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# New York Utilization Management Level of Care Guidelines

**Document Number**: UHCNY_UM -GUP2-P1-HC(a)  
**Effective Date**: August, 2019

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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 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")).

INSTRUCTIONS FOR USE

This guideline is used to make coverage determinations as well as to inform discussions about evidence-based practices and discharge planning for behavioral health benefit plans managed by Optum®1. When deciding coverage, the member’s specific benefits must be referenced.

All reviewers must first identify member eligibility, the member-specific benefit plan coverage, and any federal or state regulatory requirements that supersede the member’s benefits prior to using this guideline. In the event that the requested service or procedure is limited or excluded from the benefit, is defined differently or there is otherwise a conflict between this guideline and the member's specific benefit, the member’s specific benefit supersedes this guideline. Other clinical criteria may apply. Optum reserves the right, in its sole discretion, to modify its clinical criteria as necessary using the process described in Clinical Criteria.

This guideline is provided for informational purposes. It does not constitute medical advice.

Optum may also use tools developed by third parties that are intended to be used in connection with the independent professional medical judgment of a qualified health care provider and do not constitute the practice of medicine or medical advice.

Optum may develop clinical criteria or adopt externally-developed clinical criteria that supersede this guideline when required to do so by contract or regulation.

1 Optum is a brand used by United Behavioral Health and its affiliates.
COMMON CRITERIA

Admission Criteria

- 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.
  - The member’s condition includes consideration of the acute and chronic symptoms in the member’s history and presentation including co-occurring behavioral health or medical conditions, informed by the information collected by the provider following evaluation and treatment planning described in the Common Best Practices.

AND

- The member’s condition can be safely, efficiently, and effectively assessed and/or treated in the proposed level of care. Assessment and/or treatment of the member’s condition require the intensity and scope of services provided in the proposed level of care.

AND

- Co-occurring behavioral health and medical conditions can be safely managed in the proposed level of care.

AND

- Services are medically necessary.

AND

- For all levels of care, services must be for the purpose of diagnostic study or reasonably be expected to improve the patient’s condition. The treatment must, at a minimum, be designed to reduce or control the patient’s psychiatric symptoms so as to prevent relapse or hospitalization, and improve or maintain the patient’s level of functioning.
  - It is not necessary that a course of therapy have as its goal restoration of the patient to the level of functioning exhibited prior to the onset of the illness, although this may be appropriate for some patient. For many other psychiatric patients, particularly those with long-term chronic conditions, control of symptoms and maintenance of a functional level to avoid further deterioration or hospitalization is an acceptable expectation of improvement. “Improvement” in this context is measured by comparing the effect of continuing treatment versus discontinuing it. Where there is a reasonable expectation that if treatment were withdrawn the patient’s condition would deteriorate, relapse further, or require hospitalization, this criterion is met.
  - In addition to the above, for outpatient services, some patients may undergo a course of treatment that increases their level of functioning but then reach a point where further significant increase is not expected. Such claims are not automatically considered noncovered because conditions have stabilized, or because treatment is now primarily for the purpose of maintaining a present level of functioning. Rather, coverage depends on whether the criteria discussed above are met; for example, that stability can be maintained without further treatment or with less intensive treatment.

Continuing Stay Criteria

- 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 consistent with Common Clinical Best Practices;
  - Reasonably expected to improve the member’s presenting problems.

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 and feasible.
Discharge Criteria

- The continued stay criteria are no longer met. Examples include:
  - The member’s condition no longer requires care.
  - The member’s condition has changed to the extent that the condition now meets admission criteria for another level of care.
  - Treatment is primarily for the purpose of providing social, custodial, recreational, or respite care.
  - The member requires medical/surgical treatment.
  - After an initial assessment the member is unwilling or unable to participate in treatment despite motivational support or intervention to engage in treatment, and involuntary treatment or guardianship is not being pursued.

COMMON CLINICAL BEST PRACTICES

Introduction

In assessing whether the criteria set forth in these guidelines is satisfied, staff should consider the clinical information collected from the provider following evaluation and treatment planning described in Common Clinical Best Practices. Staff should update the clinical information through continued consultation with the provider at appropriate intervals as the treatment progresses, including information about new or different symptoms or conditions that may emerge in the course of treatment.

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 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 the member’s condition including 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.
  o When the member’s condition has improved, the provider determines if the treatment plan should be altered, or if treatment is no longer required.
  o 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:
  o An appropriate discharge plan is in place prior to discharge;
  o The discharge plan is designed to mitigate the risk that the factors precipitating admission will reoccur;
  o The member agrees with the discharge plan.

• For members continuing treatment:
  o 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:
  o 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.
  o The provider explains the risk of discontinuing treatment when the member refuses treatment or repeatedly does not adhere with the treatment plan.
MENTAL HEALTH: 23 HOUR OBSERVATION

23 Hour Observation: A program that provides a medically-safe environment for up to 23 hours during which the factors that precipitated the need for service (e.g., changes in the member’s signs and symptoms, psychosocial and environmental factors, or level of functioning) are rapidly assessed and stabilized to the point that the member’s condition can be safely, efficiently, and effectively treated in an ambulatory setting, or it is determined that the member’s condition requires treatment in a more intensive level of care.

Admission Criteria
- See Common Criteria
  AND
- The factors leading to admission and/or the member’s history of treatment suggest that the member is likely to respond to rapid assessment and stabilization.
  OR
- The factors leading to admission require immediate assessment and intervention to determine if admission to an inpatient setting is warranted.

Continuing Stay Criteria
- See Common Criteria

Discharge Criteria
- See Common Criteria

Clinical Best Practices
- See Common Clinical Best Practices
- The focus of evaluation and treatment planning is to determine whether the member’s condition can be safely, efficiently, and effectively treated in an ambulatory setting, or whether the member should be admitted to an inpatient setting.

MENTAL HEALTH: CRISIS STABILIZATION & ASSESSMENT

Crisis Stabilization & Assessment: A program in which the factors that precipitated the need for service (e.g., changes in the member’s signs and symptoms, psychosocial and environmental factors, or level of functioning) are rapidly assessed and stabilized to the point that the member’s condition can be safely, efficiently and effectively treated in a less intensive level of care, or it is determined that the member’s condition requires treatment in a more intensive level of care.

There are different types of Crisis Stabilization & Assessment programs. For example, mobile crisis teams are designed to rapidly triage members in crisis who are unable or unwilling to go to an Emergency Room or a facility-based Crisis Stabilization & Assessment program.

More extended and extensive services are offered in Crisis Stabilization & Assessment programs which employ behavioral health professionals and peers to deliver a range of 24-hour services over the course of several days. These programs may be freestanding or co-located with another facility-based program, and the services they provide may include crisis stabilization with/without medication management, peer support, recovery/resiliency planning, an organized sobriety group, social and recreational activities, facilitated access to the next appropriate level of care, and information about community resources.

Admission Criteria
- See Common Criteria
  AND
- The factors leading to admission and/or the member’s history of treatment suggest that the member is likely to respond to rapid assessment and stabilization.
  OR
- The factors leading to admission require immediate assessment and intervention to determine if admission to an inpatient setting is warranted.

Continuing Stay Criteria
• See Common Criteria

**Discharge Criteria**
• See Common Criteria

**Clinical Best Practices**
• See Common Clinical Best Practices
• The focus of evaluation and treatment planning is to determine whether the member’s condition can be safely, efficiently, and effectively treated in an ambulatory setting, or whether the member should be admitted to an inpatient setting.
• The evaluation addresses the following:
  o Presenting concerns;
  o Urgent needs, including those related to the risk of harm to self, others, and/or property;
  o The history of crises, including:
    ▪ Response to prior interventions;
    ▪ Issues since last crisis stabilization;
  o Current living situation;
  o Availability of supports;
  o Current treatment;
  o Use of alcohol or drugs;
  o Co-occurring behavioral health or medical conditions.
• The treatment plan addresses the following:
  o The member’s urgent needs;
  o Immediate services needed to respond to the current crisis;
  o How the member’s family and other natural resources will be involved in resolving the crisis when clinically indicated;
  o How the member will be transitioned to other services.

**MENTAL HEALTH: DAY TREATMENT**

**Day Treatment:** A structured program most commonly found in state-funded benefit plans that maintains hours of service for at least 3 hours per day, at least 4 days per week. Day Treatment provides a combination of diagnostic, treatment, and rehabilitative procedures which, through supervised and planned activities and extensive interactions between the provider and the member, provides the services of the clinic treatment program, as well as social training, task and skill training and socialization activities. The purpose of services is to promote recovery through improved level of functioning, skill building, and disease management.

Day Treatment services are typically provided to members with more severe mental health conditions and related functional impairments as an alternative to services in a Residential Treatment Center or Inpatient, or as a transition from these services. Examples of at-risk members include children and adolescents with Serious Emotional Disturbance (SED)\(^2\), and adults with Serious Mental Illness (SMI)\(^3\).

The course of treatment is focused on addressing the member’s condition to the point that the member’s condition can be safely, efficiently and effectively treated in a less intensive level of care or no longer requires treatment. The member’s condition includes consideration of the acute and chronic symptoms in the member’s history and presentation, including co-occurring behavioral health or medical conditions, informed by information collected by the provider following evaluation and treatment planning as described in Common Clinical Best Practices.

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\(^2\) According to Federal Register Volume 62, Number 193, Serious Emotional Disturbance (SED) 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.

\(^3\) 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.
When supported by the benefit plan, coverage may be available for Day Treatment Program services that are coupled with overnight housing.

**Admission Criteria**
- See Common Criteria
- AND
- The member has a Serious Emotional Disturbance (SED) or Serious Mental Illness (SMI)
- AND
- Assessment and diagnosis and/or treatment planning requires observation and interaction for at least 3 hours per day, 4 days per week. Examples include:
  - Assessment requires frequent interaction with the member, and observation of the member with others.
  - The treatment plan must be changed frequently, which requires that the provider have face-to-face interactions with the member several times a week.
- OR
- The member requires engagement and support, which requires extended interaction between the member and the program. Examples include:
  - The member requires a coordinated transition back into the community after treatment in inpatient or a residential treatment center.
  - The member has been unable to access or utilize the member’s family or other natural resources on his or her own.
- OR
- The member requires a structured environment to practice and enhance skills. This requires face-to-face interactions several times a week that cannot be provided in a less intensive setting. Examples of skills include those that help the member:
  - Maintain his or her current living situation;
  - Return to work or school.
- OR
- The member requires a structured environment to complete goals and develop a plan for post-discharge services in a less intensive setting. Examples of assistance include the following:
  - Assistance with developing the skills needed to self-manage medications;
  - Assistance with making progress towards goals in spite of an environment that does not support recovery and/or limited community support services.

**Additional Criteria for Overnight Housing Coupled with a Day Treatment Program**
- Overnight housing is covered by the benefit plan.
- AND
- The treatment setting is separate from the housing.
- AND
- Either of the following apply:
  - An unsupportive or high-risk living situation is undermining the member’s recovery;
  - Routine attendance at Day Treatment is hindered by a lack of transportation.

**Continuing Stay Criteria**
- See Common Criteria

**Discharge Criteria**
- See Common Criteria

**Clinical Best Practices**
- See Common Clinical Best Practices
- The psychiatrist and treatment team complete the initial evaluation commensurate with the member’s needs, no later than 24 hours following admission.
- During admission, a psychiatrist is available to consult with the program during and after normal business hours.
- A psychiatrist sees the member commensurate with the member’s needs, with no less than weekly visits.
MENTAL HEALTH: INPATIENT

**Inpatient:** A structured hospital-based program which provides 24-hour/7-day nursing care, medical monitoring, and physician availability; assessment and diagnostic services, active behavioral health treatment, and specialty medical consultation with an immediacy needed to avoid serious jeopardy to the health of the member or others.

*The course of treatment is focused on addressing the member’s condition to the point that the member’s condition can be safely, efficiently and effectively treated in a less intensive level of care or no longer requires treatment. The member’s condition includes consideration of the acute and chronic symptoms in the member’s history and presentation, including co-occurring behavioral health or medical conditions, informed by information collected by the provider following evaluation and treatment planning as described in Common Clinical Best Practices.*

**Admission Criteria**

- See Common Criteria
- The member’s condition and/or the member’s history of response to treatment suggest that there is imminent or current risk of harm to self, others, and/or property which cannot be safely, efficiently, and effectively managed in a less intensive level of care. Examples include the following:
  - A life-threatening suicide attempt;
  - Self-mutilation, injury, or violence towards others or property;
  - Threat of serious harm to self or others;
  - Command hallucinations directing harm to self or others.
- The member’s condition cannot be safely, efficiently, and effectively treated in a less intensive setting due to a physical complication. Examples include:
  - A physical cause for the member’s signs and symptoms cannot be ruled out in a less intensive setting.
  - A severe medication side effect requires the level of monitoring and intervention available in an inpatient setting.
- The factors leading to admission cannot be safely, efficiently, and effectively assessed and/or treated in a less intensive setting due to changes in the member’s signs and symptoms, and/or psychosocial and environmental factors. Examples include:
  - Impairment of behavior or cognition that interferes with activities of daily living (ADLs) to the extent that the welfare of the member or others is endangered.
  - Psychosocial and environmental problems that threaten the member’s safety or undermines engagement in a less intensive level of care.
- The factors which led to admission to Crisis Stabilization & Assessment or 23-Hour Observation cannot be addressed, and the member must be admitted to inpatient.

**Continuing Stay Criteria**

- See Common Criteria
- Treatment is not primarily for the purpose of providing custodial care. Services are custodial when they are any of the following:
  - Non-health-related services, such as assistance with Activities of Daily Living (examples include feeding, dressing, bathing, transferring, and ambulating);
  - Health-related services provided for the primary purpose of meeting the personal needs of the member or maintaining a level of function (even if the specific services are considered to be skilled services), as opposed to improving that function to an extent that might allow for a more independent existence;
  - Services that do not require continued administration by trained medical personnel in order to be delivered safely and effectively.

**Discharge Criteria**

- See Common Criteria
Clinical Best Practices

- See Common Clinical Best Practices
- The psychiatrist, in conjunction with the treatment team, completes the initial evaluation within 24 hours of admission.
- During admission, the psychiatrist sees the member at least 5 times per week, and supervises and evaluates the treatment program to determine the extent to which treatment goals are being realized and whether changes in the treatment plan are needed.
- The first treatment appointment and medication management visit are scheduled to occur within a timeframe that is commensurate with the risk that the factors which led to admission will reoccur, but no later than 7 days from discharge.

MENTAL HEALTH: INTENSIVE OUTPATIENT PROGRAM

**Intensive Outpatient Program:** A structured program that maintains hours of service for at least 9 hours per week for adults and 6 hours per week for children/adolescents during which assessment and diagnostic services, and active behavioral health treatment are provided to members who are experiencing moderate signs and symptoms that result in significant personal distress and/or significant psychosocial and environmental issues. The purpose of services is to monitor and maintain stability, decreasing moderate signs and symptoms, increase functioning, and assist members with integrating into community life.

The course of treatment is focused on addressing the member’s condition to the point that the member’s condition can be safely, efficiently and effectively treated in a less intensive level of care or no longer requires treatment. The member’s condition includes consideration of the acute and chronic symptoms in the member’s history and presentation, including co-occurring behavioral health or medical conditions, informed by information collected by the provider following evaluation and treatment planning as described in Common Clinical Best Practices.

Intensive Outpatient Programs provide education, treatment, and the opportunity to practice new skills outside the program.

An Intensive Outpatient Program can be used to treat mental health conditions or can specialize in the treatment of co-occurring mental health and substance-related disorders.

When supported by the benefit plan, coverage may be available for Intensive Outpatient Program services that are coupled with overnight housing.

**Admission Criteria**

- See Common Criteria
  
  AND
  
  Assessment and diagnosis and/or treatment planning requires observation and interaction a minimum of 9 hours per week for adults and 6 hours per week for children/adolescents. Examples include the following:
  
  - Assessment requires frequent interaction with the member and observation of the member with others.
  - The treatment plan must be frequently changed, which requires that the provider have face-to-face interactions with the member several times a week.

  OR

  - The member requires engagement and support which requires extended interaction between the member and the program. Examples include:
    
    - The member requires a coordinated transition back into the community after treatment in inpatient or a residential treatment center.
    - The member has been unable to access or utilize the member’s family or other natural resources on his or her own.

  OR

  - The member requires a structured environment to practice and enhance skills. This requires face-to-face interactions several times a week that cannot be provided in a less intensive setting. Examples of skills include those that help the member:
    
    - Maintain their current living situation;
    - Return to work or school.
• The member requires a structured environment to complete goals and develop a plan for post-discharge services in a less intensive setting. Examples of skills include those that help the member:
  o Assistance with developing the skills needed to self-manage medications;
  o Assistance with making progress toward goals in spite of an environment that does not support recovery and/or limited community support services.

Additional Criteria for Overnight Housing Coupled with an Intensive Outpatient Program

• Overnight housing is covered by the benefit plan.
  AND
• The treatment setting is separate from the housing.
  AND
• Either of the following apply:
  o An unsupportive or high-risk living situation is undermining the member’s recovery;
  o Routine attendance at an Intensive Outpatient Program is hindered by a lack of transportation.

Continuing Stay Criteria

• See Common Criteria

Discharge Criteria

• See Common Criteria

Clinical Best Practices

• See Common Clinical Best Practices
• The responsible provider and the treatment team complete the initial evaluation commensurate with the member’s needs, no later than 3 treatment days after admission.
• During admission, a psychiatrist is available to consult with the program during and after normal program hours.

MENTAL HEALTH: OTHER LICENSED PRACTITIONER

Other Licensed Practitioner: OLP service is delivered by a Non-physician licensed behavioral health practitioner (NP-LBHP) who is licensed in the state of New York operating within the scope of practice defined in State law and in any setting permissible under State practice law. OLP does not require a DSM diagnosis in order for the service to be delivered. NP-LBHPs include individuals licensed and able to practice independently as a:

• Licensed Psychoanalyst
• Licensed Clinical Social Worker (LCSW)
• Licensed Marriage & Family Therapist; or
• Licensed Mental Health Counselor

An NP-LBHP also includes the following individuals who are licensed under supervision or direction of a licensed Clinical Social Worker (LCSW), a Licensed Psychologist, or a Psychiatrist:

• Licensed Master Social Worker (LMSW)

In addition to licensure, service providers that offer addiction services must demonstrate competency as defined by state law and regulations. Any practitioner above must operate within a child serving agency that is licensed, certified, designated and/or approved by OCFS, OMH, OASAS OR DOH or its designee, in settings permissible by that designation.

Admission Criteria

• See Common Criteria
• The child/youth is being assessed by the NP-LBHP to determine the need for treatment. The NP-LBHP develops a treatment plan for goals and activities necessary to correct or ameliorate conditions discovered during the initial assessment visits that:
  o Corrects or ameliorates conditions that are found through an EPSDT screening; OR
  o Addresses the prevention, diagnosis, and/or treatment of health impairments; the ability to achieve age-appropriate growth and development, and the ability to attain, maintain, or regain functional capacity.
Continuing Stay Criteria

- See Common Criteria
- The child/youth is making some progress but has not fully reached established service goals and there is expectation that if the child/youth continues to improve, then the service continues OR
- Continuation of the service is needed to prevent the loss of functional skills already achieved.
- The child/youth continues to meet admission criteria AND
- The child/youth and/or family/caregiver(s) continue to be engaged in services AND
- An alternative service(s) would not meet the child/youth needs AND
- The treatment plan has been appropriately updated to establish or modify ongoing goals.

Discharge Criteria

- See Common Criteria
- The child/youth no longer meets continued stay criteria OR
- The child/youth has successfully reached individual/family established service goals for discharge; OR
- The child/youth or parent/caregiver(s) withdraws consent for services; OR
- The child/youth is not making progress on established service goals, nor is there expectation of any progress with continued provision of services; OR
- The child/youth is no longer engaged in the service, despite multiple attempts on the part of the provider to apply reasonable engagement strategies; OR
- The child/youth and/or family/caregiver(s) no longer needs OLP as he/she is obtaining a similar benefit through other services and resources.

Clinical Best Practices

- See Common Clinical Best Practices

Limits/Exclusions

- Groups must not exceed more than 6-8 members. Consideration may be given to a smaller limit of participants are younger than eight years of age.
- Evidence Based Practices (EBPs) require prior approval, designations, and fidelity reviews on an ongoing basis as determined necessary by New York State.
- Inpatient hospital facilities are allowed for licensed professional other than social workers if a Preadmission Screening and Resident Review (PASRR) indicate it is medically necessary treatment. Social worker visits are included in the Nursing Facility Visit and may not be billed separately.
- Visits to Intermediate Care Facilities for individuals with Mental Retardation (ICF-MR) are not covered.
- All NP-LBHP services provided while the person is a resident of an institution for Mental Disease, such a free standing psychiatric hospital or psychiatric residential treatment facility, are part of the institutional service and not otherwise reimbursable by Medicaid.
- If a child requires medically necessary services that are best delivered in the school setting by a community provider the service needs to be detailed on the treatment plan.
- If a child needs assistance in the schools (educationally necessary) and a school employee will be providing the service, the service must be on the child’s Individualized Education Plan (IEP)(504 plan services are not reimbursable by Medicaid).
- Evidence based practices (EBP) require approval, designations, and fidelity reviews on an ongoing basis as determined necessary by New York State. Treatment services must be a part of a treatment plan including goals and activities necessary to correct or ameliorate conditions discovered during the initial assessment visits.
MENTAL HEALTH: OUTPATIENT

**Outpatient:** Assessment and diagnosis and active behavioral health treatment that are provided in an ambulatory setting, via a secure two-way real time interactive telemental health system, or in the member’s home. The course of treatment is focused on addressing the member’s condition to the point that the member’s condition can be safely, efficiently and effectively treated in a less intensive level of care or no longer requires treatment. The member’s condition includes consideration of the acute and chronic symptoms in the member’s history and presentation, including co-occurring behavioral health or medical conditions, informed by information collected by the provider following evaluation and treatment planning as described in Common Clinical Best Practices. Individual outpatient psychotherapy is generally provided in sessions lasting up to 45 minutes.

The following are not considered telemental health because they don’t utilize a secure two-way real time interactive telemental health system:
- Phone-based services including phone counseling, email, texting, voicemail, or facsimile except when allowed by State regulation;
- Remote medical monitoring devices;
- Virtual reality devices;
- Internet-based services including internet-based phone calls.

Extended outpatient sessions are individual psychotherapy sessions with or without evaluation and management services lasting 60 minutes or longer (53+ minutes, per the CPT Time Rule). Extended outpatient sessions may require prior authorization before services are received, except in extenuating circumstances, such as a crisis.

Home-based assessment and treatment are separate services, and the findings of a home-based assessment may or may not support the need for home-based treatment.

**Admission Criteria**

- See Common Criteria

Coverage for extended outpatient sessions lasting longer than 60 minutes (53+ minutes, per the CPT Time Rule) may be indicated in the following non-routine circumstances:

- The member is experiencing a crisis but is not at imminent risk of harm to self or others, and an extended outpatient session is appropriate for providing rapid and time-limited assessment and stabilization.
  - Consider extending coverage for crisis situations in 30-minute increments when clinically indicated.
  - Prior authorization is not required when there is a crisis.
- An individual psychotherapy session with evaluation and management is being provided, and there is an unexpected complication resulting from pharmacotherapy, or a worsening of the member’s condition that would likely require a more intensive level of care if the outpatient session is not extended.
- Periodic involvement of children, adolescent, or geriatric members’ family in a psychotherapy sessions when such involvement is essential to the member’s progress (e.g., when psychoeducation or parent management skills are provided).
  - This is not synonymous with marital or family therapy.
- An extended session is otherwise needed to address new symptoms of the reemergence of old symptoms with a rapid, time-limited assessment and stabilization response. Without an extended outpatient session, the new-re-emerging symptoms are likely to worsen and require a more intensive level of care.

Extended outpatient sessions may be covered in the following circumstances, as indicated by the member’s condition and specific treatment needs:
- The member has been diagnosed with Posttraumatic Stress Disorder, Panic Disorder, Obsessive Compulsive Disorder, or Specific Phobia, and is being treated with Prolonged Exposure Therapy.
- The member is being treated with Eye Movement Desensitization and Reprocessing (EMDR) or Traumatic Incident Reduction (TIR) for Posttraumatic Stress Disorder (PTSD).
- Borderline Personality Disorder is a covered condition, and the member is being treated with Dialectical Behavior Therapy (DBT).

Home-Based outpatient assessment and/or treatment may be covered when the member is homebound. A member is homebound when:
• A physical condition restricts the member’s ability to leave his/her residence except with the aid of supportive devices such as crutches, canes, wheelchairs, and walkers; the use of special transportation; or the assistance of another person; or if leaving home is medically contraindicated.

• A behavioral health condition is manifested in part by an inability to leave home, or is such that it would not be considered safe for the member to leave home unattended.

Home-based outpatient assessment may be covered when:
• An assessment of the changes in the member’s signs and symptoms, and/or psychosocial and environmental factors is required to determine if behavioral health services are needed.
• An assessment of psychosocial and environmental factors conducted in an ambulatory setting was inconclusive.

Home-based outpatient treatment may be covered when:
• The member’s signs and symptoms are primarily or exclusively experienced at home.
• The member’s condition undermines participation in treatment at an ambulatory setting.

Coverage for outpatient telemental health service may be covered when:
• The Outpatient Admission Criteria are met.
AND
• A secure two-way real time interactive telemental health system is available to facilitate interaction between the member and the provider.

Continuing Stay Criteria
• See Common Criteria

Discharge Criteria
• See Common Criteria

Clinical Best Practices
• See Common Clinical Best Practices
• The frequency and duration of outpatient visits allows for safe, efficient, and effective achievement of treatment goals, and supports the member’s recovery and resiliency. Initially, the frequency of visits varies from weekly in routine cases to several times a week. As the member’s functional status improves, the frequency of visits decreases to meet the member’s current needs and treatment goals. Factors that may impact frequency and duration include the following:
  o The goals of treatment;
  o The member’s preferences;
  o Evidence from clinical best practices which supports frequency and duration;
  o The need to monitor and manage imminent risk of harm to self, others, and/or property.
• The provider informs the member of the process to be followed in the event of an after-hours emergency, such as the availability of on-call services. The process is not solely reliant on the Emergency Room.

Additional best practices for home-based assessment and treatment are:
• The following conditions may support home-based assessment and/or treatment:
  o Agoraphobia or Panic Disorder;
  o Disorders of thought processes wherein the severity of delusions, hallucinations, agitation and/or impairments of thoughts/cognition grossly affect the member’s judgment and decision making, and therefore the member’s safety;
  o Depression with severe vegetative symptoms;
  o Behavioral health problems associated with medical problems that render the member homebound.

Additional best practices for telemental health are:
• Asynchronous store and forward technologies (i.e., the transmission of a member’s clinical record, lab results, or other clinical information from an originating site to the provider at a distant site) is not part of the standard of care for telemental health.
• The following are not considered telemental health because they don’t utilize a secure two-way real time interactive telemental health system:
  o Phone-based services including phone counseling, email, texting, voicemail, or facsimile except when allowed by State regulation;
Remote monitoring devices;
- Virtual reality devices;
- Internet-based services including internet-based phone calls.

- A qualified provider at the distant site is licensed in the state where the member resides.
- Delivery of group or family psychotherapy to members at different locations (i.e., multipoint videoconferencing) may be covered when all members are in the state where the provider is licensed, and all locations provide secure two-way real time interactive telemental health systems.
- Services are delivered in a manner consistent with the Health Insurance Portability and Accountability Act (HIPAA) and other applicable privacy and security regulations and standards.

**MENTAL HEALTH: PARTIAL HOSPITAL PROGRAM**

**Partial Hospital Program:** A structured program that maintains hours of service for at least 20 hours per week during which assessment and diagnostic services, and active behavioral health treatment are provided to members who are experiencing serious signs and symptoms that result in significant personal distress and/or significant psychosocial and environmental issues. While a Partial Hospital Program generally maintains at least 20 hours of service per week, the frequency of weekly visits provided to a member may lessen as the member nears discharge in order to promote a safe and timely transition between levels of care.

Partial Hospital Programs provide education, treatment, and the opportunity to practice new skills outside the program.

The course of treatment is focused on addressing the member’s condition to the point that the member’s condition can be safely, efficiently and effectively treated in a less intensive level of care or no longer requires treatment. The member’s condition includes consideration of the acute and chronic symptoms in the member’s history and presentation, including co-occurring behavioral health or medical conditions, informed by information collected by the provider following evaluation and treatment planning as described in Common Clinical Best Practices.

Partial Hospital Program can be used to treat mental health conditions or can specialize in the treatment of co-occurring mental health and substance-related disorders.

When supported by the benefit plan, coverage may be available for Partial Hospital Program services that coupled with overnight housing.

**Admission Criteria**

- See Common Criteria AND
- Assessment and diagnosis and/or treatment planning requires observation and interaction for at least 20 hours per week. Examples include the following:
  - Assessment requires frequent interaction with the member, and observation of the member with others.
  - The treatment plan must be changed frequently, which requires that the provider have face-to-face interactions with the members several times a week.

  OR

- The member requires engagement and support, which requires extended interaction between the member and the program. Examples include the following:
  - The member requires a coordinated transition back into the community after treatment in inpatient or a residential treatment center, such as engagement with wraparound services or natural resources.
  - The member has been unable to access or utilize family or other natural resources on his or her own.

  OR

- The member requires a structured environment to practice and enhance skills. This requires face-to-face interactions several times a week that cannot be provided in a less intensive setting. Examples of skills include those that help the member:
  - Maintain their current living situation;
  - Return to work or school.

  OR

- The member requires a structured environment to complete goals and develop a plan for post-discharge services in a less intensive setting. Examples of assistance include the following:
o Assistance with developing the skills needed to self-manage medication.
o Assistance with making progress toward goals in spite of an environment that does not support recovery and/or limited community support services.

Additional Criteria for Overnight Housing Coupled with a Partial Hospital Program

- Overnight housing is covered by the benefit plan.
  AND
- The treatment setting is separate from the housing.
  AND
- Either of the following apply:
  o An unsupportive or high-risk living situation is undermining the member’s recovery;
  o Routine attendance at a Partial Hospital Program is hindered by a lack of transportation.

Continuing Stay Criteria

- See Common Criteria

Discharge Criteria

- See Common Criteria

Clinical Best Practices

- See Common Clinical Best Practices
- The psychiatrist and treatment team complete the initial evaluation commensurate with the member’s needs, no later than 24 hours following admission.
- During admission, a psychiatrist is available to consult with the program during and after normal business hours.
- A psychiatrist sees the member commensurate with the member’s needs, with no less than weekly visits.
- The frequency of weekly visits provided to a member may lessen as the member nears discharge in order to promote a safe and timely transition between levels of care.

WRAPAROUND SERVICES: ASSERTIVE COMMUNITY TREATMENT - ADULT

Assertive Community Treatment: 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.

The course of treatment is focused on addressing the member’s condition to the point that the member’s condition can be safely, efficiently and effectively treated in a less intensive level of care or no longer requires treatment. The member’s condition includes consideration of the acute and chronic symptoms in the member’s history and presentation, including co-occurring behavioral health or medical conditions, informed by information collected by the provider following evaluation and treatment planning as described in Common Clinical Best Practices.

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.

Admission Criteria

- See Common Criteria
  AND
- The member’s condition indicates indicate that the member requires assistance with accessing treatment and/or community resources. Examples include:
  o The member primarily relies on the emergency room for behavioral health services.
  o Impairment of behavior or cognition interferes with Activities of Daily Living (ADLs) to the extent that the member requires significant support or assistance.
• The member has been diagnosed with a severe and persistent mental illness listed in the DSM that seriously impairs their functioning in the community. Priority is given to people with schizophrenia, other psychotic disorders (e.g., schizoaffective disorder), bipolar disorder and/or major or chronic depression, because these illnesses more often cause long-term psychiatric disability.

• Recipients with serious functional impairments should demonstrate at least one of the following conditions:
  o Inability to consistently perform practical daily living tasks required for basic adult functioning in the community without significant support or assistance from others such as friends, family or relatives.
  o Inability to be consistently employed at a self-sustaining level or inability to consistently carry out the homemaker role.
  o Inability to maintain a safe living situation (e.g., repeated evictions or loss of housing).
  o Recipients with continuous high service needs should demonstrate one or more of the following conditions:
    ▪ Inability to participate or succeed in traditional, office-based services or case management.
    ▪ High use of acute psychiatric hospitals (two hospitalizations within one year, or one hospitalization of 60 days or more within one year).
    ▪ High use of psychiatric emergency or crisis services.
    ▪ Persistent severe major symptoms (e.g., affective, psychotic, suicidal or significant impulse control issues).
    ▪ Co-existing substance abuse disorder (duration greater than 6 months).
    ▪ Current high risk or recent history of criminal justice involvement.
    ▪ Court ordered pursuant to participate in Assisted Outpatient Treatment.
    ▪ Inability to meet basic survival needs or homeless or at imminent risk of becoming homeless.
    ▪ Residing in an inpatient bed or in a supervised community residence, but clinically assessed to be able to live in a more independent setting if intensive community services are provided.
    ▪ Currently living independently but clinically assessed to be at immediate risk of requiring a more restrictive living situation (e.g., community residence or psychiatric hospital) without intensive community services.

• The member receives an immediate needs assessment within 7 days of admission

• The initial Comprehensive Service Plan is completed within 30 days and reviewed and revised every 6 months.

Continuing Stay Criteria

• See Common Criteria
• Initial authorization criteria continue to be met.
• An immediate needs assessment and documentation of a plan to address these immediate needs is completed within 7 days of receipt of a referral.
• A Comprehensive Assessment is completed within 30 days of admission, with specific objectives and planned services to achieve recovery goals.
• The comprehensive service plan is reviewed and updated at least every 6 months which includes status of progress towards set goals, adjustment of goals and treatment plan if no progress is evident.
• There is evidence of coordination of care with other providers/stakeholders such as PCPs, specialty providers, inpatient treatment team, AOT, community supports, family, etc.
• When clinically indicated psychopharmacological intervention has been evaluated/instituted.

Discharge Criteria

• See Common Criteria
• Individuals who demonstrate, over a period of time, an ability to function in major life roles (i.e., work, social, self-care) and can continue to succeed with less intensive service.
• Individuals who move outside the geographic area of the ACT team’s responsibility. The ACT team must arrange for transfer of mental health service responsibility to an appropriate provider and maintain contact with the recipient until the provider and the recipient are engaged in this new service arrangement.
• Individuals who need a medical nursing home placement, as determined by a physician.
• Individuals who are hospitalized or locally incarcerated for three months or longer. However, an appropriate provision must be made for these individuals to return to the ACT program upon their release from the hospital or jail.
• Individuals who request discharge, despite the team’s best, repeated efforts to engage them in service planning. Special care must be taken in this situation to arrange alternative treatment when the recipient has a history of suicide, assault or forensic involvement.
• Individuals who are lost to follow-up for a period of greater than 3 months after persistent efforts to locate them, including following all local policies and procedures related to reporting individuals as "missing persons."
• For all persons discharged from ACT to another service provider within the team’s primary service area or county, there is a three-month transfer period during which recipients who do not adjust well to their new program may voluntarily return to the ACT program. During this period, the ACT team is expected to maintain contact with the new provider, to support the new provider’s role in the recipient’s recovery and illness management goals.
• The decision not to take medication is not a sufficient reason for discharging an individual from an ACT program.
• If a recipient of ACT services is under a court order to receive Assisted Outpatient Treatment, any discharge must be planned in coordination with the County’s AOT program administrator.

Clinical Best Practices

• See Common Clinical Best Practices
• The Assertive Community Treatment team is coordinated by a responsible behavioral health provider who:
  o Has knowledge and competencies that meet the member’s needs;
  o AND
  o Provides clinical supervision of the Assertive Community Treatment team.
• The Assertive Community Treatment team includes a psychiatrist who:
  o Provides assessment and treatment services;
  AND
  o Participates in team meetings;
  AND
  o 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.
  o 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.
  o 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.
  o 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:
  o Behavioral health illness or symptom reduction;
  o Housing;
  o Activities of Daily Living (ADLs);
  o Daily structure and employment;
  o 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:
  o Education about the member’s condition and its treatment;
  o Education about the member’s strengths;
  o Education about the family’s role in the member’s treatment;
  o Assistance with resolving conflicts;
  o 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 a 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.

**Limits/Exclusions**
- Individuals with a primary diagnosis of a personality disorder(s), substance abuse disorder or mental retardation are not appropriate for ACT.

### WRAPAROUND SERVICES: CASE MANAGEMENT - ADULT

**Case Management:** 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. The course of treatment is focused on addressing the member’s condition to the point that the member’s condition can be safely, efficiently and effectively treated in a less intensive level of care or no longer requires treatment. The member’s condition includes consideration of the acute and chronic symptoms in the member’s history and presentation, including co-occurring behavioral health or medical conditions, informed by information collected by the provider following evaluation and treatment planning as described in Common Clinical Best Practices.

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.

**Admission Criteria**
- See Common Criteria AND
- The member’s condition indicates 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.

**Continuing Stay Criteria**
- See Common Criteria

**Discharge Criteria**
Clinical Best Practices

- See Common Clinical Best Practices

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.

WRAPAROUND SERVICES: COMMUNITY PSYCHIATRIC SUPPORTS AND TREATMENT (CPST) - ADULT AND CHILD

CPST – Adult: includes time-limited goal-directed supports and solution-focused interventions intended to achieve identified person-centered goals or objectives as set forth in the individual’s Plan of Care and CPST Individual Service Plan.

The following activities under CPST are designed to help individuals with serious mental illness to achieve stability and functional improvement in the following areas: daily living, finances, housing, education, employment, personal recovery and/or resilience, family and interpersonal relationships and community integration. CPST is designed to provide mobile treatment and rehabilitation services to individuals who have difficulty engaging in site-based programs who can benefit from off-site rehabilitation or who have not been previously engaged in services, including those who had only partially benefited from traditional treatment or might benefit from more active involvement of their family of choice in their treatment.

Admission Criteria

- See Common Criteria

AND

Services are intended to help engage individuals with mental health and/or a substance use diagnosis who are unable to receive site-based care or who may benefit from community based services, including those who had only partially benefited from traditional treatment or might benefit from more active involvement of their family in their treatment. In addition, this service is intended for individuals who are being discharged from inpatient units, jail or prisons, and with a history of non-engagement in services; individuals who are transitioning from crisis services; and, for individuals who have disengaged from care.

Continuing Stay Criteria

- See Common Criteria

Discharge Criteria

- See Common Criteria

Clinical Best Practices

- See Common Clinical Best Practices

Limits/Exclusions

Community treatment for eligible individuals can continue as long as needed, within the limits, based on the individual’s needs. The intent of this service is to eventually transfer the care to a place based clinical setting.
The total combined hours for CPST, Psychosocial Rehabilitation (PSR) and Habilitation are limited to no more than a total of 500 hours in a calendar year.

**CPST - Child:** CPST services are goal-directed supports and solution-focused interventions intended to address challenges associated with a behavioral health need and to achieve identified goals or objectives as set forth in the child/youth’s treatment plan. This includes the implementation of interventions using evidenced-based techniques, drawn from cognitive-behavioral therapy and/or other evidenced-based psychotherapeutic interventions approved by New York State.

CPST includes the following components: Rehabilitative Psychoeducation, Intensive Interventions, Strengths Based Treatment Planning, Rehabilitative Supports, Crisis Avoidance, and Intermediate Term Crisis Management.

CPST is designed to provide community-based services to children and families who may have difficulty engaging in formal office settings, but can benefit from community based rehabilitative services. CPST allows for delivery of services within a variety of permissible settings including community locations where the member lives, works, attends school, engages in services (e.g. provider office sites), and/or socializes.

**Admission Criteria**

- See Common Criteria
- The child/youth has a behavioral health diagnosis that demonstrates symptoms consistent or corresponding with the DSM OR the child/youth is at risk of development of a behavioral health diagnosis; AND
- The child/youth is expected to achieve skill restoration in one of the following areas:
  - Participation in community activities and/or positive peer support networks;
  - Personal relationships;
  - Personal safety and/or self-regulation;
  - Independence/productivity;
  - Daily living skills;
  - Symptom management;
  - Coping strategies and effective functioning in the home, school, social or work environment; AND
- The child/youth is likely to benefit from and respond to the service to prevent the onset or the worsening of symptoms; AND
- The services are recommended by the following Licensed Practitioners of the Health Arts operating within the scope of their practice under state license:
  - Licensed Master Social Worker
  - Licensed Clinical Social Worker
  - Licensed Mental Health Counselor
  - Licensed Creative Arts Therapist
  - Licensed Marriage and Family Therapist
  - Licensed Psychoanalyst
  - Licensed Psychologist
  - Physician’s Assistant
  - Psychiatrist
  - Physician
  - Registered Professional Nurse or
  - Nurse Practitioner

**Continuing Stay Criteria**

- See Common Criteria
- The child/youth continues to meet admission criteria; AND
- The child/youth shows evidence of engagement toward resolution of symptoms but has not fully reached established service goals and there is expectation that if the service continues, the child/youth will continue to improve; AND
- The child/youth does not require an alternative and/or higher, more intensive level of care or treatment; AND
- The child/youth is at risk of losing skills gained if the service is not continued; AND
• Treatment planning includes family/caregiver(s) and/or other support systems, unless not clinically indicated or relevant.

Discharge Criteria
• See Common Criteria
• The child/youth no longer meets admission criteria and/or meets criteria for another level of care, either more or less intensive; OR
• The child/youth has successfully met the specific goals outlined in the treatment plan for discharge; OR
• The child/youth or parent/caregiver(s) withdraws consent for services; OR
• The child/youth is not making progress on established service goals, nor is there expectation of any progress with continued provision of services; OR
• The child/youth is no longer engaged in the service, despite multiple attempts on the part of the provider to apply reasonable engagement strategies; OR
• The child/youth and/or family/caregiver(s) no longer needs this service as he/she is obtaining a similar benefit through other services and resources.

Clinical Best Practices
• See Common Clinical Best Practices

Limits/Exclusions
• The provider agency will assess the child prior to developing a treatment plan for the child.
• Treatment services must be part of the treatment plan including goals and activities necessary to correct or ameliorate conditions discovered during the initial assessment visits.
• A child with a developmental disability diagnosis without a co-occurring behavioral health condition is ineligible to receive this rehabilitative service.
• Group face-to-face may occur for Rehabilitative Supports
• Group should not exceed more than 6-8 members. Consideration may be given to a smaller limit of members if participants are younger than eight years of age.

WRAPAROUND SERVICES: CRISIS RESPONSE - CHILD

Crisis Response: interventions designed to assist children and families when they are in a crisis. A crisis is an unplanned event that requires a rapid response. A crisis includes instances in which a person cannot manage his/her behavior or psychiatric symptoms without the help of a third party. A crisis may also include situations in which the experience of challenges in daily life have resulted in, or are at risk of creating, an escalation in psychiatric symptoms which cannot be managed without acute crisis intervention. This may include de-escalation techniques, assessment, consultation, facilitating the safety plan interventions, and referral when necessary. Crisis response services are to be made available on a 24 hour/7 day a week basis.

Admission Criteria
• See Common Criteria

Continuing Stay Criteria
• See Common Criteria

Discharge Criteria
• See Common Criteria

Clinical Best Practices
• See Common Clinical Best Practices
**Family Support Services – Adult:** Training and support necessary to facilitate engagement and active participation of the family in the treatment planning process and with the ongoing instruction and reinforcement of skills learned throughout the recovery process. This service is provided only at the request of the individual. A person-centered or person-directed, recovery oriented, trauma-informed approach to partnering with families and other supporters to provide emotional and information support, and to enhance their skills so that they can support the recovery of a family member with a substance use disorder/mental illness. The individual, his or her treatment team and family are all primary members of the recovery team.

For purposes of this service, "family" is defined as the persons who live with or provide care to a person served on the waiver and may include a parent, spouse, significant other, children, relatives, foster family, or in-laws. "Family" does not include individuals who are employed to care for the participant.

Training includes instruction about treatment regimens, elements, recovery support options, recovery concepts, and medication education specified in the Individual Service Plan and shall include updates, as necessary, to safely sustain the participant at home and in the community. All family support and training must be included in the individual’s service plan and for the benefit of the Medicaid covered participant.

**Admission Criteria**
- See Common Criteria
- Individual assessed to need, and has a preference for family support and training services. All families and those in the individual’s support network are eligible for this service at the discretion of the individual
- A release of information from the individual is always required to allow staff to contact significant people, except in cases of threat of injury or death

**Continuing Stay Criteria**
- See Common Criteria

**Discharge Criteria**
- See Common Criteria

**Clinical Best Practices**
- See Common Criteria

**Limits/Exclusions**
The total combined hours for Family Support and Training are limited to no more than a total of 40 hours in a calendar year.

**Family Support Services (FSS) – Child:** FSS are an array of formal and informal services and supports provided to families raising a child who is experiencing social, emotional, developmental and/or behavioral challenges in their home, school, placement, and/or community. FSS activities can consist of engaging the parent/caregiver in activities in the home and community that are designed to address one or more goals on the waiver participant’s service plan; assisting parent/caregiver in meeting the needs of the youth through educating, supporting, coaching, modeling and guiding; teaching parent/caregiver how to network/link to community resources and treatment providers; teaching parent/caregiver how to advocate for services and resources to meet the youth’s needs; and guiding and supporting linkage to individual, peer/parent support, and self-help groups for parent/caregiver.
Family Support Workers (FSW) are parents who are raising or have raised a child with mental health concerns and are personally familiar with the associated challenges. FSW’s offer the integrity of their experience to the families they serve and are often able to connect with waiver families based on a unique understanding of their circumstances. FSW’s have first-hand knowledge of the services and supports available in the community. FSW’s offer waiver families’ activities designed to enhance the family unit, ultimately developing safe, stable, and supportive families who are connected to their communities.

**Admission Criteria**
- See Common Criteria

**Continuing Stay Criteria**
- See Common Criteria

**Discharge Criteria**
- See Common Criteria

**Clinical Best Practices**
- See Common Clinical Best Practices

### WRAPAROUND SERVICES: EDUCATION SUPPORT SERVICES - ADULT

*Education Support Services:* are provided to assist individuals with mental health or substance use disorders who want to start or return to school or formal training with a goal of achieving skills necessary to obtain employment. Services may also include classes, vocational training, and tutoring to receive a Test Assessing Secondary Completion (TASC) diploma, as well as support to the participant to participate in an apprenticeship program.

**Admission Criteria**
- See Common Criteria

**Continuing Stay Criteria**
- See Common Criteria

**Discharge Criteria**
- See Common Criteria

**Clinical Best Practices**
- See Common Clinical Best Practices

### WRAPAROUND SERVICES: INTENSIVE IN-HOME - CHILD

*Intensive In-Home (IIH):* Services that support the child's social and emotional development and learning. IIH supports the child and family in implementing both the Treatment Plan (from the clinical provider) and the Waiver Service Plan (established by the Waiver program). Strategies are designed to be sensitive to the culture and values of each individual family and may include:
- anger management,
- psycho-education,
- post crisis de-briefing,
- re-enforcing the integration of safety plans in the home,
- parent-child relationship building,
- teaching parenting skills,
- providing support in emotional self-regulation in situational contexts including anger management,
- encouraging supportive sibling relationships with the Waiver child,
- developing healthy coping mechanisms,
- making healthy choices,
- building self-esteem,
- clarifying identity issues, etc.

**Admission Criteria**
• See Common Criteria

Continuing Stay Criteria

• See Common Criteria

Discharge Criteria

• See Common Criteria

Clinical Best Practices

• See Common Clinical Best Practices

WRAPAROUND SERVICES: PEER SERVICES AND SUPPORTS – ADULT

Peer Services and Supports - ADULT: Peer Support services are peer-delivered services with a rehabilitation and recovery focus. They are designed to promote skills for coping with and managing behavioral health symptoms while facilitating the utilization of natural resources and the enhancement of recovery-oriented principles (e.g. hope and self-efficacy, and community living skills). Peer support uses trauma-informed, non-clinical assistance to achieve long-term recovery from a behavioral health disorder.

Activities included must be intended to achieve the identified goals or objectives as set forth in the individual’s individualized service plan, which delineates specific goals that are flexibly tailored to the participant and attempt to utilize community and natural supports. The intent of these activities is to assist individuals in initiating recovery, maintaining recovery, and enhancing the quality of personal and family life in long-term recovery.

The structured, scheduled activities provided by this service emphasize the opportunity for peers to support each other in the restoration and expansion of the skills and strategies necessary to move forward in recovery. Individuals providing these services will do so through the paradigm of the shared personal experience of recovery. There are 6 categories of peer support components:

• Advocacy
• Outreach and Engagement
• Self-help tools
• Recovery Supports
• Transitional Supports
• Pre-crisis and Crisis Supports

Admission Criteria

• See Common Criteria

AND

• Peer support is voluntary, subject to periodic review of goals and based on medical necessity.

Continuing Stay Criteria

• See Common Criteria

Discharge Criteria

• See Common Criteria

Clinical Best Practices

• See Common Clinical Best Practices

Limits/Exclusions

Peer support services are limited to no more than a total of 500 hours in a calendar year. Individuals receiving SUD outpatient treatment may not receive Peer Supports, if they are receiving an OASAS state plan peer service.

Note: peer services while an individual is incarcerated or institutionalized are not reimbursable. Time spent on the phone with individuals is not reimbursable. The cost of admission to an event (i.e.,
sports event or concert) is not reimbursable. Advocacy for community improvement (not specific to the Medicaid eligible individual) is not reimbursable.

WRAPAROUND SERVICES: PERSONALIZED RECOVERY ORIENTED SERVICES (PROS) - ADULT

**PROS:** PROS is a comprehensive recovery oriented program for individuals with severe and persistent mental illness. Through a single plan of care, the program model integrates treatment, support, and rehabilitation in a manner that facilitates the individual's recovery. The PROS model is person-centered, strength based, and comprised of a menu of group and individual services designed to assist a participant to overcome mental health barriers and achieve a desired life role. As PROS is individualized, a person can participate in one service or multiple services as needed. Examples of goals for program participants are to: improve functioning, reduce inpatient utilization, reduce emergency services, reduce contact with the criminal justice system, increase employment, attain higher levels of education, and secure preferred housing.

PROS programs offer combinations of the following 4 service components:

1. Community Rehabilitation and Support (CRS): includes services designed to engage and assist individuals in managing their illness and restoring those skills and supports necessary for living successfully in the community.

2. Intensive Rehabilitation (IR) consists of four different services:
   a. Intensive Rehabilitation Goal Acquisition to help an individual attain a specific goal within a certain area such as education, housing or employment.
   b. Intensive Relapse Prevention includes targeted interventions to reduce the risk of hospitalization or involvement in the criminal justice system.
   IR also includes two evidence-based practices:
   c. Family Psychoeducation
   d. Integrated Dual Disorder Treatment (IDDT) (includes smoking cessation)

3. Ongoing Rehabilitation and Support (ORS): ORS, as a service, provides supports to assist individuals in managing their symptoms in the competitive workplace. OMH recommends that PROS programs use the Individual Placement & Support evidence-based model for employment services.

4. Clinical Treatment: an optional component of a PROS program, Clinical Treatment provides a recovery-focused, disability management approach with medication management, health assessment, clinical counseling and therapy, symptom monitoring, and treatment for co-occurring disorders. PROS participants can choose to receive their Clinical Treatment through PROS program or from another provider. As of 2015, 87 of the 90 NYS PROS programs offer the Clinical Treatment component and 78% of PROS recipients receive their clinical treatment at their PROS program.

**Admission Criteria**
- See Common Criteria
- The member is Be 18 years of age or older;
- The member has been diagnosed with a mental illness diagnosis;
- The member has a functional disability due to the severity and duration of mental illness; and
- The member has been recommended for admission by a Licensed Practitioner of the Healing Arts.
- Pre-Admission begins with initial visit and ends when Initial Service Plan (ISR) is submitted to MMCO/HARP.
- Admission begins when ISR is approved by MMCO/HARP. IRP must be developed within 60 days of admission date.
- Active Rehabilitation begins when the IRP is approved by the MMCO/HARP.
- Individualized Recovery Plan (IRP) is developed within 60 days of admission
- The IRP is reviewed and updated, at a minimum, every 6 months
- For individuals receiving Intensive Rehabilitation (IR) or Ongoing Rehabilitation and Supports (ORS), the IR or ORS services identified in the IRP shall be assessed for continued need, at a minimum, every 3 months

**Continuing Stay Criteria**
• See Common Criteria
• Concurrent review and authorizations should occur at 3-month intervals for IR and ORS services and at 6-month intervals for Community Rehabilitation and Support (CRS) and Clinic Treatment services. Continuing stay criteria may include:
  o The member has an active recovery goal and shows progress toward achieving it; OR
  o The member has met and is sustaining a recovery goal, but would like to pursue a new goal; OR
  o The member requires a PROS level of care in order to maintain psychiatric stability and there is not a less restrictive level of care that is appropriate; OR without PROS services the individual would require a higher level of care.

**Discharge Criteria**
• See Common Criteria
• Any one of the following must be met:
  o The member has sustained recovery goals for 6-12 months and a lower level of care is clinically indicated.
  o The member has achieved current recovery goals and can identify no other goals that would require additional PROS services.
  o The member is not participating in a recovery plan, is not making progress toward any goals, extensive engagement efforts have been exhausted, and no significant benefit is expected from continued participation.
  o The member can live, learn, work and socialize in the community with supports from natural and/or community resources.

**Clinical Best Practices**
• See Common Clinical Best Practices
• PROS services are offered in 3 phases that are defined based upon the pace of service planning and the specific service components offered: Pre-Admission, Admission, and Active Rehabilitation. NYS issued guidance on prior and concurrent review authorization for ambulatory services on May 14, 2015, which lists authorization and review requirements for each of the 3 phases. A person-centered approach is key when applying level of care criteria for PROS. The 3 phases of PROS include:
  o Pre-Admission: This phase begins with the initial visit and ends when the PROS provider submits an Initial Service Recommendation (ISR) to the MMCO/HARP. PROS providers bill a monthly Pre-Admission rate but add-ons for Intensive Rehabilitation, Ongoing Rehabilitation and Supports, and Clinical Treatment are not allowed. The Pre-Admission phase is open-ended to allow flexibility for recipients who may be ambivalent about participation or who may need an extended period of time to develop an initial goal. Although there is no time limit, PROS providers may not bill the Pre-Admission rate for more than 2 consecutive months. For example, a PROS provider may bill for month A but not month B because the recipient did not participate in month B. If the recipient returns and receives Pre-Admission services in months C and D, the PROS provider may bill for months C and D but may not bill for month E. If the recipient still has not decided to enroll and the provider has not submitted an Initial Service Recommendation, the recipient can remain in Pre-Admission status and the PROS provider could bill for month F and G (but not month H) if the recipient attends the program, etc.
  o Admission begins when the ISR is approved by the MMCO/HARP. Upon admission, providers may offer additional services and bill add-on rates accordingly for:
    • Intensive Rehabilitation (IR);
    • Ongoing Rehabilitation and Supports (ORS); or
    • Clinical Treatment.
  o Prior authorization for the Admission phase will ensure that individuals are not receiving duplicate services from other clinical or HCBS providers. An Individualized Recovery Plan (IRP) must be developed within 60 days of the admission date.
• Active Rehabilitation begins when the IRP is approved by MMCO/HARP. Concurrent review and authorizations should occur at 3-month intervals for IR and ORS services and at 6-month intervals for Base/Community Rehabilitation and Support (CRS) and Clinic Treatment services.
**Psychosocial Rehabilitation (PSR) – Adult:** services are designed to assist the individual with compensating for or eliminating functional deficits and interpersonal and/or environmental barriers associated with their behavioral health condition (i.e., SUD and/or mental health). Activities included must be intended to achieve the identified goals or objectives as set forth in the individual’s Service Plan. The intent of PSR is to restore the individual’s functional level to the fullest possible (i.e., enhancing SUD resilience factors) and as necessary for integration of the individual as an active and productive member of his or her family, community, and/or culture with the least amount of ongoing professional intervention.

**Admission Criteria**
- See Common Criteria
- Individuals must have the desire and willingness to receive rehabilitation and recovery services as part of his or her individual service plan, with the goal of living their lives fully integrated in the community and, if applicable, to learn skills to support long-term recovery from substance use through independent living, social support, and improved social and emotional functioning.
- Providers who did not apply for both PSR and Habilitation are encouraged to apply for both of these services. Programs without a joint designation will not be allowed to serve individuals having both a PSR and Habilitation goal on their Plan of Care.

**Continuing Stay Criteria**
- See Common Criteria

**Discharge Criteria**
- See Common Criteria

**Clinical Best Practices**
- See Common Clinical Best Practices

**Limits/Exclusions**
These services may complement, not duplicate, services aimed at supporting an individual to achieve an employment-related goal in their plan of care. The total combined hours for Psychosocial Rehabilitation, Community Psychiatric Support and Treatment, and Habilitation are limited to no more than a total of 500 hours in a calendar year.

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**Prevocational Services – Adult:** time-limited services that prepare an individual for paid or unpaid employment. This service specifically provides learning and work experiences where the individual with mental health and/or disabling substance use disorders can develop general, non-job-task-specific strengths and soft skills that contribute to employability in competitive work environment as well as in the integrated community settings. Pre-vocational services occur over a defined period of time and with specific person centered goals to be developed and achieved, as determined by the individual and his/her employment specialist and support team and ongoing person-centered planning process as identified in the individual’s person-centered Plan of Care. Pre-vocational services provide supports to individuals who need ongoing support to learn a new job and/or maintain a job in a competitive work environment or a self-employment arrangement. The outcome of this pre-vocational activity is documentation of the individual’s stated career objective and a career plan used to guide individual employment support.

**Admission Criteria**
- See Common Criteria
- Individuals must have a clear desire to work in competitive employment.

**Continuing Stay Criteria**
- See Common Criteria
Discharge Criteria
- See Common Criteria

Clinical Best Practices
- See Common Clinical Best Practices

Limits/Exclusions
The total combined hours (for pre-vocational services and transitional supported employment) are limited to no more than a total of 250 hours and a duration of 9 months of service in a calendar year.

For all employment supports services, documentation is maintained in the file of each individual receiving this service that the service is not available under a program funded under section 110 of the Rehabilitation Act of 1973 or the IDEA (20 U.S.C. 1401 et seq.). Federal financial participation is not claimed for incentive payments, subsidies, or unrelated vocational training expenses, such as the following:
- Incentive payments made to an employer to encourage or subsidize the employer's participation in a supported employment program
- Payments that are passed through to users of supported employment programs
- Payments for training that is not directly related to an individual's supported employment program

When Pre-vocational services are provided at a work site where individuals are competitively employed, payment is made only for the adaptations, supervision, and training required by individuals receiving services as a result of their disabilities but does not include payment for the supervisory activities rendered as a normal part of the business setting or work environment.

Prevocational Services - Child: structured around teaching concepts based on a specific Plan related to youth with disabilities. Services include activities that are not primarily directed at teaching skills to perform a certain job, but at underlying habilitative goals (e.g., attention span, motor skills, interpersonal relations with co-workers and supervisors) that are associated with building skills necessary to perform work and optimally to perform competitive, integrated employment such as:
- facilitating appropriate work habits;
- learning job production requirements;
- ability to communicate effectively with supervisors, co-workers and customers;
- generally accepted community workplace conduct and dress;
- ability to follow directions;
- ability to attend to and complete tasks;
- punctuality and attendance;
- appropriate behaviors in and outside the workplace;
- workplace problem solving skills and strategies;
- mobility training;
- career planning;
- proper use of job-related equipment and general workplace safety.

Admission Criteria
- See Common Criteria

Continuing Stay Criteria
- See Common Criteria

Discharge Criteria
- See Common Criteria

Clinical Best Practices
- See Common Clinical Best Practices
**Intensive Supported Employment (ISE) – Adult:** services that assist recovering individuals with MH/SUDs to obtain and keep competitive employment. These services consist of intensive supports that enable individuals to obtain and keep competitive employment at or above the minimum wage. This service uses evidence-based principles of the Individual Placement and Support (IPS) model.

This service is based on Individual Placement Support (IPS) model which is an evidence-based practice of supported employment. It consists of intensive employment supports that enable individuals for whom competitive employment at or above the minimum wage is unlikely, absent the provision of supports, and who, because of their clinical and functional needs, require supports to perform in a regular work setting.

Individual employment support services are individualized, person-centered services that provide supports to individuals who need ongoing support to learn a new job and maintain a job in a competitive employment or self-employment arrangement. Individuals in a competitive employment arrangement receiving Individual Employment Support Services are compensated at or above the minimum wage and receive not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities. The outcome of this activity is documentation of the individual’s stated career objective and a career plan used to guide individual employment support.

**Admission Criteria**

- See Common Criteria
- AND
- In order to achieve a successful outcome in ISE, an individual must have made a clear decision to work in competitive employment in the community.
- The basic tenet of ISE is that all individuals are capable of working in competitive employment in the community even without prior training and all individuals interested in employment should be given the opportunity.
- The ongoing level of care criteria including service duration, intensity and effectiveness should be reviewed by the BH HCBS provider and/or the MCO at least quarterly.

**Continuing Stay Criteria**

- See Common Criteria

**Discharge Criteria**

- See Common Criteria

**Clinical Best Practices**

- See Common Clinical Best Practices

**Limits/Exclusions**

250 hours per calendar year. For all employment supports services, documentation is maintained in the file of each individual receiving this service that the service is not available under a program funded under section 110 of the Rehabilitation Act of 1973 or the IDEA (20 U.S.C. 1401 et seq.). Federal financial participation is not claimed for incentive payments, subsidies, or unrelated vocational training expenses, such as the following:

- incentive payments made to an employer to encourage or subsidize the employer's participation in a supported employment program,
- payments that are passed through to users of supported employment programs,
- and payments for training that is not directly related to an individual's supported employment program.

When employment support services are provided at an integrated work site where individuals without disabilities are employed, payment is made only for the adaptations, supervision, and training required by OMH participants who receive services as a result of their disabilities but does not include payment for the supervisory activities rendered in as a normal part of the regular business setting.
**Supported Employment - Child**: services that are individually designed to prepare individuals with severe disabilities age 14 or older to engage in paid work. Supported Employment provides ongoing supports to participants who, because of their disabilities, need intensive on-going support to obtain and maintain an individual job in competitive or customized employment, or self-employment, in an integrated work setting in the general workforce for which an individual is compensated at or above the minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities. The outcome of this service is sustained paid employment at or above the minimum wage in an integrated setting in the general workforce, in a job that meets personal and career goals.

Supported employment services are individualized and may include any combination of the following services:
- vocational/job-related discovery or assessment;
- person-centered employment planning;
- job placement;
- job development;
- negotiation with prospective employers;
- job analysis;
- job carving;
- training and systematic instruction;
- job coaching;
- benefits support;
- training and planning;
- transportation;
- career advancement services;
- and other workplace support services including services not specifically related to job skill training that enable the waiver participant to be successful in integrating into the job setting.

**Admission Criteria**
- See Common Criteria

**Continuing Stay Criteria**
- See Common Criteria

**Discharge Criteria**
- See Common Criteria

**Clinical Best Practices**
- See Common Clinical Best Practices

**WRAPAROUND SERVICES: TRANSITIONAL EMPLOYMENT - ADULT**

**Transitional Employment**: This service is designed to strengthen the participant’s work record and work skills toward the goal of achieving assisted or unassisted competitive employment at or above the minimum wage paid by the competitive sector employer. This service is provided, instead of individual supported employment, only when the person specifically chooses this service and may only be provided by clubhouse, psychosocial club program certified provider or recovery center. This service specifically provides learning and work experiences where the individual with behavioral health and/or substance use disorders can develop general, non-job-task-specific strengths and soft skills that contribute to employability in the competitive work environment in integrated community settings paying at or above minimum wage. The outcome of this activity is documentation of the participant’s stated career objective and a career plan used to guide individual employment support.

**Admission Criteria**
- See Common Criteria
  AND
- An individual must have made a clear decision to work in competitive employment in the community regardless of limited or unsuccessful work history, or present status of sobriety and/or abstinence.
• The basic tenet of Transitional Employment is that all individuals are capable of working in competitive employment in the community even without prior training and all individuals interested in employment should be given the opportunity.

Continuing Stay Criteria
• See Common Criteria

Discharge Criteria
• See Common Criteria

Clinical Best Practices
• See Common Clinical Best Practices

Limits/Exclusions
The total combined hours for pre-vocational and transitional supported employment) are limited to no more than a total of 250 hours and a duration of 9 months of service in a calendar year.

Additionally, Transitional Employment placements should be part-time and time-limited, usually 15-20 hrs/week from 6-9 months in duration.

For all employment supports services, documentation is maintained in the file of each individual receiving this service that the service is not available under a program funded under section 110 of the Rehabilitation Act of 1973 or the IDEA (20 U.S.C. 1401 et seq.). Federal financial participation is not claimed for incentive payments, subsidies, or unrelated vocational training expenses, such as the following:
• incentive payments made to an employer to encourage or subsidize the employer’s participation in a supported employment program,
• payments that are passed through to users of the state VR supported employment programs, and payments for training that is not directly related to an individual's supported employment program.

When employment support services are provided in a competitive and integrated work site where individuals without disabilities are employed, payment is made only for the adaptations, supervision, and training required by individuals who receive services as a result of their disabilities and does not include payment for the supervisory activities rendered as a normal part of the business setting.

WRAPAROUND SERVICES: SHORT-TERM CRISIS RESPITE SERVICES - ADULT
Short-Term Crisis Respite: a short-term care and intervention strategy for individuals who have a mental health or co-occurring diagnosis and are experiencing challenges in daily life that create risk for an escalation of symptoms that cannot be managed in the individual’s home and community environment without onsite supports including:
• A mental health or co-occurring diagnosis and are experiencing challenges in daily life that create imminent risk for an escalation of symptoms and/or a loss of adult role functioning but who do not pose an imminent risk to the safety of themselves or others
• A challenging emotional crisis occurs which the individual is unable to manage without intensive assistance and support

When there is an indication that an individual’s symptoms are beginning to escalate

Referrals to Crisis Respite may come from the emergency room, the community, self-referrals, a treatment team, or as part of a step-down plan from an inpatient setting. Crisis respite is provided in site-based residential settings. Crisis Respite is not intended as a substitute for permanent housing arrangements.

Admission Criteria
• See Common Criteria
AND
• All individuals receiving this service must be experiencing a crisis, and be:
  o Willing to voluntarily stay at a Crisis Respite
  o Willing to be assessed by a treating professional including undergo a BH HCBS assessment
  o Willing to authorize release of medical records by relevant treating providers
Have a mental health or co-occurring diagnosis and are experiencing challenges in daily life that create imminent risk for an escalation of symptoms and/or a loss of adult role functioning but who do not pose an imminent risk to the safety of themselves or others.

**Continuing Stay Criteria**
- See Common Criteria

**Discharge Criteria**
- See Common Criteria

**Clinical Best Practices**
- See Common Clinical Best Practices

**Limits/Exclusions**
- Diagnosis of dementia, organic brain disorder or TBI
- Those with an acute medical condition requiring higher level of care
- At imminent risk to self or others that requires higher level of care
- Displays symptoms indicative of active engagement in substance use manifested in a physical dependence or results in aggressive or destructive behavior
- Is not willing or able to respect and follow the guest agreement during his/her stay
- Is not willing to sign necessary registration documentation
- Is not willing to participate in the wellness process during his/her stay
- No longer than 1 week per episode, not to exceed a maximum of 21 days per year. Individual stays of greater than 72 hours require prior authorization. Individuals requiring crisis respite for longer periods may be evaluated on an individual basis and approved for greater length of stay based on medical necessity.

**WRAPAROUND SERVICES: INTENSIVE CRISIS RESPITE – ADULT**

**Intensive Crisis Respite (ICR):** a short-term, residential care and clinical intervention strategy for individuals who are facing a behavioral health crisis, including individuals who are suicidal, express homicidal ideation, or have a mental health or co-occurring diagnosis and are experiencing acute escalation of mental health symptoms. In addition, the person must be able to contract for safety.

*Individuals in need of ICR are at imminent risk for loss of functional abilities, and may raise safety concerns for themselves and others without this level of care. The immediate goal of ICR is to provide supports to help the individual stabilize and return to previous level of functioning or as a step-down from inpatient hospitalization.*

**Admission Criteria**
- See Common Criteria
- AND
- Individuals who may be a danger to self or others and are experiencing acute escalation of mental health symptoms and/or at imminent risk for loss of functional abilities, and raise safety concerns for themselves and others but can contract for safety.
- Experiencing symptoms beyond what can be managed in a short term crisis respite.
- Individual does not require inpatient admission or can be used as an alternative to inpatient admission if clinically indicated and person can contract for safety.

**Continuing Stay Criteria**
- See Common Criteria

**Discharge Criteria**
- See Common Criteria

**Clinical Best Practices**
- See Common Clinical Best Practices

**Limits/Exclusions**
• 7 days maximum
• Intensive Crisis Respite services include a limit of 21 days per year. Individuals requiring Intensive Crisis Respite for longer periods than those specified may be evaluated on an individual basis and approved for greater length of stay based on medical necessity.
• Have an acute medical condition requiring higher level of care.

WRAPAROUND SERVICES: HABILITATION AND RESIDENTIAL SUPPORT SERVICES - ADULT

Habilitation and Residential Support Services: Habilitation services are provided on a 1:1 basis and are designed to assist individuals with a behavioral health diagnosis (i.e. SUD or mental health) in acquiring, retaining and improving skills such as communication, self-help, domestic, self-care, socialization, fine and gross motor skills, mobility, personal adjustment, relationship development, use of community resources and adaptive skills necessary to reside successfully in home and community-based settings.

These services assist individuals with developing skills necessary for community living and, if applicable, to continue the process of recovery from an SUD disorder. Services include things such as: instruction in accessing transportation, shopping and performing other necessary activities of community and civic life including self-advocacy, locating housing, working with landlords and roommates and budgeting. Services are designed to enable the participant to integrate full into the community and ensure recovery, health, welfare, safety and maximum independence of the participant.

Admission Criteria
• See Common Criteria
AND
• The individual requires habilitation and onsite services that may include, but are not limited to: cognition (cognitive skills), functional status (ADLs), and recovery-oriented community support.
• Providers who did not apply for both PSR and Habilitation are encouraged to apply for both of these services. Programs without a joint designation will not be allowed to serve individuals having both a PSR and Habilitation goal in their Plan of Care. The state will work with these programs to facilitate this process.

Continuing Stay Criteria
• See Common Criteria

Discharge Criteria
• See Common Criteria

Clinical Best Practices
• See Common Clinical Best Practices

Limits/Exclusions
The total combined hours for Psychosocial Rehabilitation, Community Psychiatric Support and Treatment and Habilitation are limited to no more than a total of 500 hours in a calendar year. Time limited exceptions to this limit for individuals transitioning from institutions are permitted if prior authorized and found to be part of the cost-effective package of services provided to the individual compared to institutional care.
**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. The course of treatment is focused on addressing the member’s condition to the point that the member’s condition can be safely, efficiently and effectively treated in a less intensive level of care or no longer requires treatment. The member’s condition includes consideration of the acute and chronic symptoms in the member’s history and presentation, including co-occurring behavioral health or medical conditions, informed by information collected by the provider following evaluation and treatment planning as described in Common Clinical Best Practices.

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.

**Admission Criteria**
- See Common Criteria
- The member’s condition indicates 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.

**Continuing Stay Criteria**
- See Common Criteria

**Discharge Criteria**
- See Common Criteria

**Clinical Best Practices**
- See Common Clinical Best Practices
- 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.

**Youth Peer Support and Training:** Youth Peer Support and Training (YPST) services are formal and informal services and supports provided to youth, who are experiencing social, medical, emotional, developmental, substance use, and/or behavioral challenges in their home, school, placement, and/or community centered services. These services provide the training and support necessary to ensure engagement and active participation of the youth in the treatment planning process and with the ongoing implementation and reinforcement of skills. Youth Peer Support and Training activities must be intended to develop and achieve the identified goals and/or objectives as set forth in the youth’s individualized treatment plan. The structured, scheduled activities provided by this service emphasize the opportunity for the youth to expand the skills and strategies necessary to move forward in meeting their personal, individualized life goals, develop self-advocacy skills, and to support their transition into adulthood.
Admission Criteria

- See Common Criteria
- The youth has a behavioral health diagnosis that demonstrates symptoms consistent or corresponding with the DSM; OR
- The youth displays demonstrated evidence of skill(s) lost or undeveloped as a result of the impact of their physical health diagnosis; AND
- The youth requires involvement of a Youth Peer Advocate to implement the intervention(s) outlined in the treatment plan, AND
- The youth demonstrates a need for improvement in the following areas such as but not limited to:
  - Enhancing youth’s abilities to effectively manage comprehensive health needs
  - Maintaining recovery
  - Strengthening resiliency, self-advocacy
  - Self-efficacy and empowerment
  - Developing competency to utilize resources and supports in the community
  - Transition into adulthood or participate in treatment; AND
- The youth is involved in the admission process and helps determine service goals; AND
- The youth is available and receptive to receiving this service; AND
- The services are recommended by the following Licensed Practitioners of the Healing Arts operating within the scope of their practice under State License:
  - Licensed Master Social Worker
  - Licensed Clinical Social Worker
  - Licensed Mental Health Counselor
  - Licensed Creative Arts Therapist
  - Licensed Marriage and Family Therapist
  - Licensed Psychoanalyst
  - Licensed Psychologist
  - Physician's Assistant
  - Psychiatrist
  - Physician
  - Registered Professional Nurse or
  - Nurse Practitioner

Continuing Stay Criteria

- See Common Criteria
- The youth continues to meet admission criteria; AND
- The youth shows evidence of engagement toward resolution of symptoms but has not fully reached established service goals and there is expectation that if the service continues, the youth will continue to improve; AND
- The youth does not require an alternative and/or higher, more intensive level of care or treatment; AND
- The youth is at risk of losing skills gained if the service is not continued.; AND
- Treatment planning includes family/caregiver(s) and/or other support systems, unless not clinically indicated.

Discharge Criteria

- See Common Criteria
- The youth no longer meets admission criteria ; OR
- The youth has successfully met the specific goals outlined in the treatment plan for discharge; OR
- The youth or parent/caregiver withdraws consent for services; OR
- The youth is not making progress on established service goals, nor is there expectation of any progress with continued provision of services; OR
- The youth is no longer engaged in the service, despite multiple attempts on the part of the provider to apply reasonable engagement strategies; OR
- The youth no longer needs this service as they are obtaining a similar benefit through other services and resources.

Clinical Best Practices

- See Common Clinical Best Practices
Limits/Exclusions

- The provider agency will assess the child prior to developing the treatment plan for the child.
- Treatment services must be part of the treatment plan including goals and activities necessary to correct or ameliorate conditions discovered during the initial assessment visits.
- A youth with a developmental disability diagnosis without a co-occuring behavioral health condition is ineligible to receive this rehabilitative service.
- A group is composed of two or more youth and cannot exceed more than 12 individuals total.
- The intervention plan should identify the medical or remedial services intended to reduce the identified condition as well as the anticipated outcomes of the individual. The intervention plan must specify the amount, duration and scope of services. The intervention plan must be signed by the licensed mental health practitioner or physician responsible for developing the plan with the participant (or authorized representative) also signing to note concurrence with the treatment plan. The plan will specify a timeline for reevaluation of the plan that is at least a quarterly review. The reevaluation should involve the individual, family and providers and include a reevaluation of plan to determine whether services have contributed to meeting the stated goals. A new treatment plan should be developed if there is no measureable reduction of disability or restoration of functional level. The new plan should identify different rehabilitation strategies with revised goals and services.
- 12-step programs run by peers.
- General outreach and education including participation in health fairs, and other activities designed to increase the number of individuals served or the number of services received by individuals accessing services; community education services, such as health presentations to community groups, PTAs, etc.
- Contacts that are not medically necessary.
- Time spent doing, attending, or participating in recreational activities.
- Services provided to teach academic subjects or as a substitute for educational personnel such as, but not limited to, a teacher, teacher’s aide, or an academic tutor.
- Time spent attending school (e.g., during a day treatment program).
- Habilitative services for the beneficiary (child) to acquire self-help, socialization, and adaptive skills necessary to reside successfully in community settings.
- Child Care services or services provided as a substitute for the parent or other individuals responsible for providing care and supervision.
- Respite care.
- Transportation for the beneficiary or family. Services provided in the car are considered transportation and time may not be billed under rehabilitation.
- Services not identified on the beneficiary’s authorized treatment plan.
- Services not in compliance with the service manual and not in compliance with State Medicaid standards.
- Services provided to children, spouse, parents, or siblings of the eligible beneficiary under treatment or others in the eligible beneficiary’s life to address problems not directly related to the eligible beneficiary’s issues and not listed on the eligible beneficiary’s treatment plan.
- Any intervention or contact not documented or consistent with the approved treatment/recovery plan goals, objectives, and approved services will not be reimbursed.
- The state assures that rehabilitative services do not include and FFP is not available for any of the following in accordance with section 1905(a0(13) of the Act.
  - Educational
  - Room and board
  - Habilitation services
  - Services to inmates in public institutions as defined in 42 CFR 435.1010;
  - Services to individuals residing in institutions for mental disease as described in 42 CFR 435.1010
  - Recreational and social activities
  - Services that must be covered elsewhere in the state Medicaid plan
WRAPAROUND SERVICES: YOUTH PEER ADVOCATE - YOUTH

**Youth Peer Advocate (YPA):** This service will promote skills for coping and managing psychiatric symptoms. YPA service will facilitate the use of natural and community resources. In addition, YPA service promotes wellness through modeling and will assist waiver participants with gaining and regaining the ability to make independent choices and playing a proactive role in their own treatment. This service may be delivered in either a one-to-one session or a group setting of 2 or 3 waiver participants.

YPA activities must be intended to develop and achieve the identified goals and/or objectives as set forth in the youth’s individualized care plan. Activities provided by the YPA can include problem solving, mentoring, community resources exploration, and life skills support. The structured, scheduled activities provided by this service emphasize the opportunity for the YPA to support participant in the restoration and expansion of the skills and strategies necessary to move forward in meeting their personal, individualized life goals and to support their transition into adulthood.

**Admission Criteria**

- See Common Criteria

**Continuing Stay Criteria**

- See Common Criteria

**Discharge Criteria**

- See Common Criteria

**Clinical Best Practices**

- See Common Clinical Best Practices

WRAPAROUND SERVICES: SKILL BUILDING - CHILD

**Skill Building:** Skill Builders focus on the developmental stage of the child and work with the child towards achieving age appropriate developmental tasks. In collaboration with the Intensive In-Home provider, they design and provide activities that assist children in developing skills for performing age appropriate tasks needed to live successfully in their homes and communities. Skill Builders help the child to identify current strengths and strategies for acquiring additional desired ones. Activities may support areas such as completing schoolwork, being part of a team, handling money and performing activities of daily living. Skill Builders may work with children or groups of Waiver children on developing specific social skill sets necessary for acceptable social interactions such as how to give and receive compliments, how to start a conversation, how to ask for something, the etiquette of common courtesy, etc. Skill Builders may also work with youth in developing skills for independent living and in accessing vocational skills training. Skill Builders can provide any of their services to an individual child or in a group with other Waiver children. They may also work with the Waiver child’s family, including siblings, in teaching them how to best support the child in maintaining the skill sets.

**Admission Criteria**

- See Common Criteria

**Continuing Stay Criteria**

- See Common Criteria

**Discharge Criteria**

- See Common Criteria

**Clinical Best Practices**

- See Common Clinical Best Practices
**WRAPAROUND SERVICES: TRANSITIONAL CASE MANAGEMENT - CHILD**

**Transitional Case Management (TCM):** designed to provide coordination and continuity of care by supporting youth and family/natural support system in transition from an inpatient or residential setting to a community setting. TCM provides case management to youth enrolled in Waiver that require temporary inpatient care.

TCM coordinators work closely with youth, family/natural support system and collaborate with all providers to address service plan goals and objectives. TCM coordinators focus on promoting, engaging and empowering youth and family/natural support system to enhance safety and resiliency in all aspects of the youth’s life including: behavioral health care, social, education, vocation, and/or community resources and supports. TCM coordinators ensures that the youth and natural support systems’ preferences and priorities are addressed through a partnership of shared decision-making and service plan implementation throughout their transition and enrollment into Waiver.

TCM is provided during temporary inpatient stays while the youth is participating in the Waiver Program. By nature of their clinical eligibility for Waiver, it is expected that some youth that are enrolled in Waiver will need short-term psychiatric hospitalization to stabilize in the event of a crisis. Youth may also require medical hospitalization while enrolled in the Waiver. In that case, TCM coordinators will continue to collaborate with a comprehensive set of supports and providers to ensure the participant has the necessary supports, resources, strategies and linkages upon discharge. Ongoing contact with the child and family will be maintained to assure continuity of care and facilitate seamless transition back into the Waiver program. Natural supports will be utilized to assure optimal outcomes for the youth through on-going assessment and documentation to depict the needs and strengths of the participant and family and/or support unit.

Transitional Case Management and HCBS Individualized Care Coordination (ICC) will be provided by the same individual to assure continuity of care. This will provide consistency to the family and participant while allowing for a smooth and efficient transition from inpatient care to the community.

**Admission Criteria**

- See Common Criteria

**Continuing Stay Criteria**

- See Common Criteria

**Discharge Criteria**

- See Common Criteria

**Clinical Best Practices**

- See Common Clinical Best Practices

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**REVISION HISTORY**

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