Based Mental Health Services

(Must meet I/II and III)

or

7. Symptoms improve in response to comprehensive treatment at a higher level of care, but child needs FBMHS to sustain and reinforce stability while completing the transition back to home and community.

AND

C. Behavior is assessed to be manageable in the home setting, and degree of risk is assessed to be responsive to, and effectively reduced by the implementation of the treatment plan, as a result of:

1. the delivery of the therapy and casework services in the home, required to serve the child's specific treatment needs;
and

2. there is documented commitment by the family to the treatment plan
and

3. if endangerment/destruction is a relevant feature of the presenting problem, both child or adolescent (age 14+) and family member develop a **safety plan** which, the family member signs.

AND

D. The severity and expression of the child's symptoms are such that:

1. continuation with a less intense level of care cannot offer either an expectation of improvement, or prevention of deterioration, as identified above;
and
2. on-site intervention in the home or community offers a more effective preventive to longer term consequences.

Family Based Mental Health Services

(Must meet I/II and III)

III. SUPPORT CRITERIA

The on-site clinical expertise necessary must be available as appropriate to the SEVERITY OF BEHAVIORS. There must be family commitment to the treatment process of the child or adolescent. The treatment must support community integrative objectives including development of the child/adolescent's network of personal, family, and community support.

IV. CONTINUED CARE

Child must be reevaluated every 30 days for the purpose of updating the child's progress, progress toward developing community linkages, and the necessity for continuing Family Based Mental Health Services in the treatment plan.

A. The review of the child being served must:

1. clarify the child's progress in treatment, within the family context, and toward developing community linkages; and
 - a. clarify the goals in continuing FBMHS; and
 - b. the need for continuing FBMHS, if continuation beyond 32 weeks is recommended; *and*
2. whenever FBMHS service is considered for a term greater than 32 weeks:
 - a. a psychiatrist, licensed psychologist, or physician must revise and/or update the diagnosis; *and*
 - b. review includes consideration/evaluation of alternative Levels of Care, therapeutic approaches, informal approaches, and resources;

AND

B. Treatment plan is updated to reflect the recommendation to continue care.

AND

C. Treatment plan is addresses the presenting problem within the context of the family and/or contributing psychosocial stressor(s)/event(s); *and*

AND

D. Child demonstrates:

1. measured improvement *and/or* begins to demonstrate alternative/replacement behaviors (document indicators in the evaluation);

or
2. increased *or* continued behavioral or emotional disturbance with continued expectation for improvement (indicate rationale in the treatment plan);

V. DISCHARGE CRITERIA

A. Prescriber, with the participation of the interagency team, determines that:

1. Up to 32 weeks of FBMHS services has been completed;
and/or
2. The service results in an expected level of stability and treatment goal attainment for the intervention such that the child meets:
 - a. expected positive behavioral response; *and/or*
 - b. FBMHS are no longer necessary in favor of a reduced level of support provided by other services;
or
3. FBMHS should be discontinued because it *ceases to be effective*, requiring reassessment of services and alternative planning prior to authorization of any further Family Based Mental Health Services;
or
4. the services provided create a service dependency interfering with the family-child development and the development of the child's progress toward his/her highest functional level; requiring reassessment of the treatment plan and careful analysis of the benefits derived in light of the potential for problems created;
or

AND

B. The parent/guardian or adolescent, 14 years old or older, requests reduction in service or termination of the service.

HEALTHCHOICES BEHAVIORAL HEALTH SERVICES
GUIDELINES for MENTAL HEALTH SERVICE NECESSITY CRITERIA

CHILD/ADOLESCENT

TARGETED CASE MANAGEMENT SERVICES

Admission Criteria

An individual who meets the minimum staff requirements for an Intensive Case Manager as defined by Chapter 5221, Mental Health Intensive Case Management; or a Resource Coordinator as defined by Mental Health Bulletin OMH-93-09 —Resource Coordination: Implementation; or a **Blended Case Manager** as defined by Office of Mental Health and Substance Abuse Bulletin OMHSAS-10-03 Blended Case Management (BCM) - Revised and has received training on the use of the environmental matrix has conducted an evaluation and has determined that:

- I. The child/adolescent meets either the eligibility criteria for Resource Coordination Services as defined by Mental Health Bulletin OMH-93-09 —Resource Coordination: Implementation; or Intensive Case Management Services as defined by Chapter 5221, Mental Health Intensive Case Management; or **Blended Case Management as defined by Office of Mental Health and Substance Abuse Bulletin OMHSAS-10-03 Blended Case Management (BCM) - Revised;**

or

- II. **The child/adolescent meets the criteria for serious emotional disturbance (SED) as described in *Federal Register Volume 58 No. 96, May 20, 1993, pages 29422-29425;***

and

- III. The child/adolescent is in need of Targeted Case Management Services as indicated by the evaluation of the functional level through utilization of the Targeted Case Management — Child/Adolescent Environmental Matrix and in conjunction with clinical information and the professional judgement of the reviewer.

Continued Stay and/or Change of Level of Need

The child/adolescent and his/her family and/or guardian, or caregiver/natural support must be reassessed at the point of concurrent review, but no less frequently than six month intervals, and when there are significant changes in the individual's situation that warrants a change in level of TCM services.

- I. The child/adolescent continues to meet either I or II of Admission Criteria.

and
- II. The child/adolescent is in need of Targeted Case Management Services as indicated by the evaluation of the functional level through utilization of the *Targeted Case Management — Child/Adolescent Environmental Matrix* and in conjunction with clinical information and the professional judgement of the reviewer

Discharge Indicators

Targeted Case Management may be terminated when one of the following criteria is met:

- A. The child/adolescent or family receiving the service determines that targeted case management is no longer needed or wanted and the child/adolescent no longer meets the continued stay criteria; or
- B. Determination by the targeted case manager in consultation with his/her supervisor or the director of targeted case management, and with written concurrence by the county administrator that targeted case management is no longer necessary or appropriate for the child/adolescent receiving the service and the child/adolescent no longer meets the continued stay criteria; or
- C. The child/adolescent or family receiving the service determines that targeted case management is no longer wanted, even though, the child/adolescent does meet continued stay criteria; or
- D. the child/adolescent and family has moved outside of the current geographical service area (e.g., county, state, country).

TCM ENVIRONMENTAL MATRIX —CHILDREN INSTRUCTIONS

The Environmental Matrix — Children is a scale that evaluates the functional and need levels of children and adolescents who are under the age of 18 years old or who are over 18 years of age but who are still attending a school program. *Note: Adolescents age 16 – 22 may be assessed on either the child/adolescent environmental matrix or the adult environmental matrix, depending on the adolescent’s current circumstances. The parent/guardian and adolescent, in discussion with the reviewer, should determine which Environmental Matrix will be used.* The child/adolescent and family and/or guardian or care giver/natural support must be assessed in a face to face interview assessment with the evaluator. Cultural competency will be recognized throughout the entire evaluation process and the entire document. Individuals should be reassessed as needed, but no less than every six months. There are ten (10) assessment areas identified in relationship to Targeted Case Management services:

1. Accessing Mental Health Services
 2. Informal Support Network Building
 3. Education/Vocation
 4. Children and Youth System Involvement
 5. Juvenile Justice/Criminal Justice System Involvement
 6. Parent/Guardian and/or Other Family Members with Significant Family Needs.
 7. Drug and Alcohol System Involvement
 8. Mental Retardation System Involvement
 9. Physical Health System Involvement
 - 10a. At Risk of Out-of-Home Placement
- Or**
- 10b. Currently in RTF, Other Out of Home Placements or Inpatient

Please note: Although items 10a. and 10b. both deal with residential placement, scoring is done for **only one of the items, either** item 10a. **or** item 10b., since only one of these items can be relevant to the child/adolescent’s current residential status.

The scale has a range from 0 to 5 with the following values for each activity:

0	1	2	3	4	5
No assistance needed	Minimum of assistance needed		Needs moderate assistance in this area		Needs significant assistance in this area

Appendix T
Part B (4)

All ten assessment areas are ranked on the above scale. The evaluator must complete the environmental matrix in a face-to-face, strengths-based assessment interview with the child/adolescent and his/her family and/or guardian, or care giver/natural support. Evaluators should incorporate in their assessment a recognition/determination of cultural strengths (i.e., extended family, resourcefulness and responsibility). The evaluator should consider the child's/adolescent's and parent's/guardian's (family) strengths and needs in the following life domains for each assessment area in order to produce a score that reflects the full dimension of need:

- . Housing/living situation
- . Income/benefits/financial management
- . Socialization/support
- . Activities of daily living
- . Medical treatment

Each assessment area is defined at the “ 1”, “ 3 ”, and “ 5 ” levels (See attached Environmental Matrix) and the subtotal score is divided by 10 to obtain the EM Score (when scoring the individual, refer to the Environmental Matrix TCM Scoring Grid which identifies the expected frequency of TCM contact needed for the individual for that particular assessment area). Scoring levels may be gradated to the 0.5 level only; this allows for minor differentiation of the child's/adolescent's needs without compromising the integrity of the scale.

Looking at the behavior, inclusive of the lowest level of functioning, and situation of the child/adolescent during the last ninety (90) days, rate the child's/adolescent's need for TCM in each of the ten areas. Please note that the rating for each area should be made in whole numbers; in cases where there are extraordinary factors that make the assignment of whole numbers extremely difficult, if not impossible, 0.5 points may be added to or subtracted from the base scores. The sum of the ten (10) scores should then be taken and divided by 10 and the resulting subtotal score should be reviewed and compared to other known factors that may affect the consumer's need for service. Note: If a particular assessment area does not apply to the individual being assessed, a score should not be given for that assessment area and the total score should be divided by the number of assessment areas scored. This should be noted on the scoring sheet. If after averaging the scores, the average is lower by at least 2 points than any one value given in any one assessment area (e.g., if a person's average is 2 and he/she received a score of 4 in any one area), the evaluator must provide written justification for assignment to the level that corresponds to the average, rather than the higher value. The Environmental Matrix score, your *professional judgement* *, and other information (e.g., cultural factors, records of past treatment, etc.) that impacts on the child's/adolescent's level of need should then be considered and the recommended level of TCM service should be entered on the recommended level of TCM line of the scoring sheet. (These levels are consistent with minimum levels of contact as defined

in Chapter 5221, *Intensive Case Management* regulations and bulletin *OMH-93-09, Resource Coordination: Implementation*.) If the recommended level of TCM services differs from the Environmental Matrix Score, the difference must be justified with professional judgement in the “Other Factors/Issues Affecting Score” section of the scoring sheet. **Note: The level of service indicated by the assessment represents the individuals needs at the time of the assessment. Service intensity could change as an individual’s needs and/or desires for service change.**

Please note:

**ENVIRONMENTAL MATRIX — CHILD/ADOLESCENT
TCM SERVICE SCORING GRID**

MATRIX LEVEL	NEED LEVEL	INTENSITY OF CARE
4.0 –5.0	ICM	At least 1 contact every 14 days (Face to face contact strongly recommended).
1.5 –3.9	RC	At least 1 contact every 30 days (Face to Face)
0.0 - 1.4	NO TCM NEEDED	Alternative services may be needed and if necessary, referrals should be made.

** professional judgement: opinion based on a thorough and ethical analysis of facts, data, history, and issues in accordance with one’s training and experience.*

ACCESSING MENTAL HEALTH SERVICES

Child’s/adolescent’s mental health problems require mental health services and the family requires help to access them. The TCM should take into consideration that the behavioral health system may pose a number of barriers which serve as obstacles to assessing services (e.g., language, perceived/actual institutional racism/discrimination, the family may mistrust the behavioral health system, the family may lack the capability to access services, the family may lack information, be overwhelmed, poorly informed about the benefits of such services, or intimidated by the system). The TCM is instrumental in assuring that the child/adolescent receives the necessary services for therapy, medication monitoring, etc.

**The decision for level of TCM needed in this area must be determined in collaboration with family and/or guardian, or care giver/natural support and child/adolescent.*

0	1	2	3	4	5
	Needs minimal assistance in this area		Needs moderate assistance in this area		Needs significant assistance in this area

- 0=** Parent/guardian and child/adolescent does not require/desire any assistance in this area.

- 1=** Parent/guardian and child/adolescent requires/desires a minimal level of assistance, guidance and support to obtain mental health and other essential services to meet the child's/adolescent's multiple needs.

- 3=** Parent/guardian and child/adolescent requires/desires a moderate level of assistance, guidance and support to obtain mental health and other essential services to meet the child's/adolescent's multiple needs.

- 5=** Parent/guardian and child/adolescent requires/desires a significant level of assistance, guidance and support to obtain mental health and other essential services to meet the child's/adolescent's multiple needs.

INFORMAL SUPPORT NETWORK BUILDING

The child/adolescent and parent/guardian identifies, communicates, and interacts with family, friends, significant others, and community groups from whom the child/adolescent may gain informal support. Service system barriers and other factors, however, may impede the child/adolescent and parent/guardian from interacting with family, friends, significant others and community groups. The child/adolescent may need assistance to challenge and remove barriers so as to enhance the informal building of supports. The child/adolescent may need the assistance of the targeted case manager and/or others to identify, enhance and/or maintain existing relationships and the encouragement to develop new ones.

*The decision for level of TCM needed in this area must be determined in collaboration with family and/or guardian, or care giver/natural support and child/adolescent.

0	1	2	3	4	5
	Needs minimal assistance in this area		Needs moderate assistance in this area		Needs significant assistance in this area

- 0=** Parent/guardian and child/adolescent does not require/desire any assistance in this area.

- 1=** Child/adolescent is able to identify and provide meaningful/accurate/relevant information about family, friends, significant others, and social/religious groups with whom he/she interacts and from whom the child/adolescent may gain informal support. The parent/guardian and child/adolescent requires and/or desires minimal assistance, to access and maintain positive relationships with these people and groups who provide personal social support and/or companionship.

- 3=** Child/adolescent needs and/or requests moderate assistance in identifying and communicating with family, friends, significant others, and social/religious groups from whom the child/adolescent may gain informal support. The parent/guardian and child/adolescent requires and/or desires moderate assistance from others in order to enhance and/or maintain existing relationships and to develop new ones.

- 5=** Child/adolescent is unable to identify nor interact with family, friends, significant others, and/or social/religious groups who may serve as personal supports. The child/adolescent has few, if any, personal or familial relationships and is unable/unwilling to interact positively, if at all, with these persons or groups. The parent/guardian and child/adolescent requires and/or desires significant assistance from others to elicit information and support on his/her behalf.

EDUCATION/VOCATION

The need for additional or more appropriate educational and/or vocational services, based on the needs of the child/adolescent, including a more appropriate educational and/or vocational placement, may require school meetings, IEP meetings, meetings with the Office of Vocational Rehabilitation or other vocational planning or service groups (e.g., vocational service providers), advocacy for the child's/adolescent's needs and providing information to the parent/guardian

regarding their rights in determining the appropriate education/vocational setting for their child/adolescent. The child/adolescent should have everything that is necessary to be successful in an educational and/or vocational environment, including access to the family’s primary language for all meetings. TCM assists the parent/guardian in accessing educational and/or vocational advocacy and obtaining the appropriate education and/or vocational training for the child/adolescent and offers support in conflicts between the school and parent/guardian concerning the child/adolescent’s needs and services to be provided.

*The decision for level of TCM needed in this area must be determined in collaboration with family and/or guardian, or care giver/natural support and child/adolescent.

0	1	2	3	4	5
	Needs minimal assistance in this area		Needs moderate assistance in this area		Needs significant assistance in this area

0= Parent/guardian and child/adolescent does not require/desire any assistance in this area.

1= Parent/guardian and child/adolescent requires/desires a minimal level of assistance, guidance and advocacy to obtain support for and to maintain appropriate educational services.

3= Parent/guardian and child/adolescent requires/desires a moderate level of assistance, guidance and advocacy to obtain support for and to maintain appropriate educational services.

5= Parent/guardian and child/adolescent requires/desires a significant level of assistance, guidance and advocacy to obtain support for and to maintain appropriate educational services.

CHILDREN AND YOUTH SYSTEM INVOLVEMENT

TCM may assist family in working with CYS and meeting CYS requirements for the parent/guardian or care giver/natural support and their child/adolescent with serious emotional disturbances. TCM assists the family in responding to the

CYS family services plan. TCM may be needed to assure collaboration between the Children and Youth and Mental Health systems and a need for collaboration among multiple providers from these two systems. TCM may also participate in court processes for the family and the child/adolescent.

**The decision for level of TCM needed in this area must be determined in collaboration with family and/or guardian, or care giver/natural support and child/adolescent.*

0	1	2	3	4	5
	Needs minimal assistance in this area		Needs moderate assistance in this area		Needs significant assistance in this area

N/A= Parent/Guardian and child/adolescent does not need/have involvement with the Children and Youth System.

0= Parent/guardian and child/adolescent does not require/desire any assistance in this area.

1= Parent/guardian and child/adolescent requires/desires a minimal level of assistance, guidance and support from TCM to carry out the goals of CYS plan, maintain a safe and healthy environment and assure child's/adolescent's participation in mental health services.

3= Parent/guardian and child/adolescent requires/desires a moderate level of assistance, guidance and support from TCM to carry out the goals of CYS plan, maintain a safe and healthy environment and assure child's/adolescent's participation in mental health services.

5= Parent/guardian and child/adolescent requires/desires a significant level of assistance, guidance and support from TCM to carry out the goals of CYS plan, maintain a safe and healthy environment and assure child's/adolescent's participation in mental health services.

JUVENILE JUSTICE/CRIMINAL JUSTICE SYSTEM INVOLVEMENT

A child or adolescent with a serious emotional disturbance who demonstrates delinquent behavior and/or is not compliant with probation and mental health service needs may require TCM support in addition to probation services. TCM uses his/her ongoing relationship with the child/adolescent and family to encourage compliance with the probation plan and participation in mental health services. TCM may be needed to assure collaboration between the Juvenile Justice/Criminal Justice and Mental Health systems. The TCM may also participate in court processes with family/juvenile.

**The decision for level of TCM needed in this area must be determined in collaboration with family and/or guardian, or care giver/natural support and child/adolescent.*

0	1	2	3	4	5
	Needs minimal assistance in this area		Needs moderate assistance in this area		Needs significant assistance in this area

N/A= Parent/Guardian and child/adolescent does not need/have involvement with the Juvenile Justice/Criminal Justice System.

0= Parent/guardian and child/adolescent does not require/desire any assistance in this area.

1= Parent/guardian and child/adolescent requires/desires minimal level of assistance, guidance, advocacy, support and TCM involvement to assure child's/adolescent's cooperation with the probation plan.

3= Parent/guardian and child/adolescent requires/desires moderate level of assistance, guidance, advocacy, support and TCM involvement to assure child's/adolescent's cooperation with the probation plan.

5= Parent/guardian and child/adolescent requires/desires a significant level of assistance, guidance, advocacy, support and TCM involvement to assure child's/adolescent's cooperation with the probation plan.

**PARENT/GUARDIAN AND/OR OTHER FAMILY MEMBERS WITH
SIGNIFICANT FAMILY NEEDS**

Other members of the family may have individual needs that have a serious impact on the child/adolescent’s ability to function at home and in the community. Other family members may have chronic mental illness, serious emotional disturbances, substance abuse problems, and/or physical illness that combine to compromise caretaker availability to the child. TCM provides culturally consistent and language appropriate service to the child/adolescent and family, assuring access and participation in services, including mental health services.

**The decision for level of TCM needed in this area must be determined in collaboration with family and/or guardian, or care giver/natural support and child/adolescent.*

0	1	2	3	4	5
	Needs minimal assistance in this area		Needs moderate assistance in this area		Needs significant assistance in this area

- 0=** Parent/guardian and child/adolescent does not require/desire any assistance in this area.
- 1=** Other family members may have mental illness, serious emotional disturbance, physical illness, or substance abuse problems and/or there are significant family needs which may require or the family may desire a minimal level of TCM services to support the family in meeting the child’s/adolescent’s basic living needs and emotional well-being.
- 3=** Other family members may have mental illness, serious emotional disturbance, physical illness, or substance abuse problems and/or there are significant family needs which may require or the family may desire a moderate level of TCM services to support the family in meeting the child’s/adolescent’s basic living needs and emotional well-being.
- 5=** Other family members may have a mental illness, serious emotional disturbance, physical illness, or substance abuse problems and/or there are significant family needs which may require or the family may desire a significant level of TCM services to support the family in meeting the child’s/adolescent’s basic living needs and emotional well-being.

DRUG AND ALCOHOL SYSTEM INVOLVEMENT

TCM assists family in obtaining drug and alcohol treatment for a child/adolescent with serious emotional disturbances and co-occurring drug and alcohol problems and encouraging child/adolescent to accept and comply with these services. The TCM supports the child’s/adolescent’s participation in all phases of treatment, including aftercare. TCM assists the family in obtaining culturally competent, language appropriate services for the child/adolescent.

*The decision for level of TCM needed in this area must be determined in collaboration with family and/or guardian, or care giver/natural support and child/adolescent.

0	1	2	3	4	5
	Needs minimal assistance in this area		Needs moderate assistance in this area		Needs significant assistance in this area
N/A= Parent/Guardian and child/adolescent does not need/have involvement with the Drug and Alcohol System.					
0= Parent/guardian and child/adolescent does not require/desire any assistance in this area.					
1= Parent/guardian and child/adolescent requires/desires minimal level of assistance, guidance, advocacy, and support to obtain and maintain the child’s/adolescent’s participation in drug and alcohol services.					
3= Parent/guardian and child/adolescent requires/desires moderate level of assistance, guidance, advocacy, and support to maintain the child’s/adolescent’s participation in drug and alcohol services.					
5= Parent/guardian and child/adolescent requires/desires a significant level of assistance, guidance, advocacy, and support to obtain and maintain the child’s/adolescent’s participation in drug and alcohol services.					

MENTAL RETARDATION SYSTEM INVOLVEMENT

TCM assists the family in obtaining and maintaining participation in mental retardation services for a child/adolescent with a serious emotional disturbance and a co-occurring diagnosis of mental retardation. The TCM supports the child's/adolescent's and parent's/guardian's participation in all phases of mental retardation services. TCM assists the family in obtaining culturally competent, language appropriate services for the child/adolescent.

**The decision for level of TCM needed in this area must be determined in collaboration with family and/or guardian, or care giver/natural support and child/adolescent.*

0	1	2	3	4	5
	Needs minimal assistance in this area		Needs moderate assistance in this area		Needs significant assistance in this area

N/A= Parent/Guardian and child/adolescent does not need/have involvement with the Mental Retardation System.

0= Parent/guardian and child/adolescent does not require/desire any assistance in this area.

1= Parent/guardian and child/adolescent requires/desires minimal level of assistance, guidance, advocacy, and support to obtain and maintain the child's/adolescent's participation in mental retardation services.

3= Parent/guardian and child/adolescent requires/desires moderate level of assistance, guidance, advocacy, and support to maintain the child's/adolescent's participation in mental retardation services.

5= Parent/guardian and child/adolescent requires/desires a significant level of assistance, guidance, advocacy, and support to obtain and maintain the child's/adolescent's participation in mental retardation services.

PHYSICAL HEALTH SYSTEM INVOLVEMENT

TCM assists family and child/adolescent with a serious emotional disturbance in attending to significant physical/medical needs by helping parent/guardian to access medical care, and to develop confidence in working with physical health care providers. TCM assists the family in obtaining culturally competent, language appropriate services for the child/adolescent.

**The decision for level of TCM needed in this area must be determined in collaboration with family and/or guardian, or care giver/natural support and child/adolescent.*

0	1	2	3	4	5
	Needs minimal assistance in this area		Needs moderate assistance in this area		Needs significant assistance in this area

0= Parent/guardian and child/adolescent does not require/desire any assistance in this area.

1= Parent/guardian and child/adolescent requires/desires minimal level of assistance, guidance, advocacy, and support to obtain medical services and to assure coordination between physical and behavioral health care services.

3= Parent/guardian and child/adolescent requires/desires moderate level of assistance, guidance, advocacy, and support to obtain medical services and to assure coordination between physical and behavioral health care services.

5= Parent/guardian and child/adolescent requires/desires a significant level of assistance, guidance, advocacy, and support to obtain medical services and to assure coordination between physical and behavioral health care services.

CHILD/ADOLESCENT AT RISK OF OUT-OF-HOME PLACEMENT

The risk that a child/adolescent with a serious emotional disturbance will require an out-of-home placement may be reduced significantly through TCM services which assist parent/guardian in accessing needed child serving systems. TCM assistance may include information sharing with parent/guardian, advocacy with mental health service providers and other systems and support in working with multiple service providers. Every effort should be made to consider the child’s ethnicity, culture and religious background in any out-of-home placement. TCMs may need to provide assistance in the provision of cultural competence supports for children (e.g., grooming, leisure activities, etc.).

**The decision for level of TCM needed in this area must be determined in collaboration with family and/or guardian, or care giver/natural support and child/adolescent.*

0	1	2	3	4	5
	Needs minimal assistance in this area		Needs moderate assistance in this area		Needs significant assistance in this area

0= Parent/guardian and child/adolescent does not require/desire any assistance in this area.

1= Child’s/adolescent’s ongoing emotional/behavioral issues place the child/adolescent at low risk of out-of- home placement.

3= Child’s/adolescent’s ongoing emotional/behavioral issues place the child/adolescent at moderate risk of out-of-home placement.

5= Child’s/adolescent’s ongoing emotional/behavioral issues place the child/adolescent at high risk of out-of-home placement.

CURRENTLY IN RTE, OTHER OUT-OF-HOME PLACEMENTS OR INPATIENT

Child/adolescent with a serious emotional disturbance is currently or has been receiving services in an RTF, other out-of-home placement or inpatient setting. The child/adolescent has been discharged within the past 30 days or discharge is anticipated within thirty 30 days. The child/adolescent may have been discharged for more than 30 days, however, TCM services are needed to assist with the discharge plan.

**The decision for level of TCM needed in this area must be determined in collaboration with family and/or guardian, or care giver/natural support and child/adolescent.*

0	1	2	3	4	5
	Needs minimal assistance in this area		Needs moderate assistance in this area		Needs significant assistance in this area
0=	Parent/guardian and child/adolescent does not require/desire any assistance in this area.				
1=	Development and implementation of a multi-service-system plan for a child/adolescent discharged or anticipated to be discharged from RTF, other out-of-home placement or inpatient requires a minimal level of TCM service.				
3=	Development and implementation of a multi-service-system plan for a child/adolescent discharged or anticipated to be discharged from RTF, other out-of-home placement or inpatient requires a moderate level of TCM service.				
5=	Development and implementation of a multi-service-system plan for a child/adolescent discharged or anticipated to be discharged from RTF, other out-of-home placement or inpatient requires a significant level of TCM service.				

**TARGETED CASE MANAGEMENT
ENVIRONMENTAL MATRIX - CHILD/ADOLESCENT**

Agency

County

CHILD/ADOLESCENT INFORMATION:

Name :

(Last)

(First)

(MI)

Parent/Guardian Name:

Identifying Number(s):

Date of Birth: / /
(MM)/(DD)/(YYYY)

Social Security Number: - -

CIS/BSU/MCO Number:

PHMCO:

BHMCO:

Form Completed by:

Date Completed:

The purpose of this form is to assess what environmental and cultural factors help to determine an individual's need for the various levels of case management services. Please complete this form utilizing the individual's behavior and situation during the last ninety days as a basis for scoring each indicator. Please note that the decision for level of need in each of the areas must be determined in collaboration with family and/or guardian, or care giver/natural supports and child/adolescent. Please see the *Scoring Sheet* for additional information on determining the Environmental Matrix Score and its meaning for level of care assignments.

ENVIRONMENTAL MATRIX CHILD/ADOLESCENT SCORING SHEET

CHILD/ADOLESCENT
NAME: _____

ID#(SOCIAL SECURITY/CIS/BSU): _____

SCORES:

- | | | |
|-----------------|---|-------|
| 1. | Accessing Mental Health Services | _____ |
| 2. | Informal Support Network Building | _____ |
| 3. | Education | _____ |
| 4. | Children and Youth System Involvement | _____ |
| 5. | Juvenile Justice System Involvement | _____ |
| 6. | Parent/Guardian and/or Other Family Members
With Significant Needs | _____ |
| 7. | Drug and Alcohol System Involvement | _____ |
| 8. | Mental Retardation System Involvement | _____ |
| 9. | Physical Health System Involvement | _____ |
| 10a. | At Risk of Out-of-Home Placement | _____ |
| Or | | |
| 10b. | Currently in RTF, Other Out-of-Home Placements
or Inpatient | _____ |
| SUBTOTAL | | _____ |

**ENVIRONMENTAL MATRIX SCORE = SUBTOTAL ÷ BY ALL
APPLICABLE ASSESSMENT AREAS (AREAS SCORED "N/A" ARE NOT
USED IN DETERMINING OVERALL SCORE)** _____

OTHER FACTORS/ISSUES AFFECTING SCORE:

**ENVIRONMENTAL MATRIX — CHILD/ADOLESCENT
TCM SERVICE SCORING GRID**

MATRIX LEVEL	NEED LEVEL	INTENSITY OF CARE
4.0 –5.0	ICM	At least 1 contact every 14 days (Face to face contact strongly recommended)
1.5 –3.9	RC	At least 1 contact every 30 days (Face to Face)
0.0 - 1.4	NO TCM NEEDED	Alternative services may be needed and if necessary, referrals should be made.

* **professional judgement:** opinion based on a thorough and ethical analysis of facts, data, history, and issues in accordance with one’s training and experience.

RECOMMENDED LEVEL OF TARGETED CASE MANAGEMENT SERVICE: _____

CONSUMER (if age appropriate): _____ **DATE:** _____

PARENT/GUARDIAN _____ **DATE:** _____

PERSON COMPLETING THE FORM: _____ **DATE:** _____

APPROVED LEVEL OF TARGETED CASE MANAGEMENT SERVICE:

REVIEWER _____ **DATE:** _____