LEVEL OF CARE GUIDELINES: WRAPAROUND SERVICES

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Table of Contents **Page**

INTRODUCTION 1
COMMON ADMISSION CRITERIA FOR ALL LEVELS OF CARE 2
COMMON CONTINUED SERVICE CRITERIA FOR ALL LEVELS OF CARE 2
COMMON DISCHARGE CRITERIA FOR ALL LEVELS OF CARE 2
COMMON CLINICAL BEST PRACTICES FOR ALL LEVELS OF CARE 3
ASSERTIVE COMMUNITY TREATMENT 4
CASE MANAGEMENT 6
FAMILY PEER SERVICES AND SUPPORTS 6
PEER SERVICES AND SUPPORTS 7
PSYCHOSOCIAL REHABILITATION 8
RESPITE CARE 10
SOBER LIVING ARRANGEMENTS 11
SUPERVISED LIVING ARRANGEMENTS 12
THERAPEUTIC FOSTER CARE 13
REFERENCES 13
HISTORY/REVISION INFORMATION 15

INTRODUCTION

The *Level of Care Guidelines* is a set of objective and evidence-based behavioral health criteria used by medical necessity plans to standardize coverage determinations, promote evidence-based practices, and support members' recovery, resiliency, and wellbeing[1] for behavioral health benefit plans that are managed by Optum and U.S. Behavioral Health Plan, California (doing business as OptumHealth Behavioral Solutions of California ("Optum-CA")).

The *Level of Care Guidelines* is derived from generally accepted standards of behavioral health practice. These standards include guidelines and consensus statements produced by professional specialty societies, as well as guidance from governmental sources such as CMS' National Coverage Determinations (NCDs) and Local Coverage Determinations (LCDs). The *Level of Care Guidelines* is also derived from input provided by clinical personnel, providers, profesisonal specialty societies, consumers, and regulators.

For more information on guiding principles for the *Level of Care Guidelines* and their development, approval, dissemination, and use, please see the *Introduction to the Level of Care Guidelines*, available at: www.providerexpress.com > Clinical Resources > Level of Care Guidelines.

Before using this guideline, please check the member's specific benefit plan requirements and any federal or state mandates, if applicable.

[1] The terms "recovery" and resiliency" are used throughout the Level of Care Guidelines. SAMHSA defines "recovery" as a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential. SAMHSA defines "resilience" as the ability to adapt well over time to life-changing situations and stressful conditions. The American Society of Addiction Medicine defines "recovery" as a process of overcoming both physical and psychological dependence on a psychoactive substance, with a commitment to sobriety, and also refers to the overall goal of helping a patient to achieve overall health and well-being.

COMMON ADMISSION CRITERIA FOR ALL LEVELS OF CARE

- The member is eligible for benefits.
  AND
- The member's condition and proposed service(s) are covered by the benefit plan.
  AND
- Service(s) are within the scope of the provider's professional training and licensure.
  AND
- The member's current condition cannot be safely, efficiently, and effectively assessed and/or treated in a less intensive level of care.
  - Failure of treatment in a less intensive level of care is **not** a prerequisite for authorizing coverage.

  AND
- The member's current condition can be safely, efficiently, and effectively assessed and/or treated in the proposed level of care. Assessment and/or treatment of the factors leading to admission~~)~~ require the intensity of services provided in the proposed level of care.
  AND
- Co-occurring behavioral health and medical conditions can be safely managed.
  AND
- Service(s) are the following:
  - Consistent with generally accepted standards of clinical practice;
  - Consistent with services backed by credible research soundly demonstrating that the service(s) will have a measurable and beneficial health outcome, and are therefore not considered experimental;
  - Consistent with Optum's best practice guidelines;
  - Clinically appropriate for the member's behavioral health conditions based on generally accepted standards of clinical practice and benchmarks.

  AND
- There is a reasonable expectation that service(s) will improve the member's presenting problems within a reasonable period of time.
  - Improvement of the member's condition is indicated by the reduction or control of the signs and symptoms that necessitated treatment in a level of care.
  - Improvement in this context is measured by weighing the effectiveness of treatment against evidence that the member's signs and symptoms will deteriorate if treatment in the current level of care ends. Improvement must also be understood within the broader framework of the member's recovery, resiliency, and wellbeing.

COMMON CONTINUED SERVICE CRITERIA FOR ALL LEVELS OF CARE

- The admission criteria continue to be met and active treatment is being provided. For treatment to be considered "active", service(s) must be as follows:
  - Supervised and evaluated by the admitting provider;
  - Provided under an individualized treatment plan that is focused on addressing the factors leading to admission, and makes use of clinical best practices;
  - Reasonably expected to improve the member's presenting problems within a reasonable period of time.

  AND
- The factors leading to admission have been identified and are integrated into the treatment and discharge plans.
  AND
- Clinical best practices are being provided with sufficient intensity to address the member's treatment needs.
  AND
- The member's family and other natural resources are engaged to participate in the member's treatment as clinically indicated.

COMMON DISCHARGE CRITERIA FOR ALL LEVELS OF CARE

- The continued stay criteria are no longer met. Examples include:
  - The factors which led to admission have been addressed to the extent that the member can be safely transitioned to a less intensive level of care, or no longer requires care.
  - The factors which led to admission cannot be addressed, and the member must be transitioned to a more intensive level of care.
  - Treatment is primarily for the purpose of providing social, custodial, recreational, or respite care.
  - The member requires medical/surgical treatment.

- The member is unwilling or unable to participate in treatment, and involuntary treatment or guardianship is not being pursued.

COMMON CLINICAL BEST PRACTICES FOR ALL LEVELS OF CARE

Evaluation & Treatment Planning

- The initial evaluation:
  - Gathers information about the presenting issues from the member's perspective, and includes the member's understanding of the factors that lead to requesting services;
  - Focuses on the member's specific needs;
  - Identifies the member's goals and expectations;
  - Is completed in a timeframe commensurate with the member's needs, or otherwise in accordance with clinical best practices.
- The provider collects information form the member and other sources, and completes an initial evaluation of the following:
  - The member's chief complaint;
  - The history of the presenting illness;
  - The factors leading to the request for service;
  - The member's mental status;
  - The member's current level of functioning;
  - Urgent needs, including those related to the risk of harm to self, others, and/or property;
  - The member's use of alcohol, tobacco, or drugs;
  - Co-occurring behavioral health and physical conditions;
  - The member's history of behavioral health services;
  - The member's history of trauma;
  - The member's medical history and current physical health status;
  - The member's developmental history;
  - Pertinent current and historical life information;
  - The member's strengths;
  - Barriers to care;
  - The member's instructions for treatment, or appointment of a representative to make decisions about treatment;
  - The member's broader recovery, resiliency, and wellbeing goals.
- The provider uses the findings of the evaluation to assign a DSM-ICD diagnosis.
- The provider and, whenever possible, the member use the findings of the initial evaluation and diagnosis to develop a treatment plan. The treatment plan addresses the following:
  - The short- and long-term goals of treatment;
  - The type, amount, frequency, and duration of treatment;
  - The expected outcome for each problem to be addressed expressed in terms that are measurable, functional, time-framed, and directly related to the factors leading to admission;
  - How the member's family and other natural resources will participate in treatment when clinically indicated;
  - How treatment will be coordinated with other provider(s), as well as with agencies or programs with which the member is involved.
- As needed, the treatment plan also includes interventions that enhance the member's motivation, promote informed decisions, and support the member's recovery, resiliency, and wellbeing. Examples include psychoeducation, motivational interviewing, recovery and resiliency planning, advance directive planning, and facilitating involvement with self-help and wraparound services.
- The provider informs the member of safe and effective treatment alternatives, as well as the potential risks and benefits of the proposed treatment. The member gives informed consent acknowledging willingness and ability to participate in treatment and abide by safety precautions.
- Treatment focuses on addressing the factors precipitating admission to the point that the member's condition can be safely, efficiently, and effectively treated in a less intensive level of care, or the member no longer requires care.
- The treatment plan and level of care are reassessed when the member's condition improves, worsens, or does not respond to treatment.
  - When the member's condition has improved, the provider determines if the treatment plan should be altered, or if treatment is no longer required.
  - When the member's condition has worsened or not responded to treatment, the provider verifies the diagnosis, alters the treatment plan, or determines if the member's condition should be treated in another level of care.
- In the event that all information is unavailable at the time of the evaluation, there must be enough information to provide a basis for the diagnosis, guide the development of the treatment plan, and support the need for treatment in the proposed level of care.

Discharge Planning

- The provider and, whenever possible, the member develops an initial discharge plan at the time of admission, and estimates the length of treatment.
- The provider and, whenever possible, the member updates the initial discharge plan during the admission, ensuring that:
  - An appropriate discharge plan is in place prior to discharge;
  - The discharge plan is designed to mitigate the risk that the factors precipitating admission will reoccur;
  - The member agrees with the discharge plan.
- For members continuing treatment:
  - The discharge plan includes the following:
    - The discharge date;
    - The post-discharge level of care, and the recommended forms and frequency of treatment;
    - The name(s) of the provider(s) who will deliver treatment;
    - The date of the first appointment, including the date of the first medication management visit;
    - The name, dose, and frequency of each medication, with a prescription sufficient to last until the first medication management visit;
    - An appointment for necessary lab tests;
    - Resources to assist the member with overcoming barriers to care, such as lack of transportation or child care;
    - Recommended self-help and community support services;
    - Information about what the member should do in the event of a crisis prior to the first appointment.
- For members not continuing treatment:
  - The discharge plan includes the following:
    - The discharge date;
    - Recommended self-help and community support services;
    - Information about what the member should do in the event of a crisis or to resume services.
  - The provider explains the risk of discontinuing treatment when the member refuses treatment or repeatedly does not adhere with the treatment plan.

ASSERTIVE COMMUNITY TREATMENT

Assertive Community Treatment (a.k.a. Program of Assertive Community Treatment, PACT, ACT) is an intensive community-based program that uses a multi-disciplinary team of behavioral health professionals and trained peers to provide or coordinate treatment, rehabilitation, and community support services for members who are recovering from severe mental health conditions. Assertive Community Treatment is focused on addressing the factors that precipitated access to this service (e.g., changes in the member's signs and symptoms, psychosocial and environmental factors, or level of functioning) to the point that the member's condition can be safely, efficiently and effectively treated without the support of Assertive Community Treatment.

Assertive Community Treatment services may be mobile or delivered within an outpatient treatment setting, and are available 24 hours a day, 7 days a week.

Assertive Community Treatment services vary in intensity, frequency, and duration in order to support the member's ability to utilize behavioral health and medical services, manage functional difficulties, or otherwise realize recovery and resiliency goals.

Assertive Community Treatment Admission Criteria

- See *Common Admission Criteria for All Levels of Care*
  AND
- The member is not in imminent or current risk of harm to self, others, and/or property.
  AND
- Factors that precipitated access to this service (e.g., changes in the member's signs and symptoms, psychosocial and environmental factors, or level of functioning) indicate that the member requires assistance with accessing treatment and/or community resources. Examples include:
  - The member primarily relies on the emergency room for behavioral health services.
  - Impairment of behavior or cognition interferes with Activities of Daily Living (ADLs) to the extent that the member requires significant support or assistance.

Assertive Community Treatment Continued Service Criteria

- See *Common Continued Service Criteria for All Levels of Care*

Assertive Community Treatment Discharge Planning and Criteria

- See *Common Discharge Criteria for All Levels of Care*

Assertive Community Treatment Clinical Best Practices

- See *Common Clinical Best Practices for All Levels of Care*
- The Assertive Community Treatment team is coordinated by a responsible behavioral health provider who:
  - Has knowledge and competencies that meet the member's needs;
  - AND
  - Provides clinical supervision of the Assertive Community Treatment team.
- The Assertive Community Treatment team includes a psychiatrist who:
  - Provides assessment and treatment services;
    AND
  - Participates in team meetings;
    AND
  - Provides clinical supervision and case consultation.
- The responsible provider, in conjunction with the Assertive Community Treatment team, completes the initial evaluation within 24 hours of admission.
  - The focus of the initial evaluation is on the member's mental and functional status, the effectiveness of past treatment, and the member's current needs for treatment, rehabilitation, and support services.
  - The initial evaluation guides services until the comprehensive assessment and Assertive Community Treatment plan are completed.
- The responsible provider, in conjunction with the Assertive Community Treatment team, completes a comprehensive assessment without one month of admission.
  - The comprehensive assessment builds on information obtained during the initial assessment, and is used to develop the Assertive Community Treatment plan.
- The responsible provider, in conjunction with the Assertive Community Treatment team, and whenever possible, the member, develops a multidisciplinary service plan that addresses the following:
  - Behavioral health illness or symptom reduction;
  - Housing;
  - Activities of Daily Living (ADLs);
  - Daily structure and employment;
  - Family and social relationships.
- The service plan includes a crisis intervention plan.
- The Assertive Community Treatment team provides services such as the following to the member's family, with the member's consent:
  - Education about the member's condition and its treatment;
  - Education about the member's strengths;
  - Education about the family's role in the member's treatment;
  - Assistance with resolving conflicts;
  - Interventions aimed at promoting the family's collaboration with the ACT team.
- On average, the member is seen 3 times per week. The Assertive Community Treatment team has the capacity to see the member more frequently. Reasons for more frequent contact may include:
  - The member's signs and symptoms have worsened;
  - The member's response to a new medication needs to be monitored;
  - The member is experiencing an acute serious life event.
- The Assertive Community Treatment team psychiatrist assesses the member's signs and symptoms, prescribes appropriate medication, and monitors the member's response to the medication.
- The Assertive Community Treatment team provides ongoing support and liaison services for members who are hospitalized or incarcerated.
- The Assertive Community Treatment team reaches out and maintains contact with the member when the member becomes isolated or is admitted to a higher level of care.
- The Assertive Community Treatment team conducts regularly scheduled planning meetings. The purpose of planning meetings is to:
  - Ensure that staff remain familiar with each member's Assertive Community Treatment plan;
  - Provide an opportunity to assess the member's progress and reformulate the Assertive Community Treatment plan as needed;
  - To problem-solve treatment issues;
  - To obtain input from the member, and incorporate the member into decisions about the Assertive Community Treatment plan.
- The service plan is reviewed and modified as necessary commensurate with the member's needs, or no less than quarterly.

CASE MANAGEMENT

Case Management is a community-based program in which a behavioral health professional or trained peer assists members who are at risk of being underserved in their efforts to identify, access, and utilize medical, behavioral health, or social services, or to otherwise achieve recovery and resiliency goals. Case Management is focused on addressing the factors that precipitated access to this service (e.g., changes in the member's signs and symptoms, psychosocial and environmental factors, or level of functioning) to the point that the member's condition can be safely, efficiently and effectively treated without the support of Case Management.

Targeted Case Management is a form of case management services provided only to specific classes of members, or to members who reside in specified areas.

Case Management may be mobile or delivered in an outpatient treatment setting.

Case Management services vary in intensity, frequency, and duration in order to support the member's ability to utilize behavioral health and medical services, manage functional difficulties, or otherwise realize recovery and resiliency goals.

Case Management Admission Criteria

- See *Common Admission Criteria for All Levels of Care*
  AND
- The member is not in imminent or current risk of harm to self, others, and/or property.
  AND
- Factors that precipitated admission (e.g., changes in the member's signs and symptoms, psychosocial and environmental factors, or level of functioning) indicate that the member requires assistance with accessing treatment and/or community resources. Examples include:
  - The member requires assistance with navigating the system of care.
  - The member requires assistance with accessing transportation services, employment services, childcare, or other community resources.

Case Management Continued Service Criteria

- See *Common Continued Service Criteria for All Levels of Care*

Case Management Discharge Planning and Criteria

- See *Common Discharge Criteria for All Levels of Care*

Case Management Clinical Best Practices

- See *Common Clinical Best Practices for All Levels of Care*
- The responsible Case Manager, in conjunction with the treatment team, completes an initial evaluation of the member's case management needs upon admission.
- The responsible Case Manager, in conjunction with the treatment team and, whenever possible, the member, develops a service plan that includes a description of the following:
  - The member's recovery and resiliency goals;
  - Strengths;
  - Problems;
  - Specific and measurable goals for each problem;
  - Interventions that will support the member in meeting the goals.
- The service plan may be informed by the findings of the initial clinical evaluation.
- With the member's permission, the Case Manager advocates for the member by sharing feedback about the member's experience with the treatment provider, as well as agencies or other programs with which the member is involved.

FAMILY PEER SERVICES AND SUPPORTS

Family Peer Services and Supports provides families and other caregivers with support, information, and the opportunity to develop skills in support of a member's recovery and resiliency. While providing these services, the family peer utilizes his/her training, lived experience and experiential knowledge to reduce the likelihood that the family and member will become isolated, disempowered, or disengaged. Family Peer services and Supports is focused on addressing the factors that precipitated access to this service (e.g., changes in the member's signs and symptoms, psychosocial and environmental factors, or level of functioning) to the point that the member's condition can be safely, efficiently and effectively treated without the support of Family Peer Services and Supports.

Family Peer Services and Supports complement the member's behavioral health treatment, and may be delivered while the member is in treatment or in advance of the start of treatment.

Family Peer Services and Supports vary in intensity, frequency, and duration in accordance with the member's family and member's ability to utilize behavioral health services, manage psychosocial challenges, or otherwise make progress in achieving the member's recovery and resiliency goals.

Family Peer Services and Supports Admission Criteria

- See *Common Admission Criteria for All Levels of Care*
  AND
- The member has a Serious Emotional Disturbance (SED)[2] or a Substance-Related Disorder.
  AND
- The member is not in imminent or current risk of harm to self, others, and/or property.
  AND
- Factors that precipitated access to this service (e.g., changes in the member's signs and symptoms, psychosocial and environmental factors, or level of functioning) indicate that the member's family and member require assistance with accessing treatment and/or community resources. Examples include:
  - The member's family requires information about the member's behavioral health condition, evidence-based treatment, approaches to self-care, or community resources.
  - The member's family could benefit from learning skills related to problem-solving, communication, managing crises or stress, supporting and engaging the child's activation and self-care, or promoting recovery and resiliency.
  - The member's family requires assistance navigating the system of care.

  AND
- The member is receiving behavioral health services, or is likely to engage in treatment with the provision of Family Peer Services and Supports.

Family Peer Services and Supports Continued Service Criteria

- See *Common Continued Service Criteria for All Levels of Care*

Family Peer Services and Supports Discharge Planning and Criteria

- See *Common Discharge Criteria for All Levels of Care*

Family Peer Services and Supports Clinical Best Practices

- See *Common Clinical Best Practices for All Levels of Care*
- The family peer completes an evaluation of the family's needs upon referral.
  - For members who are transitioning from Inpatient or Residential Treatment, the family peer contacts the member's family prior to discharge or within 24 hours of referral.
- As part of the evaluation, the family peer provides the member's family with information about Family Peer Services and Supports, and verifies that the member's family wants these services.
  - In the event that the member's family declines services, the family peer provides information about obtaining services should the family's needs change.
- The family peer, in conjunction with the member's family, develops a service plan that addresses the following:
  - The member's resiliency goals;
  - The member and family's strengths;
  - The member and family's educational needs;
  - The member and family's self-care needs and resources;
  - Problems;
  - Specific and measurable goals for each problem;
  - Interventions that will support the member's family and member in meeting the goals.
- The service plan may be informed by the findings of the member's clinical evaluation.

PEER SERVICES AND SUPPORTS

Peer Services and Supports provides members with support, information, and the opportunity to develop skills in support of the member's recovery. While providing these services, the Peer utilizes his/her training, lived experience, and experiential knowledge to reduce the likelihood that the member will become isolated, disempowered, or disengaged. Peer Services and Supports is focused on addressing the factors that precipitated access to this service (e.g., changes in the member's signs and symptoms, psychosocial and environmental factors, or level of functioning)

[2] According to Federal Register Volume 62, Number 193, Serious Emotional Disturbance occurs in persons from birth up to the age of 18, who currently or at any time during the past year have had a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria specified with the DSM that resulted in functional impairment which substantially interferes with or limits the child's role or functioning in family, school, or community activities.

to the point that the member's condition can be safely, efficiently and effectively treated without the support of Peer Services and Supports

Peer Services and Supports complement the member's behavioral health treatment, and may be delivered while the member is in treatment or in advance of the start of treatment.

Peer Services and Supports vary in intensity, frequency, and duration in accordance with the member's ability to utilize behavioral health services, manage psychosocial challenges, or otherwise make progress in achieving the member's recovery goals.

Peer Services and Supports Admission Criteria

- See *Common Admission Criteria for All Levels of Care*
  AND
- The member has a Serious Mental Illness (SMI)[3] or a Substance-Related Disorder
  AND
- The member is not in imminent or current risk of harm to self, others, and/or property.
  AND
- Factors that precipitated access to this service (e.g., changes in the member's signs and symptoms, psychosocial and environmental factors, or level of functioning) indicate that the member requires assistance with accessing treatment and/or community resources. Examples include:
  - The member requires information about their behavioral health condition, evidence-based treatment, approaches to self-care, or community resources;
  - The member could benefit from learning skills related to problem-solving, communication, manageing crises or stress, activating and engaging in self-care, or promoting recovery;
  - The member requires assistance navigating the system of care.

  AND
- The member is receiving behavioral health services, or is likely to engage in treatment with the provision of Peer Services and Supports.

Peer Services and Supports Continued Service Criteria

- See *Common Continued Service Criteria for All Levels of Care*

Peer Services and Supports Discharge Planning and Criteria

- See *Common Discharge Criteria for All Levels of Care*

Peer Services and Supports Clinical Best Practices

- See *Common Clinical Best Practices for All Levels of Care*
- The Peer completes an evaluation of the family's needs upon referral.
  - For members who are transitioning from inpatient or residential treatment, the Peer contacts the member's family prior to discharge or within 24 hours of referral.
- As part of the evaluation, the Peer provides the member with information about Peer Services and Supports, and verifies that the member wants these services.
  - In the event that the member declines services, the Peer provides information about obtaining services should the family's needs change.
- The Peer, in conjunction with the member's family, develops a service plan that addresses the following:
  - The member's recovery and resiliency goals;
  - The member's strengths;
  - The member's educational needs;
  - The member's self-care and activation strategies;
  - Problems;
  - Specific and measurable goals for each problem;
  - Interventions that will support the member in meeting the goals.
- The service plan may be informed by the findings of the member's clinical evaluation.

PSYCHOSOCIAL REHABILITATION

[3] According to Federal Register 58, Number 96, the definition of Serious Mental Illness (SMI) includes persons aged 18 or older who currently or at any time in the past year have had a diagnosable mental, behavioral, or emotional disorder (excluding developmental, dementias, mental disorders due to a medical condition and substance use disorders) of sufficient duration to meet diagnostic criteria specified within the DSM that has resulted in serious functional impairment, which substantially interferes with or limits one or more major life activities.

Psychosocial Rehabilitation is a program that promotes recovery, full community integration, and improved quality of life for members who have been diagnosed with a behavioral health condition that seriously impairs their ability to lead meaningful lives. Interventions aim to help members develop skills and access resources needed to increase their capacity to succeed in their living, working, learning, and social environments. Interventions are collaborative, person-directed, individualized, and based on the member's capacity for recovery. Psychosocial Rehabilitation is focused on addressing the factors that precipitated the need for this service (e.g., changes in the member's signs and symptoms, psychosocial and environmental factors, or level of functioning) to the point that the member's condition can be safely, efficiently and effectively treated without the support of Psychosocial Rehabilitation.

Psychosocial Rehabilitation is provided in conjunction with traditional pharmacologic and psychosocial treatments.

Psychosocial Rehabilitation services vary in intensity, frequency, and duration in order to support the member's ability to manage functional difficulties and realize recovery and resiliency goals.

Psychosocial Rehabilitation Admission Criteria

- See *Common Admission Criteria for All Levels of Care*
  AND
- The member is not in imminent or current risk of harm to self, others, and/or property.
  AND
- Factors that precipitated admission (e.g., changes in the member's signs and symptoms, psychosocial and environmental factors, or level of functioning) indicates that the member requires assistance with accessing treatment and/or community resources. Examples include:
    - The member has difficult gaining and utilizing necessary functional skills, such as those related to:
        - Education or work;
        - Finances;
        - Housing;
        - Health/medical;
        - Social needs;
        - Basic living skills;
        - Legal needs.

Psychosocial Rehabilitation Continued Service Criteria

- See *Common Continued Service Criteria for All Levels of Care*

Psychosocial Rehabilitation Discharge Planning and Criteria

- See *Common Discharge Criteria for All Levels of Care*
- The discharge plan:
    - Identifies the member's progress meeting their rehabilitation goal(s);
    - Identifies the plan for services and supports needed to further assist the member with community integration, recovery, and realizing a higher quality of life;
    - Includes information on the continuity of the member's medications.

Psychosocial Rehabilitation Clinical Best Practices

- See *Common Clinical Best Practices for All Levels of Care*
- Services are organized around:
    - The member's stated goals;
    - The member's preferences;
    - The identified needs of the member;
    - Improving the member's ability to understand their needs;
    - Assisting the member with achieving goal, such as:
        - Community living skills, including food planning and preparation, money management, maintenance of living environment, etc.;
        - Interpersonal relations;
        - Recreation or use of leisure time activities;
        - Vocational development or employment;
        - Educational development;
        - Self-advocacy;
        - Access to non-disability related social resources.
- The responsible provider, in conjunction with the rehabilitation team, completes the initial evaluation of the following within 24 hours of admission:
    - Factors leading the member to access services;
    - Assessment of harm to self, others, and/or property;
    - The member's readiness for rehabilitation;

    - The member's overall rehabilitation goal(s);
    - The member's functional skills and knowledge in relation to the overall rehabilitation goal(s);
    - The member's resources in relation to the overall rehabilitation goal(s).
- The responsible provider, in conjunction with the rehabilitation team and whenever possible, the member, develops a multidisciplinary rehabilitation plan that focuses on the following:
    - The member's rehabilitation goal(s);
    - The member's present level of skills and knowledge relative to the rehabilitation goal(s);
    - The skills and knowledge needed to achieve the member's rehabilitation goal(s);
    - The member's present resources and the resources needed to achieve the member's rehabilitation goal.
- The rehabilitation plan includes specific and measurable objectives aimed at assisting the member with achieving the rehabilitation goal(s), and interventions for each skill, knowledge, or resource objective.
- The rehabilitation plan may be informed by the findings of the initial clinical evaluation.
- When the initial assessment identifies a potential risk of harm to self, others, and/or property, a personal safety plan is completed that includes:
    - Triggers;
    - Current coping skills;
    - Warning signs;
    - Preferred interventions;
    - Advance directives, when available.
- The program provides an effective system for reaching out to members who are not attending, becoming isolated, or who are hospitalized.

RESPITE CARE

Respite Care is a temporary care that is intermittently provided to members with a Serious Mental Illness[4] or a Serious Emotional Disturbance[5] when the family/caregiver requires a temporary break from caregiving, when members are at risk for abuse or neglect, or when members need additional support following a crisis. Respite Care can include assistance with Activities of Daily Living (ADLs), reinforcing life skills, or otherwise supporting the member's recovery and resiliency goals. Respite Care is focused on addressing the factors that precipitated the need for this service (e.g., changes in the member's signs and symptoms, psychosocial and environmental factors, or level of functioning). Respite Care can include assistance with Activities of Daily Living, reinforcing life skills, or otherwise supporting the member's recovery and resiliency goals.

Respite Care is provided in the member's home, or in a community-based setting, such as a day care center. The duration of Respite Care also varies, and may include an overnight stay.

Respite Care Admission Criteria

- See *Common Admission Criteria for All Levels of Care*
  AND
- The member is not in imminent or current risk of harm to self, others, and/or property.
  AND
- Factors that precipitated admission (e.g., changes in the member's signs and symptoms, psychosocial and environmental factors, or level of functioning) indicates that the member's family or caregiver requires a temporary break from caregiving. Examples include:
    - The stress of caregiving has put the member at imminent risk of abuse or neglect.
    - Other responsibilities temporarily prevent the member's family or caregiver from assisting the member with Activities of Daily Living (ADLs).

Respite Care Continued Service Criteria

- See *Common Continued Service Criteria for All Levels of Care*

Respite Care Discharge Planning and Criteria

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[4] According to Federal Register 58, Number 96, the definition of Serious Mental Illness (SMI) includes persons aged 18 or older who currently or at any time in the past year have had a diagnosable mental, behavioral, or emotional disorder (excluding developmental, dementias, mental disorders due to a medical condition and substance use disorders) of sufficient duration to meet diagnostic criteria specified within the DSM that has resulted in serious functional impairment, which substantially interferes with or limits one or more major life activities.

[5] According to Federal Register Volume 62, Number 193, Serious Emotional Disturbance occurs in persons from birth up to the age of 18, who currently or at any time during the past year, have had a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria specified with the DSM that resulted in functional impairment which substantially interferes with or limits the child's role or functioning in family, school, or community activities.

- See *Common Discharge Criteria for All Levels of Care*

Respite Care Clinical Best Practices

- See *Common Clinical Best Practices for All Levels of Care*
- The responsible provider evaluates the member and caregiver's need upon admission.
- The responsible provider, in conjunction with the member and/or member's family or caregiver, develops a service plan that includes the following:
  - The goal(s) of Respite Care;
  - Specific, measurable objectives aimed at achieving the goal(s) of Respite Care.
- The service plan incorporates instructions for medical care, special needs and emergencies.
- The service plan also addresses the need for other services and resources that become apparent during the provision of Respite Care. As needed, the provider assists the member with accessing other services and resources.
- The service plan may be informed by the findings of the initial clinical evaluation.
- The provider ensures that necessary medication, medical equipment, and assistive technology accompany the member when Respite Care is provided at a site other than the member's residence.

SOBER LIVING ARRANGEMENTS

Sober Living Arrangements (a.k.a. Drug-Free Housing, Alcohol/Drug Halfway House) are transitional, supervised living arrangements that provide stable and safe housing, an alcohol/drug-free environment, and support for recovery from alcohol or drug use. A Sober Living Arrangement may be utilized as an adjunct to ambulatory treatment when treatment doesn't offer the intensity and structure needed to support the member's recovery. Sober Living Arrangement is focused on addressing the factors that precipitated the need for this service (e.g., changes in the member's signs and symptoms, psychosocial and environmental factors, or level of functioning) to the point that that the member's condition can be safely, efficiently and effectively treated without the support of a Sober Living Arrangement.

Sober Living Arrangements vary in intensity and duration in order to support the member's ability to utilize behavioral health services, manage functional difficulties, and otherwise realize recovery goals.

Sober Living Arrangements Admission Criteria

- See *Common Admission Criteria for All Levels of Care*
  AND
- The member is not in imminent or current risk of harm to self or others, and/or property.
  AND
- There is no risk of withdrawal, or the signs and symptoms of withdrawal can be safely managed.
  AND
- Factors that precipitated admission (e.g., changes in the member's signs and symptoms, psychosocial and environmental factors, or level of functioning) indicates that the member's recovery from alcohol or drug use requires the structure and support available in a Sober Living Arrangement. Examples include:
  - The member's environment doesn't support recovery to the extent that the member is at risk of relapse.
  - The member is isolated and needs the structure and support available in a Sober Living Arrangement to practice relapse prevention.

Sober Living Arrangements Continued Service Criteria

- See *Common Continued Service Criteria for All Levels of Care*

Sober Living Arrangements Discharge Planning and Criteria

- See *Common Discharge Criteria for All Levels of Care*

Sober Living Arrangements Clinical Best Practices

- See *Common Clinical Best Practices for All Levels of Care*
- The responsible staff member evaluates the member's needs upon admission.
- The responsible staff member and the member develop a service plan that includes the following:
  - The goal of the Sober Living Arrangement; and
  - Specific, measurable objectives aimed at achieving the goal(s) of the Sober Living Arrangement.
- The responsible staff member provides the members with information about:
  - Accessing community resources;
  - Accessing emergency care;
  - Dealing with onsite safety issues, including:
    - Environmental risks;

        - Abuse or neglect;
        - Self-protection;
        - Medication management;
    - Guidelines related to guests.
- The responsible staff member ensures that the following are provided:
    - Regular meetings with staff;
    - Opportunities to improve Activities of Daily Living (ADLs);
    - Linkages with behavioral health and medical services.
- The service plan may be informed by the findings of the initial clinical evaluation.

SUPERVISED LIVING ARRANGEMENTS

Supervised Living Arrangements are residences such as transitional living facilities, group homes, and supervised apartments that provide a member with a Serious Mental Illness[6] with stable and safe housing, 24-hour supervision, the opportunity to learn how to manage Activities of Daily Living (ADLs), and support for the member's broader recovery and resiliency goals. A Supervised Living Arrangement is focused on addressing the factors that precipitated the need for this service (e.g., changes in the member's signs and symptoms, psychosocial and environmental factors, or level of functioning) to the point that that the member's condition can be safely, efficiently and effectively treated without the support of a Supervised Living Arrangement.

Supervised Living Arrangements may be utilized as an adjunct to ambulatory treatment when treatment doesn't offer the intensity and structure needed to assist the member with recovery and resiliency.

Supervised Living Arrangements vary in the amount of available staff, the intensity of recovery and resiliency-related services, and the length of residence.

Supervised Living Arrangements Admission Criteria

- See *Common Admission Criteria for All Levels of Care*
  AND
- The member has a Serious Mental Illness
  AND
- The member is not in imminent or current risk of harm to self, others, and/or property.
  AND
- Factors that precipitated access to this service (e.g., changes in the member's signs and symptoms, psychosocial and environmental factors, or level of functioning) indicate that the member is unable to maintain tenure in the community without the structure and support available in a Supervised Living Arrangement. Examples include:
    - The member is unable to maintain a safe living environment or sustained housing to the extent that the member is at risk for admission.
    - The member requires a transitional period of supervised living after discharge from inpatient or residential treatment.

Supervised Living Arrangements Continued Service Criteria

- See *Common Continued Service Criteria for All Levels of Care*

Supervised Living Arrangements Discharge Planning and Criteria

- See *Common Discharge Criteria for All Levels of Care*

Supervised Living Arrangements Clinical Best Practices

- See *Common Clinical Best Practices for All Levels of Care*
- The responsible staff member evaluates the member's needs upon admission.
- The responsible staff member and the member develop a service plan that includes the following:
    - The goal(s) of the Supervised Living Arrangement; and
    - Specific, measurable objectives aimed at achieving the goal(s) of the Supervised Living Arrangement.
- The responsible staff member provides the member with information about:
    - Accessing community resources;
    - Accessing emergency care;

[6] According to Federal Register 58, Number 96, the definition of Serious Mental Illness (SMI) includes persons aged 18 or older who currently or at any time in the past year have had a diagnosable mental, behavioral, or emotional disorder (excluding developmental, dementias, mental disorders due to a medical condition and substance use disorders) of sufficient duration to meet diagnostic criteria specified within the DSM that has resulted in serious functional impairment, which substantially interferes with or limits one or more major life activities.

        - Dealing with onsite safety issues, including:
            - Environmental risks;
            - Abuse or neglect;
            - Self-protection;
            - Medication management;
        - Guidelines related to guests.
- The responsible staff member ensures that the following are provided:
    - Regular meetings with staff;
    - Opportunities to improve Activities of Daily Living (ADLs);
    - Linkages with behavioral health and medical services.
- The service plan may be informed by the findings of the initial clinical evaluation.

THERAPEUTIC FOSTER CARE

Therapeutic Foster Care provides a structured home environment in which specifically trained foster parents teach social, behavioral, and emotional skills to children and adolescents who are at risk of placement, or who have complex and significant behavioral health problems which cannot be managed at home. Therapeutic Foster Care is focused on addressing the factors that precipitated the need for this service (e.g., changes in the member's signs and symptoms, psychosocial and environmental factors, or level of functioning) to the point that that the member can safely transition back to the family of origin or to an alternative family placement.

Placements in a therapeutic foster home are usually limited to two youths per family. Whenever appropriate, Therapeutic Foster Care supports family permanence by also training the parent(s)/guardian(s) to manage the member's needs and behavior, and by providing case management.

Therapeutic Foster Care varies in intensity and duration in order to support the member's ability to manage functional difficulties and enhance the member's resiliency.

Therapeutic Foster Care Admission Criteria

- See *Common Admission Criteria for All Levels of Care*
  AND
- The member is not in imminent or current risk of harm to self, others, and/or property.
- Factors that precipitated access to this service (e.g., changes in the member's signs and symptoms, psychosocial and environmental factors, or level of functioning) indicate that the member cannot be suitably cared for in the member's home. Examples include:
    - The member is at risk for placement.
    - The member has complex and significant behavioral health problems that cannot be managed by the member's family or caregiver.

Therapeutic Foster Care Continued Service Criteria

- See *Common Continued Service Criteria for All Levels of Care*

Therapeutic Foster Care Discharge Planning and Criteria

- See *Common Discharge Criteria for All Levels of Care*

Therapeutic Foster Care Clinical Best Practices

- See *Common Clinical Best Practices for All Levels of Care*
- The responsible Therapeutic Foster Care provider evaluates the member's needs as well as the needs of the family or caregiver upon admission.
- The responsible Therapeutic Foster Care provider, in conjunction with the member and/or member's family or caregiver, develops a plan that includes a description of the following:
    - The goal of Therapeutic Foster Care;
    - Objectives aimed at achieving the goal(s) of Therapeutic Foster Care, including interventions aimed at promoting effective parenting skills as appropriate.
- The plan includes instructions for accessing behavioral health services.

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HISTORY/REVISION INFORMATION

Date	Action/Description
01/10/2017	• Version 1 (Approved by UMC)
02/07/2018	• Version 2 (Approved by UMC)