

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

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I. Purpose:

The authorization of out-of-home 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/youth'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/youth's progress and success within the context of family and community. Community based care may include times when a child/youth 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/youth and family so that the child/youth 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:

- A. Assess clinical eligibility for the out-of-home placement including but not limited to residential treatment 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).
- B. Triage children/youth based on clinical acuity and level of family plan.
- C. Evaluate the progress of child/youth and family for continued clinical eligibility (See Section #V).
- D. Advise families of their rights and responsibilities when their child/youth is placed out of the home, including that out-of-home placements should not exceed 6 months unless otherwise approved by DMH.

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- E. 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 – Rights and Responsibilities for Parents/Guardians of children & youth placed out of home
- 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/youth'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/youth, 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

A. Criteria for all Out-of-Home Treatment

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

1. Child/youth meets the out-of-home eligibility criteria (see below); and
2. Child/youth is a resident of Vermont; and
3. Child/youth has not reached their twenty-first birthday and is still enrolled in school; and
4. is an active child/youth of a designated agency(DA) or specialized services agency (SSA); and
5. child/youth remains in the custody of their parent(s) or guardian(s); and
6. child/youth is diagnosed with a mental illness as defined by the current DSM codes. (The diagnosis must have been made by a qualified, licensed, mental health/health care provider within the last six months, and the child/youth 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.)

Note: Conduct disorder, Autism Spectrum Disorder, substance abuse, or intellectual disability without a co-occurring mental illness diagnosis is not sufficient to meet the diagnostic criteria.

7. child/youth meets medical necessity criteria for an out-of-home placement.

Medical Necessity

It is the decision of the Medicaid Managed Care Entity (MCE), the Department of Vermont Health Access (DVHA), to determine medical necessity. However, DVHA delegates that authority to AHS Departments who then delegate specific components of authority to the Designated Agencies (DA), including determination of medical necessity for out-of-home/residential treatment. (If an outside provider finds medical necessity for out-of-home/residential treatment where a DA/Department/DVHA (MCE) does not, then the DA/Department/DVHA (MCE) decision prevails.) Appeal rights for MCE decisions follow the standard MCE departmental process.

B. 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/youth in their home and/or community or return children/youth 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:

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

and

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

and

3. are children and youth who have not yet reached the age of 21 years and are still enrolled in school;

and

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

and

5. are currently receiving the level of care provided in an inpatient psychiatric facility for individuals under age 21 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 21 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

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to receive mental health services:

- A. The child/youth's behavior profile is marked by disturbance of conduct and/or delinquency exclusive of a mental illness.
- B. Admission is primarily:
 - 1. an attempt to prevent, or to serve in lieu of, incarceration or detention.
 - 2. for custodial or placement care.
 - 3. for respite.
 - 4. 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.
 - 5. a result of unmanageability within the home or community.
 - 6. a result of an impaired caregiver.
 - 7. a substitute for less intensive levels of care which would be sufficient.
- C. The child/youth and/or family consistently refuse treatment. Documentation of recent family participation in treatment must be present.
- D. Conduct disorder, autism spectrum disorder, substance abuse, or intellectual disability 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:

- A. The child/youth has an eligible mental health diagnosis that is the primary reason for placement.
- B. The child must be an open client with a DA/SSA.
- C. A Child and Adolescent Needs and Strengths (CANS) has been completed within the last 3 months.
- D. The child/youth is a danger to self/others or is at risk of becoming a danger due to mental illness.
- E. The child/youth 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/youth cannot be managed in the community (e.g., in therapeutic foster care) as evidenced by recent setbacks in the community or by a history of being unresponsive to community based services.

- F. There is clear identification of the behaviors or symptoms that cannot be managed in the community and that the out-of-home treatment program needs to address.
- G. 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/youth is placed in out-of-home treatment. If the child/youth 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.
- H. The family is informed of their rights and responsibilities for children/youth placed out of their home.
- I. The treatment plan must include a detailed description of how the parent(s)/guardian(s) will remain actively involved in treatment.
- J. The treatment team must have clearly defined clinical goals that include family involvement in treatment.
- K. The treatment team must have a clearly defined method to gauge progress and assess outcomes, especially how the team knows when the child/youth and family have achieved their clinical goals.
- L. The plan must include a detailed description of how the child/youth is to be reintegrated back into their home and community.

V. Criteria for Continued Placement

A. Enhanced Family Treatment

Enhanced Family Treatment requires a utilization review and application for renewal at minimum every 6-months. The guidelines for EFT continuation, including therapeutic foster care, are detailed in the EFT manual.

B. Residential Placements

When considering whether a child/youth should continue in residential treatment or discharge, the treatment team should review the progress the child/youth has made in treatment and assess whether the home and community is ready to meet the on-going needs of the child/youth.

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Treatment team meetings: these meetings occur on a regular basis (typically monthly or quarterly) and discuss the client's day-to-day functioning; progress towards treatment goals; updates on education, psychiatry, residential milieu, individual, group and family therapies; and discharge planning as the discharge date approaches. These meetings include the child when appropriate, family, local treatment providers, local education, residential clinical, case management and education, and at times, the State placing entity.

Utilization Review: Comprehensive meeting focused on a review of the client's progress towards clinical treatment goals, readiness to transition to a lower level of care, and the readiness of the receiving providers to implement the discharge plan.

All documentation is forwarded to the DMH Care Manager and the local DA Case Manager connected to the case, and the family. In order to justify continued placement, there should be documented evidence that:

1. An eligible mental health diagnosis remains the primary reason the child/youth continues in out-of-home placement.
2. The OOH treatment program has provided regular documentation, at minimum quarterly, of current functioning, treatment provided and indicators of progress.
3. At six months and at minimum quarterly thereafter, there is clear evidence of progress (decrease in symptoms and increase in functioning as demonstrated by use of standardized tool) and incremental readiness to return to community/family.
4. At six months and at 3-6 month intervals thereafter, DMH will conduct utilization review meetings.
 - a. Review of clinical documentation and standardized tool
 - b. When there has been clear progress, the team identifies what has contributed to the child/youth's progress in the residential setting [Refer to side bar].

Utilization Review

When determining whether the child/ youth is ready to return to their community, the team could consider the following questions:

A. What is it within the structure of the residential setting that supports the youth achieving their behavioral goals? Some examples are:

- Consistent daily schedule?
- Common expectations of all peers?
- Specialized physical setting or programming?

B. What staff interventions and cueing support the youth? How often is cueing or intervention necessary?

C. What skills do staff/caregivers need in order to cue and intervene when necessary?

D. What level/type of supervision is necessary to keep the child/youth safe and support their engagement in treatment?

E. Is there a specialized behavioral plan that is necessary to support the youth's specific needs?

F. What motivates the youth to make behavioral changes?

- Tangible external rewards?
- Peer relationships or interactions?
- Contact with family?
- What could these motivations look like in the home/community?

G. How much does the youth still rely on all these supports in order to meet expectations?

H. What does the youth want?

When a child/youth is developmentally able, they may not be able to make the decision about their continued placement, but they should have a voice in the discussion.

I. How have visits with the family in the community and/or home gone?

- c. The treatment team must evaluate whether the supports necessary to keep the child/youth safe and maintain their progress are replicable and available in the community?
 - d. If the supports are replicable and available, then the team should move forward with planning for discharge.
 - e. If the supports are *not* replicable or available, then the local team must identify and develop a plan to address any barriers or gaps in services and move forward with discharge as soon as possible.
5. Initial work on a comprehensive discharge plan should be started at admission and is formulated within 90 days and reviewed at regular updates. The discharge plan should indicate specific target dates for implementation.
 6. The child/youth and family continue to be invested and actively involved in the treatment process and participate in creating the treatment plan. The family continues to have regular contact and visits with the child/youth, unless specifically counter-indicated by the treatment providers. If the treatment recommendations include family-focused treatment, the family actively participates or works with the team to identify accommodations for participation.
 7. For children/youth placed in residential treatment by the Department of Mental Health, the ultimate goal is always for the child/youth to return to their family. If this goal changes during the residential stay, then the treatment team, family, and other identified partners will convene to determine how this impacts the discharge plan. If the child/youth's treatment goals have been met, a change in the family's reunification plan is not sole justification to remain at this level of care. The team must develop a new discharge plan and a long-term permanency plan.
 8. The local DA is actively involved in treatment planning, treatment meetings and discharge planning.

VI. Service Priorities for Out-of-Home Placements

- A. Severity of mental illness** – Highest level of severity/acuity will receive priority for funding.
- B. Active family involvement** – The family and/or primary caregivers are actively participating in treatment both for the child/youth 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.
- C. Treatment plan reflects activities to return child/youth home** -
The treatment plan clearly defines the goals and objectives that need to

be addressed to return the child/youth to their home. It is clear the out-of-home placement is a continuum of the overall treatment plan, not “the plan.”

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:

- A. Comprehensive evaluation** – The ability for the team or facility to provide comprehensive mental health evaluations that enable the treatment team to determine the following:
 1. Clarification of diagnosis
 2. Appropriateness and effectiveness of medication
 3. Appropriate treatment planning and goals
 4. Progress

- B. Active family involvement** – The family is actively involved in the planning and treatment for their child/youth. The team values the role of the family in the child/youth’s treatment, supports the family to address any barriers to participate in the treatment, and provides effective psycho-education and clinical intervention to address dynamics that may impact the child/youth and family’s functioning. It is essential:
 1. for the family to attend meetings and treatment sessions and to have family visits;
 2. for the family to be included as an important contributor to the progress their child/youth makes; and
 3. for the family to acquire skills to help the child/youth learn new behaviors and coping mechanisms.

- C. 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/youth’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 behaviors that resulted in the admission and clearly identifies how learned skills can be transferred to the home and community.

It is also important that a systems approach be used; that is, the child/youth's behavior is not treated as "the problem," but the way the family system functions is the focus of treatment along with the child/youth's specific mental health treatment needs (Schaefer and Swanson, 1988).

- D. 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/youth and Adolescent Psychiatry, 1996).
- E. 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).
- F. Best practices** – The team or facility implements best practices, including evidence-based treatments when available, to address the child/youth's and family's needs. The values of the Vermont System of Care are incorporated into the child's plan as guided by the family, DA and DMH.
- G. Structured milieu (for residential only)** – The milieu offers the child/youth positive peer interaction consistent with the child/youth's diagnosis and clinical goals within the structured environment.
- H. Active involvement of DA** – The out-of-home/ residential program will involve the DA in the treatment. The DA will be receiving the child/youth back into the community and must be actively involved in both ongoing treatment plans and discharge/community plans. Discharge planning with the family and local team should begin at the time of referral.
- I. 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/youth with mental health issues and their families.

- J. Additional training** - The staff are current in the appropriate trainings to carry out the functions of their job, including basic care, first aid, universal precautions, de-escalation and management of high-risk behaviors, and other relevant best practices.
- K. 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.
- L. Education** – A child/youth will receive a *free and appropriate public education* regardless of living situation. If the child/youth is living out of their 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/youth is in a facility, the facility can provide or has access to special education services to maintain a child/youth’s Individualized Education Plan.
- M. 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/youth and family once the child/youth 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/youth (Schaefer and Swanson, 1988). There is not an expectation of a child/youth improving in isolation, but, rather, of a child/youth and family building skills that complement each other and allow for the child/youth’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.
- N. 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/youth 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 and guides the intervention plan at the residential program. The plan receives regular review and revision, is developed with increasing

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detail, and includes 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/youth is actively involved in making the choice when appropriate. The main question in developing a discharge plan is, "What are we preparing the child/youth for?"

The DA and local team are responsible to actively bring the child back to the community as soon as possible. The DA and local team will clearly identify the services and supports available to meet the child & family needs. The local team will identify when the needed services are ready for the child to transition back to the community.

- O. 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.
- P. Medicaid** – Any in-state or out-of-state program must be enrolled or eligible for enrollment as a provider in Vermont's Medicaid Program.
- Q. Contract** – The PNMI residential program must have or being willing to develop a contract for services with a funding agency or department of the State of Vermont.
- R. Interstate Compact** – For a child/youth to be placed in a residential program outside Vermont, an Interstate Compact request must be submitted and approved by the receiving state prior to placement.

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