Procedural Guidelines for Prior Authorization of Out-of-Home Treatment

For Children and Families with Intensive Mental Health Needs

Vermont Department of Mental Health

Child, Adolescent and Family Unit

Department of Mental Health
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I. PURPOSE:

The authorization of residential treatment by the Child, Adolescent and Family Unit (CAFU) of the Department of Mental Health (DMH) is guided by the philosophy and best practice that children and adolescents have better outcomes when they are treated, whenever possible, in their homes or communities. Research shows that community-based interventions are crucial for a child's and family's long-term success (Haogwood, Burns, Kiser, Ringeisen, and Schoenwald, 2001). The system of care is designed to provide community-based mental health treatment with the goal of supporting a child's progress and success within the context of family and community. Community based care may include times when a child requires a brief out-of-home placement as part of the family's primary community-based treatment plan. Any out of home placement should be designed to support the child and family so that the child can quickly return to their primary living situation with in home supports.

AUTHORITY:

3 V.S.A. § 835; 18 V.S.A. §§ 7401(14),(15),(17); 8907; Chapter 43 of Title 33; Vermont Administrative Code §§ 12-7-1:7103 (medical necessity); 12-2-201:10 and 12-7-4:7411 (authorization and payment for private non-medical institutions).

PROCEDURAL GUIDELINES:

These guidelines discuss how a Designated Agency or Specialized Service Agency (DA/SSA) will:

- Assess clinical eligibility for the out-of-home placement including but not limited to residential or therapeutic foster care. The out-of-home placement must be for the purpose of mental health treatment and a component of the family's Plan of Care (See Section #II).
- Triage children based on clinical acuity and level of family plan.
- Evaluate the progress of child and family for continued clinical eligibility (See Section #V).
- Advise families that out-of-home placements should not exceed 6 months unless otherwise approved by DMH.
- Provide ongoing family treatment in order for the child/youth to return home quickly.

These guidelines also provide assistance to DMH for CRC and waiver approval as well as triage of available resources. These guidelines connect to additional Department of Mental Health practices including:

- DMH – Out-of-home Placements: Utilization Review and Length of Stay
- DMH – DA Involvement with Referrals to CRC
- DMH – Adoption Assistance standards
- DMH – Children with SSI standards – draft
- DMH – Developmental Services Shared Funding guidelines
- DMH – Child Placement Agreement
- DMH – Enhanced Family Treatment Policy and Procedures
- DMH – Procedural Guidelines for the Prior Authorization of Out of State Residential Treatment
- SIT – Case Review Committee Policies and Procedures For Children and Adolescents
- SIT - Unilateral Placement standards

The 2001 document, *Mental Health: A Report of the Surgeon General,* states that transferring gains from a residential setting back into the community may be difficult without clear coordination between residential staff and community services, particularly schools, medical care or community clinics. In Vermont's system of care, a community-based in-home plan is the core of a child's plan; residential treatment or out-of-home placement may be a step in reaching that plan. Therefore, it is imperative that the community and the residential program coordinate from the very first step of referral to the discharge. Furthermore the Surgeon General's report stresses the importance of developing coordinated aftercare services in order to support the skills gained during a residential or out-of-home placement; that can only be accomplished through collaboration between the community team, the out-of-home therapeutic provider and the family.

For some children, short-term, residential placement or out-of-home resources are an important step towards long-term home and community-based success. The local team should explore barriers to home-based supports if an out-of-home placement is required. The ACT 264 process and the Local Interagency Team may be helpful to explore these barriers to establish a plan for permanency and development of a family plan.

II. Eligibility Criteria

Out-of-home services, funded through the Department of Mental Health, may be provided to a family only where the:

- child meets the out-of-home eligibility criteria (see below); and
- child is a resident of Vermont; and
- child has not reached his/her eighteenth birthday; and
- is an active client of a designated agency(DA) or specialized services agency (SSA); and
- child remains in the custody of his/her parent(s) or guardian(s); and
- child is diagnosed with a mental illness as defined by the current DSM codes. (The diagnosis must have been made by a psychiatrist within the last six months, and the child must currently be receiving treatment for this diagnosis. The diagnosis is the main contributing factor to the child's need for out-of-home placement.)

Conduct disorder, pervasive developmental disorder, substance abuse, or mental retardation without a co-occurring mental illness diagnosis is not sufficient to meet the diagnostic criteria.

Specific Enhanced Family Treatment (waiver) Criteria

The goal of Enhanced Family Treatment (EFT) (formerly known as 1915(c) MH Waiver services) is to maintain children in their home and/or community or return children to their home and/or community. All alternative funding resources must have been explored and determined to be inappropriate or unavailable before an application for EFT services is submitted for consideration.

Services included under the EFT may be provided only to persons who:

A. are otherwise eligible Medicaid recipients; or will become eligible for home and community-based services under 42 CFR 435.232

and

B. those services prescribed in the Individualized Plan of Care (IPC) cannot be provided by any other means;

and

C. are children and youth who have not yet reached the age of 22 years and are still enrolled in school;

and

D. have a primary diagnosis of mental illness (other than Autism and Conduct Disorder)

and

E. are currently receiving the level of care provided in an inpatient psychiatric facility for individuals under age 22 which is reimbursable under the State Plan, and for whom home and community-based services are determined to be an appropriate alternative; or are likely to receive the level of care provided in an inpatient psychiatric facility for individuals under age 22 which would be reimbursable under the State Plan in the absence of home and community-based services which are determined to be an appropriate alternative.

III. Exclusions

By themselves, the following situations do not justify out-of-home placement to receive mental health services:

- The client's behavior profile is marked by disturbance of conduct and/or delinquency exclusive of a mental illness.

- Admission is primarily:
  - an attempt to prevent, or to serve in lieu of, incarceration or detention.
  - for custodial or placement care.
  - for respite.
  - for removing a person from an undesirable environment. This includes situations involving abuse or neglect within the home or substance abuse within the home, for example.
  - a result of unmanageability within the home or community.
  - a result of an impaired caregiver.
  - a substitute for less intensive levels of care which would be sufficient.

- The client and/or family consistently refuse treatment. Documentation of recent family participation in treatment must be present.

- Conduct disorder, pervasive developmental disorder, substance abuse, or mental retardation without a co-occurring mental illness diagnosis is not sufficient to meet the diagnostic criteria.

IV. Criteria for Placement

Documented evidence contained within the Coordinated Service Plan or Waiver application, recent clinical assessments and clinical notes demonstrate the following:

1. The child must have an eligible diagnosed mental illness that can be documented through the assignment of appropriate current DSM codes, and the Child Behavior Checklist (CBCL) with at least one syndrome score or the total score in the clinical range within the last 3 months; **and**
2. the child is a danger to self/others or is at risk of becoming a danger due to mental illness; **and**
3. the child cannot be managed in the home, as evidenced by recent in-home supports needed and not successful or, if referring for residential care, the child cannot be managed in the community (*e.g.,* in therapeutic foster care) as evidenced by recent failures in the community or by a history of being unresponsive to community based services in the community; **and**
4. the family must have a recent history of active participation in treatment, including in-home supports. The expectation is that the DA/SSA will be actively involved in providing ongoing treatment to the family while the child is placed in out-of-home treatment. If the child is placed in residential treatment, the residential program and local team will work together on how to best treat the other family members which may involve the family participating in treatment at the facility and in their home community **Furthermore,**
5. the treatment plan must include a detailed description of how the parent(s)/guardian(s) will remain actively involved in treatment; **and**
6. the local treatment team must have clearly defined clinical goals that include family involvement in treatment; **and**
7. the local treatment team must have a clearly defined method to gauge progress and assess outcomes, especially how the team knows when the child and family have achieved their clinical goals; **and,**
8. the plan must include a detailed description of how the child is to be reintegrated back into his/her home and community; **and**
9. Child Placement Agreement is signed by involved parties. A copy must be sent to DMH.

V. Criteria for Continued Placement

Documented evidence that:

1. The eligible diagnosis remains the primary reason the client continues in out-of-home placement. The diagnosis continues to be the focus of treatment within this level of care and/or a home plan continues to be determined clinically ineffective and/or the focus of the treatment continues to be stabilization/alleviation of symptoms. The client continues to exhibit clinical-range behaviors as documented by CBCL scores.
2. Based on clinical judgment, the client is a danger to self/others or is at risk of becoming a danger shortly after discharge.
3. The comprehensive discharge plan is formulated and reviewed regularly and includes specific target dates for implementation. Also, there continues to be active involvement by the child's team and family in continuity of care, including discharge planning within the approved length of stay timeframe not to exceed 6 months. DA/SSA is expected to evaluate effectiveness of child and family treatment plan every month.
4. The psychiatric symptoms continue to show objective improvement and are not yet stabilized.
5. The family or guardian continues to be actively involved in the treatment process. The goal is to return the child to his/her family and, if not, other community partners need to be active in the process so that a permanency plan is developed. DMH is not the lead in permanency planning.
6. The client and family continue to be invested and actively involved in the treatment process and agree with the treatment plan.
7. The local DA staff continue to participate in treatment planning, meetings and the entire process to ensure this portion of a child's plan is meeting the child's treatment needs.
8. The local treatment team (which includes DA staff, education, parents/guardian and other community partners) has not yet been able to establish comprehensive services to maintain the child in the home as evidenced by one or more of the following circumstances:
    - the treatment team lacks some necessary service(s), or
    - these services may be of inadequate quality, or
    - the placement may be notably ambivalent about maintaining the child in the home, or
    - the treatment team has no capacity to work with the placement to implement comprehensive services.

Therefore the local treatment team will need to identify and develop a plan to address these barriers in order to create the appropriate permanency plan.

Quarterly review of the admission, continued stay and discharge criteria will take place to assure consistent application of the criteria.

VI. Service Priorities for Out-of-Home Placements

- **Severity of mental illness** – Highest level of severity/acuity will receive priority for funding.

- **Active family involvement** – The family and/or primary caregivers are actively participating in treatment both for the child as an individual and the family. The family attends regular treatment team meetings, participates in parent education concerning the mental illness, and contributes to the overall plan.

- **Treatment plan reflects activities to return child home** - The treatment plan clearly defines the goals and objectives that need to be address to return the child to his/her home. It is clear the out-of-home placement is a continuum of the overall treatment plan, not "the plan."

- **Equitable Distribution** – All above variables being comparable, funding priorities will be distributed equally throughout the state.

VII. Elements of Out-of-Home Programs

The following qualities are a minimum consideration for out-of-home placements. DMH will only endorse a residential program or out-of-home placement for plans that include the following qualities:

Comprehensive evaluation – The ability for the team or facility to provide comprehensive mental health evaluations that enable the treatment team to determine the following:

- Clarification of diagnosis
- Appropriateness and effectiveness of medication
- Appropriate treatment planning and goals
- Progress

Active family involvement – The family is included in the planning and treatment for the individual child. The team respects and supports the family to engage in the treatment and offers appropriate psycho-education opportunities. It is essential:

- for the family to attend meetings and treatment sessions and to have family visits;
- for the family to be included as an important contributor to the progress their child makes; and
- for the family to acquire skills to help the child learn new behaviors and coping mechanisms.

Mental health treatment as primary focus – The primary focus of the placement is to treat the mental health issues that are contributing to the child's inability to function fully at home. The identified mental health issues are the focus of the treatment plan, with additional goals as needed. The treatment plan clearly identifies the goals and objectives to alleviate the specific symptoms and impairments that resulted in the admission. It is also important that a systems approach be used; that is, the child's behavior is not treated as "the problem," but the way the family system functions is the focus of treatment along with the child's specific mental health treatment needs (Schaefer and Swanson, 1988).

Progress and outcomes – The team or facility is able to measure positive outcomes and incorporates tools to gauge progress. The progress is evidenced by a measurable reduction in symptoms and/or behaviors to the degree that indicates continued responsiveness to the treatment (American Academy of Child and Adolescent Psychiatry, 1996).

Treatment plans - The team or facility will conduct regular treatment team meetings that will update and change plans based on progress and barriers to treatment. Treatment goals will be realistic and achievable and directed towards re-stabilization to allow treatment to continue, matching the child's needs with home and community capacity. (American Academy of Child and Adolescent Psychiatry, 1996).

Best practices – The team or facility implements best practices, including evidence-based treatments when available, to address the child's and family's needs. The values of the system of care are incorporated. The staff is trained in the values of the system of care, best practices and evidence-based treatment, and makes these a primary focus of their program.

Structured milieu (for residential only) – The milieu offers the child positive peer interaction consistent with the child's diagnosis and clinical goals within the structured environment.

Active involvement of DA – If the placement is not within the DA's catchment area or is referred to the SSA or a residential facility, the DA is supported to collaborate and participates actively in the treatment. The DA will be receiving the child back into the community and must be actively involved in both ongoing treatment plans and discharge/community plans. Discharge planning should begin at the time of referral.

Level of staff training and credentials – The staff or contracted staff include a licensed psychiatrist and mental health clinicians. The staff are credentialed and have training and expertise in treating children with mental health issues and their families.

Additional training - The staff are trained in basic care, first aid, universal precautions, de-escalation and management of aggressive behavior and ongoing improvements in skills needed for best practices.

Confidentiality – The team and/or staff maintain confidentiality and obtain releases from parents in order to clarify with whom they need to speak to address treatment needs. All HIPPA regulations are followed.

Education – A child will receive a *free and appropriate public education* regardless of living situation. If the child is living out of his/her school district, the team maintains a connection to the sending school and works with that school to establish an educational discharge plan in conjunction with the transition plan to home. Additionally, if the child is in a facility, the facility can provide or has access to special education services to maintain a child's Individualized Education Plan.

Coordination on overall treatment plan – There is a clear individualized mental health and family treatment plan that builds on what has been accomplished in the out-of-home placement and what will continue to be developed in the home to support the child and family once the child returns. Short-term and long-term goals are clearly connected and build on each other. The object should be to treat the family as a unit. From the outset the work should be to change and influence the family system rather than just treat the child (Schaefer and Swanson, 1988). There is not an expectation of a child improving in isolation, but, rather, of a child and family building skills that complement each other and allow for the child's successful reintegration into the family unit. There is clear communication among all parties in establishing, refining and accomplishing goals. Each entity recognizes the other's part in the overall plan.

Discharge plan – An initial discharge plan is part of the referral to the out-of-home placement prior to placement and is reviewed prior to accepting the child in placement. The initial discharge plan is a joint plan by the providers and the family, and it establishes a direct link to the behaviors and/or symptoms that resulted in the placement. The plan receives regular review and revision, including an appropriate and timely evaluation of post-discharge treatment needs. An appropriate and realistic plan of post-discharge treatment is tentatively designated upon placement, and the child is actively involved in making the choice when appropriate. The main question in developing a discharge plan is, "What are we preparing the child for?"

Certification – A license as either a residential program or a foster home from the Department for Children and Families (DCF) is required for all Vermont out-of-home placements. For all out of state residential programs a residential treatment license in good standing from the appropriate state licensing entity of the receiving state is required. In addition, residential national certification is preferred for residential programs.

Medicaid – Any in-state or out of state program must be enrolled or eligible for enrollment as a provider in Vermont's Medicaid Program.

VIII. References:

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