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 intellectual disability, 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 the following:

* 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,
* 24 hour availability of professional nursing care to implement the treatment plan and monitor/assess the person's condition and response to treatment, and
* 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.

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

I. A mental health professional, as defined in 55 Pa. Code § 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 intellectual disability, 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 55 Pa. Code 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 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 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/ Intellectual Disabilities (MH/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), System of Care (SOC) and the Community Service Program (CSP).

Background

The Office of Mental Health and Substance Abuse Services (OMHSAS) promulgated 55 Pa. Code Chapters 4210, 5100, 5200, 5210, 5300, and 5310, to regulate the general delivery of services in community psychiatric inpatient, outpatient, residential, and partial hospitalization settings, while OMAP promulgated 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/SOC 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 and Intellectual Disability 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) /System of Care (SOC) philosophy. The OMHSAS summary representation of CASSP, is provided below:

The CASSP/SOC philosophy of collaborative service delivery to children, adolescents and their families undergirds all treatment methods. CASSP/SOC involves all child-serving systems including mental health, intellectual disability, 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.

The National Institute of Mental Health was charged with defining what a system of care is and providing guidance to states and communities about how to build a SOCe.

Beth Stroul and Robert Friedman, two early national leaders in SOC, wrote that "A system of care is defined as a comprehensive spectrum of mental health and other necessary services that are organized into a coordinated network to meet the multiple and changing needs of children and adolescents with serious behavioral disturbances and their family." They stressed that a SOC is more than just a network of services; it is a philosophy of how that care should be provided. They stated that while systems may be organized slightly differently, there should be shared values and philosophy.

The current SOC principles are 1) comprehensive array of services and supports; 2) individualized, strengths-based services and supports; 3) evidence-based practices and practice-based evidence; 4) trauma-informed; 5) least restrictive natural environment; 6) partnerships with families and youth; 7) interagency collaboration; 8) care coordination; 9) health-mental health integration; 10) developmentally appropriate services and supports; 11) public health approach; 12) mental health equity; 13) data driven and accountability; and 14) rights protection and advocacy.

The CASSP/SOC 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 the child’s is/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].

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 multiaxial, face-to-face diagnostic examination (ID or D&A cannot stand alone) and in accordance to ICD-9 codes, by a licensed physician[1] 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

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

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:

-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 SELF
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.

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 multiaxial, face-to-face diagnostic examination (ID or D&A cannot stand alone) and in accordance to ICD-9 codes, by a psychiatrist (as defined in 55 Pa. Code § 5200.3) 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 evaluation[2] 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.

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[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)

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:

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.

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 multiaxial diagnostic examination (ID or D&A cannot stand alone) by a psychiatrist or psychologist (as defined in 55 Pa. Code § 5200.3);

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 55 Pa. Code § 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 55 Pa. Code § 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 55 Pa. Code § 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.

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 multiaxial, face-to-face assessment (ID or D&A cannot stand alone), by a Mental Health Professional (as defined under 55 Pa. Code § 5200.3) and reviewed and approved as outlined in 55 Pa. Code § 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 55 Pa. Code § 5100.2], as informed by the *treatment team* [described in 55 Pa. Code § 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 reenforce 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 (as defined under 55 Pa. Code § 5200.3) and reviewed and approved as outlined in 55 Pa. Code § 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 a n d ***/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/ID 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 55 Pa. Code 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 strengths** 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 oversite 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?

References

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1993 "Interdistrict Placements-New School Code Provisions." Basic Education Circular, BEC 19-93. Harrisburg, Commonwealth of Pennsylvania, Department of Education.

1993 "Mental Health Procedures," 55 Pa. Code Chapter 5100, Commonwealth of Pennsylvania, Office of Mental Health.

1993 "Psychiatric Outpatient Clinics," 55 Pa. Code Chapter 5200, Commonwealth of Pennsylvania, Office of Mental Health.

1993 "Partial Hospitalization," 55 Pa. Code Chapter 5210, Commonwealth of Pennsylvania, Office of Mental Health.

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1985 "Description of Services and Service Areas," 55 Pa. Code Chapter 4210, Commonwealth of Pennsylvania, Office of Mental Health. “Inpatient Psychiatric Services,” 55 Pa. Code Chapter 1151, Commonwealth of Pennsylvania, Office of Medical Assistance Programs. “Outpatient Psychiatric Services,” 55 Pa. Code Chapter 1153, Commonwealth of Pennsylvania, Office of Medical Assistance Programs.

1976 Mental Health Procedures Act of 1976, P. L. 817, No. 143.

1966 Mental Health and Intellectual Disability Act of 1966, P. L. 96, No.6 .
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APPENDIX T
Part B (2)

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/SOC 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 multiaxial, face-to-face assessment (ID or D&A cannot stand alone), by a Mental Health Professional (as defined under 55 Pa. Code § 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

Family Based Mental Health Services (Must meet I/II and III)
I. & II. [Combined] DIAGNOSTIC INDICATORS [Axis I or Axis II; D&A on Axis I, and ID on Axis II do not stand alone] (Must meet A, B, C & D)
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,
AND
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.
1. 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 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; And
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 a. the family recognizes the child's risk of out-of-home placement and the problem of maintaining their child at home

Family Based Mental Health Services

(Must meet I/II and III)

without intensive therapeutic interventions in the context of the family; and/or

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

Family Based Mental Health Services (Must meet I/II and III)
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; 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;

Family Based Mental Health Services

(Must meet I/II and III)

and

2. 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 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 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 55 Pa. Code 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. Intellectual Disability 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

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= P a r e n t /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.

INTELLECTUAL DISABILITY SYSTEM INVOLVEMENT

TCM assists the family in obtaining and maintaining participation in intellectual disability services for a child/adolescent with a serious emotional disturbance and a co-occurring diagnosis of intellectual disability. The TCM supports the child's/adolescent's and parent's/guardian's participation in all phases of intellectual disability 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 Intellectual Disability 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 intellectual disability 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 intellectual disability 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 intellectual disability 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 RTF, 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.

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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)/(Y
YYY)

Social Security Number: **-** **-** **CIS/BSU/MCO**

Number:

PHM

CO:

BHM

CO:

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.	Intellectual disability 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:

Appendix T
Part B (3)

PERSON COMPLETING THE FORM:

DATE:

APPROVED LEVEL OF TARGETED CASE MANAGEMENT SERVICE:

REVIEWER

DATE:

Appendix T
Part B (3)

Placement Guidelines for Drug and Alcohol Services

AMERICAN SOCIETY OF ADDICTION MEDICINE

The ASAM CRITERIA

ASAM Website: https://www.asam.org/resources/the-asam-criteria/about

Can be purchased through The Change Companies, see below:

Phone: **1-888-889-8866**
E-Mail: **contact@changecompanies.net**
Website: **https://www.changecompanies.net/products/?id=ASM0**

The Department requires all substance use disorder placement, continued stay, and discharge be conducted in accordance with the most recent version of the *American Society of Addiction Medicine (ASAM) criteria.* Additional guidance is available at:

https://www.ddap.pa.gov/Documents/ASAM/ASAM%20Application%20Guidance%20Final.pdf

https://www.ddap.pa.gov/Professionals/Pages/ASAM-Transition.aspx

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