Texas Resilience and Recovery

Utilization Management Guidelines: Adult Mental Health Services

Effective September 2013

Introduction

Resiliency and Disease Management, or RDM, was a term that originated during the 79th Legislative Session (2004-2005) to describe the new service delivery system in Texas for community mental health services. Since that time, there have been some slight changes in the system; however the mission remains the same: To foster resilience and recovery with respect to mental illness and severe emotional disturbances. A primary aim of the Department of State Health Services, (DSHS) service delivery system is to ensure the provision of interventions and evidence-based practices with empirical support to promote recovery from psychiatric disorders and resilience from severe emotional disturbances.

The Substance Abuse and Mental Health Services Administration, or SAMSHA, defines **Recovery** from Mental Disorders and Substance Use Disorders as follows:

> *A process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential.*

Through the **Recovery Support Strategic Initiative**, SAMHSA has delineated four major dimensions that support a life in recovery:

- ***Health***: overcoming or managing one's disease(s) as well as living in a physically and emotionally healthy way;
- ***Home:*** a stable and safe place to live;
- ***Purpose:*** meaningful daily activities, such as a job, school, volunteerism, family caretaking, or creative endeavors, and the independence, income and resources to participate in society; and
- ***Community***: relationships and social networks that provide support, friendship, love, and hope.

The Texas Resilience and Recovery System or public mental health service design in Texas includes the following components:

(a) establishes who is eligible to receive services through a uniform assessment,
(b) establishes ways to manage the use of services as outlined in the Utilization Management (UM) Guidelines
(c) measures clinical outcomes or the impact of services, and
(d) determines how much these services should cost.

The UM Guidelines are an integral part of the program to ensure the delivery of mental health services are properly tailored to the individual's needs and strengths in order to achieve the best possible results, while utilizing limited available resources in the most efficient and cost-effective manner possible.

These guidelines assist the clinician in determining the best possible course of treatment for the individual. There will be circumstances when an individual may require a greater or lesser level of care. The services offered within each level of care are designed to provide the optimum care for the individual.

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I. LEVEL OF CARE 0: Crisis Services

Purpose for Level of Care

The services in this level of care are brief interventions provided in the community that ameliorate the crisis situation, and prevent utilization of more intensive services. The desired outcome is resolution of the crisis and avoidance of intensive and restrictive intervention or relapse.

These services do not require prior authorization. However, Utilization Management (UM) staff must authorize the crisis service within 2 business days of presentation. If further crisis follow-up and relapse prevention services are needed, then the individual may be authorized for Level of Care 5 (LOC-5).

Note: A provider is not required to develop a Recovery/Treatment Plan for the provision of crisis services within this LOC; however an individual crisis treatment plan is required.

Level of Care Assignment

The admission criteria to be met are:

- No diagnosis is needed for admission to LOC- 0;
- The Adult Needs Strengths Assessment (ANSA) indicates a Recommended Level of Care (LOC-R) of 0; or ANSA indicates LOC-R of 1,2,3,4,5 or 9 and it is clinically determined that the individual is in crisis.

Criteria for Level of Care Review

- LOC A -0 is only available at intake, with new individuals or individuals who have received services and no longer have a current assessment. Any individual already in a LOC receives crisis services within that current LOC-A.
- This LOC-A will terminate in 7 days, unless reauthorized. Additional authorizations may be given as medically necessary.
- Following a crisis, providers should reassess the individual to determine further eligibility and the most appropriate LOC-1S – 5 for continuation of services.
- LOC-0 is the highest outpatient LOC-A available. If acuity level increases, hospitalization may be indicated.

Expected Outcomes

- Individual self-reports reduction or stabilization in symptoms as verified by scores in ANSA.
- Individual is able to use natural and community support systems as resources.

Discharge Criteria

ANY of these indicators would support discharge from this LOC:

- Identified crisis is resolved and the individual has been transitioned to LOC-1S-5.
- Identified crisis is resolved and the individual is placed on a waiting list for LOC-1S-4.
- Referred and linked to community resources outside the DSHS system.
- The individual terminates services.
- Individual is referred to a higher LOC for crisis management (e.g. hospitalization).

LOC-0 Table Overview

Authorization Period 7 Days	
Crisis Services	**Unit Type**
Crisis Intervention Services	15 min
Psychiatric Diagnostic Interview Examination	Event
Pharmacological Management	Event (avg. event = 25 min per mo.)
Crisis Transportation (Event)	Event
Crisis Transportation (Dollar)	$1
Safety Monitoring	15 min
Day Programs for Acute Needs (when indicated)	45-60 min
Extended Observation	1 bed day
Crisis Residential Treatment	1 bed day
Crisis Stabilization Unit	1 bed day
Crisis Flexible Benefits (Event)LOC-0 & LOC-5	Event
Crisis Flexible Benefits (Dollar) LOC-0 & LOC-5	$1
Respite Services: Community-based	15 min
Respite Services: Program-based (not in home)	1 bed day
Inpatient Hospital Services	Event
Inpatient Services (Psychiatric)	1 bed day
Emergency Room Services (Psychiatric)	Event
Crisis Follow-up & Relapse Prevention	15 min

*Available services vary from location to location.

II. LEVEL OF CARE 1M (Medication Management): Basic Services

Purpose for Level of Care

Individuals appropriate for this level of care are individuals who meet the definition for priority population of the DSHS. Services in Level of Care 1M (Medication Management) are generally intended for adults who have attained and maintained a level of recovery in treatment such that, except for the ongoing need for medications, would be eligible for discharge from services. This level of service is intended only to complement natural and/or alternative supports available in the community that promote the individual's recovery and his or her continued pursuit of goals related to social inclusion and participation, independence, and/or productivity. Individuals appropriate for this level of care are ready to transition out of the public mental health system and would make that transition except for the limited community resources available to allow these individuals to make that transition (i.e. no available physicians in the community, no pharmacological resources available to this individual).

The general focus of this service is to prevent deterioration of the individual's condition--specifically, through medication therapy until such time that he or she is able to access psychiatric and & pharmacological resources in the community. Treatment is provided in outpatient, office-based settings, and limited to medication therapy, medication training & support and routine case management.

The authorization at the LOC level and medical necessity determination at the LOC level is required prior to service delivery. Medical necessity must be established with any new/initial authorization. Medical Necessity must be reestablished with any request for additional service amounts or a change in level of care authorized.

The Recovery/Treatment Plan review is required at least every 365 days for LOC-1M.

Level of Care Assignment Criteria

The admission criteria to be met are:

- The individual must be determined to have schizophrenia and related disorders or a bipolar disorder or MDD with or without psychotic features, (GAF ≤ 50 at intake).
- The individual has maintained an LOC-R of 1 during all on-going assessments administered during the previous 12 month period. Please note initial assessments are not counted.
- ANSA scores reveal extreme stability and remain for at least 12 months.
- There is no crisis event/episode for an individual in the level of care or period of decompensation during the previous 12 months; and
- No hospitalization relating to mental condition during the previous 12 months.

Expected Outcomes

- Continued recovery and stability resulting in improved quality of life.
- It is expected that individuals participating in LOC-1M services will eventually move into a provider system outside of their LMHA when resources are available for them to do so.

Discharge Criteria

- Community resources outside the LMHA have been identified that can provide the necessary services (e.g., there is a primary care physician available to provide medication-related services) and the individual has been successfully referred to those services.
  The individual declines or opts out of services despite not having an identified provider in the community. Please note that there should be sufficient education regarding risk factors related to relapse if there is no identified provider upon discharge.

LOC-1M Table Overview

Authorization Period: 365 Days		
Average 6 Month Utilization Standard For This Level of Care: .5 Hours Across the population served at this level of care (LOC), some individuals may require more/less intense provision of services or utilize services at a higher/lower rate than .5 hours per 6 months. Ideally, the average hours of service(s) delivered should include the Core Services and be supplemented with Adjunct Services when clinically appropriate.		
Level of Care 1M **Estimated Utilization Per Month**		
Core Services: Identified by the uniform assessment and indicated in the recovery/treatment plan.	**Standard Therapeutic- .5 hours per 6 months**	**High Need Therapeutic hours per 6 months**
Pharmacological Management	.5 hour/2 units	.75 hour/ 3 units
Adjunct Services: Identified by the uniform assessment and indicated in the recovery/treatment plan.	**Standard Therapeutic**	**High Need Therapeutic**
Psychiatric Diagnostic Interview Examination	N/A (1 Event per year)	N/A (1 Event per year)
Routine Case Management	.5 hour/2 units	2.15 hours/ 9 units
Crisis Services Array: Authorized as medically necessary and available during psychiatric crisis. Utilization of crisis services within this Level of Care is the same as LOC-0. Please refer to LOC-0 for utilization guidelines.		

III. LEVEL OF CARE 1S (Skills Training): Basic Services

Purpose for Level of Care

Services in this level of care are generally intended for individuals who meet the definition for priority population of the DSHS. Individuals in this level of care present with very little risk of harm and have supports and a level of functioning that does not require higher levels of care.

The general focus of this array of services is to facilitate recovery by reducing or stabilizing symptoms, improve the level of functioning, and/or prevent deterioration of the individual's condition. Natural and/or alternative supports are developed to help the individual move out of the public mental health system. Services are most often provided in outpatient, office-based settings, and are primarily limited to medication, rehabilitative services, and education.

The authorization at the LOC level and medical necessity determination at the LOC level is required prior to service delivery. Medical necessity must be established with any new/initial authorization. Medical Necessity must be reestablished with any request for additional service amounts or a change in level of care authorized.

The Recovery/Treatment Plan review is required at least every 180 days for LOC-1S.

Level of Care Assignment Criteria

The admission criteria to be met are:

- The individual must be determined to have schizophrenia and related disorders or a bipolar disorder or MDD with or without psychotic features, (GAF ≤ 50 at intake).
- This level of care may also be provided to individuals eligible for a higher LOC, but due to lack of capacity must be served in LOC1S until capacity is available.

Special Considerations Regarding Peers and Recovery

SAMHSA recognizes peer services as a critical component to the recovery process. The DSHS endeavors to facilitate processes that acknowledge this role. As such, the following recommendation(s) highlight how peers might be best utilized within this level of service:

- Share individual experience related to recovery and act as a model of hope and resilience.
- Provide education about the recovery process.
- Promote social integration by educating about resources in the community that may support continued recovery, such as individual-operated service providers, mutual aid groups, social organizations related to the individual's interests, health clubs, etc.
- Provide medication training and support as appropriate to the peer specialist role (i.e. share experience related to use of medication as a tool in one's own recovery).
- Provide education about LOC-1S.
- Provide engagement interventions to individuals to foster full participation in treatment.

NOTE: All the tasks identified in this section are services/assistance that can be provided by any treatment providing staff with the exception of the very peer specific functions such as shared individual experience.

Expected Outcomes

The following outcome(s) can be expected as a result of delivering services at this level of care:

- The individual receiving services reports stabilization of symptoms or maintenance of stability.
- The individual will need a lesser level of care, or
- The individual achieves a level of recovery that allows them to move out of LMHA system and receive services in their community of choice with a provider of their choice.

Discharge Criteria

ANY of these indicators would support discharge from this LOC:

- Clinical documentation exists to support that the individual has obtained the maximum benefit from this LOC and further treatment will not promote continued relief and/or change (e.g., individual has progressed sufficiently and thus no longer needs the service).
- Individual is not receptive to all treatment even after reasonable efforts and accommodations have been made to engage the individual, and the individual is not at risk of harm to self or others if treatment is suspended. [Note: In accordance with 25 TAC, Chapter 412, Subchapter G, the refusal of, or non-compliance with one type of service does not affect the individual's eligibility to receive other services]
- Individual withdraws or requests discharge from treatment or moves outside service area.
- Community resources outside the LMHA have been identified that can provide the necessary services (e.g., there is a primary care physician available to provide medication-related services) and the individual has been successfully referred to those services.

This indicator supports discontinuation of Cognitive Processing Therapy (CPT):
If an individual has not made progress in symptoms or cognition after several sessions, he or she should be re-evaluated for his or her appropriateness for CPT versus other treatment options.

LOC-1S Table Overview

Authorization Period: 180 Days Recovery/Treatment Plan: 180 Days		
Average Monthly Utilization Standard For This Level of Care: 1.3 Hours per month Across the population served at this level of care (LOC), some individuals may require more/less intense provision of services or utilize services at a higher/lower rate than 1.3 hours per month. Ideally, the hours of service(s) delivered should include the Core Services and be supplemented with Adjunct Services when clinically appropriate.		
Level of Care 1S Estimated Utilization Per Month		
Core Services: Identified by the uniform assessment and indicated in the recovery/treatment plan	**Standard Therapeutic- 1.3 hours per month**	**High Need Therapeutic- 2.25 hours per month**
Pharmacological Management	.25 hours/1 unit	.5 hours/ 2 units
Routine Case Management	.75 hours/3 units	1.25 hours/ 5 units
Adjunct Services: Identified by the uniform assessment and indicated in the recovery/treatment plan.	**Standard Therapeutic**	**High Need Therapeutic**
Psychiatric Diagnostic Interview Examination	N/A (1 Event per year)	N/A (1 Event per year)
Medication Training & Support Services (Individual)	1 hour/4 units	1.75 hours / 7 units
Medication Training & Support Services (Group)	.75 hours/3 units	1.25 hours / 5 units
Engagement Activity	1.5 hours/6 units	2.75 hours/ 11 units
Skills Training & Development (Individual)	2 hours/8 units	3.5 hours/ 14 units
Skills Training & Development (Group)	.75 hours/3 units	5 hours/ 20 units
Supported Employment	3 hours/12 units	3 hours/ 12 units
Supported Housing	3 hours/12 units	3 hours/ 12 units
Cognitive Processing Therapy (Standard duration- 12 sessions)	3 hours/3 units	4 hours/ 4 units
Peer Support		
Flexible Funds	Unit type: $1	Unit type: $1
Flexible Community Supports	Unit type: 15 min = 1 unit	Unit type: 15 min = 1 unit
Crisis Services Array: Authorized as medically necessary and available during psychiatric crisis. Utilization of crisis services within this Level of Care is the same as LOC-0. Please refer to LOC-0 for utilization guidelines.		

IV. LEVEL OF CARE 2: Basic Services including Counseling

Purpose for Level of Care

Services in this level of care are intended for individuals with symptoms of MDD (GAF ≤ 50 at intake) who present very little risk of harm, who have supports, and a level of functioning that does not require more intensive levels of care, and who can benefit from psychotherapy.

The overall focus of services in this level care is to improve level of functioning and/or prevent deterioration of the individual's condition so that the individual is able to continue to work towards identified recovery goals. Natural and/or alternative supports are developed to help the individual move out of the public mental health system. Services are most often provided in outpatient, office-based settings and include psychotherapy services in addition to those offered in LOC-1.

The authorization at the LOC level and medical necessity determination at the LOC level is required prior to service delivery. Medical necessity must be established with any new/initial authorization. Medical Necessity must be reestablished with any request for additional service amounts or a change in level of care authorized.

The Recovery/Treatment Plan review is required at least every 180 days for LOC-2.

Level of Care Assignment Criteria

The admission criteria to be met are:

- The individual must be determined to have a MDD regardless of the diagnostic qualifier of with or without psychosis;
- The individual has MDD (GAF ≤ 50 at intake) and still has a significant level of residual symptoms;
- ANSA indicates a LOC-R of 2.

Special Considerations Regarding Peers and Recovery

SAMHSA recognizes peer services as a critical component to the recovery process. The DSHS endeavors to facilitate processes that acknowledge this role. As such, the following recommendation(s) highlight how peers might be best utilized within this level of care:

- Share individual experience related to recovery and act as a model of hope and resilience.
- Provide education about the recovery process.
- Promote social integration by educating about resources in the community that may support continued recovery, such as individual-operated service providers, mutual aid groups, social organizations related to the individual's interests, health clubs, etc.
- Provide medication training and support as appropriate to the peer specialist role (i.e. share experience related to use of medication as a tool in one's own recovery).
- Provide education about LOC-1M.
- Provide engagement interventions to individuals to foster full participation in therapy.

NOTE: All the tasks identified in this section are services/assistance that can be provided by any treatment providing staff with the exception of the very peer specific functions such as shared individual experience.

Expected Outcomes

The following outcome(s) can be expected as a result of delivering services at this level of care:

- The individual completes the CBT counseling protocol.
- The individual receiving services reports stabilization of symptoms or maintenance of stability.
- The individual will develop the necessary skills needed to continue working towards, maintaining or achieving recovery.

Discharge Criteria

ANY of these indicators would support discharge from this LOC:

- Individual has met the psychotherapy objectives as defined upon admission to this LOC.
- Individual refuses to participate in psychotherapy. [Note – an individual discharged from this LOC under this provision should generally be served in LOC-1S unless clinically contraindicated]

This indicator supports discontinuation of Cognitive Processing Therapy (CPT):
If an individual has not made progress in symptoms or cognition after several sessions, he or she should be re-evaluated for his or her appropriateness for CPT versus other treatment options.

LOC-2 Table Overview

Authorization Period: 180 Days Recovery/Treatment Plan: 180 Days		
Average Monthly Utilization Standard For This Level of Care: 3.25 hours per month Across the population served at this level of care (LOC), some individuals may require more/less intense provision of services or utilize services at a higher/lower rate than 3.25 hours per month. Ideally, the hours of service(s) delivered should include the Core Services and be supplemented with Adjunct Services when clinically appropriate.		
Level of Care 2 Estimated Utilization Per Month		
Core Services: Identified by the uniform assessment and indicated in the recovery/treatment plan.	**Standard Therapeutic- 3.25 hours per month**	**High Need Therapeutic- 5.5 hours per month**
Pharmacological Management	.25 hours/1 unit	.5 hours/ 2 units
Routine Case Management	.25 hours/1 unit	1 hour/ 4 units
Counseling (CBT - Individual) Standard duration – 16 sessions	3 hours/3 Events	4 hours/ 4 units
Adjunct Services: Identified by the uniform assessment and indicated in the recovery/treatment plan.	**Standard Therapeutic**	**High Need Therapeutic**
Counseling (CBT - Group) Standard duration – 16 sessions	2 hours/2 Events	3 hours/3 Events
Psychiatric Diagnostic Interview Examination	N/A (1 Event/year)	N/A (1 Event/year)
Medication Training & Support Services (Individual)	1 hour/ 4 units	1.5 hours/ 6 units
Medication Training & Support Services (Group)	.75 hours/ 3 units	2.15 hours/ 9 units
Engagement Activity	1.5 hours/ 6 units	2.25 hours/ 5 units
Skills Training & Development (Individual)	1 hour/ 4 units	2 hours/ 8 units
Skills Training & Development (Group)	1 hour/ 4 units	4.25 hours/17units
Supported Employment	3 hours/ 12 units	4.5 hours/ 18 units
Supported Housing	3 hours/ 12 units	4.5 hours/ 18 units
Cognitive Processing Therapy (Standard duration - 12 sessions)	3 hours/ 3 Events	4 hours/ 4 Events
Flexible Funds	Unit type: $1	Unit type: $1
Flexible Community Supports	Unit type: 15 min=1 unit	Unit type: 15 min=1 unit
Crisis Services Array: Authorized as medically necessary and available during psychiatric crisis. Utilization of crisis services within this Level of Care is the same as LOC-0. Please refer to LOC-0 for utilization guidelines.		

V. LEVEL OF CARE 3: Intensive TRR Services with Team Approach

Purpose for Level of Care

The general focus of services in this level of care is to support the individual served in his or her recovery, through a team approach that engages the individual served as a key partner, to stabilize symptoms that interfere with the person's functioning, improve functioning, develop skills in self-advocacy, and increase natural supports in the community and sustain improvements made in more intensive Level of Care. Service focus is on leveraging identified strengths amelioration of functional deficits through skill training activities focusing on symptom management, independent living, self-reliance, non-job-task specific employment interventions, impulse control, and effective interaction with peers, family, and community. Services are provided in outpatient office-based settings and community settings.

Services in this level of care are generally intended for individuals who enter the system of care with moderate to severe levels of need (or for those whose LOC-R has increased) who require intensive rehabilitation to increase community tenure, establish support networks, increase community awareness, and develop coping strategies in order to function effectively in their social environment (family, peers, school). This may include maintaining the current level of functioning. A rehabilitative case manager who is a member of the therapeutic team must provide supported housing and COPSD services, if indicated. Supported employment services must be provided by a rehabilitative case manager or a supported employment specialist. It is highly recommended a dedicated employment specialist provide the supported employment services.

The authorization at the LOC level and medical necessity determination at the LOC level is required prior to service delivery. Medical necessity must be established with any new/initial authorization. Medical Necessity must be reestablished with any request for additional service amounts or a change in level of care authorized.

The Recovery/Treatment Plan review is required at least every 180 days for LOC-3.

Level of Care Assignment Criteria

The admission criteria to be met are:

- The individual must be determined to have schizophrenia and related disorders or a bipolar disorder or MDD with psychotic features, (GAF ≤ 50 at intake).
- Individuals who meet the definition of the priority, may be overridden into services if the override criteria are met;
- ANSA indicates a LOC-R of 3

Special Considerations Regarding Peers and Recovery

SAMHSA recognizes peer services as a critical component to the recovery process. The DSHS endeavors to facilitate processes that acknowledge this role. As such, the following recommendation(s) highlight how peers might be best utilized within this level of service:

- Share individual experience related to recovery and act as a model of hope and resilience.
- Provide education about the recovery process.
- Promote social integration by educating about resources in the community that may support continued recovery, such as individual-operated service providers, mutual aid groups, social organizations related to the individual's interests, health clubs, etc.
- Provide medication training and support as appropriate to the peer specialist role (i.e. share experience related to use of medication as a tool in one's own recovery).
- Provide education about LOC 3.
- Provide engagement interventions to individuals to foster full participation in treatment.

If a peer has been credentialed by Via Hope as a Certified Peer Specialist, they may serve as a member of the treatment team offering feedback to other providers regarding their observations

of an individual's stage of recovery and/or efforts made towards fulfilling the individual's recovery goals.

NOTE: All the tasks identified in this section are services/assistance that can be provided by any treatment providing staff with the exception of the peer specific only functions such as shared individual experience.

Expected Outcomes

The following outcome(s) can be expected as a result of delivering services at this level of care:

- The individual receiving services reports stabilization of symptoms or maintenance of stability.
- The individual begins to develop natural supports in the community and sustains improvement acquired in a higher level of care.
- The individual will develop additional skills needed to continue working towards, maintaining or achieving recovery.

Discharge Criteria

This indicator supports discharge from this LOC:
Individual refuses all services. [Note: In accordance with 25 TAC, Chapter 412, Subchapter G, the refusal of, or non-compliance with one type of service does not affect the individual's eligibility to receive other services]

This indicator supports discontinuation of Cognitive Processing Therapy (CPT):
If an individual has not made progress in symptoms or cognition after several sessions, he or she should be re-evaluated for his or her appropriateness for CPT versus other treatment options.

LOC-3 Table Overview

Authorization Period: 180 Days Recovery/Treatment Plan: 180 Days		
Average Monthly Utilization Standard For This Level of Care: 5.87 Hours per month Across the population served at this level of care (LOC), some individuals may require more/less intense provision of services or utilize services at a higher/lower rate than 5.87 hours per month. Ideally, the hours of service(s) delivered should include the Core Services and be supplemented with Adjunct Services when clinically appropriate.		
Level of Care 3 **Estimated Utilization Per Month**		
Core Services: Identified by the uniform assessment and indicated in the recovery/treatment plan.	**Standard Therapeutic- 5.87 hours per month**	**High Need Therapeutic- 20.35 hours per month**
Pharmacological Management	.25 hours/ 1 unit	0.5 hr/ 2 units
Psychosocial Rehabilitative Services (Individual)	3.5 hours/ 14 units	7 hours/ 29 units
Psychosocial Rehabilitative Services (Group)	2.25 hours/ 9 units	8.6 hours/ 35 units
Supported Housing	3 hours/ 12 units	4.25 hours/ 17 units
Adjunct Services: Identified by the uniform assessment and indicated in the recovery/treatment plan.	**Standard Therapeutic**	**High Need Therapeutic**
Psychiatric Diagnostic Interview Examination	N/A (1 Event/year)	N/A (1 Event/year)
Medication Training & Support Services (Individual)	1 hour/4 units	1.5 hours/ 6 units
Medication Training & Support Services (Group)	.75 hour/ 3 units	5 hours/ 21 units
Engagement Activity	1.5 hours/ 6 units	2.25 hours/ 9 units
Supported Employment	3 hours/ 12 units	4.5 hours/ 18 units
Cognitive Processing Therapy (Standard duration- 12 sessions)	3 hours/ 3 Events	4 hours/ 16 Events
Day Programs for Acute Needs	Unit type: 45-60 continuous min	Unit type: 45-60 continuous min
Residential Treatment	Unit type: bed day	Unit type: bed day
Flexible Funds	Unit type: $1	Unit type: $1
Flexible Community Supports	Unit type: 15 min=1 unit	Unit type: 15 min=1 unit
Crisis Services Array: Authorized as medically necessary and available during psychiatric crisis. Utilization of crisis services within this Level of Care is the same as LOC-0. Please refer to LOC-0 for utilization guidelines.		

VI. LEVEL OF CARE 4: Assertive Community Treatment (ACT)

Purpose for Level of Care

The purpose of ACT is to provide a comprehensive program that serves as the fixed point of responsibility for providing treatment, rehabilitation and support services to identified individuals with severe and persistent mental illnesses. Person's receiving ACT services may have a diagnosis of schizophrenia or another serious mental illness such as bipolar disorder and has experienced multiple psychiatric hospital admissions either at the state or community level.

Using an integrated services approach, the ACT team merges clinical and rehabilitation staff expertise, (e.g., psychiatric, substance abuse, employment, and housing) within a mobile service delivery team that works in partnership with the person in recovery from his or her home). Accordingly, there will be minimal referral of individuals to other programs for treatment, rehabilitation, and support services. Limited use of group activities designed to reduce social isolation, or address substance use/abuse issues is also acceptable as part of ACT.

ACT includes an Urban ACT program and a Rural ACT program. The Local Mental Health Authority's (LMHA) ACT designation status shall be based on the total number of individuals with an LOC-R = 4. If an LMHA has 60 or greater individuals with an LOC-R of 4 or the population density for the LMHA's local service area is greater than or equal to 300 individuals per square mile, then the LMHA shall be considered an Urban ACT team. All other teams shall be considered to be a Rural ACT team. (Performance Contract Contains details for each LMHA.)

The authorization at the LOC level and medical necessity determination at the LOC level is required prior to service delivery. Medical necessity must be established with any new/initial authorization. Medical Necessity must be reestablished with any request for additional service amounts or a change in level of care authorized.

The Recovery/Treatment Plan review is required at least every 180 days for LOC-4.

Level of Care Assignment Criteria

The admission criteria to be met are:

- The individual must be determined to have schizophrenia and related disorders or a bipolar disorder or MDD with psychotic features, (GAF ≤ 50 at intake).
- Individuals who meet the definition of the priority population other than MDD (GAF ≤ 50 at intake), bipolar disorder or schizophrenia and related disorders, may be overridden into services if the override criteria are met;
- ANSA indicates a LOC-R of 4.

Special Considerations Regarding Peers and Recovery

SAMHSA recognizes peer services as a critical component to the recovery process. The DSHS endeavors to facilitate processes that acknowledge this role. As such, the following recommendation(s) highlight how peers might be best utilized within this level of service:

- Share individual experience related to recovery and act as a model of hope and resilience.
- Provide education about the recovery process.
- Promote social integration by educating about resources in the community that may support continued recovery, such as individual-operated service providers, mutual aid groups, social organizations related to the individual's interests, health clubs, etc.
- Provide medication training and support as appropriate to the peer specialist role (i.e. share experience related to use of medication as a tool in one's own recovery).
- Provide education about LOC-4.
- Provide engagement interventions to individuals to foster full participation in treatment.
- If a peer has been credentialed by Via Hope as a Certified Peer specialist, they may serve as a member of the treatment team offering feedback to other providers regarding their

observations of an individual's stage of recovery and/or efforts made towards fulfilling the individual's recovery goals.

NOTE: All the tasks identified in this section are services/assistance that can be provided by any treatment providing staff with the exception of the very peer specific functions such as shared individual experience.

Expected Outcomes

The following outcome(s) can be expected as a result of delivering services at this level of care:

- The individual receiving services reports stabilization of symptoms or maintenance of stability.
- The individual begins to develop natural supports in the community and sustains improvement.
- The individual will develop additional skills needed to continue working towards, maintaining or achieving recovery.
- The individual will move to a lower level of care and continue to work towards self-directed recovery goals.

Discharge Criteria

ANY of these indicators would support discharge from this LOC:

- The individual moves outside of the geographic service area of the ACT team. To the extent possible, the ACT team must facilitate referral of the individual to a provider of services sufficiently capable of satisfactorily addressing the individual's needs.
- Individual refuses all services. [Note: In accordance with 25 TAC, Chapter 412, Subchapter G, the refusal of, or non-compliance with one type of service does not affect the individual's eligibility to receive other services]

This indicator supports discontinuation of Cognitive Processing Therapy (CPT):

If an individual has not made progress in symptoms or cognition after several sessions, he or she should be re-evaluated for his or her appropriateness for CPT versus other treatment options.

LOC- 4 Table Overview

Authorization Period: 180 Days Recovery/Treatment Plan: 180 Days		
Average Monthly Utilization Standard For This Level of Care: 10 Hours per month Across the population served at this level of care (LOC), some individuals may require more/less intense provision of services or utilize services at a higher/lower rate than 10 hours per month. Ideally, the hours of service(s) delivered should include the Core Services and be supplemented with Adjunct Services when clinically appropriate.		
Level of Care 4 Estimated Utilization Per Month		
Core Services: Identified by the uniform assessment and indicated in the recovery/treatment plan.	**Standard Therapeutic- 10 hours per month**	**High Need Therapeutic- 26.65 hours per month**
Pharmacological Management	.25 hours/ 1 unit	.3 hours/ 2 units
Psychosocial Rehabilitative Services (Individual)	5.75 hours/ 23 units	14. 25 hours/ 57units
Psychosocial Rehabilitative Services (Group)	2.5 hours/ 10 units	8.6 hours/ 35 units
Supported Housing	3 hours / 12 units	3.5 hours/ 14 units
Adjunct Services: Identified by the uniform assessment and indicated in the recovery/treatment plan.	**Standard Therapeutic**	**High Need Therapeutic**
Psychiatric Diagnostic Interview Examination	N/A (1 Event per year)	N/A (1 Event per year)
Medication Training & Support Services (Individual)	1 hour/ 4 units	2.5 hours/ 10 units
Medication Training & Support Services (Group)	.75 hour / 3 units	2.75 hours/ 11 units
Engagement Activity	1.5 hours / 6 units	1.75 hours/ 7 units
Supported Employment	3 hours/ 12 units	3.5 hours/ 14 units
Cognitive Processing Therapy (standard duration-12 sessions)	3 hours/ 3 Events	3.5 hours/ 14 Events
Counseling (CBT - Individual) Standard duration – 16 sessions	3 hours/3 Events	4 hours/ 4 Events
Counseling (CBT - Group) Standard duration – 16 sessions	2 hours/2 Events	3 hours/3 Events
Day Programs for Acute Needs	Unit type: 45-60 continuous min	Unit type: 45-60 continuous min
Residential Treatment	Unit type: bed day	Unit type: bed day
Flexible Funds	Unit type: $1	Unit type: $1
Flexible Community Supports	Unit type: 15 min = 1 unit	Unit type: 15 min = 1 unit
Crisis Services Array: Authorized as medically necessary and available during psychiatric crisis. Utilization of crisis services within this Level of Care is the same as LOC-0. Please refer to LOC-0 for utilization guidelines.		

VII. LEVEL OF CARE 5: Transitional Services

Purpose for Level of Care

The major focus for this LOC is to provide flexible services that assist individuals in maintaining stability, preventing further crisis, and engaging the individual into the appropriate LOC or assisting the individual in obtaining appropriate community-based services. This LOC is highly individualized and the level of service intensity and length of stay is expected to vary dependent on individual need. This LOC is available for up to 90 days.

The authorization at the LOC level and medical necessity determination at the LOC level is required prior to service delivery. Medical necessity must be established with any new/initial authorization. Medical Necessity must be reestablished with any request for a change in the level of care authorized.

A Recovery/Treatment Plan is required. In the event that an additional LOC-5 post-initial 90 days is required, a new plan would be required for every 90 day LOC-5 authorization.

Special Considerations during Crisis

As in other LOCs, if a crisis occurs during the time an individual is in LOC-5, crisis services are considered a part of the authorization for LOC-5 and crisis services should be delivered without a change in the LOC. LOC-0 may only be used for an individual who is newly admitted to services, or who has been transitioned out of LOC-5 and is experiencing a crisis.

Level of Care Assignment Criteria

The admission criteria to be met are:

- The individual has been discharged from LOC-0 services or released from the hospital and is not eligible for ongoing services, and is in need of more than crisis services to stabilize; or
- The individual has been discharged from LOC-0 services or released from the hospital and is eligible for ongoing services, but ongoing services are not available or the provider has had difficulty engaging the individual and the individual is in need of transitional services; or
- The individual is identified as part of a high need population e.g. homelessness, substance abuse issues, primary healthcare needs or has a history of criminal justice involvement and is not eligible for ongoing services, but is in need of more than crisis services to stabilize; or
- The individual is identified as part of a high need population e.g. homelessness, substance abuse issues, primary healthcare needs or has a history of criminal justice involvement and is eligible for ongoing services, but ongoing services are not available or the provider has had difficulty engaging the individual and the individual is in need of transitional services; or
- The individual has been discharged from LOC-0 services, released from the hospital or is part of a high need population e.g. homelessness, substance abuse issues, primary healthcare needs or has a history of criminal justice involvement and has chosen an external provider for ongoing services but is in need of transitional services.

Special Considerations

In addition to the above level of care assignment criteria, the following may indicate this as the most appropriate LOC:

- Individual is high need and is underserved or on the Waiting List for all services LOC A 8. This individual may be authorized into LOC-5 to stabilize or avoid repeated crises until the appropriate level of care is provided for up to 90 days.

- Special care needs to be provided for individuals who receive Medicaid benefit to ensure access to medically necessary services.

Adjunct Service Criteria:
Counseling (Cognitive Processing Therapy (CPT) :
- CPT is clinically indicated when there is an Axis I diagnosis of PTSD.

Any of the following may indicate the need to continue Cognitive Processing Therapy (CPT):
- Even if an individual has obtained maximum benefit or has located other community resources, if he or she has not completed all 12 sessions in the CPT protocol, the individual is not discontinued from CPT unless he or she requests discontinuation.
- If an individual's condition worsens and a more intensive Level of Care is appropriate and available, CPT or any other add-on service is continued in the new Level of Care as clinically appropriate as long as the individual is willing to continue services.
- A follow-up session to assess progress and target problem areas is recommended approximately one month after completion of CPT and may be conducted individually or in a group. This 13th session is at the individual's and therapist's discretion.

Criteria for Level of Care Review

Continued Stay: This LOC will terminate in 90 days. If eligibility criteria are met, continued services may be provided in LOCs 1S-4 or LOC-0.

Indication for potential increase in LOC: Individual's condition worsens as indicated by a LOC-R 0-4 on the Adult-TRAG.

Discharge Criteria

ANY of these indicators would support discharge from this LOC:
- Referred to a higher LOC for crisis management, e.g. psychiatric hospitalization.
- The identified crisis is resolved and the individual has been engaged and transitioned to LOC-1S-4.
- The identified crisis is resolved, but resources do not support placement of the individual in LOC-1S-4. Therefore, the individual is placed on a waiting list for LOC1S-4.
- Individual has been referred and linked to community resources outside the DSHS system.
- The individual terminates services.

This indicator supports discontinuation of Cognitive Processing Therapy (CPT):
- If an individual has not made progress in symptoms or cognition after several sessions, he or she should be re-evaluated for his or her appropriateness for CPT versus other treatment options.

Expected Outcomes

- Individual self-reports reduction or stabilization in presenting problem severity and improved **quality of life as evidenced by scores on the ANSA.**
- Individual becomes engaged into the appropriate level of care.
- Individual is better able to use natural and community support systems as resources.

LOC-5 Overview

LOC-5 is designed to flexibly meet the needs of the individual prior to admission into ongoing services. All services are available in this Level of Care. There are no average expected units. Services should reflect the individual's needs.

UM Guidelines	
Level of Care 5 Transitional Services	**Authorization Period 90 Days**
	Unit
Routine Case Management	15 min
Psychiatric Diagnostic Interview Examination	Event
Pharmacological Management	Event 25 min
Medication Training and Support Services (Individual, Curriculum-based)	15 min
Medication Training and Support Services (Group, Curriculum-based)	15 min
Skills Training & Development (Individual)	15 min
Skills Training & Development (Group)	15 min
Supported Employment	15 min
Supported Housing	15 min
Flexible Funds	$1
Flexible Community Supports	15 min
Engagement Activity	15 min
The following Crisis Services are also considered Core Services for LOC 5 and are Available to All individuals During Crisis	**Unit**
Counseling (Cognitive Processing Therapy)	45-60 min
Crisis Intervention Services	15 min
Psychiatric Diagnostic Interview Examination	Event
Pharmacological Management	Event 25 min
Crisis Transportation (Event)	Event
Crisis Transportation (Dollar)	$1
Safety Monitoring	15 min
Day Programs for Acute Needs (when indicated)	45-60 min
Extended Observation	1 bed day
Crisis Residential Treatment	1 bed day
Crisis Stabilization Unit	1 bed day
Flexible Funds (Dollars)	$1
Flexible Community Supports (Time)	15 min
Respite Services: Community-based	15 min
Respite Services: Program-based (Not In Home)	1 bed day
Inpatient Hospital Services	Event
Inpatient Services (Psychiatric)	1 bed day
Emergency Room Services (Psychiatric)	Event
Crisis Follow-up & Relapse Prevention.	15 min

LOC – 6 Overview :

Individual Refuses Services (LOC-A only)

The Adult Needs Strengths Assessment (ANSA) indicates a Recommended Level of Care (LOC-R) of 1M-4; however, the individual refuses services. These individual's will be authorized into Level of Care (LOC-A) 6.

LOC – 8 Overview:

Waiting for all Authorized Services (LOC-A only)

All providers who maintain a waitlist must adhere to the standards outlined in the performance contract. For information related to managing a waitlist please refer to the performance contract.

LOC – 9 Overview:

Not Eligible for Services (LOC-R or A)

The Adult Needs Strengths Assessment (ANSA) indicates a Recommended Level of Care (LOC-R) 9.

A provider may request a review from the each provider's Utilization Management Department if, based on the individual's clinical presentation and the provider's clinical judgment, it is determined that a different level of care may be clinically appropriate. The necessary clinical information will be reviewed in accordance with the provider's Utilization Management Policy and Procedures for those individuals with a LOC-R of 9. If it is determined the individual is clinically appropriate to receive services the individual may be authorized into a level of care.

VIII. Deviations

Definitions and Usage

The following Reasons for Deviation are allowed with indicated requirements when authorizing a level of care (LOC-A) other than the level of care recommended (LOC-R):

Resource Limitations: To be used when the Utilization Management staff member identifies that there are not enough resources to offer services at the recommended level of care (Note: Resources are defined as individual, a slot within a specific level of care, or monetary resources necessary to provide services within the level of care).

Recommendation:

- This reason for deviation is not to be used to increase a level of care.

Individual Refused: To be used when the individual is provided with information necessary to make an informed decision and refuses the recommended level of care. The information discussed with the individual must be documented in the medical record.

Recommendation:

- A contractual threshold will be established for this deviation reason

Clinical Need: To be used when the LPHA's judgment identifies the clinical need for a more or less intensive level of care than the level of care recommended. Justification for the deviation must be documented in the medical record.

The following is an example of appropriate utilization of this deviation reason:

- The Uniform Assessment recommends a lower level of care than the individual is currently receiving but based on individual's history and needs, the clinician recommends and the LMHA authorizes the current level of care to ensure that improvements are maintained (identified needs must be documented in the Uniform Assessment).

- Mandatory description of the reason for deviation in the notes section when deviating to a LOC-A that is lower than the LOC-R

Continuity of Care: To be used when there is an identified need to authorize a level of care that is different from the level of care recommended by DSHS in order to maintain continuity of care for the individual. Justification for the deviation must be documented in the medical record.

The following are examples of appropriate utilization of this deviation reason:

- The individual is incarcerated or placed in juvenile detention center but continues to need services from the provider that the facility is not obligated to provide or are provided under a contract with the facility;

Or

- The individual is hospitalized and provider communicates with the individual and hospital staff regarding care and transition to the community.

Other: To be used when none of the reasons listed above accurately describe the Reason for Deviation. Justification for the deviation must be documented in the "Notes" field of the uniform assessment and retained in the medical record.

Deviation Reasons and Deviation Grid Table

LOC-R	LOC-A Deviation Reason(s)
1M	▪ No deviations allowed into LOC-1M from other LOC's. ▪ May deviate into LOC-1S through LOC-4 due to clinical need.
1S	▪ No deviations allowed into LOC-1M. ▪ May deviate LOC-2 through LOC-4 due to clinical need.
2	▪ No deviations allowed into LOC 1M. ▪ May deviate into LOC 1S due to resource limitations, clinical need or individual refused services. ▪ May deviate into LOC-3 or LOC-4 due to clinical need
3	▪ No deviations allowed into LOC-1M. ▪ May deviate into LOC-1S due to resource limitations, clinical need or individual refused services. ▪ May deviate into LOC-2 or LOC-4 due to clinical need.
4	▪ No deviations allowed into LOC-1M. ▪ May deviate into LOC-2 due to clinical need, or resource limitations. ▪ May deviate into LOC-3 due to clinical need, resource limitations or individual refused.
9	▪ Deviations into LOC-9 are limited to 2 consecutive authorization periods. ▪ May deviate into LOC 1S-4 due to clinical need, or resource limitation ▪ May deviate to LOC-5 if the individual has been recently discharged from crisis services or released from a hospital, after being treated for a psychiatric condition, and <u>is not eligible</u> for ongoing services, and there is a need for more than crisis services to stabilize, due to clinical need ▪ May deviate to LOC-5 if the individual is identified as part of a high need population (e.g. homelessness, substance abuse issues, primary healthcare needs, or has a history of criminal justice involvement and <u>is not eligible</u> for ongoing services, but is in the need of transitional services due to clinical need.
1S-4	▪ May deviate to LOC-5 if the individual has been recently discharged from crisis or a hospital, after being treated for a psychiatric condition, and <u>is eligible</u> for ongoing services, but ongoing services are not available or the provider has had difficultly engaging the individual and the individual is in need of transitional services, due to clinical need ▪ May deviate to LOC-5 if the individual is identified as part of a high need population e.g. homelessness, substance abuse issues, primary healthcare needs or has a history of criminal justice involvement and <u>is eligible</u> for ongoing services, but ongoing services are not available or the provider has had difficulty engaging the individual but is in the need of transitional services, due to clinical need ▪ May deviate to LOC-5, if the individual has been recently discharged from crisis services, released from the hospital, after being treated for a psychiatric condition, or is part of a high need population e.g. homelessness, substance abuse issues, primary healthcare needs or has a history of criminal justice involvement and has chosen an external provider for ongoing services but is in need of transitional services, due to clinical need
1S-9	▪ May deviate into LOC-0; if the individual does not have a current authorization due to clinical need/medical necessity warrants crisis services

Purpose of the Level of Care Deviation

The purpose of the Request for Deviation Option, or LOC-D, is to allow the provider the option to request a deviation from the recommended LOC (LOC-R) as calculated by the ANSA/Uniform Assessment.

Options for the Use of LOC-D

- The individual does not have an authorization of LOC 1-5; (no current UA); if the clinical circumstances warrant the individual may be deviated into LOCA-0 (intake UA only).
- The LOC-R is 1-4 or 9; then the LOC-D, shall only be completed when requesting a deviation from the LOC-R. (Intake or Update UA).
- The clinician provides the reason for deviation. See the above table -Deviation Reasons and Deviation Grid Table for each LOC-R and LOC-A.

Expected Outcomes

The individual receives the appropriate care, based on clinical need through the deviation request.

The individual will eventually be authorized in the LOC based on the LOC-R.

IX. Definitions

Key Terms

Core Service definition: The services in a level of care that are essential and are expected to be delivered to all individuals to support their recovery.

Exceptions for not providing core services include:

- The UA does not indicate the need for a specific core service; or
- Delivery of a core service is clinically contraindicated (documentation required); or
- The individual refuses a core service (documentation required; engagement services must be delivered and efforts documented.)

Adjunct Service definition**:** Clinically indicated services that are customized and may be delivered to support the recovery of the individual.

Note: When a level of care is authorized, all core and adjunct services are also authorized; however, some LMHAs may require additional authorizations for certain Core and Adjunct Services. Please follow your local authorization policy.

Service Definitions:

- **Counseling (Cognitive Behavioral Therapy (CBT)):** Individual, family and group therapy focused on the reduction or elimination of an individual's symptoms of mental illness and increasing the individual's ability to perform activities of daily living. Cognitive-behavioral therapy is the selected treatment model for adult counseling services. Counseling must be

provided by a Licensed Practitioner of the Healing Arts (LPHA), practicing within the scope of their license or by an individual with a master's degree in a human services field pursuing licensure under the direct supervision of an LPHA, if not billed to Medicaid. This service includes recovery/treatment planning to enhance recovery and resiliency. *Note: Group CBT falls under the category of adjunct service*.

- **Counseling (Cognitive Processing Therapy (CPT)):** Individual therapy focused on the reduction or elimination of an individual's symptoms of post traumatic stress disorder (PTSD). CPT is the selected treatment model for adults with PTSD, including but not limited to military veterans. CPT is clinically indicated when there is an Axis I diagnosis of PTSD. Counseling must be provided by a Licensed Practitioner of the Healing Arts (LPHA), also trained in CPT by DSHS, practicing within the scope of their license. Alternative CPT Certification may be sought for those individuals who have received adequate CPT training outside of DSHS. CPT may also be provided by an individual with a master's degree in a human services field pursuing licensure under the direct supervision of an LPHA who has been trained in CPT, if not billed to Medicaid. This service includes recovery/treatment planning to enhance recovery and resiliency.

- **Crisis Flexible Benefits:** Non-clinical supports that reduce crisis situations, symptomatology, and enhance an individual's ability to remain in the home or community. Benefits in adult mental health services include spot rental, partial rental subsidies, utilities, emergency food, housewares, clothing, transportation assistance, and residential services. (LOC 0 & LOC 5)

- **Crisis Follow-up and Relapse Prevention:** Supported services provided to individuals who are not in imminent danger of harm to self or others but require additional assistance to avoid reoccurrence of the crisis event. The service is provided to ameliorate the situation that gave rise to the crisis event, ensure stability, and prevent future crisis events. (This service includes ongoing assessment to determine crisis status and needs, provides time-limited (up to 30 days) brief, solution-focused interventions to individuals and families and focuses on providing guidance and developing problem-solving techniques to enable the individual to adapt and cope with the situation and stressors that prompted the crisis event).

- **Crisis Intervention Services:** Interventions in response to a crisis in order to reduce symptoms of severe and persistent mental illness or emotional disturbance and to prevent admission of an individual or individual to a more restrictive environment. Must be provided in accordance with Title 25 of the Texas Administrative Code (TAC), Chapter 419, Subchapter L, *MH Rehabilitative Services*. This service does not require prior authorization. The average time necessary to stabilize the crisis is 4.5 hours per crisis episode.

- **Crisis Residential Treatment:** Short-term, community-based residential treatment to individuals with some risk of harm who may have fairly severe functional impairment and who require direct supervision and care but do not require hospitalization.

- **Crisis Stabilization Unit:** Short-term residential treatment designed to reduce acute symptoms of mental illness provided in a secure and protected clinically staffed, psychiatrically supervised, treatment environment that is licensed under and complies with a crisis stabilization unit licensed under Chapter 577 of the Texas Health and Safety Code and 25 TAC, Chapter 411, Subchapter M, *Standards of Care and Treatment in Crisis Stabilization Units*. The maximum length of stay is 14 days.

- **Crisis Transportation:** Transporting individuals receiving crisis services or crisis follow-up and relapse prevention services from one location to another. Transportation is provided in accordance with state laws and regulations by law enforcement personnel or, when appropriate, by ambulance or qualified staff.

- **Day Programs for Acute Needs:** Programs that provide short-term, intensive treatment to an individual who requires multidisciplinary treatment in order to stabilize acute psychiatric symptoms or prevent admission to a more restrictive setting. Must be provided in accordance with 25 TAC, Chapter 419, Subchapter L, *and MH Rehabilitative Services.*

- **Engagement Activity:** Face-to-face activities with the individual or collaterals (in accordance with confidentiality requirements) in order to develop treatment alliance and rapport with the individual and includes activities such as motivational interviewing, providing an explanation of services recommended, education on service value, education on adherence to the recommended LOC and its importance in recovery, and short term planned activities designed to develop a therapeutic alliance and strengthen rapport. This service shall not be provided in a group

- **Extended Observation:** Up to 48 hour emergency and crisis stabilization service that provides emergency stabilization in a secure and protected, clinically staffed (including medical and nursing professionals), psychiatrically supervised treatment environment with immediate access to urgent or emergent medical evaluation and treatment. Individuals are provided appropriate and coordinated transfer to a higher LOC when needed.

- **Flexible Community Supports:** Non-clinical supports that assist individuals with community integration, reducing symptomatology, and maintaining quality of life. Non-clinical supports must be:
  - Included as strategies in the individual's Case Management Plan;
  - Based on the preference of the individual and focus on the outcomes that the individual chooses;
  - Monitored for effectiveness by the Case Manager and adjusted based on effectiveness;
  - Available through GR funding; and
  - Not readily available through other sources (e.g., other agencies, volunteers).

  Flexible community supports include but are not limited to: transportation services, educational training, (e.g. computer skills, budgeting, etc.) temporary child care, job development and placement activities, and independent living support.

- **Flexible Funds:** These should be considered funds of last resort as applicable.
  - The Local Authority has the responsibility to evaluate the need and prioritize the use of available dollars.
  - NOTE: A <u>general formula guideline may be applied</u> to calculate the amount of the stipend:
    - (Amount of Income) X (0.30) = Individual Contribution
    - (Cost of Housing) – (Individual Contribution) = Center Contribution
  - This support is not intended as a source of funds for individuals wishing to change residences for reasons not related to either one's mental illness or one's recovery/treatment plan (it is not simply a moving fund).

    Flexible funds include:
  - <u>Non-Clinical Supports</u> - Services for assisting individuals to access and maintain safe and affordable housing in the community. Services consist of assistance with rent and utility deposits, initial rent/utilities or temporary rental/utilities assistance or other necessities, to facilitate independent living.
  - <u>Transportation</u> - Temporary transportation to meet needs of the recovery/treatment plan or to address basic life needs that may have a clinical impact if not met. It is anticipated that most individuals will receive one-time situational/temporary transportation assistance. However, for some individuals, the plan may indicate that an extended period of assistance is necessary before other resources are available to the individual.

- **Inpatient Hospitalization Services:** Hospital services staffed with medical and nursing professionals who provide 24-hour professional monitoring, supervision, and assistance in an environment designed to provide safety and security during acute psychiatric crisis. Staff will provide intensive interventions designed to relieve acute psychiatric symptomatology and restore patient's ability to function in a less restrictive setting. The hospital must be contracting with or operated by Contractor.

- **Inpatient Services (Psychiatric):** Inpatient psychiatric hospital bed days - Room and Board.

- **Medication Training & Support Services:** Education and guidance about medications and their possible side effects as described in 25 TAC, Part 1, Chapter 419, Subchapter L, *MH Rehabilitative Services,* provided to individuals and family members. The department has reviewed and approves the use of the material that are available on the department's internet site at http://www.dshs.state.tx.us/mhsa/patient-family-ed/

- **Pharmacological Management:** A service provided by a physician or other prescribing professional which focuses on the use of medication and the in-depth management of psychopharmacological agents to treat a individual's signs and symptoms of mental illness.

- **Psychiatric Diagnostic Interview Examination:** An assessment that includes relevant past and current medical and psychiatric information and a documented diagnosis by a licensed professional practicing within the scope of his/her license. Must be provided in accordance with 25 TAC, Chapter 412, Subchapter G, *MH Community Services Standards*.

- **Psychosocial Rehabilitative Services:** Social, educational, vocational, behavioral, and cognitive interventions provided by members of a individual's therapeutic team that address deficits in the individual's ability to develop and maintain social relationships, occupational or educational achievement, independent living skills, and housing, that are a result of a severe and persistent mental illness. This service includes recovery/treatment planning to facilitate recovery. Must be provided in accordance with 25 TAC, Chapter 419, Subchapter L, *MH Rehabilitative Services.*

- **Respite Services:** Services provided for temporary, short-term, periodic relief for primary caregivers. Program-based respite services are provided at temporary residential placement outside the individual's usual living situation. Community-based respite services are provided by respite staff at the individual's usual living situation. Respite includes both planned respite and crisis respite to assist in resolving a crisis situation.

- **Residential Treatment:** Twenty-four hour specialized living environments. Residential treatment includes administration of medications, room and board, and all daily living needs. Adult Foster Care, Individual Care Homes, and Assisted Living facilities are included in this category.

- **Routine Case Management:** Primarily site-based services that assist an adult, child or adolescent, or caregiver in gaining and coordinating access to necessary care and services appropriate to the individual's needs. Routine case management activities must be provided in accordance with 25 TAC, Chapter 412, Subchapter I, *MH Case Management Services. Contractor shall not subcontract for the delivery of these services.*

- **Safety Monitoring:** Ongoing observation of an individual to ensure the individual's safety. An appropriate staff individual must be continuously present in the individual's immediate vicinity, provide ongoing monitoring of the individual's mental and physical status, and ensure rapid response to indications of a need for assistance or intervention. Safety monitoring includes maintaining continuous visual contact with frequent face-to-face contacts as needed.

- **Skills Training & Development:** Training provided to an individual that addresses the severe and persistent mental illness and symptom-related problems that interfere with the individual's functioning, provides opportunities for the individual to acquire and improve skills needed to function as appropriately and independently as possible in the community, and facilitates the individual's community integration and increases his or her community tenure. This service may address skill deficits in vocational and housing areas and includes recovery/treatment planning to facilitate recovery. Must be provided in accordance with 25 TAC, Chapter 419, Subchapter L, *MH Rehabilitative Services.*

- **Supported Employment:** Intensive services designed to result in employment stability and to provide individualized assistance to individuals in choosing and obtaining employment in integrated work sites in regular community jobs. Includes activities such as assisting the individual in finding a job, helping the individual complete job applications, advocating with

potential employers, assisting with learning job-specific skills, and employer negotiations. Concurrent rehabilitative training should be identified as a separate encounter with the appropriate rehabilitative service code.

- **Supported Housing:** Activities to assist individuals in choosing, obtaining, and maintaining regular, integrated housing. Services consist of individualized assistance in finding and moving into habitable, regular, integrated (i.e., no more than 50% of the units may be occupied by individuals with serious mental illness), and affordable housing. Supported housing includes:
  - Housing Assistance - Funds for rental assistance (unless the Contractor has and documents evidence that housing is affordable for people on SSI or that rental assistance funds are guaranteed from another source). To receive rental assistance, individuals must be willing to make application for Section 8/public housing or have a plan to increase individual income so housing will become affordable without assistance. Housing assistance without services and supports cannot be counted as supported housing.
  - Services and Supports - Assistance in locating, moving into and maintaining regular integrated housing that is habitable. This service includes recovery/treatment planning to facilitate recovery. While activities that fall under services and supports cannot be billed as rehabilitative services, concurrent rehabilitative training should be identified as a separate encounter with the appropriate rehabilitative service code.

X. Provider Qualifications

In accordance with 25 TAC, Chapter 412, Subchapter G, *MH Community Services Standards:* "*All staff must demonstrate required competencies before contact with individuals and periodically throughout the staff's tenure of employment or association with the LMHA, MMCO, or provider.*"
Pharmacological Management: MD, RN, PA, Pharmacy D, APN, LVN
Psychiatric Diagnostic Interview Examination: LPHA
Counseling: LPHA or LPHA Intern (See Add-On Definitions for CPT Provider Requirements)
Routine Case Management: QMHP-CS, or CSSP
Rehabilitative Services: QMHP-CS, Licensed medical personnel, CSSP, or Peer Provider (consult 25 TAC, Chapter 419, Subchapter L, *MH Rehabilitative Services* for specific credential requirements for sub-component services)
Supported Employment: QMHP-CS or CSSP or Peer Provider
Supported Housing: QMHP-CS or CSSP or Peer Provider
Crisis Intervention Services: QMHP-CS