Nebraska Continuum of Care Manual

for

Mental Health

and

Substance Use Disorders

Supported by Title 206
of the Administrative Code
for
Behavioral Health Services

Department of Health & Human Services
Division of Behavioral Health

NEBRASKA
Good Life. Great Mission.
DEPT. OF HEALTH AND HUMAN SERVICES

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MISSION STATEMENT

The Division of Behavioral Health's mission is to provide leadership and resources for a system of care that promotes and facilitates resilience and recovery for Nebraskans.

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Rehabilitation Services

Service Definitions: Substance Use Disorder

Appendices

QUICK REFERENCE

The subjects listed below are found in the appendices to this document. Click on a subject name to be taken directly to that page.

Documentation Requirements

Describes documentation required in the clinical record for persons receiving mental health or substance use disorder services. Includes demographic, assessment, diagnostic and chronological record of all services provided to the individual as well as a medication use profile as applicable.

Medical and Therapeutic Leave

Describes allowable "bed-hold" periods for a patient who is absent their facility for medical or therapeutic reasons.

Service Delivery Chart (Telehealth and Populations)

A reference chart that details mental health and substance use disorder services that may be delivered via telehealth and/or phone, for both adult and youth populations.

Contact Information

Department of Health and Human Services
Division of Behavioral Health
(402) 471-3121
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Email: DHHS.BehavioralHealthDivision@nebraska.gov

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PREVENTION

There is no health without Behavioral Health

CONTINUUM OF CARE

for

Mental Health

and

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PREVENTION

The state is mandated to report to the federal government on who is being served, and what approaches are being utilized. Prevention approaches are part of the *Continuum of Care* for mental health and substance use disorders. All funded prevention activities must fall within the following *Institute of Medicine* (IOM) *Prevention Classification* categories:

UNIVERSAL PREVENTION - activities targeted to the general public or a whole population group that has not been identified on the basis of individual risk.

- **Universal Direct** – directly serve an identifiable group of participants but who have not been identified on the basis of individual risk. (e.g., school curriculum, parenting class). This also could include interventions involving interpersonal and ongoing/repeated contact (e.g., coalitions).

- **Universal Indirect** – support population-based programs and environmental strategies (e.g., establishing ATOD policies). This could also include programs and policies implemented by coalitions.

SELECTIVE PREVENTION - activities targeted to individuals or a subgroup of the population whose risk of developing a disorder is significantly higher than average.

INDICATED PREVENTION - activities targeted to individuals in high-risk environments, identified as having minimal but detectable signs or symptoms foreshadowing disorder or having biological markers indicating predisposition for disorder but not yet meeting diagnostic levels.

- ❖ In a broad sense, the **3 IOM Classification Categories** answer: Who your target population is.

PREVENTION STRATEGIES

The SAMHSA Center for Substance Abuse Prevention requires that all prevention activities be identified as fitting into the framework of one of the following *6 Primary Prevention Strategies*. All DBH funded prevention activities must also fall within one of these overarching strategies. One way to think of these 6 strategies is that they represent the array of services that are provided to specific target populations.

- The **6 strategies** answer: How the activity is used to address the population.

(1) Information Dissemination:

This strategy provides awareness and knowledge of the nature and extent of alcohol, tobacco and drug use, abuse and addiction and their effects on individuals, families and communities. It also provides knowledge and awareness of available prevention programs and services. Information dissemination is characterized by one-way communication from the source to the audience, with limited contact between the two. Examples of activities conducted and methods used for this strategy include (but are not limited to) the following:

- Clearinghouse/information resource center(s)
- Resource directories
- Media campaigns
- Brochures
- Radio/TV public service announcements
- Speaking engagements
- Health fairs and other health promotion e.g., conferences, meetings, seminars
- Information lines/Hot lines

(2) Education:

This strategy involves two-way communication and is distinguished from the Information Dissemination strategy by the fact that interaction between the educator/facilitator and the participants is the basis of its activities. Activities under this strategy aim to affect critical life and social skills, including decision-making, refusal skills, critical analysis (e.g., of media messages) and systematic judgment abilities.
Examples of Educational activities conducted and methods used for this strategy include (but are not limited to) the following:

- Parenting and family management classes
- Ongoing classroom and/or small group sessions
- Peer leader/helper programs
- Education programs for youth groups
- Mentors
- Preschool ATOD prevention programs

(3) Alternative Activities:

This strategy provides for the participation of target populations in activities that exclude alcohol, tobacco and other drug use. The assumption is that constructive and healthy activities offset the attraction to, or otherwise meet the needs usually filled by alcohol,

tobacco and other drugs and would, therefore, minimize or prevent resorting to the latter. Examples of activities conducted and methods used for this strategy include (but are not limited to) the following:

- Drug free dances and parties
- Youth/adult leadership activities
- Community drop-in centers
- Community service activities
- Outward Bound
- Recreation activities

(4) Problem Identification and Referral:

This strategy aims at identification of those who have indulged in illegal/age-inappropriate use of tobacco or alcohol and those individuals who have indulged in the first use of illicit drugs in order to assess if their behavior can be reversed through education. It should be noted, however, that this strategy does not include any activity designed to determine if a person is in need of treatment. Examples of activities conducted and methods used for this strategy include (but are not limited to) the following:

- Employee assistance programs
- Student assistance programs
- Driving while under the influence/driving while intoxicated education program

(5) Community-Based Process:

This strategy aims to enhance the ability of the community to more effectively provide prevention and treatment services for alcohol, tobacco and drug abuse disorders. Activities in this strategy include organizing, planning, enhancing efficiency and effectiveness of services implementation, interagency collaboration, coalition building and networking. Examples of activities conducted and methods used for this strategy include (but are not limited to) the following:

- Community and volunteer training, e.g., neighborhood action training, impact or
- Training of key people in the system, staff/officials training
- Systematic planning
- Multi-agency coordination and collaboration/coalition
- Accessing services and funding
- Community team-building

(6) Environmental:

This strategy establishes or changes written and unwritten community standards, codes and attitudes, thereby influencing incidence and prevalence of the abuse of alcohol, tobacco and other drugs used in the general population. This strategy is divided into two subcategories to permit distinction between activities which center on legal and regulatory initiatives and those that relate to the service and action-oriented initiatives. Examples of activities conducted and methods used for this strategy include (but are not limited to) the following:

- Promoting the establishment or review of alcohol, tobacco and drug use policies in schools
- Guidance and technical assistance on monitoring enforcement governing availability and distribution of alcohol, tobacco, and other drugs

- Modifying alcohol and tobacco advertising practices
- Product pricing strategies

RESOURCES AND CONTACT INFORMATION

DHHS/DBH Prevention Web Site: https://dhhs.ne.gov/Pages/Prevention.aspx

Email: DHHS.DBHNPIRS@nebraska.gov

Prevention Directory:
https:/ /dhhs.ne.gov/Behavioral%20Health%20Documents/Prevention%20Directory.pdf

SERVICE DEFINITIONS

- **Crisis/Emergency Services**
- **Treatment Services**
  - **Hospital**
  - **Outpatient**
- **Rehabilitation Services**
- **Substance Use Disorder Services**

● **Basic Definitions** ● **Expectations** ● **Length of Services** ● **Staffing Requirements** ● **Utilization Guidelines**

CRISIS/EMERGENCY SERVICES

SERVICE CATEGORY: CRISIS/EMERGENCY SERVICES

SERVICE DEFINITION

Service Name	24-HOUR CRISIS LINE
Funding Source	Behavioral Health
Setting	Non Facility-Based
Facility License	Not required
Basic Definition	The 24-Hour Crisis Line must be answered by a live voice 24 hours a day and 7 days a week and have the ability to link to a licensed behavioral health professional, law enforcement, and other emergency services. The 24-Hour Crisis Line is designed to assist callers in pre-crisis or crisis situations related to a behavioral health problem. The desired outcome is ensuring the safety of the consumer in a time of distress that has the potential to lead to a life-threatening situation.
Service Expectations	• Perform brief screening of the intensity of the situation. • Work with the consumer toward immediate relief of consumer's distress in pre-crisis and crisis situations; reduction of the risk of escalation of a crisis; arrangements for emergency onsite responses when necessary; and referral to appropriate services when other or additional intervention is required. • Provide access to a licensed behavioral health professional consult when needed. • Establish collateral relationship with law enforcement and other emergency services. • Advertise 24-Hour Crisis Line throughout the Region. • Provide free access to the 24-Hour Crisis Line. • Provide language compatibility when necessary. • Provide access to Nebraska Relay Service or TDD and staff appropriately trained on the utilization of the service.
Length of Services	Call continues until the caller agrees to safely assume his/her activities or emergency assistance arrives or caller voluntarily ends call.
Staffing	• Staff trained to recognize and respond to a behavioral health crisis. • On staff or consultative agreement with a LMHP, LIMHP, Psychiatrist, Psychologist, or Nurse Practitioner. • Direct link to law enforcement and other emergency services. • Staff trained in rehabilitation and recovery principles and trauma informed care. • Personal recovery experience preferred for all positions.
Staffing Ratio	Adequate staffing to handle call volume.

Service Name	24-HOUR CRISIS LINE
Hours of Operation	24/7
Individual Desired Outcome	• Caller experiences a reduction in distress. • Caller experiences a reduction in risk of harm to self or others. • Caller is referred to appropriate services.

UTILIZATION GUIDELINES
24-HOUR CRISIS LINE

I. Admission Guidelines

Consumer must meet all of the following admission guidelines to be admitted to this service.

1. Verbal report of a current behavioral health pre-crisis or crisis situation.
2. Verbal request for assistance in the pre-crisis or crisis situation.

II. Continued Stay Guidelines

Consumer must meet all of the following continued stay guidelines to continue receiving this service.

1. The call continues until the pre-crisis or crisis is resolved or a licensed behavioral health professional, law enforcement, or other emergency service is deemed necessary and arrives to offer assistance or the caller voluntarily ends the call.

SERVICE CATEGORY: CRISIS/EMERGENCY SERVICES

SERVICE DEFINITION

Service Name	CRISIS RESPONSE
Funding Source	Behavioral Health
Setting	Community-based setting
Facility or Professional License	As required by DHHS Division of Public Health
Basic Definition	• Crisis Response is designed to use natural supports and resources to resolve an immediate mental health or substance use crisis in the least restrictive environment by creating a plan with the individual to resolve the crisis. The goal of the service is to develop and begin implementation of a crisis intervention plan, ensure safety, and access the necessary level of care.
Service Expectations	• Face-to-face meeting with individual in crisis within one hour of initial contact. In-person response by 2 team members preferred. • Upon contact, conduct an evaluation including brief mental health status and substance use disorder screening shall include at least one of the following SBQR, ASQ, CAGE-AID, CSSRS to ensure youths and adults will be assessed for suicidality, homicidality, substance abuse, and current symptoms. • Brown-Stanley Safety Plan developed with individual and support system. • Provide mental health and/or substance use disorder interventions and crisis management. • Provide linkage to information and referral including appropriate community-based mental health and/or substance use disorder services. • Consultation to hospital emergency personnel, law enforcement, and community agencies as needed. • Provide post crisis follow-up support with first attempt made within 24 hours and three total attempts made within 72 hours including crisis disposition. • Arrange for alternatives to psychiatric hospitalization if appropriate. • Contact 988 call center and advise the crisis counselor of the outcome of the crisis response event. • All services must be culturally sensitive. • A licensed clinician must be available at all times to provide support, guidance, and direction to the responding team members. The clinician will respond within 30 minutes of contact by the team member(s). Response may indicate a need for the clinician to arrive in-person. • Non-licensed Certified Peer Support Specialists and Direct Care Staff must respond with another staff member until they have completed all training.

Service Name	CRISIS RESPONSE
Length of Services	Service continues until initial emergency is stabilized, risk has decreased, and individual is connected to behavioral health treatment as needed.
Staffing	• Access to a Crisis Response Professional such as: LMHP, LIMHP, PLMHP, Psychiatrist, Psychologist, Psychiatric APRN, Certified Peer Support Specialist, Direct Care Staff or Registered Nurse with psychiatric experience operating within scope of practice. • Staff answering phone and providing triage for crisis assistance shall have demonstrated skills and competencies in treatment with individuals with a behavioral health diagnosis, demonstrated by at least one of the following: two years' direct care experience in a human service field; two years of training in a human service field; or a bachelor's degree or higher in psychology, sociology, or related human service field, which is preferred. • Direct Care staff shall have demonstrated skills and competencies in treatment with individuals with a behavioral health diagnosis, demonstrated by at least one of the following: two years' direct care experience in a human service field; two years of training in a human service field; or a bachelor's degree or higher in psychology, sociology, or related human service field, which is preferred. • Training for all team members who respond on-site includes: o CPR and First Aid o QPR/AMSR/CAM o Diversity training o Accessing interpretation services o Opioid Overdose Safety (Narcan) o Trauma Informed Services o Mental Health First Aid (All non-licensed staff) o SBQR and ASQ o CAGE-AID o CSSRS o Brown-Stanley Safety Plan o CALM – Counseling Access to Lethal Means o Crisis Response teams that provide services to youth will complete youth specific training such as adolescent development, working with CFS or Probation involved youth, EPC alternatives for youth 18yo and under. • Personal recovery experience preferred for all positions.
Staffing Ratio	Minimum one-to-one in person; two-to-one preferred
Hours of Operation	24/7
Individual Desired Outcome	Individual has a plan in place to mitigate the crisis and will be able to safely remain in current residence OR safely transferred to additional psychiatric care.

UTILIZATION GUIDELINES
CRISIS RESPONSE

I. Admission Guidelines

Consumer must meet all of the following admission guidelines to be admitted to this service.

1. Based on current information, requires further evaluation to determine service needs.
2. Exhibits active symptomology consistent with current DSM diagnoses.
3. Exhibits potential for risk of harm to self or others if support is not provided.
4. At risk of being placed in Emergency Protective Custody and/or hospitalized if support is not provided.

II. Continued Stay Guidelines

Consumer must meet all of the following continued stay guidelines to continue receiving this service.

1. Consumer continues to meet admission guidelines.

SERVICE CATEGORY: CRISIS/EMERGENCY SERVICES

SERVICE DEFINITION

Service Name	CRISIS STABILIZATION UNIT
Funding Source	Behavioral Health
Setting	Facility Based
Facility or Professional License	As required by DHHS Division of Public Health
Basic Definition	Crisis Stabilization provides immediate, short-term, individualized, crisis-oriented treatment to stabilize acute psychiatric symptoms, alcohol or other drug use, and/or significant emotional distress for voluntary and involuntarily admitted individuals. The psychiatric and/or substance use disorder crisis results in potentially disruptive or dangerous behaviors and impaired functioning that needs a short-term, stabilizing, structured environment. The service treats and supports the individual throughout the crisis by providing crisis assessment and interventions; medication management; linkages to needed behavioral health services; and assistance in transitioning back to the individual's typical living situation.
Service Expectations	• Within 24 hours of admission, a mental health assessment and/or a substance use assessment that includes a risk assessment completed by a licensed mental health clinician or prescriber. If the individual has an assessment from a hospital stay immediately preceding the CSU admission, an assessment related to that hospital admission is acceptable if received within 24 hours. If one is not received, the admission assessment must be completed. • Multidisciplinary/bio-psychosocial assessments, including a history and physical, within 36 hours of admission • Assessments and treatment must include input from the individual and integrate strengths and needs in both MH/SUD domain as applicable • A crisis stabilization plan that is developed within 24 hours of admission and adjusted as indicated and includes relapse/crisis prevention and discharge plan components. The plan should consider community, family, and other supports as applicable. • Interdisciplinary treatment team meetings daily or as often as medically necessary including the individual, family, and other supports as appropriate to assess individual progress through stabilization and implement any needed treatment changes • Psychiatric nursing interventions are available 24/7 • Medication management and education

Service Name	CRISIS STABILIZATION UNIT
	• Individual, group, and family therapy available and offered as tolerated and/or appropriate using a brief therapy/solution focused approach • Intense discharge and recovery planning beginning at admission. Provide coordination with resources to meet biopsychosocial needs, including legal, to assist in establishing treatment and recovery supports • Consultation services available for medical, dental, pharmacology, psychological, dietary, pastoral, recreation therapy, laboratory and other diagnostic services as needed • All services must be culturally sensitive
Length of Services	Until the individual no longer meets criteria for this level of care
Staffing	• Medical Director/Supervising Practitioner: Psychiatrist or APRN or PA • Clinical Director: Psychiatrist, Psychologist, APRN, or RN with psychiatric experience • Therapist: Psychologist, APRN, LIMHP, PLMHP, LMHP, LADC, PLADC • Nursing: APRN, RNs (psychiatric experience preferred), LPNs under the direct supervision of appropriately licensed medical professional • Direct Care staff shall have demonstrated skills and competencies in treatment with individuals with a behavioral health diagnosis, demonstrated by at least one of the following: two years lived experience; two years' direct care experience in a human service field; two years of training in a human service field; or a bachelor's degree or higher in psychology, sociology, or related human service field, which is preferred.
Staffing Ratio	• 1 staff to 4 individuals during awake hours (day and evening shifts); • 1 awake staff to 6 individuals with on-call availability of additional support staff during overnight hours; access to on-call, licensed mental health professionals 24/7 • RN services and therapist services are provided in a staff to client ratio sufficient to meet client care needs
Hours of Operation	24/7
Desired Individual Outcome	• Symptoms are stabilized and the individual no longer meets clinical guidelines for crisis stabilization • The precipitating condition and relapse potential is stabilized such that individual's condition can be managed with professional external supports and interventions outside of the crisis stabilization facility. • The individual has been connected to additional services for treatment needs and is knowledgeable on how to access those resources

UTILIZATION GUIDELINES
CRISIS STABILIZATION UNIT

I. Admission Guidelines

All *of the following guidelines are necessary for admission to this level of care:*

1. Individual demonstrates a significant incapacitating or debilitating disturbance in mood/thought interfering with ADLs to the extent that immediate stabilization is required; and
2. Individual demonstrates active symptomatology consistent with a DSM (current version) diagnosis which requires and can reasonably be expected to respond to intensive, structured intervention; and
3. Clinical evaluation of the individual's condition indicates dramatic and sudden decompensation with a strong potential for danger (but not imminently dangerous) to self or others and individual has no available supports to provide continuous monitoring; and
4. Individual requires 24 hour observation and supervision but not the constant observation of an inpatient psychiatric setting; and
5. Clinical evaluation indicates that the individual can be effectively treated with short-term intensive crisis intervention services and returned to a less intensive level of care within a brief time frame; and
6. A less intensive or restrictive level of care has been considered/tried *or* clinical evaluation indicates the onset of a life-endangering psychiatric condition, but there is insufficient information to determine the appropriate level of care.

II. Continued Stay Guidelines

All *of the following Guidelines are necessary for continuing treatment at this level of care:*

1. The individual's condition continues to meet admission guidelines at this level of care.
2. The individual's treatment does not require a more intensive level of care, and no less intensive level of care would be appropriate.
3. Care is rendered in a clinically appropriate manner and focused on individual's behavioral and functional outcomes as described in the discharge plan.
4. Treatment planning is individualized and appropriate to the individual's changing condition with realistic and specific goals and objectives stated.
5. All services and treatment are carefully structured to achieve optimum results in the most time efficient manner possible consistent with sound clinical practice.
6. Progress in relation to specific symptoms or impairments is clearly evident and can be described in objective terms, but goals of treatment have not yet been achieved or adjustments in the treatment plan to address lack of progress are evident.
7. When medically necessary, appropriate psychopharmacological intervention has been prescribed and/or evaluated.
8. There is documented active discharge planning.

SERVICE CATEGORY: CRISIS/EMERGENCY SERVICES

SERVICE DEFINITION

Service Name	EMERGENCY COMMUNITY SUPPORT
Funding Source	Behavioral Health
Setting	Individual's home or other community-based setting
Facility or Professional License	As required by DHHS Division of Public Health
Basic Definition	Emergency Community Support is designed to assist individuals who can benefit from high levels of support due to an urgent behavioral health need. Often individuals are either at risk of loss of community residence due to behavioral health crisis, are homeless, or are transitioning from a psychiatric hospital into a community setting. Emergency Community Support services offer stabilization during a behavioral health crisis by providing case management, behavioral health referrals, assistance with daily living skills, and coordination between the individual, the formal and informal support system, and behavioral health providers.
Service Expectations	• Complete a screening for risk and safety plan within three days of referral or, if individual is hospitalized, within three days of discharge from the hospital • Complete a strengths-based assessment with the individual within 14 days of referral • Development of an initial, brief service plan within five days of admission in partnership with the individual and support system. The finalized service plan should be completed within 14 days • The service plan will include a crisis relapse/prevention plan and discharge plan • Consumer advocacy as needed • Individual assisted in initiating resources such as SSI, housing, SNAP, Medicaid, as needed • Education to individual/family/significant others with the individual's permission as needed • Referrals to appropriate community-based behavioral health services • Collaboration with psychiatric hospital and hospital emergency personnel, and community agencies as needed • Arrange alternatives to psychiatric hospitalization as needed • Clinical consultation on individual's service plan must occur at least once a month • All services must be culturally sensitive and trauma informed • A minimum of 1 hour direct contact is expected. Contact for individuals transitioning from hospitalization is a minimum of six hours (includes direct and indirect) per month and for other individuals the minimum is of 4 hours (includes direct and indirect) per month. Documentation of rationale for not achieving either the 6 hours per month or 4 hours per month should be documented in the individual's record.

Service Name	EMERGENCY COMMUNITY SUPPORT
Length of Services	Service continues until initial emergency is resolved and individual is connected to behavioral health treatment as needed. Typically 90 days.
Staffing	• Program Director: A bachelor's degree or higher in psychology, sociology or a related human service field is required. Demonstrated experience, skills, and competencies in behavioral health management. A master's degree in a human service field preferred. • Direct Care staff shall have demonstrated skills and competencies in treatment with individuals with a behavioral health diagnosis, demonstrated by at least one of the following: two years lived experience; two years' direct care experience in a human service field; two years of training in a human service field; or a bachelor's degree or higher in psychology, sociology, or related human service field, which is preferred. • Consultation by appropriately licensed professionals for general medical, psychopharmacology, and psychological issues, as well as overall program design must be available and used as necessary. • Personal recovery experience preferred for all positions. • Staff are trained in trauma informed care, working with individuals experiencing co-occurring disorders, suicide prevention, and resilience and recovery principles.
Staffing Ratio	1:15 caseload
Hours of Operation	Individuals utilizing this service must have 24/7 on call access to Emergency Community Support services.
Individual Desired Outcome	• Individual has made progress on service plan goals and objectives and development of a crisis relapse prevention plan. • Initial emergency necessitating care has substantially resolved. • Individual is able to remain psychiatrically stable in a community setting of choice. • Individual has a community-based support system arranged.

UTILIZATION GUIDELINES
EMERGENCY COMMUNITY SUPPORT

I. Admission Guidelines

Consumer must meet all of the following admission guidelines to be admitted to this service.

1. Consumers currently experiencing a behavioral health crisis.
2. At risk of needing a higher level of care if support is not provided.
3. Consumer demonstrates a need for support in coordinating treatment/recovery/rehabilitation options in the community.

II. Continued Stay Guidelines

Consumer must meet all of the following continued stay guidelines to continue receiving this service.

1. Consumer continues to meet Admission Guidelines.

SERVICE CATEGORY: CRISIS/EMERGENCY SERVICES

SERVICE DEFINITION

Service Name	EMERGENCY PSYCHIATRIC OBSERVATION
Funding Source	Behavioral Health
Setting	Hospital
Facility or Professional License	As required by DHHS Division of Public Health
Basic Definition	Emergency Psychiatric Observation provides less than 24 hours of care in a secure, medically supervised hospital setting for evaluation and stabilization of acute psychiatric and/or substance use disorder symptoms. The service will prevent further exacerbation or deterioration and/or inpatient hospitalization when possible, and facilitates transition to the necessary level of care.
Service Expectations	• A trauma-informed face-to-face mental health assessment and continuing with an emergency psychiatric observation level of care during a period of less than 24 hours • Substance use disorder screening during the observation period • Health screening/nursing assessment conducted by a Registered Nurse • Continuous assessment for the need of continued care or determination that the crisis has resolved and the individual can safely return to the community with follow up services • Discharge plan with emphasis on safety, crisis intervention and referral for relapse prevention and other services developed under the direction of a physician (psychiatrist preferred) at admission. • Medication evaluation and management • All services must be culturally sensitive
Length of Services	Less than 24 hours
Staffing	• Medical Director: Psychiatrist (preferred) or Physician • Clinical staff may include: APRN, RN with psychiatric experience preferred, LIMHP, LMHP, LADC, PLADC, PLMHP • Care managers
Staffing Ratio	All positions staffed in sufficient numbers to meet hospital accreditation guidelines.

Service Name	EMERGENCY PSYCHIATRIC OBSERVATION
Hours of Operation	24/7
Individual Desired Outcome	• Symptoms are stabilized and the individual no longer meets clinical utilization guidelines. • Individual has substantially recovered his/her level of functioning • Sufficient supports are in place and individual can safely return to a less restrictive environment. • Admission to a higher level of care if clinically appropriate.

UTILIZATION GUIDELINES
EMERGENCY PSYCHIATRIC OBSERVATION

I. Admission Guidelines

Consumer must meet all of the following admission guidelines to be admitted to this service.

1. The individual presents with symptoms consistent with a psychiatric crisis that requires a period of medical observation.
2. The individual's medical needs are stable.
3. The individual does not meet all inpatient level of care criteria.
4. Based on current information, there may be a lack of diagnostic clarity and further evaluation is necessary to determine the individual's service needs.

II. There are no Continued Stay Guidelines for this service

SERVICE CATEGORY: CRISIS/EMERGENCY SERVICES

SERVICE DEFINITION

Service Name	HOSPITAL DIVERSION
Funding Source	Behavioral Health Services
Setting	Residential or facility setting
Facility or Professional License	As required by DHHS Division of Public Health
Basic Definition	Hospital Diversion is a peer-operated service designed to assist individuals in decreasing psychiatric distress which may lead to hospitalization. Hospital Diversion offers individuals the opportunity to take control of a crisis or potential crisis and develop new skills through a variety of traditional self-help and proactive tools designed to maintain wellness. Certified Peer Support Specialists provide contact, support, and/or referral for services, as requested, during and after the stay, as well as manning a Warm Line. Hospital Diversion settings are fully furnished for comfort. Participation in the service is voluntary.
Service Expectations	• Completion of screening prior to admission • Individuals may be self-referred or referred by a professional or family member with input from the individual • Interview and registration information completed to gain understanding of how to best support the individual and tailor the Wellness and Recovery Service Plan (WRSP) • Review and/or implementation or provision of a WRSP • The provider makes space available for food, storage, and management of medications • The setting has available common spaces as well as private areas • Individuals are responsible for transportation to and from the program • Equipped with self-help and proactive tools to maintain wellness • Education available on behavioral health disorders, treatments, community resources, and other topics related to mental health and co-occurring disorders. Education on an array of pre-crisis and crisis/relapse prevention tools • Follow up calls available within 24 hours of discharge • Program documentation of peer-to-peer engagement, activities, supports; presence/or absence of other services; WRSP review (stressors, resolution, etc); contact with current services if requested • Support may include a referral for visits with Certified Peer Support Specialist to provide post discharge support

Service Name	HOSPITAL DIVERSION
	• Warm Line available • All services must be culturally sensitive
Length of Services	Until the individual no longer needs to be diverted from a higher level of care, the initial urgent issue has substantially resolved and individual is connected to follow on care as needed and desired.
Staffing	• 1 FTE Program Manager on site and available by phone 24/7 • Staffed by trained Certified Peer Support Specialists • Staffed at all times when individuals are present and to cover established Warm Line hours • Staff may consist of additional part-time or volunteers as needed • Staff and/or volunteers consist of individuals with specialized training in techniques of peer and recovery support. All staff must be trained to assist individuals in developing person centered, recovery focused crisis/relapse prevention plans. • All staff and volunteers must be oriented to program management and safety procedures
Staffing Ratio	1:5 Staff to guest ratio
Hours of Operation	• 24/7 access to service. • Warm Line hours and coverage – minimum evening and weekend hours.
Individual Desired Outcome	• Access to least restrictive level of care that can safely address urgent needs • Individual has taken control of the crisis or potential crisis – crisis abated and consistent with Wellness and Recovery Service Plan. • Individual has reviewed and/or developed a personal Wellness and Recovery Service Plan and substantially met their individualized goals and objectives. • Individual returns to previous living arrangement and is able to maintain independent living. • Individual has well established formal and informal community supports. • Successful diversion from psychiatric hospitalization is achieved

UTILIZATION GUIDELINES
HOSPITAL DIVERSION

I. Admission Guidelines

Individual must meet all of the following admission guidelines to be admitted to this service.

1. Individual has serious mental illness or co-occurring (mental health/substance use) disorders or at high risk for relapse of substance use.
2. Individual is in psychiatric distress or in crisis and at risk of emergency protective custody or hospitalization.
3. Individual is medically and psychiatrically stable.
4. Individual has implemented personal crisis/relapse prevention plan.
5. Individual voluntarily admits self.

II. Continued Stay Guidelines

Individual must meet all of the following continued stay guidelines to continue receiving this service.

1. Individual continues to meet admission guidelines.
2. Individual demonstrates ability to engage/implement/review individualized crisis/relapse prevention plan goals and objectives.

SERVICE CATEGORY: CRISIS/EMERGENCY SERVICES

SERVICE DEFINITION

Service Name	MENTAL HEALTH RESPITE
Funding Source	Behavioral Health
Setting	Residential Facility
Facility or Professional License	As required by DHHS Division of Public Health
Basic Definition	Mental Health Respite is a short term program designed to provide shelter and assistance to address immediate needs for individuals transitioning between residential settings or who benefit from a break from the current home or residential setting. Mental Health Respite provides a safe, protected, supported residential environment for people with a serious mental illness. The service supports an individual throughout the transition or break, provides linkages to needed behavioral health services, and assists in timely transition back into the community.
Service Expectations	• Provide the following services on-site: periodic safety checks and monitoring, personal support services, medication monitoring, assistance with activities of daily living, limited transportation, and overnight accommodations including food and lodging • Linkages to behavioral health services, psychiatric treatment, pharmaceutical services, healthcare services, and emergency care • Referrals to community services and supports, such as community housing • Provide 24-hour staff • Opportunities to be involved in a variety of community activities and services • All services must be culturally sensitive
Length of Services	Brief, transition focused care.
Staffing	• Program Manager: Bachelor's degree or higher in human services or equivalent course work, 2 years of experience/training with demonstrated skills and competencies in treatment of individuals with a behavioral health diagnosis. • Direct Care staff shall have demonstrated skills and competencies in treatment with individuals with a behavioral health diagnosis, demonstrated by at least one of the following: two years lived experience; two

Service Name	MENTAL HEALTH RESPITE
	years' direct care experience in a human service field; two years of training in a human service field; or a bachelor's degree or higher in psychology, sociology, or related human service field, which is preferred. • A consultative arrangement with a licensed behavioral health professional, physician, dietician, and Registered Nurse. • All staff must be trained in trauma-informed care, recovery principles, and crisis management. • Personal recovery experience preferred for all positions.
Staffing Ratio	• Direct care ratios are no more than 12 individuals per one staff member during 1st and 2nd shift and 1:16 on 3rd shift, with on-call support staff available.
Hours of Operation	24/7
Individual Desired Outcome	• Individual is able to transition successfully to previous or a new community setting. • Individual has a community-based support system arranged to assist in the current home environment. • Initial need for respite has resolved. • Individual has been connected to more intensive, longer term behavioral health care if required.

UTILIZATION GUIDELINES
MENTAL HEALTH RESPITE

I. Admission Guidelines

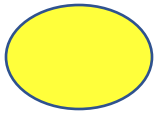
Individual must meet all of the following admission guidelines to be admitted to this service.

1. Has a current diagnosis of a serious mental illness.
2. At risk of needing a higher level of care if support is not provided.

II. Continued Stay Guidelines

Individual must meet all of the following continued stay guidelines to continue receiving this service.

1. Individual continues to meet admission guidelines.



TREATMENT SERVICES

HOSPITAL

SERVICE CATEGORY: HOSPITAL SERVICES

SERVICE DEFINITION

Service Name	ACUTE INPATIENT HOSPITALIZATION
Funding Source	Behavioral Health
Setting	Psychiatric Hospital or General Hospital w/Psychiatric Unit
Facility or Professional License	Hospital as required by DHHS Division of Public Health
Basic Definition	An acute inpatient program is designed to provide medically necessary, intensive assessment, psychiatric treatment and support to individuals who have a Diagnostic and Statistical Manual of Mental Disorders (current version) diagnosis and/or co-occurring disorder and are experiencing an acute exacerbation of a psychiatric condition. Using comprehensive medical, nursing, and multidisciplinary treatment, the acute inpatient setting provides highly structured care to serve patients requiring a safe and secured setting. The acute inpatient setting provides continuous care using multiple treatment modalities to stabilize the individual's acute psychiatric conditions.
Service Expectations	• A medical evaluation by a physician that indicates the individual's need for care in the hospital setting • A multidisciplinary/bio-psychosocial, trauma-informed assessment must be conducted for the individual by licensed clinicians, which helps inform the treatment plan • Screening for substance use disorder and further assessment if indicated • Under direction of the physician, develop and implement an active treatment plan with provisions for resolution of acute mental health and medical problems; evaluation of, and need for medications; protocol to ensure individual's safety; and discharge plan initiated at the time of admission • Under direction of the physician, plan of care reviews and complete interdisciplinary team meetings should be conducted daily, or more frequently as medically necessary. The team includes the interdisciplinary professionals, the individual served, family, and other supports as appropriate. Updates to the written plan of care should be made as often as medically indicated • Psychiatric nursing interventions are available 24/7 • Provide an intensive and comprehensive active treatment program that includes professional psychiatric, medical, nursing, social work, psychological, and activity therapies required to carry out an individual treatment plan for each individual and their family. The treatment program is available and provided daily, seven days per week beginning at admission

Service Name	ACUTE INPATIENT HOSPITALIZATION
	• Medication management, consultation and education • Individual, group, and family therapy available and offered as tolerated and/or appropriate • Face-to-face service with the physician (psychiatrist preferred) or APRN, 6 of 7 days • Psychological services as needed • Consultation services for medical, dental, pharmacology, dietary, pastoral, emergency medical, therapeutic and educational activities • Laboratory, radiological, physical and neurological exams, and other diagnostic services as needed • Discharge plan developed at admission to include referral to community-based rehabilitation/social services to assist in safe transition to community living; linkage to treatment services at next appropriate level of care; and incorporates natural supports
Length of Services	Until the individual is stabilized, able to be treated at a less intensive level of care, and meets the conditions of the discharge plan.
Staffing	Staff Requirements as per licensing and/or accreditation standards, may include: Medical Director (Boarded or Board eligible Psychiatrist) Psychiatrist (s) and/or Physicians (s) LMHP, LADC, LIMHP, PLMHP, Psychologist RN(s) and APRN(s) (psychiatric experience preferable) Social Worker(s) (at least one social worker, holding an MSW degree) Direct Care staff shall have demonstrated skills and competencies in treatment with individuals with a behavioral health diagnosis, demonstrated by at least one of the following: two years lived experience; two years' direct care experience in a human service field; two years of training in a human service field; or a bachelor's degree or higher in psychology, sociology, or related human service field, which is preferred.
Staffing Ratio	Staff ratio as per licensing and/or accreditation standards
Hours of Operation	24/7
Individual Desired Outcome	• Symptoms are stabilized and the individual no longer meets clinical guidelines for acute care • Sufficient supports are in place and individual can move to a less restrictive environment • Treatment plan goals and objectives are substantially met

UTILIZATION GUIDELINES
ADULT ACUTE INPATIENT HOSPITALIZATION

Criteria for Admission
The specified requirements for severity of need and intensity and quality of service must be met to satisfy the criteria for admission.

I. **Admission - Severity of Need**

The following guideline is necessary for admission: Criteria A and B and one of C, D or E must be met to satisfy the criteria for severity of need.

A. Individual has been evaluated by a licensed clinician and demonstrates symptomatology consistent with a DSM (current version) diagnosis which requires and can reasonably be expected to respond to therapeutic intervention.

B. The individual requires an individual plan of active psychiatric treatment that includes 24-hour access to the full spectrum of psychiatric staffing. This psychiatric staffing must provide 24-hour services in a controlled environment that may include but is not limited to medication monitoring and administration, other therapeutic interventions, restrictive safety measures, and suicidal/homicidal observation and precautions.

C. The individual demonstrates actual or potential danger to self or others. This is evidenced by having any one of the following:

1) a current plan or intent to harm self with an available and lethal means, *or*

2) a recent lethal attempt to harm self with continued imminent risk as demonstrated by poor impulse control, command hallucinations directing them to harm self or an inability to plan reliably for safety, *or*

3) an imminently dangerous inability to care adequately for his/her own physical needs or to participate in such care due to disordered, disorganized or bizarre behavior, *or*

4) other similarly clear and reasonable evidence of imminent serious harm to self.

D. The individual demonstrates a clear and reasonable inference of imminent serious harm to others. This is evidenced by having any one of the following:

1) a current plan or intent to harm others with an available and lethal means, *or*

2) a recent lethal attempt to harm others with continued imminent risk as demonstrated by poor impulse control, command hallucinations directing them to harm others or an inability to plan reliably for safety, *or*

3) violent unpredictable or uncontrolled behavior that represents an imminent risk of serious harm to the body or property of others, *or*

4) other similarly clear and reasonable evidence of imminent serious harm to others.

E. The individual's condition requires an acute psychiatric assessment technique or intervention that unless managed in an inpatient setting, would have a high probability to lead to serious, imminent and dangerous deterioration of the individual's general medical or mental health.

II. Continued Stay

Criteria A, B, C, D and E must be met to satisfy the criteria for continued stay.

A. Despite reasonable therapeutic efforts, clinical evidence indicates at least one of the following:

1) the persistence of problems that caused the admission to a degree that continues to meet the admission criteria (both severity of need and intensity of service needs), *or*

2) the emergence of additional problems that meet the admission criteria (both severity of need and intensity of service needs), *or*

3) that disposition planning, progressive increases in hospital privileges and/or attempts at therapeutic re-entry into the community have resulted in, or would result in exacerbation of the psychiatric illness to the degree that would necessitate continued hospitalization, *or*

4) a severe reaction to medication or need for further monitoring and adjustment of dosage in an inpatient setting, documented in daily progress notes by a physician or admitting qualified and credentialed professional.

5) the individual's condition continues to meet admission Guidelines for inpatient care. Acute treatment interventions (including psychopharmacological) have not been exhausted, and no other less intensive level of care would be adequate.

B. The current treatment plan includes documentation of DSM (current version) diagnosis, individualized goals of treatment, treatment modalities needed and provided on a 24-hour basis, discharge planning, and ongoing contact with the individual's family and/or other support systems, unless there is an identified, valid reason why it is not clinically appropriate or feasible. This plan receives regular review and revision that includes ongoing plans for timely access to treatment resources that will meet the individual's post-hospitalization needs.

C. The current or revised treatment plan can be reasonably expected to bring about significant improvement in the problems meeting criterion II.A. This evolving clinical status is documented by daily progress notes, one of which evidences a daily examination by a psychiatrist or admitting qualified and credentialed professional.

D. When medically necessary, appropriate psychopharmacological intervention has been prescribed and/or evaluated.

E. Progress in relation to specific symptoms or impairments is clearly evident and can be described in objective terms but goals of treatment have not yet been achieved, or adjustments in the treatment plan to address lack of progress and/or psychiatric/medical complications are evident and there is documented active discharge planning.

F. Care is rendered in a clinically appropriate manner and focused on the individual's behavioral and functional outcomes as described in the discharge plan.

SERVICE CATEGORY: HOSPITAL SERVICES

SERVICE DEFINITION

Service Name	SUBACUTE INPATIENT HOSPITALIZATION
Funding Source	Behavioral Health Services
Setting	Psychiatric Hospital or General Hospital w/Psychiatric Unit
Facility or Professional License	Hospital as required by DHHS Division of Public Health
Basic Definition	The purpose of subacute care is to provide stabilization, support, engage the individual in comprehensive treatment, rehabilitation and recovery activities, and transition the individual to the least restrictive safe setting as rapidly as possible. Subacute inpatient hospitalization is designed to resolve the presence of acute or crisis mental health symptoms, or the imminent risk of onset of acute or crisis mental health symptoms, for individuals experiencing a decreased level of functioning due to a mental health condition. The subacute treatment setting provides 24/7 care in a protective environment that is intended to be short-term, intensive, individualized, and recovery-oriented.
Service Expectations	• A medical evaluation by a physician that indicates the individual's need for subacute level of care • A multidisciplinary/bio-psychosocial, trauma-informed assessment must be conducted for the individual by licensed clinicians, which helps inform the treatment plan • Under direction of the physician, develop and implement an active treatment plan with provisions for stabilization of mental health and medical problems; evaluation of and need for medications; protocol to ensure individual's safety; relapse/crisis prevention plan, and discharge plan initiated at the time of admission • Under direction of the physician, plan of care reviews and complete interdisciplinary team meetings should be held three times a week, or more frequently as medically necessary. The team includes the interdisciplinary professionals, the individual served, family, and other supports as appropriate. Updates to the written plan of care should be made as often as medically indicated • Screening for substance use disorder conducted as needed, and addictions treatment initiated and integrated into the treatment/recovery plan for co-occurring disorders identified in initial assessment process • Psychiatric nursing interventions are available to patients 24/7 • Provide an intensive and comprehensive active treatment program that includes professional psychiatric, medical, nursing, social work, psychological, and activity therapies required to carry out an individual

Service Name	SUBACUTE INPATIENT HOSPITALIZATION
	treatment plan for each individual and their family. The treatment program is available and provided daily, seven days per week beginning at admission • 35 hours of active treatment available/provided to each individual weekly, seven days per week • Qualified staff must be available to provide treatment intervention, social interaction and experiences, education regarding psychiatric issues such as medication management, nutrition, signs and symptoms of illness, substance misuse education, recovery, appropriate nursing interventions and structured milieu therapy • Medication management, consultation and education • Face to Face service with a psychiatrist or APRN three or more times weekly • Individual, group, and family therapy as appropriate • Available services must include occupational and recreational therapy and other prescribed therapeutic activities to maintain or increase the individual's capacity to manage his/her psychiatric condition and activities of daily living. • Psychological services as needed • Consultation services for medical, dental, pharmacology, dietary, pastoral, emergency medical, therapeutic and educational activities • Laboratory, radiological, physical and neurological exams, and other diagnostic services as needed • Social Services to engage in discharge planning and help the individual develop community supports and
Length of Services	Until the individual is stabilized, able to be treated at a less intensive level of care, and meets the conditions of the discharge plan.
Staffing	Staff Requirements as per licensing and/or accreditation standards, may include: Medical Director (Boarded or Board eligible Psychiatrist) Psychiatrist (s) and/or Physicians (s) LMHP, LADC, LIMHP, PLMHP, Psychologist RN(s) and APRN(s) (psychiatric experience preferable) Social Worker(s) (at least one social worker, holding an MSW degree) Direct Care staff shall have demonstrated skills and competencies in treatment with individuals with a behavioral health diagnosis, demonstrated by at least one of the following: two years lived experience; two years' direct care

Service Name	SUBACUTE INPATIENT HOSPITALIZATION
	experience in a human service field; two years of training in a human service field; or a bachelor's degree or higher in psychology, sociology, or related human service field, which is preferred.
Staffing Ratio	Staff ratio as per licensing and/or accreditation standards
Hours of Operation	24/7
Individual Desired Outcome	• Symptoms are stabilized and the individual is able to be treated at a less intensive level of care • The precipitating condition and relapse potential is stabilized such that individual's condition can be managed without professional external supports and interventions • The individual can safely maintain in a less restrictive environment • Treatment plan goals and objectives are substantially met

UTILIZATION GUIDELINES
ADULT SUBACUTE INPATIENT HOSPITALIZATION

Criteria for Admission

The specified requirements for severity of need and intensity and quality of service must be met to satisfy the criteria for admission.

I. Admission - Severity of Need

The following guideline is necessary for admission: Criteria A, B, C and D must be met to satisfy the criteria for severity of need.

A. Individual has been evaluated by a licensed clinician and demonstrates symptomatology consistent with a DSM (current version) diagnosis which requires and can reasonably be expected to respond to therapeutic intervention.

B. Either:

1. there is clinical evidence that the individual would be at risk to self or others if he or she were not in a subacute hospitalization program, *or*

2. as a result of the individual's mental disorder, there is an inability to adequately care for one's physical needs, and caretakers/guardians/family members are unable to safely fulfill these needs, representing potential serious harm to self.

C. The individual requires an individual plan of active psychiatric treatment that includes 24-hour access to the full spectrum of psychiatric staffing. This psychiatric staffing must provide 24-hour services in a controlled environment that may include, but is not limited to, medication monitoring and administration, other therapeutic interventions, restrictive safety measures, and suicidal/homicidal observation and precautions.

D. The patient requires supervision seven days per week, 24 hours per day to develop skills necessary for daily living, to assist with planning and arranging access to a range of educational, therapeutic and aftercare services, and to develop the adaptive and functional behavior that will allow him/her to live outside of a sub-acute hospital setting.

I. Continued Stay

Criteria A, B, C, D, E, F and G must be met to satisfy the criteria for continued stay.

A. Despite reasonable therapeutic efforts, clinical evidence indicates at least one of the following:

1. the persistence of problems that caused the admission to a degree that continues to meet the admission criteria (both severity of need and intensity of service needs), *or*

2. the emergence of additional problems that meet the admission criteria (both severity of need and intensity of service needs), *or*

3. that disposition planning and/or attempts at therapeutic re-entry into the community have resulted in, or would result in exacerbation of the psychiatric illness to the degree that would necessitate continued subacute hospital treatment.

B. There is evidence of objective, measurable, and time-limited therapeutic clinical goals that must be met before the individual can be discharged from this level of care.

C. There is evidence that the treatment plan is focused on the alleviation of psychiatric symptoms and precipitating psychosocial stressors that are interfering with the individual's ability to return to a less-intensive level of care.

D. The current or revised treatment plan can be reasonably expected to bring about significant improvement in the problems meeting criterion IIA, and this is documented in at least three-times-a-week progress notes, written and signed by the psychiatrist.

E. There is evidence of at least weekly family and/or support system involvement, unless there is an identified, valid reason why such a plan is not clinically appropriate or feasible.

F. A discharge plan is formulated that is directly linked to the behaviors and/or symptoms that resulted in admission, and begins to identify appropriate treatment resources after the subacute hospitalization.

G. Care is rendered in a clinically appropriate manner and focused on the individual's behavioral and functional outcomes as described in the discharge plan.

TREATMENT SERVICES

OUTPATIENT

SERVICE CATEGORY: OUTPATIENT SERVICES

SERVICE DEFINITION

Service Name	DAY TREATMENT
Funding Source	Behavioral Health
Setting	Hospital or non-hospital community based
Facility or Professional License	As required by DHHS Division of Public Health
Basic Definition	Psychiatric Day Treatment provides a community based, intensive, and coordinated set of individualized treatment services to individuals with psychiatric disorders who have difficulty functioning full-time in a school, work, and/or home environment and need the additional structured activities of this level of care. This service includes diagnostic, medical, psychiatric, psychosocial, and adjunctive treatment modalities in a highly structured setting.
Service Expectations	• A mental health assessment conducted by a licensed, qualified clinician at admission or completed within 12 months prior to the date of admission that includes a current diagnosis, level of care recommendation and a discharge plan. If the prior assessment is not relevant or does not contain the necessary information, then a mental health assessment addendum would be necessary. The assessment will be completed within 24 hours of admission and serve as the treatment plan until the treatment plan can be developed. • Clinically appropriate programmatic assessments, as determined necessary, to assess the individual for substance use disorders, or specialized treatment needs such as eating disorders. • A treatment/recovery plan developed by the multidisciplinary team within 72 hours of admission that integrates individual strengths & needs, formal and informal supports, measurable goals, and a documented discharge and relapse prevention plan • The individual treatment plan is reviewed at least twice monthly and more often as necessary, updated as medically indicated, and signed by the supervising practitioner and other treatment team members, including the individual being served • Medication management, education and consultation

Service Name	DAY TREATMENT
	• Consultation services available for medical, pharmacology, psychological, dietary, pastoral, emergency medical, recreation therapy, laboratory, dietary if meals are served, and other diagnostic services • Ancillary service referral as needed, such as dental, optometry, ophthalmology, other mental health and/or social services • Active treatment for the psychiatric condition using individual, group, and family therapy services, recreational, occupational, and social services • Access to community based rehabilitation/social services that can be used to help the individual transition to the community • Face-to-face psychiatrist/APRN visits once weekly • All services must be culturally sensitive.
Length of Services	Length of service is individualized and based on clinical criteria for admission and continuing stay. The amount, duration, and frequency of the service should be documented in the treatment plan.
Staffing	• Supervising Practitioner (psychiatrist) • Clinical Director (APRN, RN, LMHP, LIMHP, or licensed Psychologist) working with the program to provide clinical supervision, consultation and support to staff and the individuals they serve, continually incorporating new clinical information and best practices into the program to assure program effectiveness and viability, and assure quality organization and management of clinical records, and other program documentation. Depending on the size of the program more than one Clinical Director may be needed to meet these expectations. • Nursing (APRN, RN, psychiatric experience preferred) • Therapist (Psychiatrist, APRN, Psychologist, Provisionally Licensed Psychologist, LMHP, PLMHP, LIMHP) • Direct Care staff shall have demonstrated skills and competencies in treatment with individuals with a behavioral health diagnosis, demonstrated by at least one of the following: two years lived experience; two years' direct care experience in a human service field; two years of training in a human service field; or a bachelor's degree or higher in psychology, sociology, or related human service field, which is preferred. • All staff should be educated/trained in rehabilitation and recovery principles
Staffing Ratio	Clinical Director to direct care staff ratio as needed to meet all responsibilities; Therapist/Individual: 1 to 12; Care Worker/Individual: 1 to 6

Service Name	DAY TREATMENT
Hours of Operation	May be available 7 days/week with a minimum availability of 5 days /week including days, evenings and weekends
Individual Desired Outcome	• The individual has substantially met the treatment plan goals and objectives • The precipitating condition and relapse potential is stabilized such that individual's condition can be managed without this level of professional external supports and interventions • Individual has formal and informal support systems to maintain stability in a lower level of care

UTILIZATION GUIDELINES
DAY TREATMENT

I. Admission Guidelines

Valid principal DSM (most current version) diagnosis AND All of the following:

1. The individual is unable to maintain an adequate level of functioning outside the treatment program due to a mental health disorder as evidenced by:
    a. Severe psychiatric symptoms that require medical stabilization.
    b. Inability to perform the activities of daily living.
    c. Significant interference in at least one functional area (Social, vocational/educational, etc.)
    d. Failure of social/occupational functioning or failure and/or absence of social support resources.
2. The treatment necessary to reverse or stabilize the individual's condition requires the frequency, intensity and duration of contact provided by a day program as evidenced by:
    a. Failure to reverse/stabilize with less intensive treatment that was accompanied by services of alternative delivery systems.
    b. Need for a specialized service plan for a specific impairment.
    c. Passive or active opposition to treatment and the risk of severe adverse consequences if treatment is not pursued.
    d. Can maintain safety after the program hours.
3. The individual's medical and mental health needs can be adequately monitored and managed by the staff of the facility.
4. The individual can be reasonably expected to benefit from mental health treatment at this level and needs structure for activities of daily living.

I. Continued Stay Guidelines

All of the following guidelines are necessary for continuing treatment at this level of care:

1. The individual's condition continues to meet admission guidelines for this level of care.
2. The individual does not require a more intensive level of care, and no less intensive level of care would be appropriate.

3. There is reasonable likelihood of substantial benefit as a result of active continuation in the therapeutic program, as demonstrated by objective behavioral measurements of improvement.
4. The consumer is making progress toward goals and is actively participating in the interventions.
5. Treatment planning is individualized and appropriate to the individual's changing condition with realistic and specific goals and objectives stated.
6. All services and treatment are carefully structured to achieve optimum results in the most time efficient manner consistent with sound clinical practice, including evaluating and/or prescribing appropriate psychopharmacological intervention.
7. There is documented active discharge planning, including relapse and crisis prevention planning.

SERVICE CATEGORY: OUTPATIENT SERVICES

SERVICE DEFINITION

Service Name	INTENSIVE COMMUNITY SERVICES
Funding Source	Behavioral Health
Setting	Community Based, including individual's home
Facility or Professional License	As required by DHHS Division of Public Health
Basic Definition	Intensive Community Services are designed to promote independent and community living skills and prevent the need for a higher level of care. Services are designed for individuals with serious mental illness, including those with co-occurring disorders, who experience frequent and debilitating symptoms resulting in high rates of use of acute and other intensive levels of care.
Service Expectations	• A mental health assessment conducted by a licensed, qualified clinician at admission or completed within 12 months prior to the date of admission that includes a current diagnosis, level of care recommendation and a discharge plan. If the prior assessment is not relevant or does not contain the necessary information, then a mental health assessment addendum would be necessary. The assessment will serve as the treatment plan until the treatment plan can be developed. The review and update should be completed within 10 days of admission • Development of a treatment/rehabilitation/recovery team including formal and informal supports as chosen by the individual • A treatment/recovery plan developed by the team within 30 days of admission that integrates individual strengths and needs, formal and informal supports, measurable goals, and a documented discharge and relapse prevention plan • Review the treatment/rehabilitation/recovery and discharge plan with the individual's team, including the individual, every 90 days, or as clinically indicated. Each review should be signed by members of the team, including the individual served.

Service Name	INTENSIVE COMMUNITY SERVICES
	• Care coordination activities, including coordination or assistance in accessing medical, psychiatric, psychopharmacological, psychological, social, education, housing, transportation or other appropriate treatment/support services as well as linkage to other community services identified. • Provision of active rehabilitation and support interventions with focus on vocational/education, social skills, and/or activities of daily living, and other independent living skills that enable the individual to reside in the community. • Provide education, support, and coordination with the appropriate services prior, during, and after crisis interventions. • If hospitalization or residential care is necessary, facilitate, in cooperation with the treatment provider, the individual's transition back into the community upon discharge. • Service must be trauma-informed and culturally sensitive. • Frequency of contacts as needed to address the presenting problem(s) with a minimum of face-to-face contact 6 times per month or 6 total hours of contact per month
Length of Services	Length of service is individualized and based on clinical criteria for admission and continuing stay. The amount, duration, and frequency of the service should be documented in the treatment plan.
Staffing	• Program Director: Demonstrated experience, skills, and competencies in behavioral health management. A bachelor's degree in a human service field required, master's degree in a human service field preferred. • Clinical Supervisor: Clinical Supervision by a licensed person (APRN, RN, LMHP, PLMHP, LIMHP, Psychologist) working with the program to provide clinical consultation on the individualized treatment/rehabilitation/recovery plan at least once a month. • Direct Care staff shall have demonstrated skills and competencies in treatment with individuals with a behavioral health diagnosis, demonstrated by at least one of the following: two years lived experience; two years' direct care experience in a human service field; two years of training in a human service field; or a bachelor's degree or higher in psychology, sociology, or related human service field, which is preferred.
Staffing Ratio	1 Intensive Community Services Worker to 10 individuals
Hours of Operation	24/7 Access to service during weekend/evening hours, or in time of crisis with the support of a mental health professional

Service Name	INTENSIVE COMMUNITY SERVICES
Individual Desired Outcome	• Successful transition to a less intensive level of care • Individualized goals and objectives substantially met • Crisis/relapse prevention plan is in place • Precipitating condition and relapse potential stabilized for management at lower level of care • Decreased frequency and duration of hospital stays, increased community tenure • Formal and informal support system in place • Sustained, stable housing

UTILIZATION GUIDELINES
INTENSIVE COMMUNITY SERVICES

I. Admission Guidelines

Individual must meet all of the following admission guidelines to be admitted to this service.

1. Adults with serious mental illness, including individuals with co-occurring disorders.
2. Symptoms and functional deficits are related to the primary diagnosis.
3. Presence of functional deficits in two of three functional areas: Vocational/Education, Social Skills, and Activities of Daily Living.
    a. Vocational/Education: inability to be employed or an ability to be employed only with extensive supports; or deterioration or decompensation resulting in inability to establish or pursue educational goals within normal time frame or without extensive supports; or inability to consistently and independently carry out home management tasks.
    b. Social Skills: repeated inappropriate or inadequate social behavior or ability to behave appropriately only with extensive supports; or consistent participation in adult activities only with extensive supports or when involvement is mostly limited to special activities established for persons with mental illness; or history of dangerousness to self/others.
    c. Activities of Daily Living: Inability to consistently perform the range of practical daily living tasks required for basic adult functioning.

3. Individual can reasonably be expected to benefit from mental health/substance use disorder services at this level.

II. Continued Stay Guidelines:

Individual must meet all of the following continued stay guidelines to continue receiving this service.

1. Individual's condition continues to meet Admission Guidelines at this level of care.
2. Individual's treatment does not require a more intensive level of care, and no less intensive level of care would be appropriate.
3. There is reasonable likelihood of substantial benefits as demonstrated by objective behavioral measurements of improvement in functional areas.
4. Individual demonstrates progress in relation to specific symptoms or impairments, but goals of treatment/rehabilitation/recovery plan have not yet been achieved.

SERVICE CATEGORY: OUTPATIENT SERVICES

SERVICE DEFINITION

Service Name	MEDICATION MANAGEMENT
Funding Source	Behavioral Health
Setting	Medical office, clinic, hospital, or other appropriate outpatient setting
Facility or Professional License	As required by DHHS Division of Public Health
Basic Definition	Medication Management is the evaluation of the individual's need for psychotropic medications, provision of a prescription, and ongoing medical monitoring of those medications.
Service Expectations	• Completion of an evaluation that identifies that the individual would benefit from medication and the need for medication management • Medication evaluation and documentation of monitoring • Medication monitoring routinely and as needed • Education pertaining to the medication to support the individual in making an informed decision for its use. • The service provider must make a good faith attempt to coordinate care with the individual's primary medical provider and other treating professionals as needed
Length of Services	As often and for as long as deemed medically necessary and individual/guardian continues to consent
Staffing	Psychiatrist, or other physician, Advanced Practice Registered Nurse (APRN), Physician Assistant (PA) or Nurse Practitioner (NP) meeting requirements specified within their scope of practice to evaluate the need for and provide this service
Staffing Ratio	As per physician or approved designee caseload

Service Name	MEDICATION MANAGEMENT
Hours of Operation	Generally outpatient, typically business or facility hours
Individual Desired Outcome	Stabilization/resolution of psychiatric symptoms for which medication was intended as an intervention

UTILIZATION GUIDELINES
MEDICATION MANAGEMENT

I. Admission Guidelines

Individual must meet all of the following admission guidelines to be admitted to this service

1. The individual demonstrates symptomatology consistent with a DSM (current edition) diagnosis which requires and can reasonably be expected to respond to therapeutic intervention.
2. There are significant symptoms that interfere with the individual's ability to function in at least one life area.
3. There is a need for prescribing and monitoring psychotropic medications.

II. Continuing Stay Guidelines

1. Continued to meet admission criteria.

SERVICE CATEGORY: OUTPATIENT SERVICES

SERVICE DEFINITION

Service Name	MENTAL HEALTH ASSESSMENT
Funding Source	Behavioral Health
Setting	Services are rendered in a professional office, clinic, home or other community setting as appropriate to the provision of psychotherapy or substance use services.
Facility or Professional License	As required by DHHS Division of Public Health
Basic Definition	A Mental Health Assessment is a comprehensive biopsychosocial, strengths-based assessment of an individual experiencing mental health and/or co-occurring symptoms. It must be completed prior to the initiation of any non-emergent mental health treatment or rehabilitative service. The mental health assessment is a process of gathering information to assess functioning, determine if the symptoms meet the diagnostic criteria for a mental health or co-occurring disorder, and identify treatment needs. The purpose is to rule in or rule out one or more behavioral health disorders.
Service Expectations	A Mental Health Assessment will include the following areas: • Reason the individual is seeking services • Psychosocial history, to include cultural/ethnic influences • Medical history and status, including screening for infectious diseases and follow-up recommendations regarding positive screening • School, military, and/or work history • Mental health and behavioral/cognitive/emotional functioning and history • Maladaptive or problem behaviors, functioning/functional status • Substance use screening and/or psychometric tool, as well as recommendations & referral, as appropriate • History of drug/alcohol/addictive behaviors, including current use

Service Name	MENTAL HEALTH ASSESSMENT
	• Social and peer-group history • Family relationships/circumstances/custody status/environment and home • Strengths, skills, abilities, motivation • Legal history and criminogenic risk • Current and past suicide/homicide risk assessment • Trauma screening and assessment summary recommendations include need for trauma specific follow-up/ referral, as applicable, and impact on current functioning/behavior • Collateral information (information about the individual, behaviors, patterns and/or consequences learned from other sources, e.g., family/friends/criminal justice/current and/or previous MH providers) • Summary to include a complete diagnosis which lists mental health and/or substance use needs, as well as all prioritized psychosocial factors (ICD 10 Z codes) and medical needs identified by the consumer • Individualized recommendations with rationale
Length of Services	The Mental Health Assessment may be done annually or as needed related to significant changes in clinical needs/presentation. Subsequent mental health assessments may be appropriate if there has been a break in services of at least several months or a new practitioner assumes the individual's care.
Staffing	Mental Health clinician as allowed within their scope of practice and licensed in the State of Nebraska: • Licensed Mental Health Practitioner (LMHP) • Provisionally Licensed Mental Health Practitioner (PLMHP) • Licensed Independent Mental Health Practitioner (LIMHP) • Licensed Psychologist • Provisionally Licensed Psychologist • Psychiatrist • APRN • Nurse Practitioner
Staffing Ratio	1 Therapist to 1 Individual
Hours of Operation	In an office setting during day or evening hours, weekends or by special appointment at other hours, if necessary.

Service Name	MENTAL HEALTH ASSESSMENT
Individual Desired Outcome	Upon completion of the mental health assessment, a mental health and/or co-occurring diagnosis will be determined, if appropriate, with recommendations for treatment planning including level of care and referrals to appropriate service providers, as needed.

SERVICE CATEGORY: OUTPATIENT SERVICES

SERVICE DEFINITION

Service Name	MENTAL HEALTH ASSESSMENT ADDENDUM
Funding Source	Behavioral Health
Setting	Services are rendered in a professional office, clinic, home or other environment appropriate to the provision of psychotherapy or substance use services.
Facility License	As required by DHHS Division of Public Health
Basic Definition	The purpose of the addendum is to clarify/update the diagnosis, treatment needs and recommendations and/or gather information that covers the time frame when an individual was not receiving treatment.
Service Expectations	• If the individual remains involved continuously in treatment for more than one year, an addendum is reimbursable at the annual date of the initial mental health assessment. • If the individual leaves treatment prior to a successful discharge and fails to return within six months, the provider will assess the need for an addendum or a new mental health assessment. • The need for updated information is to be reflective of the individual's current status, functioning, and treatment goals. • The addendum will reflect information that has not been addressed in the clinical notes and capture information that covers the period of time outside of treatment. • Continued assessment for co-occurring conditions throughout the addendum.
Length of Services	N/A
Staffing	Mental Health clinician as allowed within their scope of practice and licensed in the State of Nebraska: • Licensed Mental Health Practitioner (LMHP) • Provisionally Licensed Mental Health Practitioner (PLMHP) • Licensed Independent Mental Health Practitioner (LIMHP) • Licensed Psychologist • Provisionally Licensed Psychologist • Psychiatrist • APRN • Nurse Practitioner

Service Name	MENTAL HEALTH ASSESSMENT ADDENDUM
Staffing Ratio	1 to 1 typically
Hours of Operation	Typical office hours with available evening and weekend hours by appointment
Individual Desired Outcome	Upon completion of the mental health assessment addendum, the individual will have been assessed for a mental health and/or co-occurring diagnosis, an assessment of risk of dangerousness to self and/or others, and recommendation for treatment planning with the appropriate service level and referrals to appropriate service providers.

SERVICE CATEGORY: OUTPATIENT SERVICES

SERVICE DEFINITION

Service Name	MULTISYSTEMIC THERAPY (MST)
Funding Source	Behavioral Health
Setting	Services are rendered in a professional office, clinic, home or other environment appropriate to the provision of psychotherapy services.
Facility or Professional License	• As required by DHHS Division of Public Health. • In order to be considered a MST service, the provider will be trained and licensed in MST with MST Services and the Medical University of South Carolina. Teams will also receive regular consultation from MST Services or an MST network partnering agency.
Basic Definition	MST is an evidenced-based intensive treatment process that focuses on diagnosed behavioral health disorders and on environmental systems (family, school, peer groups, culture, neighborhood and community) that contribute to, or influence an individual's involvement, or potential involvement in the juvenile justice system. The target age range is youth 12-17 but youth of other ages can receive the service if medically necessary. The therapeutic modality uses family strengths to promote positive coping activities, works with the caregivers to reinforce positive behaviors, reduce negative behavior, and helps the family increase accountability and problem solving. Families accepting MST receive assessment and home based treatment that strives to change how the individuals, who are at risk of out-of-home placement or who are returning home from an out of home placement, function in their natural settings to promote positive social behavior while decreasing anti-social behavior.
Service Expectations	• A Mental Health Assessment will be completed prior to the beginning of treatment, which indicates the need for this service and will serve as the initial treatment plan until a comprehensive treatment plan is completed. • The treatment plan will be individualized and include the specific problems, behaviors, or skills to be addressed; clear and realistic goals and objectives; services, strategies, and methods of intervention to be implemented. The treatment plan is to be developed with the individual, the identified, appropriate family members, and key participants as part of the outpatient family therapy treatment planning process. • Treatment plans will be reviewed every 90 days or more often if clinically indicated.

Service Name	MULTISYSTEMIC THERAPY (MST)
	• The treating provider may consult with and/or refer to other providers for medical, psychiatric, and psychological needs as indicated. • It is the provider's responsibility to coordinate with other treating professionals as needed. • Services include collateral and telephone contacts with significant others that affect the individual including, but not limited to, the neighborhood, social, educational, and vocational environments, as well as those from the criminal justice, individual welfare, health and mental health systems. • All psychiatric/therapy services for provisionally licensed psychologists, LMHPs, PLHMPs will be provided under the direction of a supervising practitioner (physicians; licensed psychologists; and/or Licensed Independent Mental Health Practitioners). Supervision is not a billable service. • Supervision entails: critical oversight of a treatment activity or course of action; review of the treatment plan and progress notes; individual specific case discussion; periodic assessments of the individual; and diagnosis, treatment intervention or issue specific discussion. Involvement of the supervising practitioner will be reflected in the Mental Health Assessment, the treatment plan and the interventions provided. The Supervisor should track progress and outcomes on each case by completing MST case paperwork and participating in team clinical supervision and MST consultation weekly. • After hours crisis assistance is to be available and staffed by MST team members. • Services are to be culturally sensitive, age and developmentally appropriate, and incorporate evidence based practices when appropriate.
Length of Service	Length of service is individualized and based on clinical criteria for admission and continuing stay. The amount, duration, and frequency of the service should be documented in the treatment plan
Staffing	• MST treatment providers will have a master's degree or greater that allows for professional licensure by DHHS as a therapist and be a member of licensed MST treatment program in order to be trained to provide the service. An active MST team requires a MST trained clinical supervisor and two to four MST trained treatment providers(i.e., therapists) working collaboratively with one another using the MST model as defined by the international MST services program. • MST therapists are assigned to the MST program solely and have no other agency responsibilities. • One part-time clinical supervisor, spending 50% of their time, is assigned to one MST team, or one full-time clinical supervisor to two MST teams. • MST supervisors carrying a partial MST caseload should be assigned to the program on a full-time basis. • Clinical supervisors will be physicians, licensed psychologists and/or Licensed Independent Mental Health Practitioners (LIMHP). All clinical supervisors will be trained in the MST model, with experience in the practice

Service Name	MULTISYSTEMIC THERAPY (MST)
	in behavioral and cognitive behavioral therapies and pragmatic family therapies (i.e., Structural Family Therapy and Strategic Family Therapy). • Assessment providers may be any of the following: physician, psychiatric Advanced Practice Registered Nurse (APRN), Nurse Practitioners (NP), licensed psychologists, provisionally licensed psychologist, LIMHP, all acting within their scope of practice. • Treatment providers (i.e., MST therapists) may be any of the following: physician, APRN, NP, licensed psychologist, provisionally licensed psychologist, LIMHP, LMHP, and a PLMHP, acting within their scope of practice. • Non-licensed master and bachelor's level providers may not provide clinical services. All non-licensed providers will be supervised by a licensed master's level practitioner for any support activities.
Staffing Ratio	All staffing shall be adequate to meet the individualized treatment needs of the individual and meet the responsibilities of each staff position as outlined in the MST model. MST caseloads do not exceed six families per therapists with an average caseload of five families per therapist over time and a normal range being four to six families per therapist.
Hours of Operation	Services include a 24/7 on-call system to provide coverage when the designated MST treatment provider is unavailable. This system will be staffed by MST treatment providers or supervisors who are familiar with the details of each MST case.
Individual Desired Outcome	The individual and the family maintain connections to his or her home or community and have an improved level of functioning in order to successfully function in the home setting.

UTILIZATION GUIDELINES
MULTISYSTEMIC THERAPY

I. Admission Guidelines:

All of the following criteria are required to be met:

1. Externalizing behavior symptoms such as chronic or violent juvenile offenses, resulting in a DSM (current version) diagnosis of conduct disorder or other diagnoses consistent with such symptomatology (ODD, Behavior Disorder NOS, etc.)
2. Individual is at risk for out-of-home placement or is transitioning back from an out of home setting;
3. Ongoing multiple system involvement due to high risk behaviors and/or risk of failure in mainstream school settings due to behavioral problems; and
4. Less intensive treatment has been ineffective or is inappropriate.

One of the following is required to be met in addition to the criteria above:

1. Individual with behavioral health issues that manifest in outward behaviors that negatively impact multiple systems (e.g. family, school, community); or
2. Individuals with substance use disorder issues may be included if they meet the mandatory criteria, and MST is deemed clinically more appropriate than focused drug and alcohol treatment.

Exclusionary criteria (Any of the following are sufficient for exclusion from this level of care):

1. The individual meets criteria for out of home placement due to suicidal, homicidal, or psychotic behavior or are those individuals whose psychiatric problems are the primary reason leading to referral, or who have severe and serious psychiatric problems.
2. Individuals living independently, or individuals for whom a primary caregiver cannot be identified despite extensive efforts to locate all extended family, adult friends and other potential surrogate caregivers.
3. Referral problem is limited to serious sexual misbehavior.
4. Individuals with an autism spectrum diagnosis.

II. Continued Stay Guidelines:

__All__ of the following Guidelines are necessary for continuing treatment:

1. Treatment does not require more intensive level of care.
2. The treatment plan has been developed, implemented and updated based on the individual's clinical condition and response to treatment, as well as the strengths of the family, with realistic goals and objectives clearly stated.
3. Progress is clearly evident in objective terms, but goals of treatment have not yet been achieved, or adjustments in the treatment plan to address the lack of progress are evident.
4. The family is actively involved in treatment, or there are active, persistent efforts being made which are expected to lead to engagement in treatment.

SERVICE CATEGORY: OUTPATIENT SERVICES

SERVICE DEFINITION

Service Name	OUTPATIENT FAMILY PSYCHOTHERAPY
Funding Source	Behavioral Health
Setting	Outpatient Services are rendered in a professional office, clinic, or community environment appropriate to the provision of psychotherapy service.
Facility or Professional License	As required by DHHS Division of Public Health
Basic Definition	Outpatient family psychotherapy uses therapeutic principles, structure and technique to examine family patterns, strengthen communication, and resolve conflicts between an individual and family. The family members are defined by the individual. The objective of treatment is to stabilize or alleviate symptoms of psychiatric disorders that may significantly interfere with interpersonal functioning particularly in the family life domain.
Service Expectations	• A comprehensive Mental Health Assessment (including a detailed family assessment) must be completed prior to the implementation of outpatient family therapy treatment sessions which indicates the need for this level of treatment • A goal-oriented treatment plan with measurable outcomes, and a specific, realistic discharge plan must be developed with the individual and the appropriate family members. The individualized treatment/recovery plan is developed with the individual at the beginning of treatment, uses formal and informal supports, includes discharge and relapse prevention, is reviewed on an ongoing basis and adjusted as clinically indicated • Treatment is provided with the appropriate family members and the individual • Consultation and/or referral for medical, psychiatric, psychological and psychopharmacology needs • It is the provider's responsibility to coordinate with other treating professionals as needed • All services must be culturally sensitive

Service Name	OUTPATIENT FAMILY PSYCHOTHERAPY
Length of Services	Length of treatment is individualized and based on clinical criteria for admission and continuing stay. The amount, duration, and frequency of the service should be documented in the treatment plan.
Staffing	• Licensed Mental Health Practitioner (LMHP) • Provisionally Licensed Mental Health Practitioner (PLMHP) • Licensed Independent Mental Health Practitioner (LIMHP) • Licensed Psychologist • Provisionally Licensed Psychologist • Psychiatrist • Advanced Practice Registered Nurse (APRN)
Staffing Ratio	1 Therapist to 1 Family
Hours of Operation	Typical business hours with weekend and evening hours available
Individual Desired Outcome	• The family has substantially met the treatment plan goals and objectives • Each family member understands how to access support to maintain wellness and stability in the community

UTILIZATION GUIDELINES
OUTPATIENT FAMILY PSYCHOTHERAPY

I. Admission Guidelines:

Both criteria are met:

1. Involve the individual *and* his/her family with a therapist for the purpose of changing a behavior health/substance misuse condition focusing on the level of family functioning as a whole and address issues related to the entire family system.
2. Family therapy is recommended through thorough assessments completed by licensed clinicians as medically necessary to achieve goals/objectives for treatment of a behavior health/substance misuse condition.

II. Continued Stay Guidelines:

***All** of the following Guidelines are necessary for continuing treatment:*

1. Admission guidelines continue to be met.
2. Treatment planning is individualized and appropriate to the family's changing condition, with realistic and specific goals and objectives clearly stated.

SERVICE CATEGORY: OUTPATIENT SERVICES

SERVICE DEFINITION

Service Name	OUTPATIENT GROUP PSYCHOTHERAPY
Funding Source	Behavioral Health
Setting	Outpatient Services are rendered in a professional office, clinic, or community environment appropriate to the provision of psychotherapy service.
Facility or Professional License	As required by DHHS Division of Public Health
Basic Definition	Outpatient group psychotherapy is the use of therapeutic principles, structure and technique to treat psychiatric disorders through scheduled therapeutic visits between participants with a common treatment goal. Outpatient group psychotherapy treatment uses various active treatment modalities and group interaction to stabilize or alleviate symptoms of psychiatric disorders that may significantly interfere with interpersonal functioning in at least one life domain (e.g., familial, social, occupational, educational, etc.).
Service Expectations	• A comprehensive Mental Health Assessment must be completed prior to the beginning of treatment which indicates the need for this level of treatment • The individualized treatment/recovery plan is developed with the individual at the beginning of treatment, uses formal and informal supports, includes discharge and relapse prevention, is reviewed on an ongoing basis and adjusted as medically indicated. • Consultation and/or referral for medical, psychiatric, psychological, and psychopharmacology needs • It is the provider's responsibility to coordinate with other treating professionals as needed • All services must be culturally sensitive
Length of Services	Length of treatment is individualized and based on clinical criteria for admission and continuing stay. The amount, duration, and frequency of the service should be documented in the treatment plan.

Service Name	OUTPATIENT GROUP PSYCHOTHERAPY
Staffing	• Licensed Mental Health Practitioner (LMHP) • Provisionally Licensed Mental Health Practitioner (PLMHP) • Licensed Independent Mental Health Practitioner (LIMHP) • Licensed Psychologist • Provisionally Licensed Psychologist • Advanced Practice Registered Nurse (APRN) • Psychiatrist
Staffing Ratio	One therapist to a group of at least three and no more than twelve individual participants
Hours of Operation	Typical business hours with weekend and evening hours available
Individual Desired Outcome	• The individual has substantially met the treatment plan goals and objectives • Individual is able to remain stable in the community without this treatment • Individual has support systems secured as needed • The individual is connected to a higher level of care if needed

UTILIZATION GUIDELINES
OUTPATIENT GROUP PSYCHOTHERAPY

I. Admission Guidelines

__All__ of the following Guidelines are necessary for admission:

1. The individual demonstrates symptomatology consistent with a DSM (current version) diagnosis which requires and can reasonably be expected to respond to group therapeutic intervention.
2. The individual participant has an interpersonal problem related to their diagnosis and functional impairments.
3. There is an expectation that the individual has the capacity to make significant progress toward treatment from interaction with others who may have a similar experience.
4. The individual has the competency to function in a group therapy.
5. The individual has a therapeutic goal common to the group.
6. The individual may benefit from confrontation by and/or accountability to a group of peers.

II. Continuing Stay Guidelines

__All__ of the following Guidelines are necessary for continuing treatment at this level of care:

1. The individual's condition continues to meet admission Guidelines at this level of care.
2. The individual's treatment does not require a more intensive level of care, and no less intensive level of care would be appropriate.
3. Treatment planning is individualized and appropriate to the individual's changing condition, with realistic and specific goals and objectives clearly stated.
4. All services and treatment are carefully structured to achieve optimum results in the most time efficient manner possible consistent with sound clinical practice.
5. Progress in relation to specific symptoms or impairments is clearly evident and can be described in objective terms, but goals of treatment have not yet been achieved, or adjustments in the treatment plan to address lack of progress are evident.
6. Care is rendered in a clinically appropriate manner and focused on the individual's behavioral and functional outcomes as described in the discharge plan.
7. There is documented active discharge planning.

SERVICE CATEGORY: OUTPATIENT SERVICES

SERVICE DEFINITION

Service Name	OUTPATIENT INDIVIDUAL PSYCHOTHERAPY
Funding Source	Behavioral Health
Setting	Outpatient Services are rendered in a professional office, clinic, or community environment appropriate to the provision of psychotherapy service.
Facility or Professional License	As required by DHHS Division of Public Health
Basic Definition	Outpatient psychotherapy is the treatment of mental health and/or co-occurring substance use disorders through therapeutic principles, structure and technique between the therapist and the individual. Outpatient psychotherapy uses various active treatment modalities to improve or alleviate symptoms that may be troubling and significantly interfere with functioning in at least one life domain (e.g., familial, social, occupational, educational, etc.).
Service Expectations	• A comprehensive Mental Health Assessment must be completed prior to the beginning of treatment which indicates the need for this level of treatment • The individualized treatment/recovery plan is developed with the individual at the beginning of treatment, uses formal and informal supports, includes discharge and relapse prevention, is reviewed on an ongoing basis and adjusted as medically indicated. • Consultation and/or referral for medical, psychiatric, psychological, and psychopharmacology needs • It is the provider's responsibility to coordinate with other treating professionals as needed • All services must be culturally sensitive
Length of Services	Length of treatment is individualized and based on clinical criteria for admission and continued treatment. The amount, duration, and frequency of the service should be documented in the treatment plan.

Service Name	OUTPATIENT INDIVIDUAL PSYCHOTHERAPY
Staffing	• Licensed Mental Health Practitioner (LMHP) • Provisionally Licensed Mental Health Practitioner (PLMHP) • Licensed Independent Mental Health Practitioner (LIMHP) • Licensed Psychologist • Provisionally Licensed Psychologist • Advanced Practice Registered Nurse (APRN) • Psychiatrist
Staffing Ratio	1:1
Hours of Operation	Typical business hours with weekend and evening hours available.
Individual Desired Outcome	• The individual has substantially met the treatment plan goals and objectives • Individual is able to remain stable in the community without this treatment • Individual has support systems secured as needed • The individual is connected to a higher level of care if needed

UTILIZATION GUIDELINES
OUTPATIENT INDIVIDUAL PSYCHOTHERAPY

I. Admission Guidelines:

__All__ of the following Guidelines are necessary for admission:

1. The individual demonstrates symptomatology consistent with a DSM (current edition) diagnosis which requires and can reasonably be expected to respond to therapeutic intervention.
2. There are significant symptoms that interfere with the individual's ability to function in at least one life area.
3. There is an expectation that the individual has the capacity to make significant progress toward treatment goals or treatment.

II. Continuing Stay Guidelines:

__All__ of the following Guidelines are necessary for continuing treatment at this level of care:

1. The individual's condition continues to meet admission Guidelines at this level of care.
2. The individual's treatment does not require a more intensive level of care, and no less intensive level of care would be appropriate.
3. Treatment planning is individualized and appropriate to the individual's changing condition, with realistic and specific goals and objectives clearly stated.
4. All services and treatment are carefully structured to achieve optimum results in the most time efficient manner possible consistent with sound clinical practice.
5. Progress in relation to specific symptoms or impairments is clearly evident and can be described in objective terms, but goals of treatment have not yet been achieved, or adjustments in the treatment plan to address lack of progress are evident.
6. Care is rendered in a clinically appropriate manner and focused on the individual's behavioral and functional outcomes as described in the discharge plan.
7. When medically necessary, appropriate psychopharmacological intervention has been prescribed and/or evaluated.
8. There is documented active discharge planning.

SERVICE CATEGORY: OUTPATIENT SERVICES

SERVICE DEFINITION

Service Name	PEER SUPPORT
Funding Source	Behavioral Health
Setting	Peer support services may be provided in an outpatient office/clinic, individual's home and/or community setting.
Facility or Professional License	As required by DHHS Division of Behavioral Health
Basic Definition	The provision of Peer Support services facilitates recovery as the person served defines it. The service is designed to assist individuals and families in initiating and maintaining the process of recovery and resiliency to improve quality of life, increase resiliency, and to promote health and wellness. The core element of the service is the development of a relationship based on shared lived experience and mutuality between the provider and the individual/family. Services facilitate effective system navigation, empowerment, hope, resiliency, voice and choice, and system of care values. This service can be provided to individuals and families in individual and group settings.
Program Expectations	• A mental health or substance use disorder assessment describing the service needs of the individual, completed by a licensed clinician authorized to perform this service, must have been completed prior to initiating peer support services and recommends this level of care. A copy of the assessment(s) should be found in the individual's peer support file; if unable to obtain, documentation will be found describing efforts to obtain. • A Wellness and Recovery Service Plan (WRSP) is developed through shared decision making inclusive of the individual/family and must identify specific areas to be addressed; clear and realistic goals and objectives; strategies, and recovery support services to be implemented; criteria for achievement; target dates; methods for evaluating the individual's progress; a discharge plan, wellness plan, and crisis prevention plan that includes defining early warning signs and triggers and response. • The Wellness and Recovery Service Plan (WRSP) is developed within 30 days following admission, reviewed and updated a minimum of every 90 days, or more frequently as clinically necessary. The clinical consultant is responsible for reviewing and signing off on the Wellness and Recovery Service Plan. • Clinical consultation between a licensed provider and the peer support provider must occur every 90 days or as often as necessary to update progress or revise the WRSP. Clinical consultation shall be available to provide consultation as needed, including for crisis needs.

Service Name	PEER SUPPORT
	• Care coordination activities must include collaboration with other treatment providers, including obtaining copies of treatment/service plans to aid in development of the WRSP. • Family Peer Support Services provided to care-givers/family supports the acquisition of skills to assist in improved outcomes for youth with complex needs, education of the family to support building parenting skills and understanding trauma. • Developmentally appropriate screenings are used to identify strengths, ability, and at-risk behavior, including suicide risk, at admission and throughout program; if imminent danger is identified appropriate steps must be taken to minimize risk. • Interventions include: Person centered-strength based planning; system navigation, accessing community resources, and engagement with formal and informal resources and supports through coaching/mentoring; assisting individuals in locating and joining existing self-help groups; education about topics such as healthy personal boundaries, individual rights, self-management, and the significance of shared decision making; and self-advocacy activities that enhance problem solving abilities and improve health and well-being. • Crisis support to advocate and liaison with other crisis response services. • Collaborate as a member of the individual/family/guardian's care team. • Adapts services to be person centered and fit the needs of particular individuals, such as veterans, transitional age youth, families, and those with law enforcement contact. • Face to face service delivery is preferable. If in person service delivery is unavailable, telephone is acceptable with documentation regarding the barriers preventing in person service delivery
Length of Services	As identified by the individual, the coordinated treatment team, and as determined clinically necessary.
Staffing	The peer support provider must meet the following criteria: • Be 19 years of age or older; • Self-identify as having lived experience as an individual with a mental health/substance use disorder or as a parent/care-giver to a child with a mental health/substance use disorder; for family peer support providers must have experience parenting a child/youth with a behavioral health challenge. • Have a high school diploma or equivalent with two years of lived recovery. • Have certification as described by the Division of Behavioral Health. The clinical consultant assumes professional responsibility for the services provided by the peer support provider. Clinical consultants must be licensed as one of the following:

Service Name	PEER SUPPORT
	• Psychiatrist; • Licensed Psychologist; • Provisionally Licensed Psychologist; • Advanced Practice Registered Nurse (APRN), Nurse Practitioner (NP); or Registered Nurse (RN) • Licensed Independent Mental Health Practitioner (LIMHP); • Licensed Mental Health Practitioner (LMHP); • Provisionally Licensed Mental Health Professional (PLMHP); • Licensed Alcohol and Drug Counselor (LADC) for substance use only; and • Provisionally Licensed Alcohol and Drug Counselor (PLADC) for substance use only.
Staffing Ratio	• The ratio for clinical consultant to peer support provider as needed to meet clinical consultation expectations described above. • Caseloads for peer support providers must not exceed 1:25. • Peer support groups are a minimum of three participants and a maximum of twelve
Hours of Operation	Peer support services will be available during times that meet the need of the individual and families served which may include evenings and weekends.
Individual Desired Outcome	• The individual/family's recovery and wellness plan is sustainable. The individual/family demonstrates the ability to identify their strengths, needs, access resources and successfully navigate various systems to engage with those resources; • The individual/family has formal and informal supports in place; • Improved stability as indicated by using support system to reduce crisis contacts as appropriate and safe

UTILIZATION GUIDELINES
PEER SUPPORT

I. Admission Guidelines:

All criteria are met:

1. Presence of a mental health and/or a substance use disorder that would benefit from this service; and
2. The individual is enrolled in active behavioral health services; and
3. Presents with symptoms and/or functional deficits that interfere with the individual's ability to maintain a routine of wellness and sustained recovery.
4. For Family Peer Support, caregiver of a child/adolescent living with a severe emotional disturbance, substance use disorder, who is experiencing urgent behavioral/emotional challenges in the home, school, and/or community. Serious Emotional Disturbance is evidenced by significant functional impairments due to their behavioral health diagnosis.

II. Continued Stay Guidelines:

***All** of the following Guidelines are necessary for continuing treatment:*

1. The individual/family continues to meet the admission guidelines for peer support services; and
2. There is reasonable likelihood of substantial benefit as a result of active continuation of this service as demonstrated by objective behavioral measurements of improvements; and
3. The individual/family is making progress toward their goals and is actively participating in the interventions.

SERVICE CATEGORY: OUTPATIENT SERVICES

SERVICE DEFINITION

Service Name	THERAPEUTIC CONSULTATION
Funding Source	Behavioral Health
Setting	Child or adolescent's natural school environment, which in this context means: approved or accredited schools, licensed childcare centers, afterschool programs, and child-serving organizations. This may also include other natural environments, such as the child's home or other community settings in order to complete comprehensive consultative services.
Facility or Professional License	N/A
Basic Definition	**Therapeutic Consultation**, which in this context means: collaborative, organized clinical consultations and recommendations for a child or adolescent who experience symptomology of a *Serious Emotional Disturbance (SED)** and related behavioral health concerns. School staff and/or the family or caregiver initially identify the student's need for behavioral health services. Consultation is designed to focus on the child, with recommendations for behavioral health skills development and potential treatment of critical behavioral health issues that will allow the student to participate and function successfully in academics and career preparation in their natural school environment. An interdisciplinary team, consisting of behavioral health professionals, educators or school staff, the student, family or caregiver, and other key individuals (as identified by the team), will develop and implement recommendations, using a family-driven, multi-disciplinary approach that acknowledges the child and family as equal partners and utilizes the least restrictive environment and least intrusive, developmentally appropriate interventions.

Service Name	THERAPEUTIC CONSULTATION
Service Expectations	• **Observation and Assessment** of the child or adolescent in natural school environment. • **Involvement of the Student and Family or Caregiver** as an equal partner on the interdisciplinary team. • **Consultation** with current treating clinician (if applicable). • **Interviews with Educators, School Staff, and the Family or Caregiver** with relevant knowledge about the child or adolescent. Interviews with other key individuals identified by the interdisciplinary team. • **Review of relevant and appropriate Documentation**, with prior written consent from the child's parent or guardian. • **Participation on the Interdisciplinary Team** in the development and implementation of the student's behavioral health plan (as necessary), including written recommendations. • **Coaching, and mentoring** of educators and school staff on implementing the student's behavioral health plan in the school environment, as needed. • **Service Provision and Recommendations** on strength-based, trauma-informed, and culturally/linguistically-sensitive strategies, utilizing evidence-based practice(s), promising practice(s), or best practice(s) that promote the student's social-emotional development, interpersonal growth, and self- management skills. • **Continued Consultation,** through subsequent follow-up at regular intervals (e.g., 30 days, 90 days, etc.), as needed.
Length of Services	From initial consultation, until *Service Expectations* are met. Typically, consultation, plan development and written recommendations are completed within 30 days, with any additional referral and follow-up completed within 90 days.
Staffing	Appropriately licensed behavioral health professionals (PLMHP, LMHP, LIMHP, or Psychologist) with experience working with children and adolescents. The BH Professional must be trained, within their scope of practice, in trauma-informed care, social-emotional development, behavioral interventions, resiliency, medications, crisis mitigation and response. A dually-licensed clinician is preferred for any child or adolescent with a dual diagnosis of both serious emotional disturbance and substance misuse.
Staffing Ratio	N/A
Hours of Operation	Primarily school hours, with availability after school, evenings, and weekends, as necessary to complete the consultation process. Scheduling of consultations must be flexible, with availability during times that meet the needs of the child or adolescent and their family or caregiver.

Service Name	THERAPEUTIC CONSULTATION
Child/ Adolescent Desired Outcome	• The child's interdisciplinary team, including the student and the family or caregiver, have identified and implemented recommendations designed to address and minimize behavioral and emotional challenges related to student's mental health and/or substance misuse; and • Promote social-emotional development, interpersonal growth, and self-management skills necessary for the student to participate and function successfully in academics and career preparation in their natural school environment.

UTILIZATION GUIDELINES
THERAPEUTIC CONSULTATION

REMAINS UNDER DEVELOPMENT

REHABILITATION SERVICES

SERVICE CATEGORY: REHABILITATION SERVICES

SERVICE DEFINITION

Service Name	ASSERTIVE COMMUNITY TREATMENT
Funding Source	Behavioral Health
Setting	Community-based
Facility or Professional License	As required by DHHS Division of Public Health
Basic Definition	Assertive Community Treatment (ACT) Team consists of a community based group of transdisciplinary professionals who use a team approach to meet the needs of individuals with severe mental illness. The team provides comprehensive, high intensity services, with the capacity to provide crisis response and regular, frequent, face to face contacts as dictated by client need. ACT uses an assertive, recovery focused, and individualized treatment model that values self-determination, strengths, and rehabilitation.
Service Expectations	• A mental health assessment conducted by a licensed, qualified clinician at admission or completed within 12 months prior to the date of admission that includes a current diagnosis, level of care recommendation and a discharge plan. If the prior assessment is not relevant or does not contain the necessary information then a mental health assessment addendum would be necessary. The assessment will serve as the treatment plan until the treatment plan can be developed. The addendum should be completed within 30 days of admission as part of the comprehensive assessment. • An ACT Comprehensive Assessment is completed to evaluate the individual's past history and current condition in order to identify strengths and needs, outline goals, and create a comprehensive, individual treatment/rehabilitation/recovery/service plan. The Comprehensive Assessment reviews information from all available resources including past medical records, self-report, interviews with family or significant others if approved by the individual, and other appropriate resources, as well as current assessment by team members from all disciplines. This assessment must include a thorough medical evaluation. A Comprehensive Assessment must be initiated and completed within 30 days after the client's admission to the ACT program. • A treatment/rehabilitation/recovery plan developed with the individual, which includes individual strengths and needs, community, family and other supports, measurable goals and specific interventions, and includes a documented discharge and relapse prevention plan. It is completed within 21 days of the completion of the

Service Name	ASSERTIVE COMMUNITY TREATMENT
	Comprehensive Assessment. The treatment plan is developed using a person centered approach, uses interventions targeting a broad range of life domains and promotes self-determination. • The treatment/rehabilitation/recovery/service plan is reviewed and revised at least every six months or more often as clinically indicated. The review includes the team leader, psychiatrist/APRN, appropriate team members, the individual, and participants such as family members as preferred by the individual. • Assess transition readiness on an ongoing basis using standardized tools. • Medical and dental assessment, management and intervention as needed, and collaboration with other medical providers. • Individual/family/group psychotherapy and substance use disorder counseling, and referrals to support groups as needed. • Medication prescribing, delivery, education, administration and monitoring. • The team is available to clients in crisis 24 hours a day, seven days a week, and is the direct responder for psychiatric crises. The team is closely involved in psychiatric hospitalizations and discharges. • Rehabilitation services address functional deficits, lack of resources, and the individual's environment. It uses targeted skills training with a focus on symptom management and psycho-educational services needed to support or maintain independent living. This includes activities of daily living, social functioning, and community living skills. • Supportive interventions target a broad range of life domains promoting independent living skills. This may be direct assistance and coordination to obtain necessities like medical appointments, housing, transportation, and maintain family/other involvement with the individual, etc. Health promotion, wellness management, and recovery strategies are used. • Supported employment and education services provided within the team to engage, assess, coach, and motivate individuals regarding competitive employment and school as achievable goals. • The team meets daily to conduct a review of all clients and contacts, develop a staff schedule focused on proactive engagement, and report on follow through. • Services are high in intensity and frequency as needed, use assertive engagement mechanisms, and incorporate natural supports. • All services must be culturally sensitive.
Length of Services	Length of service is individualized and based on clinical criteria for admission and continuing stay, as well as the client's ability to make progress on individual treatment/recovery goals. The amount, duration, and frequency of the service will be documented in the treatment plan.

Service Name	ASSERTIVE COMMUNITY TREATMENT
Staffing	• A licensed Psychiatrist or APRN who serves as the Team prescriber of the program and meets the FTE standards for evidence-based ACT programs • Team Leader with at least a Master's Degree in nursing, social work, counseling, psychiatric rehabilitation or other human service field and a license as a mental health practitioner. At least three years' experience in working with adults with severe mental illness preferred. • Licensed mental health practitioners (LIMHP, LMHP, PLMHP, Psychologist, Provisional Psychologist, LADC, PLADC) • Substance misuse Specialists with at least one year training/experience in substance use disorder treatment, or a LADC or PLADC • Vocational Specialists with at least one year training/experience in vocational rehabilitation and support • Registered Nurses with at least one year psychiatric experience with adults with severe mental illness preferred • Certified Peer Support Specialist • Mental Health Worker with a bachelor's degree or higher in psychology, sociology, or a related field is preferred, but two years of course work in a human services field, or High School Diploma and two years of experience/training or lived recovery experience with demonstrated skills and competencies in treatment with individuals with a MH diagnoses is acceptable. • Administrative support staff • All staff should be trained in rehabilitation and recovery principles, and personal recovery experience is a positive.
Staffing Ratio	Per the current Tool for Measurement of ACT (TMACT) fidelity measure for all positions
Hours of Operation	A minimum of 12 hours per day, 8 hours per day on weekends/holidays. Staff on-call 24/7 and able to provide needed services and to respond to psychiatric crises.
Individual Desired Outcome	• The individual has substantially met the agreed upon treatment plan goals and objectives and is stable in a community setting. • The individual experiences sustained reduction in psychiatric symptoms that substantially interfere with daily functioning, resulting in fewer psychiatric inpatient stays, emergency department visits, and/or involvement in the criminal justice system • The individual has formal and informal support systems in place and demonstrates skills that are necessary to be more fully integrated into the community of choice

Service Name	ASSERTIVE COMMUNITY TREATMENT
	• The individual's recovery/rehabilitation has progressed such that the precipitating condition and relapse potential is stabilized and can be managed without this level of professional interventions

UTILIZATION GUIDELINES
ASSERTIVE COMMUNITY TREATMENT

I. Admission Guidelines:

All of the following must be present:

1. DSM (current version) diagnosis consistent with a serious and persistent mental illness i.e. a primary diagnosis of schizophrenia, major affective disorders, PTSD, OCD or other major mental illness under the current edition of DSM.
2. Persistent mental illness as demonstrated by the presence of the disorder for the last 12 months or which is expected to last 12 months or longer and will result in a degree of limitation that seriously interferes with the client's ability to function independently in an appropriate manner in two of three functional areas.
3. Presence of functional deficits in two of three functional areas: Vocational/education, Social Skills, Activities of Daily Living.
   a Vocational/Education: inability to be employed or an ability to be employed only with extensive supports; or deterioration or decompensation resulting in inability to establish or pursue educational goals within normal time frame or without extensive supports; or inability to consistently and independently carry out home management tasks.
   b Social skills: repeated inappropriate or inadequate social behavior or ability to behave appropriately only with extensive supports; or consistent participation in adult activities only with extensive supports or when involvement is mostly limited to special activities established for persons with mental illness; or history of dangerousness to self/others.
   c Activities of Daily Living: Inability to consistently perform the range of practical daily living tasks required for basic adult functioning in three of five of the following:
      - Grooming, hygiene, washing clothes, meeting nutritional needs;
      - Care of personal business affairs;
      - Transportation and care of residence;
      - Procurement of medical, legal, and housing services; or
      - Recognition and avoidance of common dangers or hazards to self and possessions.
4. Functional deficits of such intensity requiring extensive professional multidisciplinary treatment, rehabilitation and support interventions with 24 hour capability
5. The individual is at significant risk of continuing in a pattern of either institutionalization or living in a severely dysfunctional way if needed treatment/rehabilitation services with 24 hour capability are not provided.
6. The individual has a history of high utilization of psychiatric inpatient and emergency services.

7. The individual has had less than satisfactory response to previous levels of treatment/rehabilitation interventions.

II. <u>Continued Stay Guidelines:</u>

All of the following guidelines are necessary for continuing treatment at this level of care:

1. The individual continues to meet admission guidelines.
2. The individual does not require a more intensive level of services and no less intensive level of care is appropriate.
3. There is reasonable likelihood of substantial benefits as demonstrated by objective behavioral measurements of improvement in functional areas.
4. The individual is making progress towards treatment/rehabilitation goals.

SERVICE CATEGORY: REHABILITATION SERVICES

SERVICE DEFINITION

Service Name	COMMUNITY SUPPORT – MENTAL HEALTH
Funding Source	Behavioral Health
Setting	Community Based – Most frequently provided in the home; not facility or office based
Facility or Professional License	As required by DHHS Division of Public Health
Basic Definition	Community Support is a rehabilitative and support service for individuals in the community with a primary mental health diagnosis consistent with a serious and persistent mental illness and who have complex and extensive treatment needs. Community Support Workers provide service coordination and restorative interventions for development of interpersonal, community, coping and independent living skills to maintain wellbeing, community living, and stabilize mental health symptoms.
Service Expectations	• A mental health assessment conducted at admission by a licensed, qualified clinician or completed within 12 months prior to the date of admission that includes a current diagnosis, level of care recommendation and a discharge plan. If the prior assessment is not relevant or does not contain the necessary information then a mental health assessment addendum would be necessary. The assessment will serve as the treatment plan until the treatment plan can be developed. The addendum should be completed within 30 days of admission. • Clinically appropriate programmatic assessments, as determined necessary, which may include skills inventories, interviews and/or use of other tools for the purpose of identifying treatment and rehabilitation goals and plans with the individual, should be completed within 30 days of admission. • A treatment/rehabilitation/recovery plan developed with the individual, which includes individual strengths and needs, community, family and other supports, measurable goals and specific interventions, and includes a documented discharge and relapse prevention plan. This is completed within 30 days of admission, reviewed, approved and signed by the Clinical Supervisor. • Review the treatment/rehabilitation/recovery and discharge plan with the individual and treatment team, every 90 days, or more often as clinically indicated. Each review should be signed by the individual and members of the treatment team, and at a minimum the Clinical Supervisor or other licensed professional, and community support worker.

Service Name	COMMUNITY SUPPORT – MENTAL HEALTH
	• Provision of active rehabilitation and support interventions with focus on activities of daily living, education/employment, budgeting, medication adherence and self-administration (as appropriate and part of the overall treatment/recovery plan), relapse prevention, social skills, and other independent living skills that enable the individual to reside in the community. • Provide service coordination and case management activities, such as accessing medical, psychiatric, psychopharmacological, psychological, social, education/employment, housing, transportation or other appropriate treatment/support services as well as linkage to other community resources identified in the treatment/rehabilitation/recovery plan. • Develop and implement strategies to encourage the individual's engagement in necessary mental health treatment services as recommended and included in the treatment/rehabilitation/recovery plan. • Participate with and report to treatment/rehabilitation team on the individual's progress and response to community support intervention in the areas of relapse prevention, substance use, application of education and skills, and the recovery environment as identified in the plan. • Provide therapeutic support and intervention to the individual in time of crisis and work with the individual to implement the crisis relapse prevention plan. • If hospitalization or residential care is necessary, facilitate, in cooperation with the treatment provider, the individual's transition back into the community upon discharge. • Face to-face contact a minimum of 3 times per month or 3 total hours of contact • All services must be culturally sensitive
Length of Services	Length of service is individualized and based on clinical criteria for admission and continuing stay, as well as the client's ability to demonstrate progress on individual treatment/recovery goals. The amount, duration, and frequency of the service will be documented in the treatment plan.

Service Name	COMMUNITY SUPPORT – MENTAL HEALTH
Staffing	• Clinical Supervision by a licensed professional (APRN, RN, LMHP, PLMHP, LIMHP, Licensed Psychologist, Provisionally Licensed Psychologist) working with the program to provide clinical supervision, consultation and support to community support staff and the individuals they serve. The Clinical Supervisor will review client clinical needs with the worker every 30 days. The review should be completed preferably face to face but phone review is acceptable. The Clinical Supervisor may complete the review in a group setting with more than one worker as long as each client on the worker's case load is reviewed. • Direct Care staff shall have demonstrated skills and competencies in treatment with individuals with a behavioral health diagnosis, demonstrated by at least one of the following: two years lived experience; two years' direct care experience in a human service field; two years of training in a human service field; or a bachelor's degree or higher in psychology, sociology, or related human service field, which is preferred.
Staffing Ratio	Clinical Supervisor to Community Support Worker ratio as needed to meet all clinical supervision responsibilities outlined above. 1:25 Community Support worker to individuals served
Hours of Operation	24/7 Access to service during weekend/evening hours; in times of crisis, access to a mental health professional
Individual Desired Outcome	• The individual has substantially met the treatment plan goals and objectives • The precipitating condition and relapse potential is stabilized such that individual's condition can be managed without this level of professional interventions and external supports • Individual has natural support systems secured to help the individual progress in active recovery and stability in the community • The individual has progressed through stages of change and is willing to engage in treatment at a higher level of care if clinically indicated

UTILIZATION GUIDELINES
COMMUNITY SUPPORT – MENTAL HEALTH

I. Admission Guidelines:

All of the following must be present:

1. DSM (current version) diagnosis consistent with a serious and persistent mental illness; i.e. a primary diagnosis of schizophrenia, major affective disorders, PTSD, OCD or other major mental illness under the current edition of DSM.
2. Persistent mental illness as demonstrated by the presence of the disorder for the last 12 months or which is expected to last 12 months or longer and will result in a degree of limitation that seriously interferes with the client's ability to function independently in an appropriate manner in two of three functional areas.
3. Presence of functional deficits in two of three functional areas: Vocational/education, Social Skills, and Activities of Daily Living.
    a. Vocational/Education: inability to be employed or an ability to be employed only with extensive supports; or deterioration or decompensation resulting in inability to establish or pursue educational goals within normal time frame or without extensive supports; or inability to consistently and independently carry out home management tasks.
    b. Social skills: repeated inappropriate or inadequate social behavior or ability to behave appropriately only with extensive supports; or consistent participation in adult activities only with extensive supports or when involvement is mostly limited to special activities established for persons with mental illness; or history of dangerousness to self/others.
    c. Activities of Daily Living: Inability to consistently perform the range of practical daily living tasks required for basic adult functioning in three of five of the following:

    a) Grooming, hygiene, washing clothes, meeting nutritional needs;
    b) Care of personal business affairs;
    c) Transportation and care of residence;
    d) Procurement of medical, legal, and housing services; or
    e) Recognition and avoidance of common dangers or hazards to self and possessions.
    f) Client is at significant risk of continuing in a pattern of either institutionalization or living in a severely dysfunctional way if needed rehabilitation services are not provided.
4. Symptoms and functional deficits are related to the primary diagnosis.

5. There is an expectation that the client will benefit from rehabilitation treatment.

II. <u>Continued Stay Guidelines:</u>

All of the following guidelines are necessary for continuing treatment at this level of care:

1. The individual continues to meet admission guidelines.
2. The individual does not require a more intensive level of services and no less intensive level of care is appropriate.
3. There is reasonable likelihood of substantial benefits as demonstrated by objective behavioral measurements of improvement in functional areas.
4. The individual is making progress towards rehabilitation goals.

SERVICE CATEGORY: REHABILITATION SERVICES

SERVICE DEFINITION

Service Name	DAY REHABILITATION
Funding Source	Behavioral Health
Setting	Facility based/non-hospital
Facility or Professional License	As required by DHHS Division of Public Health
Basic Definition	Day Rehabilitation services provide individualized treatment and recovery, psychiatric rehabilitation and support for individuals with a severe and persistent mental illness or co-occurring disorders. Day Rehabilitation focuses on skill and resource development related to the individual's ability to manage the illness and the recovery process in order to function as independently as possible and be successful in a community living setting of choice.
Service Expectations	• A mental health assessment conducted by a licensed, qualified clinician at admission or completed within 12 months prior to the date of admission that includes a current diagnosis, level of care recommendation and a discharge plan. If the prior assessment is not relevant or does not contain the necessary information then a mental health assessment addendum would be necessary. The assessment will serve as the treatment plan until the treatment plan can be developed. The addendum should be completed within 30 days of admission. • Clinically appropriate programmatic assessments, as determined necessary, which may include skills inventories, interviews and/or use of other tools for the purpose of identifying treatment and rehabilitation goals and plans with the individual, should be completed within 30 days of admission. • An initial treatment/rehabilitation/recovery plan to guide the first 30 days of treatment developed by the end of the third scheduled program day if there is no prior completed mental health assessment functioning as the treatment plan. • Alcohol and drug screening during admission assessments and thereafter as indicated • A treatment/rehabilitation/recovery plan developed by the treatment team within 30 days of admission that integrates individual strengths and needs, formal and informal supports, measurable goals, and a documented discharge and relapse prevention plan.

Service Name	DAY REHABILITATION
	• Review the treatment/rehabilitation/recovery and discharge plan with treatment team, including the individual, every 90 days, or as often as clinically indicated. Each review will be signed by members of the treatment team, and at a minimum the Clinical Supervisor, direct care staff and the individual. • Arrange for medical, pharmacology, psychological, dental, vision, dietary, pastoral, emergency medical, laboratory and other diagnostic/treatment or ancillary services as needed • Engage and strengthen informal support system as appropriate • Therapeutic milieu providing active treatment/recovery/rehabilitation activities led by individuals trained in the provision of recovery principles. These activities include skill building in areas such as community living, personal care, social relationships, vocational/educational, and use of leisure time • The on-site capacity to provide medication administration and/or self-administration, with an emphasis on symptom management, self-determination, and wellness education • All services must be culturally sensitive
Length of Services	Length of service is individualized and based on clinical criteria for admission and continuing stay, as well as the individual's ability to make progress on individual treatment/recovery goals. The amount, duration, and frequency of the service will be documented in the treatment plan.
Staffing	• Clinical Supervision by a licensed professional (APRN, RN, LMHP, PLMHP, LIMHP, Licensed Psychologist, Provisionally Licensed Psychologist); working with the program to provide clinical supervision, consultation and support to direct care staff and the individuals they serve. • Direct Care staff shall have demonstrated skills and competencies in treatment with individuals with a behavioral health diagnosis, demonstrated by at least one of the following: two years lived experience; two years' direct care experience in a human service field; two years of training in a human service field; or a bachelor's degree or higher in psychology, sociology, or related human service field, which is preferred. • All staff must be educated/trained in rehabilitation and recovery principles.

Service Name	DAY REHABILITATION
Staffing Ratio	• Clinical Supervisor to direct care staff ratio as needed to meet all clinical responsibilities. The Clinical Supervisor will review clinical needs with the worker every 30 days. The review should be completed preferably face to face but phone review is acceptable. The review may be accomplished by the supervisor consulting with the worker on the list of assigned clients and identifying any clinical recommendations in serving the client. The Clinical Supervisor may complete the review in a group setting with more than one worker as long as each client on the worker's case load is reviewed. • 1 staff to 6 clients during day and evening hours; access to licensed clinicians as described for Clinical Supervision 24/7
Hours of Operation	• Regularly scheduled day, evening and weekend hours with 24/7 on call access to a mental health provider.
Individual Desired Outcome	• The individual has substantially met the treatment/recovery/rehabilitation plan goals and objectives • The precipitating condition and relapse potential is stabilized such that individual's condition can be managed without this level of professional interventions and external supports • Individual has formal and informal support systems secured to maintain stability in a lower level of care

UTILIZATION GUIDELINES
DAY REHABILITATION

I. Admission Guidelines:

All of the following must be present:

1. DSM (current version) diagnosis consistent with a serious and persistent mental illness i.e. a primary diagnosis of schizophrenia, major affective disorder, PTSD, OCD or other major mental illness under the current edition of DSM.
2. Persistent mental illness as demonstrated by the presence of the disorder for the last 12 months or which is expected to last 12 months or longer and will result in a degree of limitation that seriously interferes with the client's ability to function independently in an appropriate manner in two of three functional areas.
3. Presence of functional deficits in two of three functional areas: Vocational/education, Social Skills, and Activities of Daily Living.
    a. Vocational/Education: inability to be employed or an ability to be employed only with extensive supports; or deterioration or decompensation resulting in inability to establish or pursue educational goals within normal time frame or without extensive supports; or inability to consistently and independently carry out home management tasks.
    b. Social skills: repeated inappropriate or inadequate social behavior or ability to behave appropriately only with extensive supports; or consistent participation in adult activities only with extensive supports or when involvement is mostly limited to special activities established for persons with mental illness; or history of dangerousness to self/others.
    c. Activities of Daily Living: Inability to consistently perform the range of practical daily living tasks required for basic adult functioning in three of five of the following:
    a) Grooming, hygiene, washing clothes, meeting nutritional needs;
    b) Care of personal business affairs;
    c) Transportation and care of residence;
    d) Procurement of medical, legal, and housing services; or
    e) Recognition and avoidance of common dangers or hazards to self and possessions.
4. Functional deficits of such intensity requiring multiple hours of rehabilitative interventions daily in a structured day setting.
5. The individual is at significant risk of continuing in a pattern of either institutionalization or living in a severely dysfunctional manner if needed multiple hours of rehabilitation services are not provided.
6. Symptoms and functional deficits are related to the primary diagnosis.
7. There is an expectation that the client will benefit from rehabilitation treatment.

II. Continued Stay Guidelines:

All of the following guidelines are necessary for continuing treatment at this level of care:

1. The individual continues to meet admission guidelines.
2. The individual does not require a more intensive level of services and no less intensive level of care is appropriate.
3. There is reasonable likelihood of substantial benefits as demonstrated by objective behavioral measurements of improvement in functional areas.
4. The individual is making progress towards rehabilitation goals.

SERVICE CATEGORY: REHABILITATION SERVICES

SERVICE DEFINITION

Service Name	DAY SUPPORT
Funding Source	Behavioral Health
Setting	Facility-based/non-hospital
Facility or Professional License	As required by DHHS Division of Public Health
Basic Definition	Day Support is designed to provide social support to individuals who currently receive, or have received, treatment for serious mental illness and are in the recovery process. The intent of the service is to support the individual's wellbeing so he/she can benefit from socialization, leisure skill development, communication and coping skill development.
Service Expectations	• A mental health assessment conducted by a licensed, qualified clinician at admission or completed within 12 months prior to the date of admission that includes a current diagnosis, level of care recommendation and a discharge plan. If the prior assessment is not relevant or does not contain the necessary information, then a mental health assessment addendum would be necessary. The assessment will serve as the treatment plan until the treatment plan can be developed. • A treatment/rehabilitation/recovery plan developed by the treatment team within 30 days of admission that integrates individual strengths and needs, formal and informal supports, measurable goals, and a documented discharge and relapse prevention plan. The treatment plan is reviewed by the treatment team, including the individual served, every 120 days or as clinically indicated. • Therapeutic milieu providing active treatment/recovery/rehabilitation activities led by individuals trained in the provision of recovery principles. These activities include skill building in areas such as community living, personal care, social relationships, vocational/educational, and use of leisure time. The individual selects activities that meet their goals and needs. • Provide referrals to behavioral health and other community resources as needed. • Access to support during pre-crisis or crisis situation, with active linkage to more intensive level of care if necessary. • All services must be culturally sensitive.

Service Name	DAY SUPPORT
Length of Services	Length of service is individualized and based on clinical criteria for admission and continuing stay, as well as the client's ability to demonstrate progress on individual treatment/recovery goals. The amount, duration, and frequency of the service will be documented in the treatment plan.
Staffing	• Clinical Supervision by a licensed professional (APRN, RN, LMHP, PLMHP, LIMHP, Licensed Psychologist, Provisionally Licensed Psychologist); working with the program to provide clinical supervision, consultation and support to direct care staff and the individuals they serve. • Direct Care staff shall have demonstrated skills and competencies in treatment with individuals with a behavioral health diagnosis, demonstrated by at least one of the following: two years lived experience; two years' direct care experience in a human service field; two years of training in a human service field; or a bachelor's degree or higher in psychology, sociology, or related human service field, which is preferred. • Personal recovery experience preferred for all positions.
Staffing Ratio	Staffing one worker to no more than twelve individuals
Hours of Operation	Regularly scheduled day, evening, and weekend hours.
Individual Desired Outcome	• Individual has established formal and informal community supports. • Individual strengthens social skills, communication abilities, and connection to others in recovery. • Individual has substantially met the individualized Day Support treatment plan goals and objectives.

UTILIZATION GUIDELINES
DAY SUPPORT

I. Admission Guidelines

Consumer must meet all of the following admission guidelines to be admitted to this service.

1. Serious mental illness or co-occurring (mental health/substance misuse) disorders.
2. Consumer desires supports to engage in a personal recovery process.
3. Consumer does not require more intensive intervention.
4. Medically and psychiatrically stable.

II. Continued Stay Guidelines

Consumer must meet all of the following continued stay guidelines to continue receiving this service.

1. Continues to meet Admission Guidelines.
2. Consumer participates in social and other personal recovery opportunities.

SERVICE CATEGORY: REHABILITATION SERVICES

SERVICE DEFINITION

Service Name	PSYCHIATRIC RESIDENTIAL REHABILITATION
Funding Source	Behavioral Health
Setting	Facility based
Facility or Professional License	As required by DHHS Division of Public Health
Basic Definition	Psychiatric Residential Rehabilitation is designed to provide individualized treatment, psychiatric rehabilitation and support for individuals with a severe and persistent mental illness and/or co-occurring disorder needing structured recovery and rehabilitation activities within a residential setting. Psychiatric Residential Rehabilitation is provided by a treatment/recovery team in a 24-hour staffed residential facility. The intent of the service is to support the individual by improving symptom management and life skills so that he/she can be successful in a community living setting of choice.
Service Expectations	• A mental health assessment conducted by a licensed, qualified clinician at admission or completed within 12 months prior to the date of admission that includes a current diagnosis, level of care recommendation and a discharge plan. If the prior assessment is not relevant or does not contain the necessary information, then a mental health assessment addendum would be necessary. The assessment will serve as the treatment plan until the treatment plan can be developed. • If the mental health assessment was completed within 12 months prior to admission, a licensed professional should review and update as necessary via an addendum, to ensure information is reflective of the client's current status, functioning, and level of care recommendation. The review and update should be completed within 30 days of admission. • Clinically appropriate programmatic assessments, as determined necessary, which may include skills inventories, interviews and/or use of other tools for the purpose of identifying treatment and rehabilitation goals and plans with the individual, should be completed within 30 days of admission • An initial treatment/rehabilitation/recovery plan to guide the first 30 days of treatment developed within 72 hours of admission. • Arrange for psychiatric services as needed.

Service Name	PSYCHIATRIC RESIDENTIAL REHABILITATION
	• Alcohol and drug screening; assessment as needed. • A treatment/rehabilitation/recovery plan developed by the treatment team within 30 days of admission that integrates individual strengths and needs, formal and informal supports, measurable goals, and a documented discharge and relapse prevention plan. The treatment plan is reviewed by the treatment team, including the individual served, every 90 days or as clinically indicated. The clinical supervisor, appropriate team members, the individual, and others as requested by the individual participate. • Arrange for medical, pharmacology, psychological, dental, vision, dietary, pastoral, emergency medical, laboratory and other diagnostic/treatment or ancillary services as needed. • Therapeutic milieu offering 25 hours per 7 day week of staff led active treatment/rehabilitation/recovery services. • The on-site capacity to provide medication administration and/or self-administration and education. • Active recovery services include symptom management, nutritional support, social, vocational/educational, and life-skills building activities, self-advocacy, peer support services, recreational activities, and other independent living skills that enable the individual to reside in the community. • Coordinate and offer a minimum of 20 hours/week of additional off-site rehabilitation, vocational, and educational activities. • Ability to coordinate other services the individual may be receiving and refer to other necessary services. • Active discharge planning, including linkage to services and supports to enhance independence in the community. • All services must be culturally sensitive.
Length of Services	Length of service is individualized and based on clinical criteria for admission and continuing stay, as well as the client's ability to make progress on individual treatment/recovery goals. The anticipated duration of the service will be documented in the treatment plan.
Staffing	• Clinical Supervision by a licensed professional (APRN, RN, LMHP, PLMHP, LIMHP, Licensed Psychologist, Provisionally Licensed Psychologist); working with the program to provide clinical supervision, consultation and support to direct care staff and the individuals they serve. The Clinical Supervisor will review client clinical needs with the direct care worker every 30 days. The review should be completed preferably face to face but phone review is acceptable. The Clinical Supervisor may complete the review in a group setting with more than one worker as long as each client on the worker's case load is reviewed.

Service Name	PSYCHIATRIC RESIDENTIAL REHABILITATION
	• Direct Care staff shall have demonstrated skills and competencies in treatment with individuals with a behavioral health diagnosis, demonstrated by at least one of the following: two years lived experience; two years' direct care experience in a human service field; two years of training in a human service field; or a bachelor's degree or higher in psychology, sociology, or related human service field, which is preferred. • All staff must be educated/trained in rehabilitation and recovery principles.
Staffing Ratio	• Clinical Supervisor to direct care staff ratio as needed to meet all responsibilities • Direct Care staff sufficient to cover safety and activities.
Hours of Operation	24/7
Individual Desired Outcome	• The individual has substantially met the treatment/rehabilitation/recovery plan goals and objectives • The precipitating condition and relapse potential is stabilized such that the individual's condition can be managed without this level of professional interventions • Individual has formal and informal support systems secured to maintain stability in a lower level of care

UTILIZATION GUIDELINES
PSYCHIATRIC RESIDENTIAL REHABILITATION

I. Admission Guidelines:

All of the following must be present:

1. DSM (current version) diagnosis consistent with a serious and persistent mental illness i.e. a primary diagnosis of schizophrenia, major affective disorder, PTSD, OCD or other major mental illness under the current edition of DSM.
2. Persistent mental illness as demonstrated by the presence of the disorder for the last 12 months or which is expected to last 12 months or longer and will result in a degree of limitation that seriously interferes with the client's ability to function independently in an appropriate manner in two of three functional areas.
3. Presence of functional deficits in two of three functional areas: Vocational/education, Social Skills, and Activities of Daily Living.
    a. Vocational/Education: inability to be employed or an ability to be employed only with extensive supports; or deterioration or decompensation resulting in inability to establish or pursue educational goals within normal time frame or without extensive supports; or inability to consistently and independently carry out home management tasks.
    b. Social skills: repeated inappropriate or inadequate social behavior or ability to behave appropriately only with extensive supports; or consistent participation in adult activities only with extensive supports or when involvement is mostly limited to special activities established for persons with mental illness; or history of dangerousness to self/others.
    c. Activities of Daily Living: Inability to consistently perform the range of practical daily living tasks required for basic adult functioning in three of five of the following:
        - Grooming, hygiene, washing clothes, meeting nutritional needs;
        - Care of personal business affairs;
        - Transportation and care of residence;
        - Procurement of medical, legal, and housing services; or
        - Recognition and avoidance of common dangers or hazards to self and possessions.
4. Functional deficits of such intensity requiring professional interventions in a 24 hour psychiatric residential setting.
5. The individual is at significant risk of continuing in a pattern of either institutionalization or living in a severely dysfunctional way if needed residential rehabilitation services are not provided.
6. Requires 24-hour awake staff to assist with psychiatric rehabilitation.

II. **Continued Stay Guidelines:**

All of the following guidelines are necessary for continuing treatment at this level of care:

1. The individual continues to meet admission guidelines.
2. The individual does not require a more intensive level of services and no less intensive level of care is appropriate.
3. There is reasonable likelihood of substantial benefits as demonstrated by objective behavioral measurements of improvement in functional areas.
4. The individual is making progress towards rehabilitation goals.
5. Continues to require 24-hour awake staff to assist with psychiatric rehabilitation.

SERVICE CATEGORY: REHABILITATION SERVICES

SERVICE DEFINITION

Service Name	RECOVERY SUPPORT - MENTAL HEALTH AND/OR SUBSTANCE USE
Funding Source	Behavioral Health
Setting	Community based
Facility or Professional License	As required by DHHS Division of Public Health
Basic Definition	Recovery Support services promote successful independent community living by assisting individuals in achieving behavioral health goals, supporting recovery, and connecting the individual to services aiding the goals. Recovery Support links individuals to community resources, identifies and problem solves barriers that limit independent living, and builds on strengths and interests that support wellbeing. Crisis relapse prevention, active case management, and referral to other independent living and behavioral health services are provided to assist the individual in maintaining self-sufficiency and wellbeing.
Service Expectations	• A mental health assessment and/or substance use assessment conducted by a licensed, qualified professional at admission or completed within 12 months prior to the date of admission that includes a current diagnosis, level of care recommendation and a discharge plan. If the prior assessment is not relevant or does not contain the necessary information then a mental health or substance use assessment addendum would be necessary. The assessment will serve as the treatment plan until the treatment plan can be developed • A treatment/rehabilitation/recovery plan developed by the treatment team within 30 days of admission that integrates individual strengths & needs, formal and informal supports, measurable goals, and a documented discharge and relapse prevention plan. The treatment plan is reviewed by the treatment team, including the individual served, every 120 days or as clinically indicated • Implementation or development of a crisis relapse prevention plan, addressing mental health and/or substance use disorder needs • Connection to community resources for behavioral health and independent community living needs • Advocacy, problem solving, active intervention for stabilization, prevention of increased impairment, and psychoeducation for illness management • Face-to-face contact a minimum of 1 time per month • All services must be culturally sensitive

Service Name	RECOVERY SUPPORT - MENTAL HEALTH AND/OR SUBSTANCE USE
Length of Services	Length of service is individualized and based on clinical criteria for admission and continuing stay, as well as the client's ability to demonstrate progress on individual treatment/recovery goals. The amount, duration, and frequency of the service will be documented in the treatment plan.
Staffing	• Supervision by a licensed clinician • Recovery Support Worker: High school diploma or equivalent; two years lived experience or two years direct care experience in the human services field; knowledge of community resources, trauma informed care principles, recovery and rehabilitation principles. Peer Support certification preferred.
Staffing Ratio	1 Recovery Support Worker:50 individuals
Hours of Operation	24/7 Access to service during weekend/evening hours, or in time of crisis with the support of a behavioral health professional.
Individual Desired Outcome	• Individual has substantially met the individualized Recovery Support Plan goals and objectives. • Individual demonstrates ability to maintain independent living without ongoing active intervention. • Individual has established formal and informal community supports.

UTILIZATION GUIDELINES
RECOVERY SUPPORT

I. Admission Guidelines

Consumer must meet all of the following admission guidelines to be admitted to this service.

1. Diagnosed with a behavioral health disorder.
2. Demonstrated inability to sustain independent housing and living without professional support.
3. History of multiple treatment episodes and/or recent episode with a history of poor treatment adherence or outcome.
4. Requires assistance in obtaining and coordinating treatment, rehabilitation, and social services.
5. Does not require more intensive intervention.

II. Continued Stay Guidelines

Consumer must meet all of the following continued stay guidelines to continue receiving this service.

1. Continues to meet Admission Guidelines.
2. Demonstrated ability to engage in individualized treatment/recovery/rehabilitation goals and objectives.

SERVICE CATEGORY: REHABILITATION SERVICES

SERVICE DEFINITION

Service Name	SECURE RESIDENTIAL TREATMENT
Funding Source	Behavioral Health
Setting	Facility based with the capacity to be secured
Facility or Professional License	As required by DHHS Division of Public Health
Basic Definition	Secure Residential Treatment provides individualized recovery, psychiatric rehabilitation, and support for individuals with a severe and persistent mental illness and/or co-occurring substance use disorder demonstrating a moderate to high-risk for harm to self/others and in need of a secure, recovery/rehabilitative/therapeutic environment. The safe, structured residential setting offers extensive supports for implementing a personal, effective recovery plan geared toward independent living skills, strengthening functioning, and wellness management.
Service Expectations	• History and Physical within 24 hours of admission by a physician or APRN. A history and physical may be accepted from previous provider if completed within the last three months. An annual physical must be completed. • Mental Health Assessment within 24 hours of admission by a psychiatrist or APRN with a recommendation for this level of care if appropriate and a recommendation for other specialized assessments as needed to aid in the development of the individual treatment/recovery plan. • Nursing assessment completed within 24 hours of admission. • Initial treatment/recovery plan completed within 24 hours of admission with the psychiatrist as the supervisor of clinical treatment and direction. • Multidisciplinary bio-psychosocial assessment completed within 14 days of admission. • An individual recovery/discharge/relapse prevention plan within 30 days of admission, including clear discharge goals, and developed with input from the individual and chosen supports, reviewed weekly by the individual and recovery team. • Integration of substance use disorder and mental health needs and strengths in assessment, treatment/recovery plan, and programming.

Service Name	SECURE RESIDENTIAL TREATMENT
	• Arrange for medical, pharmacology, psychological, dental, vision, dietary, pastoral, emergency medical, laboratory and other diagnostic/treatment or ancillary services as needed. • Face-to-face with a psychiatrist at a minimum of every 30 days or as often as medically necessary. • 42 hours of active treatment available/provided weekly, seven days per week, which includes therapy, psychoeducation, and skill building. • Connection to community-based resources to assist in transition to community living. • Medication management, administration and self-administration, and medication education • Psychiatric and nursing services • Individual, group, family therapy, and substance use disorder treatment as appropriate • Psycho-educational services focus on restoring and supporting functioning. This includes skill building for adult daily living, social/leisure, community living, family education, vocational/educational, financial, and other areas as determined by the needs of the individual. • All services must be culturally sensitive
Length of Services	Length of service is individualized and based on clinical criteria for admission and continuing stay, as well as the individual's ability to make progress on individual treatment/recovery goals. The anticipated duration of the service will be documented in the treatment plan.
Staffing	• Medical Director: Psychiatrist • Program Director: APRN, RN, LMHP, LIMHP, or provisional or licensed clinical psychologist • Direct Care staff shall have demonstrated skills and competencies in treatment with individuals with a behavioral health diagnosis, demonstrated by at least one of the following: two years lived experience; two years' direct care experience in a human service field; two years of training in a human service field; or a bachelor's degree or higher in psychology, sociology, or related human service field, which is preferred. • Therapist: Provisional or licensed Psychologist, LIMHP, APRN, PLMHP, LMHP, LADC • Nursing: 24 hours per day. APRN, RN with psychiatric experience
Staffing Ratio	• 1 direct care staff to 4 individuals during awake hours (day and evening shifts); 1 awake staff to 6 individuals with on-call availability of additional support staff during sleep hours (overnight); access to on-call, licensed mental health professionals 24/7 • Appropriate care staff coverage to provide a variety of recovery/rehabilitative, therapeutic activities, and groups for clients throughout weekdays and weekends. • RN services are provided in a ratio sufficient to meet care needs • Therapist to individual, 1 to 8

Service Name	SECURE RESIDENTIAL TREATMENT
Hours of Operation	24/7
Individual Desired Outcome	• Symptoms are stabilized and the individual no longer meets clinical guidelines for secure residential care • Individual has made substantial progress on the self-developed recovery plan goals and objectives, and developed a crisis relapse/prevention plan • Individual is able to participate in and benefit from ongoing treatment in a less intensive service

UTILIZATION GUIDELINES
SECURE RESIDENTIAL

I. Admission Guidelines

Individual must meet #1 and either #2 and/or #3 of the following admission guidelines to be admitted to this service.

1. Moderate to high risk of relapse or symptoms reoccurrence, as evidenced by the following (must meet ALL criteria):
    a. Active symptomology consistent with DSM diagnoses, and
    b. High need for professional structure, intervention and observation, and
    c. High risk for re-hospitalization without 24-hour supervision, and
    d. Unable to safely reside in less restrictive residential setting and requires 24-hour supervision.
2. Moderate to high risk of danger to self as a product of the principal DSM (recent version) diagnosis, as evidenced by any of the following:
    a. Attempts to harm self, which are life threatening or could cause disabling permanent damages with continued risk without 24-hour behavioral monitoring.
    b. Suicidal ideation
    c. A level of suicidality that cannot be safely managed without 24-hour behavioral monitoring.
    d. At risk for severe self-neglect resulting in harm or injury.
3. Moderate to high risk of danger to others, as a product of the principal DSM (recent version) diagnosis, as evidenced by any of the following:
    a. Life threatening action with continued risk without 24-hour behavioral supervision and intervention.
    b. Harmful ideation

II. Continued Stay Guidelines

Individual must meet all of the following continued stay guidelines to continue receiving this service

1. Valid DSM (current version) diagnosis or co-occurring disorder that results in a pervasive level of impairment
2. The reasonable likelihood of substantial benefit as a result of recovery/rehabilitation therapeutic activities that necessitates the 24-hour secure care setting.
3. Able to participate in recovery/rehabilitation/therapeutic activities.
4. Achieve progress towards recovery goals.

5. Continuation of symptoms or behaviors that required admission, and the judgment that a less intensive level of care and supervision would be insufficient to safely support the individual.

SERVICE CATEGORY: REHABILITATION SERVICES

SERVICE DEFINITION

Service Name	SUPPORTED EMPLOYMENT
Funding Source	Behavioral Health
Setting	Community-based settings such as home, job site, neutral setting away from work place. Minimal services provided in an office-based setting.
Facility or Professional License	As required by DHHS Division of Public Health
Basic Definition	Supported Employment provides recovery and rehabilitation services and supports to individuals engaged in community-based competitive employment-related activities in integrated settings. A Supported Employment team provides assistance with all aspects of employment development as requested and needed by the individual. The intent of the service is to support the individual in the recovery process so employment goals as selected by the individual can be successfully obtained.
Service Expectations	• Initial employment assessment completed within one week of program entry • Individualized Employment Plan developed with individual within two weeks of program entry • Assistance with benefits counseling through Vocational Rehabilitation or other individual qualified to do such work for individuals who are eligible or potentially eligible but not receiving benefits from Supplemental Security Income (SSI) and/or Social Security Disability Insurance (SSDI), such as a certified work incentive coordinator • Individualized and customized job search with individual • Employer contacts based on individual's job preferences and needs and typically provided within one month of program entry • On-site job support and job skill development as needed and requested by individual • Address barriers to employment • Provide diversity in job options based on individual preference including self-employment options • Follow-along supports that are personalized, use natural supports, and are flexible provided to employer and individual • Participation on individual's treatment/rehabilitation/recovery team as needed and requested by individual including crisis relapse prevention planning • Employment Plan reviewed and updated with individual as needed but not less than every six months

Service Name	SUPPORTED EMPLOYMENT
	• Services reflect individual preferences with competitive employment as the goal and are integrated with other services and supports as requested by individual • Frequency of face-to-face contacts based upon need of the individual and the employer • Job Development/Job Match activities • All services must be culturally sensitive
Length of Services	Length of service is individualized and based on criteria for admission and continued treatment as well as individual's ability to make progress on employment goals.
Staffing	• Program Director: Three years of experience in vocationally related service, vocational related degree preferred, or a Program Director of other rehabilitation service. • Supported Employment Specialist: High school with minimum of 2 years of experience in the field and training, preferably by a nationally accredited training program, with evaluation of course competency. Supported Employment Specialists must be capable to perform all phases of vocational services (engagement, assessment, job development, job placement, job coaching, and follow-along supports). • Personal recovery experience preferred for all positions.
Staffing Ratio	One full-time Employment Specialist to 25 individuals.
Hours of Operation	The program is flexible to meet employment needs including day, evening, weekend, and holidays.
Individual Desired Outcome	• Individual has made progress on the self-developed service plan goals and objectives. • Individual is competitively employed and maintaining a job of choice.

UTILIZATION GUIDELINES
SUPPORTED EMPLOYMENT

I. Admission Guidelines

Consumer must meet all of the following admission guidelines to be admitted to this service.

1. DSM diagnosis of a behavioral health disorders i.e. mental illness, alcoholism, drug abuse, or related addictive disorder.
2. Consumer desires to return to work and requires supports to secure and maintain competitive employment.
3. Zero exclusion-This means every consumer who wants employment and meets other admission guidelines is eligible regardless of job readiness or past history.

II. Continued Stay Guidelines

Consumer must meet all of the following continued stay guidelines to continue receiving this service.

1. Consumer continues to meet Admission Guidelines.
2. Consumer is making progress towards vocational goals.

SUBSTANCE USE DISORDER SERVICES

SERVICE CATEGORY: SUBSTANCE USE DISORDER

SERVICE DEFINITION

Service Name	SUBSTANCE USE DISORDER ASSESSMENT
Funding Source	Behavioral Health
Setting	Services are rendered in a professional office, clinic, home or other community setting as appropriate to the provision of psychotherapy or substance use services.
Facility or Professional License	As required by DHHS Division of Public Health
Basic Definition	The adult substance use disorder assessment is an evaluation, through utilization of validated tools, to guide the process of the assessment in determining if a substance use disorder exists and if so, what appropriate level of intervention is recommended. It should be conducted in accordance with the American Society of Addiction Medicine (ASAM) guidelines.
Service Expectations	The Substance Use Disorder Assessment is comprised of three components: Assessment, screening tools and scores; Comprehensive biopsychosocial assessment; and Multidimensional risk profile to determine type and intensity of services. I. **ASSESSMENT AND SCREENING TOOLS AND SCORES** All initial adult substance use disorder assessment reports will include the use and results of at least one nationally accepted screening instrument. One example of an acceptable instrument is the substance misuse Subtle Screening Inventory (SASSI). The Addiction Severity Index (ASI) is required to be used as a face-to-face structured interview guide, to be scored and utilized to provide information for the assessment and the multidimensional risk profile. II. **COMPREHENSIVE BIOPSYCHOSOCIAL ASSESSMENT/SUBSTANCE USE DISORDER EVALUATION:** A comprehensive bio psychosocial assessment will include all of the following: **Demographics** **Presenting Problem/Chief Complaint** 1. Referral Source 2. When the individual was first recommended to obtain an evaluation 3. Synopsis of what led the individual to schedule this evaluation

Service Name	SUBSTANCE USE DISORDER ASSESSMENT
	Medical History **Work/School/Military History** **Alcohol/Drug History & Summary** 1. Frequency and amount 2. Drug and/or alcohol of choice 3. History of substance induced/use/disorder 4. Use patterns 5. Consequences of use (physiological, interpersonal, familial, vocational, etc.) 6. Periods of abstinence/when and why 7. Tolerance level 8. Withdrawal history and potential 9. Influence of living situation on use 10. Other addictive behaviors (e.g., gambling) 11. IV drug use 12. Prior substance use disorder evaluations and findings 13. Prior substance use disorder treatment 14. Client's family chemical use history **Legal History** 1. Criminal history and other information 2. Drug testing results 3. Simple Screening Instrument results 4. Nebraska Standardized Reporting Format for Substance Abusing Offenders **Family / Social/ Peer History** (including trauma history) **Psychiatric/Behavioral Health History** 1. Previous mental health diagnoses 2. Prior mental health treatment **Other Diagnostics/ Screening Tools – Score & Results**

Service Name	SUBSTANCE USE DISORDER ASSESSMENT
	Clinical Impression 1. Summary of evaluation A. Behavior during evaluation B. Stages of Change information C. Level of insight D. Any discrepancies of information provided 2. Diagnostic impression (including justification) to include DSM current edition diagnoses 3. Strengths of individual and family identified 4. Problems identified **Recommendations:** 1. Complete III. Multidimensional Risk Profile 2. Complete the ASAM Clinical Assessment and Placement Summary III. **MULTIDIMENSIONAL RISK PROFILE** Recommendations for individualized treatment, potential services, modalities, resources, and interventions must be based on the ASAM national criteria multidimensional risk profile. The provider is responsible for referring to the ASAM criteria for the full matrix when applying the risk profile for recommendations. For each dimension, report intensity and justification. A comprehensive substance use assessment includes collateral contacts with former and current healthcare providers, family members, friends, court contacts and others to assess medical history, substance usage, and legal history. When dually credentialed clinicians are completing the evaluation, the recommendations must include co-occurring issues. When LADCs are completing the evaluation they must include a screening for possible co-occurrence of mental health problems and include referral for mental health evaluation as appropriate in their recommendations.

Service Name	SUBSTANCE USE DISORDER ASSESSMENT
Length of Services	The substance use disorder assessment is completed prior to initiation of services and at new episodes of care. A substance use addendum may be completed if determined to be medically necessary (see ASA Addendum service definition).
Staffing	LADC, LIMHP, LMHP, PLMHP, Psychologist, Provisional Psychologist, PLADC. An individual currently holding a provisional license, without another valid full professional license, is permitted to conduct the Adult Substance Use Disorder Assessment within their scope of practice and with supervision as required by the DHHS Division of Public Health.
Staffing Ratio	1 to 1 typically
Hours of Operation	Typical office hours with available evening and weekend hours by appointment
Individual Desired Outcome	Upon completion of the substance use disorder assessment, the individual will have been assessed for a substance use disorder diagnosis, an assessment of risk of dangerousness to self and/or others, and recommendation for the appropriate service level with referrals to appropriate service providers.

SERVICE CATEGORY: SUBSTANCE USE DISORDER

SERVICE DEFINITION

Service Name	SUBSTANCE USE DISORDER ASSESSMENT ADDENDUM
Funding Source	Behavioral Health
Setting	Services are rendered in a professional office, clinic, home or other environment appropriate to the provision of psychotherapy or substance use services.
Facility or Professional License	As required by DHHS Division of Public Health
Basic Definition	The purpose of the addendum is to clarify/update the diagnosis, treatment needs and recommendations and/or gather information that covers the time frame when an individual was not receiving treatment. It should be conducted in accordance with the American Society of Addiction Medicine (ASAM) guidelines.
Service Expectations	• If the individual remains involved continuously in treatment for more than one year, an addendum is reimbursable at the annual date of the initial substance misuse assessment. • If the individual leaves treatment prior to a successful discharge and fails to return within six months, the provider will assess the need for an addendum or a new substance misuse assessment. • The need for updated information is to be reflective of the individual's current status, functioning, and treatment goals. • The addendum will reflect information that has not been addressed in the clinical notes and capture information that covers the period of time outside of treatment. • Continued assessment for co-occurring conditions throughout the addendum and a referral made to appropriately licensed clinician for further assessment when necessary.
Length of Services	N/A
Staffing	LADC, LIMHP, LMHP, PLMHP, Psychologist, Provisional Psychologist, PLADC. An individual currently holding a provisional license, without another valid full professional license, is permitted to conduct the Substance Use Disorder Assessment Addendum within their scope of practice and with supervision as required by the DHHS Division of Public Health.
Staffing Ratio	1 to 1 typically

Service Name	SUBSTANCE USE DISORDER ASSESSMENT ADDENDUM
Hours of Operation	Typical office hours with available evening and weekend hours by appointment
Individual Desired Outcome	Upon completion of the substance use disorder assessment addendum, the individual will have been assessed for a substance use disorder diagnosis, an assessment of risk of dangerousness to self and/or others, and recommendation for treatment planning with the appropriate service level and referrals to appropriate service providers.

SERVICE CATEGORY: SUBSTANCE USE DISORDER

SERVICE DEFINITION

Service Name	ASAM LEVEL 1.1 COMMUNITY SUPPORT
Funding Source	Behavioral Health
Setting	Community Based – Most frequently provided in the home
Facility or Professional License	As required by DHHS Division of Public Health
Basic Definition	Community Support - Substance Use Disorder is a rehabilitative and support service for individuals with primary substance use disorders and extensive treatment needs. Community Support Workers provide direct rehabilitation and support services to the individual in the community with the intention of supporting the individual in recovery, stable community living, and preventing exacerbation of illness and admission to higher levels of care.
Service Expectations	• A Substance Use Disorder Assessment completed by a licensed clinician prior to the beginning of treatment, which includes a diagnosis and level of care recommendation for this level of treatment. This may also be from a Substance Use Disorder Assessment Addendum. If a prior SUD assessment is determined to be clinically relevant and includes a current diagnosis, level of care recommendation and a discharge plan, it can serve as the admission assessment. If the prior assessment is not relevant or does not contain the necessary information than an SUD addendum would be necessary • Clinically appropriate programmatic assessments, as determined necessary, which may include skills inventories, interviews and/or use of other tools for the purpose of identifying treatment and rehabilitation goals and plans with the individual, should be completed within 30 days of admission • A treatment/recovery plan developed with the individual, which includes individual strengths and needs, community, family and other supports, measurable goals and specific interventions, and includes a documented discharge and relapse prevention plan. This is completed within 30 days of admission, reviewed, approved and signed by the Clinical Supervisor. • Review and update of the treatment/recovery and discharge plan with the individual and other approved family/supports every 90 days or more often as clinically indicated; approved and signed by the Clinical Supervisor, or other licensed person. • Provision of active rehabilitation and support interventions with focus on activities of daily living, education/employment, budgeting, medication adherence and self-administration (as appropriate and part of

Service Name	ASAM LEVEL 1.1 COMMUNITY SUPPORT
	the overall treatment/recovery plan), relapse prevention, social skills, and other independent living skills that enable the individual to reside in the community • Provide service coordination and case management activities, including coordination or assistance in accessing medical, psychopharmacological, psychological, psychiatric, social, education/employment, transportation, housing, or other appropriate treatment/support services as well as linkage to other community services identified in the treatment/recovery plan • Develop and implement strategies to encourage the individual's engagement in necessary substance use disorder and mental health treatment services as recommended and included in the treatment/recovery plan • Participate with and report to treatment/rehabilitation team on the individual's progress and response to community support intervention in the areas of relapse prevention, substance use disorder, application of education and skills, and the recovery environment (areas identified in the plan) • Provide therapeutic support and intervention to the individual in time of crisis • If hospitalization or residential care is necessary, facilitate, in cooperation with the treatment provider, the individual's transition back into the community upon discharge • Face-to-face contact a minimum of 3 times per month or 3 total hours of contact • If the client has a co-occurring diagnosis (MH/SUD), it is the provider's responsibility to coordinate with other treating professionals • All services must be culturally sensitive
Length of Services	Length of service is individualized and based on clinical criteria for admission and continuing stay. The amount, duration, and frequency of the service will be documented in the treatment plan.
Staffing	• Clinical Supervision (APRN, RN, LMHP, LIMHP, PLMHP, LADC, PLADC, Licensed Psychologist, Provisionally Licensed Psychologist, dual MH/SUD licensed preferred) working with the program and responsible for all clinical decisions (i.e. admissions, assessment, treatment/discharge planning and review) and to provide clinical consultation and support to community support workers and the individuals they serve. The Clinical Supervisor will review client clinical needs with the worker every 30 days. The review should be completed preferably face to face but phone review will be accepted. The Clinical Supervisor may complete the review in a group setting with more than one worker as long as each client on the worker's case load is reviewed. • Direct Care staff shall have demonstrated skills and competencies in treatment with individuals with a behavioral health diagnosis, demonstrated by at least one of the following: two years lived experience; two

Service Name	ASAM LEVEL 1.1 COMMUNITY SUPPORT
	years' direct care experience in a human service field; two years of training in a human service field; or a bachelor's degree or higher in psychology, sociology, or related human service field, which is preferred.
Staffing Ratio	Clinical Supervisor to Community Support Worker ratio as needed to meet all clinical supervision responsibilities outlined above. 1:25 Community Support Worker to individuals served.
Hours of Operation	24/7 Access to service during weekend/evening hours; in times of crisis, access to a mental health professional
Individual Desired Outcome	• The individual has substantially met treatment plan goals and objectives • The precipitating condition and relapse potential is stabilized such that individual's condition can be managed without this level of professional interventions and external supports • Individual has natural support systems secured to help the individual progress in active recovery and stability in the community • The individual has progressed through stages of change and is willing to engage in treatment at a higher level of care if clinically indicated

UTILIZATION GUIDELINES
COMMUNITY SUPPORT – LEVEL 1: SUBSTANCE USE DISORDER

I. Admission Guidelines:

1. The individual is assessed as meeting the diagnostic criteria for a Substance-Related Disorder (including Substance Use Disorder or Substance-Induced Disorder), as defined in the most recent DSM as well as the dimensional criteria for admission.
2. The individual who is identified as in need of Level 1 Dual Diagnosis Enhanced program services is assessed as meeting the diagnostic criteria for a Mental Disorder as well as a Substance Use Disorder, as defined in the most recent DSM as well as the dimensional criteria for admission.
3. The individual has a substance dependence diagnosis with functional impairments in each of the following areas: activities of daily living, employment/educational, and social which are the direct result of the diagnosis
4. The individual is assessed as meeting specifications in ALL of the following six dimensions.
5. There is an expectation that the individual has the capacity to make significant progress toward treatment goals.

The following six dimensions and criteria are abbreviated. **Providers should refer to *ASAM Criteria – 3rd Edition* beginning on page 174 for complete criteria for each dimension.**

Dimension 1: ACUTE INTOXICATION AND/OR WITHDRAWAL POTENTIAL:

- Acute Intoxication &/or Withdrawal Potential: Not experiencing withdrawal/minimal risk of severe withdrawal.

Dimension 2: BIOMEDICAL CONDITIONS AND COMPLICATIONS:

- Biomedical Conditions & Complications: None or very stable or receiving concurrent medical monitoring.

Dimension 3: EMOTIONAL, BEHAVIORAL OR COGNITIVE CONDITIONS AND COMPLICATIONS:

- None or very stable or receiving mental health monitoring.

Dimension 4: READINESS TO CHANGE:

- Ready for recovery but needs motivation and monitoring strategies to strengthen readiness OR High severity in this dimension but not in other dimensions. Needs a Level I motivational enhancement program.

Dimension 5: RELAPSE, CONTINUED USE OR CONTINUED PROBLEM POTENTIAL:

- Able to maintain abstinence or control use and pursue recovery or motivational goals with minimal support.

Dimension 6: RECOVERY ENVIRONMENT:

- Recovery environment is not supportive but, with structure and support, the client can cope.

Continued Stay Guidelines:

It is appropriate to retain the individual at the present level of care if:

1. The individual is making progress but has not yet achieved the goals articulated in the individualized treatment plan. Continued treatment at this level of care is assessed as necessary to permit the individual to continue to work toward his or her treatment goals.

   OR

2. The individual is not yet making progress, but has the capacity to resolve his or her problems. The individual is actively working toward the goals in the individualized treatment plan. Continued treatment at this level of care is assessed as necessary to permit the individual to continue to work toward his or her treatment goals.

   AND/OR

3. New problems have been identified that are appropriately treated at this level of care. This level of care is the least intensive level of care at which the individual's new problems can be addressed effectively.

To document and communicate the individual's readiness for discharge or need for transfer to another level of care, each of the six dimensions of the ASAM criteria should be reviewed. If the criteria apply to the individual's existing or new problem (s), he or she should continue in treatment at the present level of care. If not, refer to the Discharge/Transfer Criteria.

SERVICE CATEGORY: SUBSTANCE USE DISORDER

SERVICE DEFINITION

Service Name	ASAM LEVEL 1 OUTPATIENT FAMILY THERAPY
Funding Source	Behavioral Health
Setting	Outpatient Services are rendered in a professional office/clinic, or other environment appropriate to the provision of psychotherapy service.
Facility or Professional License	As required by DHHS Division of Public Health
Basic Definition	Outpatient family substance use disorder therapy describes the professionally directed evaluation, treatment and recovery services for individuals and their families who are experiencing a substance related disorder that causes moderate and/or acute disruptions in the individual's life. Outpatient family substance use disorder therapy is a therapeutic encounter between the licensed professional, the individual, and the nuclear and/or the extended family as defined by the individual. The goal is to use the family's strengths and resources to help find or develop ways to live without maladaptive use of substances.
Service Expectations	• A substance use assessment conducted by a licensed, qualified clinician or completed within 12 months prior to the date of admission that includes a current diagnosis, level of care recommendation and a discharge plan. If the prior assessment is not relevant or does not contain the necessary information, then a substance use assessment addendum would be necessary. The assessment will serve as the treatment plan until the treatment plan can be developed. • Assessment of progress towards goals should be ongoing and reviewed as part of treatment • This therapy is to be provided with the appropriate family members and the individual. While the services follow clinical protocols and best practices, they will be tailored to each individual's level of clinical severity and be designed to help the individual achieve changes in his or her alcohol or other drug using behaviors. • Interventions target major lifestyle, attitude and behavior issues that may undermine treatment goals or impair the individual's ability to function in at least one life area. • Treatment Planning: A goal-oriented treatment plan with measurable outcomes, and a specific, realistic discharge plan must be developed with the individual and the appropriate family members as part of the initial assessment and outpatient family therapy treatment planning process; the treatment and discharge plan must

Service Name	ASAM LEVEL 1 OUTPATIENT FAMILY THERAPY
	be evaluated and revised as clinically indicated during the course of treatment. The treatment plan must be signed by the treatment provider and the individual(s) served. • Consultation and/or referral for medical, psychiatric, and psychopharmacology needs • All individuals will be screened for co-occurring conditions throughout the assessment. If the clinician is a LADC or a PLADC, and suspects a possible mental health condition, a referral is to be made to a clinician capable of diagnosing/treating co-occurring mental health and substance use disorders. • Focus on the level of family functioning and health as a whole. Family therapy will address issues related to the entire family system. • All services must be culturally sensitive
Length of Services	Length of service is individualized and based on clinical criteria for admission and continuing stay. The amount, duration, and frequency of the service should be documented in the treatment plan.
Staffing	Appropriately licensed and credentialed professionals (Psychiatrist, APRN, Psychologist, Provisionally Licensed Psychologist, LIMHP, LMHP, PLMHP, LADC, PLADC) working within their scope of practice to provide substance use disorder and/or co-occurring (MH/SUD) outpatient treatment. A dually licensed clinician is preferred for any client with a co-occurring diagnosis.
Staffing Ratio	1 Therapist to 1 Family
Hours of Operation	Typical business hours with weekend and evening hours available by appointment to provide this service
Individual Desired Outcome	• The family has substantially met the treatment plan goals and objectives • Family has support systems secured to help maintain stability in the community • The specific issue that initially brought the family into therapy has improved and/or resolved and family therapy is no longer necessary for the wellbeing of the individual

UTILIZATION GUIDELINES
OUTPATIENT FAMILY PSYCHOTHERAPY: Level 1

I. Admission Guidelines:

1. The individual/family is assessed as meeting the diagnostic criteria for a Substance-Related Disorder (including Substance Use Disorder or Substance-Induced Disorder), as defined in the most recent DSM as well as the dimensional criteria for admission.
2. The individual/family who is identified as in need of Level 1 Dual Diagnosis Enhanced program services is assessed as meeting the diagnostic criteria for a Mental Disorder as well as a Substance Use Disorder, as defined in the most recent DSM as well as the dimensional criteria for admission.
3. The individual/family is assessed as meeting specifications in ALL of the following six dimensions.
4. There are significant symptoms as a result of the diagnosis that interfere with the individual's/families ability to function in at least one life area.
5. There is an expectation that the individual/family has the capacity to make significant progress toward treatment goals.

The following six dimensions and criteria are abbreviated. **Providers should refer to *ASAM Criteria – 3rd Edition* beginning on page 174 for complete criteria for each dimension.**

Dimension 1: ACUTE INTOXICATION AND/OR WITHDRAWAL POTENTIAL:

- Acute Intoxication &/or Withdrawal Potential: Not experiencing withdrawal/minimal risk of severe withdrawal.

Dimension 2: BIOMEDICAL CONDITIONS AND COMPLICATIONS:

- Biomedical Conditions & Complications: None or very stable or receiving concurrent medical monitoring.

Dimension 3: EMOTIONAL, BEHAVIORAL OR COGNITIVE CONDITIONS AND COMPLICATIONS:

- None or very stable or receiving mental health monitoring.

Dimension 4: READINESS TO CHANGE:

- Ready for recovery but needs motivation and monitoring strategies to strengthen readiness OR High severity in this dimension but not in other dimensions. Needs a Level I motivational enhancement program.

Dimension 5: RELAPSE, CONTINUED USE OR CONTINUED PROBLEM POTENTIAL:

- Able to maintain abstinence or control use and pursue recovery or motivational goals with minimal support..

Dimension 6: RECOVERY ENVIRONMENT:

- Recovery environment is not supportive but, with structure and support, the client can cope.

II. Continued Stay Guidelines:

It is appropriate to retain the individual at the present level of care if:

1. The individual/family is making progress but has not yet achieved the goals articulated in the individualized treatment plan. Continued treatment at this level of care is assessed as necessary to permit the individual to continue to work toward his or her treatment goals.

OR

2. The individual/family is not yet making progress, but has the capacity to resolve his or her problems. The individual is actively working toward the goals in the individualized treatment plan. Continued treatment at this level of care is assessed as necessary to permit the individual to continue to work toward his or her treatment goals.

AND/OR

3. New problems have been identified that are appropriately treated at this level of care. This level of care is the least intensive level of care at which the individual's/family's new problems can be addressed effectively.

To document and communicate the individual's/family's readiness for discharge or need for transfer to another level of care, each of the six dimensions of the ASAM criteria should be reviewed. If the criteria apply to the individual's existing or new problem (s), the family should continue in treatment at the present level of care. If not, refer to the Discharge/Transfer Criteria.

SERVICE CATEGORY: SUBSTANCE USE DISORDER

SERVICE DEFINITION

Service Name	ASAM LEVEL 1 OUTPATIENT GROUP THERAPY
Funding Source	Behavioral Health
Setting	Outpatient Services are rendered in a professional office/clinic, or other environment appropriate to the provision of psychotherapy service.
Facility or Professional License	As required by DHHS Division of Public Health
Basic Definition	Outpatient substance use disorder group therapy is the treatment of substance related disorders through scheduled therapeutic visits between the therapist and the individual in the context of a group setting. The focus of outpatient group treatment is substance related disorders which are causing moderate and/or acute disruptions in the individual's life.
Service Expectations	• A substance use assessment conducted by a licensed, qualified clinician or completed within 12 months prior to the date of admission that includes a current diagnosis, level of care recommendation and a discharge plan. If the prior assessment is not relevant or does not contain the necessary information, then a substance use assessment addendum would be necessary. The assessment will serve as the treatment plan until the treatment plan can be developed. • An Individualized treatment/recovery plan, including discharge and relapse prevention, which is developed with the individual at the beginning of treatment. It will consider community, family and other supports, be reviewed on an ongoing basis, adjusted as clinically necessary, and signed by the team including the individual served. • Assessment of progress towards goals should be ongoing and reviewed as part of treatment • The goals, frequency, and duration of outpatient group treatment will vary according to individual needs and response to treatment. • Assessments, treatment, and referral should address co-occurring needs • Monitoring stabilized co-occurring mental health conditions • Consultation and/or referral for medical, psychiatric, and psychopharmacology needs • Psychoeducation on elements such as biological effects of addiction, drug chemistry, relapse prevention, stages of change

Service Name	ASAM LEVEL 1 OUTPATIENT GROUP THERAPY
	• It is the provider's responsibility to coordinate with other treating professionals • All services must be culturally sensitive
Length of Services	Length of service is individualized and based on clinical criteria for admission and continuing stay. The amount, duration, and frequency of the service should be documented in the treatment plan.
Staffing	Appropriately licensed and credentialed professionals (Psychiatrist, APRN, Psychologist, Provisionally Licensed Psychologist, LIMHP, LMHP, PLMHP, LADC, PLADC) working within their scope of practice to provide substance use disorder and/or co-occurring (MH/SUD) outpatient treatment A dually licensed clinician is preferred for any client with a co-occurring diagnosis.
Staffing Ratio	One therapist to a group of at least three and no more than twelve individual participants
Hours of Operation	Typical business hours with weekend and evening hours available by appointment to provide this service
Individual Desired Outcome	• The individual has substantially met the treatment plan goals and objectives • Individual is able to remain stable and in active recovery in the community without this level of intervention. • Individual has support systems secured to help maintain stability in the community

UTILIZATION GUIDELINES
OUTPATIENT GROUP PSYCHOTHERAPY: Level 1

I. Admission Guidelines:

1. The individual is assessed as meeting the diagnostic criteria for a Substance-Related Disorder (including Substance Use Disorder or Substance-Induced Disorder), as defined in the most recent DSM as well as the dimensional criteria for admission.
2. The individual who is identified as in need of Level 1 Dual Diagnosis Enhanced program services is assessed as meeting the diagnostic criteria for a Mental Disorder as well as a Substance Use Disorder, as defined in the most recent DSM as well as the dimensional criteria for admission.
3. There are significant symptoms as a result of the diagnosis that interfere with the individual's ability to function in at least one life area.
4. The individual is assessed as meeting specifications in ALL of the following six dimensions.
5. There is an expectation that the individual has the capacity to make significant progress toward treatment goals or treatment.

The following six dimensions and criteria are abbreviated. **Providers should refer to *ASAM Criteria – 3rd Edition* beginning on page 174 for complete criteria for each dimension.**

Dimension 1: ACUTE INTOXICATION AND/OR WITHDRAWAL POTENTIAL:

- Acute Intoxication &/or Withdrawal Potential: Not experiencing withdrawal/minimal risk of severe withdrawal.

Dimension 2: BIOMEDICAL CONDITIONS AND COMPLICATIONS:

- Biomedical Conditions & Complications: None or very stable or receiving concurrent medical monitoring.

Dimension 3: EMOTIONAL, BEHAVIORAL OR COGNITIVE CONDITIONS AND COMPLICATIONS:

- None or very stable or receiving mental health monitoring.

Dimension 4: READINESS TO CHANGE:

- Ready for recovery but needs motivation and monitoring strategies to strengthen readiness OR High severity in this dimension but not in other dimensions. Needs a Level I motivational enhancement program.

Dimension 5: RELAPSE, CONTINUED USE OR CONTINUED PROBLEM POTENTIAL:

- Able to maintain abstinence or control use and pursue recovery or motivational goals with minimal support.

Dimension 6: RECOVERY ENVIRONMENT:

- Recovery environment is not supportive but, with structure and support, the client can cope.

II. Continued Stay Guidelines:

It is appropriate to retain the individual at the present level of care if:

1. The individual is making progress but has not yet achieved the goals articulated in the individualized treatment plan. Continued treatment at this level of care is assessed as necessary to permit the individual to continue to work toward his or her treatment goals.

   OR

2. The individual is not yet making progress, but has the capacity to resolve his or her problems. The individual is actively working toward the goals in the individualized treatment plan. Continued treatment at this level of care is assessed as necessary to permit the individual to continue to work toward his or her treatment goals.

   AND/OR

3. New problems have been identified that are appropriately treated at this level of care. This level of care is the least intensive level of care at which the individual's new problems can be addressed effectively.

To document and communicate the individual's readiness for discharge or need for transfer to another level of care, each of the six dimensions of the ASAM criteria should be reviewed. If the criteria apply to the individual's existing or new problem(s), he or she should continue in treatment at the present level of care. If not, refer to the Discharge/Transfer Criteria.

SERVICE CATEGORY: SUBSTANCE USE DISORDER

SERVICE DEFINITION

Service Name	ASAM LEVEL 1 OUTPATIENT INDIVIDUAL THERAPY
Funding Source	Behavioral Health
Setting	Outpatient Services are rendered in a professional office/clinic, home, or other environment appropriate to the provision of psychotherapy service.
Facility or Professional License	As required by DHHS Division of Public Health
Basic Definition	Outpatient individual substance use disorder therapy describes the professionally directed evaluation, treatment and recovery services for individuals experiencing a substance related disorder that causes moderate and/or acute disruptions in the individual's life. Individual therapy consists of interactions geared towards enabling the individual to gain insight, reduce maladaptive behaviors related to the disorder, and restore normalized functioning and appropriate interpersonal and social relationships.
Service Expectations	• A substance use assessment conducted by a licensed, qualified clinician or completed within 12 months prior to the date of admission that includes a current diagnosis, level of care recommendation and a discharge plan. If the prior assessment is not relevant or does not contain the necessary information, then a substance use assessment addendum would be necessary. The assessment will serve as the treatment plan until the treatment plan can be developed. • An Individualized treatment/recovery plan, including discharge plan and relapse prevention, which is developed with the individual at the beginning of treatment. It will consider community, family and other supports, be reviewed on an ongoing basis, adjusted as medically necessary, and signed by the clinician and the individual served. • Individuals will be screened for co-occurring conditions throughout the assessment. If the clinician is a LADC or a PLADC and suspects a possible mental health condition, a referral is to be made to a clinician capable of diagnosing/treating co-occurring mental health and substance use disorders. • Assessment of progress towards goals should be ongoing and reviewed as part of treatment • Assessments, treatment, and referral should address co-occurring needs • Monitoring stabilized co-occurring mental health conditions

Service Name	ASAM LEVEL 1 OUTPATIENT INDIVIDUAL THERAPY
	• Consultation and/or referral for general medical, psychiatric, and psychopharmacology needs • It is the provider's responsibility to coordinate with other treating professionals • All services must be culturally sensitive
Length of Services	Length of service is individualized and based on clinical criteria for admission and continuing stay. The amount, duration, and frequency of the service will be documented in the treatment plan.
Staffing	• Appropriately licensed and credentialed professionals (Psychiatrist, APRN, Psychologist, Provisionally Licensed Psychologist, LIMHP, LMHP, PLMHP, LADC, PLADC) working within their scope of practice to provide substance use disorder and/or co-occurring (MH/SUD) outpatient treatment • A dually licensed clinician is preferred for any client with a co-occurring diagnosis.
Staffing Ratio	1:1 Individual
Hours of Operation	Typical business hours with weekend and evening hours available by appointment to provide this service
Individual Desired Outcome	• The individual has substantially met the treatment plan goals and objectives • Individual is able to remain stable and in active recovery in the community without this level of intervention. • Individual has support systems secured to help maintain stability in the community

UTILIZATION GUIDELINES
OUTPATIENT INDIVIDUAL PSYCHOTHERAPY: ASAM Level 1

I. Admission Guidelines:

1. The individual is assessed as meeting the diagnostic criteria for a Substance-Related Disorder (including Substance Use Disorder or Substance-Induced Disorder), as defined in the most recent DSM as well as the dimensional criteria for admission.
2. The individual who is identified as in need of Level 1 Dual Diagnosis Enhanced program services is assessed as meeting the diagnostic criteria for a Mental Disorder as well as a Substance Use Disorder, as defined in the most recent DSM as well as the dimensional criteria for admission.
3. There are significant symptoms as a result of the diagnosis that interfere with the individual's ability to function in at least one life area.
4. The individual is assessed as meeting specifications in ALL of the following six dimensions.
5. There is an expectation that the individual has the capacity to make significant progress toward treatment goals or treatment.

The following six dimensions and criteria are abbreviated. **Providers should refer to *ASAM Criteria – 3rd Edition* beginning on page 174 for complete criteria for each dimension.**

Dimension 1: ACUTE INTOXICATION AND/OR WITHDRAWAL POTENTIAL:

- Acute Intoxication &/or Withdrawal Potential: Not experiencing withdrawal/minimal risk of severe withdrawal.

Dimension 2: BIOMEDICAL CONDITIONS AND COMPLICATIONS:

- Biomedical Conditions & Complications: None or very stable or receiving concurrent medical monitoring.

Dimension 3: EMOTIONAL, BEHAVIORAL OR COGNITIVE CONDITIONS AND COMPLICATIONS:

- None or very stable or receiving mental health monitoring.

Dimension 4: READINESS TO CHANGE:

- Ready for recovery but needs motivation and monitoring strategies to strengthen readiness OR High severity in this dimension but not in other dimensions. Needs a Level I motivational enhancement program.

Dimension 5: RELAPSE, CONTINUED USE OR CONTINUE PROBLEM POTENTIAL:

- Able to maintain abstinence or control use and pursue recovery or motivational goals with minimal support..

Dimension 6: RECOVERY ENVIRONMENT:

- Recovery environment is not supportive but, with structure and support, the client can cope.

II. Continued Stay Guidelines:

It is appropriate to retain the individual at the present level of care if:

1. The individual is making progress but has not yet achieved the goals articulated in the individualized treatment plan. Continued treatment at this level of care is assessed as necessary to permit the individual to continue to work toward his or her treatment goals.

OR

2. The individual is not yet making progress, but has the capacity to resolve his or her problems. The individual is actively working toward the goals in the individualized treatment plan. Continued treatment at this level of care is assessed as necessary to permit the individual to continue to work toward his or her treatment goals.

AND/OR

3. New problems have been identified that are appropriately treated at this level of care. This level of care is the least intensive level of care at which the individual's new problems can be addressed effectively.

4. To document and communicate the individual's readiness for discharge or need for transfer to another level of care, each of the six dimensions of the ASAM criteria should be reviewed. If the criteria apply to the individual's existing or new problem (s), he or she should continue in treatment at the present level of care. If not, refer to the Discharge/Transfer Criteria.

SERVICE CATEGORY: SUBSTANCE USE DISORDER

SERVICE DEFINITION

Service Name	ASAM LEVEL 2.1 INTENSIVE OUTPATIENT
Funding Source	Behavioral Health
Setting	Intensive Outpatient Services are provided in an office/clinic environment or other location appropriate to the provision of substance use psychotherapy services.
Facility or Professional License	As required by DHHS Division of Public Health
Basic Definition	Intensive Outpatient Services provide group based, non-residential, intensive, structured interventions consisting primarily of counseling and psychoeducation about substance related and co-occurring mental health problems. Services are goal oriented interactions with the individual or in group/family settings. This community based service allows the individual to apply skills in natural environments and promotes a rapid and stable integration into the community. IOP provides time-limited, comprehensive, and coordinated multidisciplinary treatment. Services align with ASAM 2.1 guidance.
Service Expectations	• A substance use assessment conducted by a licensed, qualified clinician or completed within 12 months prior to the date of admission that includes a current diagnosis, level of care recommendation and a discharge plan. If the prior SUD assessment is determined to be clinically relevant and includes a current diagnosis, level of care recommendation and a discharge plan, it can serve as the admission assessment. If the prior assessment is not relevant or does not contain the necessary information, then an SUD Addendum would be necessary. • A treatment/recovery plan developed with the individual, which includes individual strengths & needs, community, family and other supports, measurable goals and specific interventions, and includes a documented discharge and relapse prevention plan. This is completed within the first two contacts. • For adolescents, assessment and treatment planning input may be obtained from a parent, guardian, or other important resource such as a teacher or probation officer. • Review and update of the treatment/recovery plan under clinical guidance with the individual and other approved family/supports every two weeks or more often as clinically indicated, and obtain signatures of the individual and the treatment team

Service Name	ASAM LEVEL 2.1 INTENSIVE OUTPATIENT
	• Therapies/interventions include individual, family, and group psychotherapy, psychoeducational groups, motivational enhancement and engagement strategies • Availability of 24 hours a day emergency services • Other services could include family education, self-help group and support group orientation • Monitoring stabilized co-occurring mental health problems • Consultation and/or referral for medical, psychiatric, and psychopharmacology needs • Provides 9 or more hours per week of skilled treatment total over 3 – 5 times per week • Access to a licensed mental health/addiction professional on a 24/7 basis • It is the provider's responsibility to coordinate with other treating professionals. • All services must be culturally sensitive
Length of Services	Length of service is individualized and based on clinical criteria for admission and continuing stay. The amount, duration, and frequency of the service should be documented in the treatment plan.
Staffing	Appropriately licensed and credentialed professionals (Psychiatrist, APRN, Psychologist, Provisionally Licensed Psychologist, LIMHP, LMHP, PLMHP, LADC, PLADC) working within their scope of practice to provide substance use disorder and/or co-occurring (MH/SUD) outpatient treatment.
Staffing Ratio	1:1 Individual; 1:1 Family; 1:3 minimum and no more than 1:12 maximum for group treatment
Hours of Operation	Typical business hours with weekend and evening hours available to provide this service, including after school hours for adolescents
Individual Desired Outcome	• The individual has substantially met the treatment plan goals and objectives • The precipitating condition and relapse potential is stabilized such that there is sustained improvement in health and psychosocial functioning • Individual is able to remain stable and in active recovery in the community without this level of intervention.

UTILIZATION GUIDELINES
INTENSIVE OUTPATIENT: Level 2.1

I. Admission Guidelines:

1. The individual is assessed as meeting the diagnostic criteria for a Substance-Related Disorder (including Substance Use Disorder or Substance-Induced Disorder), as defined in the most recent DSM.
2. The individual in need of Level 2.1 Dual Diagnosis Enhanced program services is assessed as meeting the diagnostic criteria for a Mental Disorder as well as a substance-Related disorder, as defined in the most recent DSM.
3. Direct admission to a Level 2.1 program is advisable for the individual who meets specifications in Dimension 2 (if any biomedical conditions or problems exist) and in Dimension 3 (if any emotional, behavioral or cognitive conditions or problems exist), as well as in ***one*** of Dimensions 4, 5, or 6.
4. Transfer to a Level 2.1 program is advisable for an individual who (a) has met the essential treatment objectives at a more intensive level of care and (b) requires the intensity of services provided at Level 2.1 in at least one dimension.
5. An individual also may be transferred to Level 2.1 from a Level I program when the services provided at Level I have proved insufficient to address the individual's needs or when Level I services have consisted of motivational interventions to prepare the patient for participation in a more intensive level of service, for which he or she now meets the admission criteria.
6. There is an expectation that the individual has the capacity to make significant progress toward treatment goals or treatment.

The following six dimensions and criteria are abbreviated. **Providers should refer to *ASAM Criteria – 3rd Edition* beginning on page 174 for complete criteria for each dimension. Criteria varies for adults and adolescents, please see ASAM Criteria for correct guidelines.**

Dimension 1: ACUTE INTOXICATION &/OR WITHDRAWAL POTENTIAL:

- Minimal risk of severe withdrawal.

Dimension 2: BIOMEDICAL CONDITIONS & COMPLICATIONS:

- None or not a distraction from treatment. Such problems are manageable at Level 2.1.

Dimension 3: EMOTIONAL, BEHAVIORAL OR COGNITIVE CONDITIONS & COMPLICATIONS:

- Mild severity, w/potential to distract from recovery; needs monitoring.

Dimension 4: READINESS TO CHANGE:

- Has variable engagement in treatment, ambivalence, or lack of awareness of the substance use or mental health problem, and requires a structured program several times a week to promote progress through the stages of change.

Dimension 5: RELAPSE, CONT. USE OR CONT. PROBLEM POTENTIAL:

- Intensification of addiction or mental health symptoms indicate a high likelihood of relapse or continued use or continued problems without close monitoring and support several times a week.

Dimension 6: RECOVERY ENVIRONMENT:

- Recovery environment is not supportive but, with structure and support, the client can cope.

II. Continued Stay Guidelines:

It is appropriate to retain the individual at the present level of care if:

1. The individual is making progress but has not yet achieved the goals articulated in the individualized treatment plan. Continued treatment at this level of care is assessed as necessary to permit the individual to continue to work toward his or her treatment goals.

   OR

2. The individual is not yet making progress, but has the capacity to resolve his or her problems. The individual is actively working toward the goals in the individualized treatment plan. Continued treatment at this level of care is assessed as necessary to permit the individual to continue to work toward his or her treatment goals.

   AND/OR

3. New problems have been identified that are appropriately treated at this level of care. This level of care is the least intensive level of care at which the individual's new problems can be addressed effectively.

To document and communicate the individual's readiness for discharge or need for transfer to another level of care, each of the six dimensions of the ASAM criteria should be reviewed. If the criteria apply to the individual's existing or new problem (s), he or she should continue in treatment at the present level of care. If not, refer to the Discharge/Transfer Criteria.

SERVICE CATEGORY: SUBSTANCE USE DISORDER

SERVICE DEFINITION

Service Name	ASAM LEVEL 3.1 CLINICALLY MANAGED LOW INTENSITY RESIDENTIAL (HALFWAY HOUSE)
Funding Source	Behavioral Health
Setting	Facility based
Facility or Professional License	As required by DHHS Division of Public Health
Basic Definition	Halfway House is a transitional, 24-hour structured supportive living/treatment/recovery facility located in the community for individuals seeking reintegration into the community often after primary treatment at a more intense level. This service provides safe housing, structure and support, affording individuals an opportunity to develop and practice their interpersonal and group living skills, strengthen recovery skills and reintegrate into their community, find/return to employment or enroll in school. Services align with ASAM 3.1 guidance.
Service Expectation	• A strengths based substance use disorder assessment and mental health screening conducted by licensed clinician at admission, including relevant diagnosis and recommendation for level of care, with ongoing assessment as needed. If a prior SUD Assessment is determined to be clinically relevant and includes a current diagnosis, level of care recommendation and a discharge plan, it can serve as the admission assessment. If the prior assessment is not relevant or does not contain the necessary information, then an SUD Addendum would be necessary. • Individualized treatment/recovery plan, including discharge and relapse prevention, developed under clinical supervision with the individual (consider community, family and other supports) within 14 days of admission • Review and update of the treatment/recovery plan with the individual and other approved family/supports every 30 days or more often as medically indicated • Monitoring to promote successful reintegration into regular, productive daily activity such as work, school or family living • Other services could include family education, self-help group and support group orientation • Monitoring stabilized co-occurring mental health conditions • Consultation and/or referral for medical, psychiatric, psychological, and psychopharmacology needs

Service Name	ASAM LEVEL 3.1 CLINICALLY MANAGED LOW INTENSITY RESIDENTIAL (HALFWAY HOUSE)
	• Provides a minimum of 8 hours of skilled treatment and recovery focused services per week to include individual, family, and group psychotherapy and may include psychoeducational groups, motivational enhancement and engagement strategies. • Availability of 24 hours a day emergency services • All services must be culturally sensitive
Length of Services	Length of service is individualized and based on clinical criteria for admission and continuing stay. The anticipated duration of the service will be documented in the treatment plan.
Staffing	• Clinical Director (APRN, RN, LMHP, LIMHP, LADC, or licensed psychologist) working with the program and responsible for all clinical decisions (i.e. admissions, assessment, treatment/discharge planning and review) and to provide consultation and support to care staff and the individuals they serve. • Appropriately licensed and credentialed professionals working within their scope of practice to provide substance use disorder treatment. • Direct Care staff shall have demonstrated skills and competencies in treatment with individuals with a behavioral health diagnosis, demonstrated by at least one of the following: two years lived experience; two years' direct care experience in a human service field; two years of training in a human service field; or a bachelor's degree or higher in psychology, sociology, or related human service field, which is preferred. • All staff should be educated/trained in rehabilitation, recovery principles and trauma informed care.
Staffing Ratio	• Clinical Director to direct care staff ratio as needed to meet all responsibilities • 1:10 Direct Care Staff to Individual (day and evening hours), 1:12 Therapist to Individual • 1 staff awake overnight with on-call availability • On-call availability of direct care staff and licensed clinicians 24/7
Hours of Operation	24/7
Individual Desired Outcome	• The individual has substantially met the treatment plan goals and objectives • The precipitating condition and relapse potential is stabilized such that individual's condition can be managed without professional external supports and intervention at this level of care; or • The individual has progressed through stages of change and is willing to engage in treatment at a higher level of care if clinically indicated

Service Name	ASAM LEVEL 3.1 CLINICALLY MANAGED LOW INTENSITY RESIDENTIAL (HALFWAY HOUSE)
	• Individual has alternative support systems secured to help the individual maintain stability and recovery in the community

UTILIZATION GUIDELINES
HALFWAY HOUSE: Level 3.1

I. Admission Guidelines:

1. The individual meets the diagnostic criteria for a Substance Dependence Disorder, as defined in the most recent DSM, as well as the dimensional criteria for admission.
2. The individual meets specifications in each of the six dimensions for this level of care.
3. The individual is expected to benefit from this treatment.

The following six dimensions and criteria are abbreviated. **Providers should refer to *ASAM Criteria – 3rd Edition* beginning on page 174 for complete criteria for each dimension.**

Dimension 1: ACUTE INTOXICATION &/OR WITHDRAWAL POTENTIAL:

- No withdrawal risk, or minimal or stable withdrawal. Concurrently receiving Level 1-D (minimal) or Level 2-D (moderate) services.

Dimension 2: BIOMEDICAL CONDITIONS & COMPLICATIONS:

- None or stable, or receiving concurrent medical monitoring.

Dimension 3: EMOTIONAL, BEHAVIORAL OR COGNITIVE CONDITIONS & COMPLICATIONS:

- None or minimal; not distracting to recovery.

Dimension 4: READINESS TO CHANGE:

- Open to recovery, but needs a structured environment to maintain therapeutic gains.

Dimension 5: RELAPSE, CONT. USE OR CONT. PROBLEM POTENTIAL:

- Understands relapse but needs structure to maintain therapeutic gains.

Dimension 6: RECOVERY ENVIRONMENT:

- Environment is dangerous but recovery is achievable if Level 3.1 24-hour structure is available.

II. Continued Stay Guidelines:

It is appropriate to retain the individual at the present level of care if:

1. The individual is making progress but has not yet achieved the goals articulated in the individualized treatment plan. Continued treatment at this level of care is assessed as necessary to permit the individual to continue to work toward his or her treatment goals.

OR

2. The individual is not yet making progress, but has the capacity to resolve his or her problems. The individual is actively working toward the goals in the individualized treatment plan. Continued treatment at this level of care is assessed as necessary to permit the individual to continue to work toward his or her treatment goals.

AND/OR

3. New problems have been identified that are appropriately treated at this level of care. This level of care is the least intensive level of care at which the individual's new problems can be addressed effectively.

To document and communicate the individual's readiness for discharge or need for transfer to another level of care, each of the six dimensions of the ASAM criteria should be reviewed. If the criteria apply to the individual's existing or new problem (s), he or she should continue in treatment at the present level of care. If not, refer to the Discharge/Transfer Criteria.

SERVICE CATEGORY: SUBSTANCE USE DISORDER

SERVICE DEFINITION

Service Name	ASAM LEVEL 3.2WM CLINICALLY MANAGED RESIDENTIAL WITHDRAWAL MANAGEMENT (SOCIAL DETOX)
Funding Source	Behavioral Health
Setting	Facility Based
Facility or Professional License	As required by DHHS Division of Public Health
Basic Definition	Social Detoxification provides voluntary and involuntary intervention in substance use disorder emergencies on a 24 hour per day basis to individuals experiencing acute intoxication and/or withdrawal. This service has the capacity to provide a safe residential setting with staff present for observation and implementation of physician approved protocols designed to physiologically restore the individual from an acute state of intoxication when medical treatment for detoxification is not necessary. Services align with ASAM level 3.2WM guidance.
Service Expectations	• A biophysical screening (includes at a minimum, vital signs, detoxification rating scale, and other fluid intake) conducted by appropriately trained staff at admission with ongoing monitoring as needed, with licensed medical consultation available • Implementation of physician approved protocols, including withdrawal management and seizure risk protocols • An addiction focused history is obtained and reviewed with the physician if protocols indicate concern. • Physical exam to be completed prior to or at admission if the client will be self-administering detoxification medication. This is not necessary if the program has 24-hour nursing and nursing administers client medications according to the program's physician protocols • Monitor self-administered medications • Sufficient biopsychosocial screening to determine the level of care in which the patient should be placed and for the individualized care plan to address treatment priorities identified in Dimensions 2 through 6.

Service Name	ASAM LEVEL 3.2WM CLINICALLY MANAGED RESIDENTIAL WITHDRAWAL MANAGEMENT (SOCIAL DETOX)
	For individuals who are brought into care involuntarily, interventions may be restricted to meet the individual's acute intoxication and withdrawal management needs as appropriate to meet the needs of the individual • Detoxification staff will initiate a plan of care for the individual at the time of intake. Prior to discharge, the staff will develop a discharge plan which will include specific referral and relapse strategies . All efforts to engage the client in development of the client's plan of care and discharge plan will be made. • Daily assessment of individual progress through detoxification and any treatment changes at minimum. Individuals brought into care experiencing active withdrawal or acute intoxication will receive ongoing monitoring and re-assessment as indicated by their presenting condition • Medical evaluation and consultation is available 24 hours per day • Consultation and/or referral for general medical, psychiatric, psychological, psychopharmacology, and other needs • Interventions will include a variety of educational sessions for individuals and their families, and motivational and enhancement strategies and/or stabilization for individuals experiencing withdrawal or acute intoxication. Individual participation is based on the biophysical condition and ability of the individual • Assist individual to establish social supports to enhance recovery • All services must be culturally sensitive
Length of Services	Generally 2 to 5 days for individuals who are participating voluntarily. Individuals who are brought into care involuntarily will be released within 24 hours of admission unless they agree to continue services on a voluntary basis.
Staffing	• Clinical Director (APRN, RN, LMHP, LIMHP, Licensed Psychologist or LADC) providing consultation and support to care staff and the individuals they work with. This individual will also continually incorporate new clinical information and best practices into the program to assure program effectiveness and viability, and assure quality organization and management of clinical records, and other program documentation. • Appropriately licensed and credentialed professionals working within their scope of practice to provide substance use disorder and/or co-occurring (MH/SUD) treatment and are knowledgeable about the biological and psychosocial dimensions of substance use disorder.

Service Name	ASAM LEVEL 3.2WM CLINICALLY MANAGED RESIDENTIAL WITHDRAWAL MANAGEMENT (SOCIAL DETOX)
	• Direct Care staff shall have demonstrated skills and competencies in treatment with individuals with a behavioral health diagnosis, demonstrated by at least one of the following: two years lived experience; two years' direct care experience in a human service field; two years of training in a human service field; or a bachelor's degree or higher in psychology, sociology, or related human service field, which is preferred. • Special training and competency evaluation required in carrying out physician developed protocols. • All staff should be educated/trained in rehabilitation, recovery principles and trauma informed care.
Staffing Ratio	Clinical Director to direct care staff ratio as needed to meet all responsibilities 2 awake Direct Care staff overnight
Hours of Operation	24/7
Individual Desired Outcome	The individual has successfully detoxified and has been assessed and referred for additional service/treatment needs

UTILIZATION GUIDELINES
SOCIAL DETOXIFICATION: Level 3.2 WM

I. Admission Guidelines:

1. The individual in a Level 3.2 WM detoxification program presents in an intoxicated state and meets ASAM dimensional criteria for admission. **Providers should refer to *ASAM Criteria – 3rd Edition* beginning on page 174 for complete criteria for each dimension.**

The individual who is appropriately placed in a Level 3.2 WM detoxification program meets specifications in (a) *and* (b):

(a) The individual is experiencing signs and symptoms of withdrawal, or there is evidence (based on history of substance intake, age, gender, previous withdrawal history, present symptoms, physical condition, and/or emotional, behavioral, or cognitive condition) that withdrawal is imminent. The individual is assessed as not being at risk of severe withdrawal syndrome, and moderate withdrawal is safely manageable at this level of service (see examples pg. 164-169). **AND**

(b) The individual is assessed as not requiring medication, but requires this level of service to complete detoxification and enter into continued treatment or self-help recovery because of inadequate home supervision or support structure, as evidenced by meeting [1] or [2] or [3]:

- [1] The individual's recovery environment is not supportive of detoxification and entry into treatment, and the individual does not have sufficient coping skills to safely deal with the problems in the recovery environment; *or*
- [2] The individual has a recent history of detoxification at less intensive levels of service that is marked by inability to complete detoxification or to enter into continuing addiction treatment, and the individual continues to have insufficient skills to complete detoxification; *or*
- [3] The individual has demonstrated an inability to complete detoxification at a less intensive level of services, as by continued use of other-than prescribed drugs or other mind-altering substances.

II. Continued Stay Guidelines:

It is appropriate to retain the individual at the present level of care if:

1. The individual is making progress but has not yet achieved the goals articulated in the individualized treatment plan. Continued treatment at this level of care is assessed as necessary to permit the individual to continue to work toward his or her treatment goals.

   OR

2. The individual is not yet making progress, but has the capacity to resolve his or her problems. The individual is actively working toward the goals in the individualized treatment plan. Continued treatment at this level of care is assessed as necessary to permit the individual to continue to work toward his or her treatment goals.

   AND/OR

3. New problems have been identified that are appropriately treated at this level of care. This level of care is the least intensive level of care at which the individual's new problems can be addressed effectively.

To document and communicate the individual's readiness for discharge or need for transfer to another level of care, each of the six dimensions of the ASAM criteria should be reviewed. If the criteria apply to the individual's existing or new problem (s), he or she should continue in treatment at the present level of care. If not, refer to the Discharge/Transfer Criteria.

SERVICE CATEGORY: SUBSTANCE USE DISORDER

SERVICE DEFINITION

Service Name	ASAM LEVEL 3.3 CLINICALLY MANAGED POPULATION SPECIFIC HIGH- INTENSITY RESIDENTIAL (THERAPEUTIC COMMUNITY CO-OCCURRING DIAGNOSIS CAPABLE)
Funding Source	Behavioral Health
Setting	Facility based
Facility or Professional License	As required by DHHS Division of Public Health
Basic Definition	Therapeutic Community is intended for individuals with a primary substance use disorder for whom shorter term treatment is inappropriate, either because of the pervasiveness of the impact of substance use disorder on the individual's life or because of a significant history of repeated short-term or less restrictive treatment. This service provides psychosocial skill building through a set of longer term, highly structured peer oriented treatment activities which define progress toward individual change and rehabilitation and which incorporate a series of clear phases. The individual's progress must be marked by advancement through these phases to less restrictiveness and more personal responsibility. Therapeutic Community relies on group accountability and support. Services align with ASAM level 3.3 guidance.
Service Expectations	• A strengths based substance use disorder assessment and mental health screening conducted by appropriately credentialed professionals at admission with ongoing assessment as needed. Assessment includes a relevant diagnosis and level of care recommendation for this service. If the clinician is a LADC or a PLADC and suspects a possible mental health condition, a referral is to be made to a clinician capable of diagnosing/treating co-occurring mental health and substance use disorders. • If a prior SUD assessment is determined to be clinically relevant and includes a current diagnosis, level of care recommendation and a discharge plan, it can serve as the admission assessment. If the prior assessment is not relevant or does not contain the necessary information, an SUD addendum would be necessary.

Service Name	ASAM LEVEL 3.3 CLINICALLY MANAGED POPULATION SPECIFIC HIGH- INTENSITY RESIDENTIAL (THERAPEUTIC COMMUNITY CO-OCCURRING DIAGNOSIS CAPABLE)
	• An initial treatment/recovery plan to guide the first seven days of treatment developed within 24 hours. The comprehensive individualized treatment/recovery plan, including discharge and relapse prevention, developed under clinical supervision with the individual within seven days of admission. • Review and update of the treatment/recovery plan under clinical supervision with the individual and other approved family/supports every 30 days or more often as needed • Telephone or in-person consultation with physician or APRN available 24 hours a day, 7 days a week • A minimum of 30 hours of treatment and recovery focused services weekly must include individual, family, and group psychotherapy, psychoeducational groups, sober leisure skill development, motivational enhancement and engagement strategies • Program is characterized by peer oriented activities and defined progress through clear phases, designed to improve the ability to structure and organize the tasks of daily living and recovery, to stabilize and maintain the stability of the individual's substance use disorder symptoms, and to help develop and apply recovery skills • Monitoring to promote successful reintegration into regular, productive daily activity such as work, school or family living • Other services could include 24 hours crisis management, family education, self-help group and support group orientation, drug screenings • Monitoring stabilized co-occurring mental health problems • Consultation and/or referral for medical, psychiatric, psychological, and psychopharmacology needs • All services must be culturally sensitive
Length of Services	Length of service is individualized and based on clinical criteria for admission and continuing stay. The anticipated duration of the service will be documented in the treatment plan.
Staffing	• Clinical Director (APRN, RN, LMHP, LIMHP, LADC or Licensed Psychologist) to provide clinical supervision, consultation and support to all program staff and the clients they serve. This individual will also continually incorporate new clinical information and best practices into the program to assure program effectiveness and viability, and assure quality organization and management of clinical records, and other program documentation.

Service Name	ASAM LEVEL 3.3 CLINICALLY MANAGED POPULATION SPECIFIC HIGH- INTENSITY RESIDENTIAL (THERAPEUTIC COMMUNITY CO-OCCURRING DIAGNOSIS CAPABLE)
	• Appropriately licensed and credentialed professionals working within their scope of practice to provide substance use disorder and/or co-occurring (MH/SUD) treatment and are knowledgeable about the biological and psychosocial dimensions of substance use disorders and mental health conditions. • Direct Care staff shall have demonstrated skills and competencies in treatment with individuals with a behavioral health diagnosis, demonstrated by at least one of the following: two years lived experience; two years' direct care experience in a human service field; two years of training in a human service field; or a bachelor's degree or higher in psychology, sociology, or related human service field, which is preferred • All staff should be educated/trained in rehabilitation, recovery principles and trauma informed care.
Staffing Ratio	• Clinical Director to direct care staff ratio as needed to meet all responsibilities • 1 awake staff for each 10 individuals during client sleep hours (overnight) with on-call availability for emergencies, 2 awake staff overnight for 11 or more individuals served • 1:10 Therapist to individual • On-call availability of direct care staff and licensed clinicians 24/7
Hours of Operation	24/7
Individual Desired Outcome	• The individual has substantially met their treatment plan goals and objectives • The precipitating condition and relapse potential is stabilized such that there is sustained improvement in health and psychosocial functioning • Individual's condition can be managed without the professional external supports and intervention at this level of care • Individual has alternative support systems secured to help the individual maintain active recovery and stability in the community

UTILIZATION GUIDELINES
THERAPEUTIC COMMUNITY: Level3.3

I. Admission Guidelines:

1. The individual meets the diagnostic criteria for a Substance Dependence Disorder, as defined in the most recent DSM, as well as the dimensional criteria for admission.
2. Individuals in Level 3.3 Dual Diagnosis Capable programs may have co-occurring mental disorders that meet the stability criteria for placement in a Dual Diagnosis Capable program: or difficulties with mood, behavioral or cognitive symptoms that are troublesome but do not meet the DSM criteria for a mental disorder.
3. The individual who is appropriately admitted to a Level 3.3 Dual Diagnosis Enhanced program meets the diagnostic criteria for a Mental Disorder as well as a Substance Dependence Disorder, as defined in the current DSM, as well as the dimensional criteria for admission.
4. The individual meets specifications in each of the six dimensions.
5. It is expected that the individual will be able to benefit from this treatment.

The following six dimensions and criteria are abbreviated. **Providers should refer to *ASAM Criteria – 3rd Edition* beginning on page 174 for complete criteria for each dimension.**

Dimension 1: ACUTE INTOXICATION &/OR WITHDRAWAL POTENTIAL:

- Not at risk of severe withdrawal, or moderate withdrawal is manageable at Level 3.2-D.

Dimension 2: BIOMEDICAL CONDITIONS & COMPLICATIONS:

- None or stable, or receiving concurrent medical monitoring.

Dimension 3: EMOTIONAL, BEHAVIORAL OR COGNITIVE CONDITIONS & COMPLICATIONS:

- Mild to moderate severity; needs structure to focus on recovery. If stable, a Dual Diagnosis Capable program is appropriate. If not, a Dual Diagnosis Enhanced program is required. Treatment should be designed to respond to the client's cognitive deficits.

Dimension 4: READINESS TO CHANGE:

- Has little awareness and needs interventions available only at Level 3.3 to engage and stay in treatment; or there is high severity in this dimension but not in others. The client, therefore, needs a Level I motivational enhancement program.

Dimension 5: RELAPSE, CONT. USE OR CONT. PROBLEM POTENTIAL:

- Has little awareness and needs intervention available only at Level 3.3 to prevent continued use, with imminent dangerous consequences, because of cognitive deficits or comparable dysfunction.

Dimension 6: RECOVERY ENVIRONMENT:

- Environment is dangerous and client needs 24-hour structure to learn to cope.

II. Continued Stay Guidelines:

It is appropriate to retain the individual at the present level of care if:

1. The individual is making progress but has not yet achieved the goals articulated in the individualized treatment plan. Continued treatment at this level of care is assessed as necessary to permit the individual to continue to work toward his or her treatment goals.

   OR

2. The individual is not yet making progress, but has the capacity to resolve his or her problems. The individual is actively working toward the goals in the individualized treatment plan. Continued treatment at this level of care is assessed as necessary to permit the individual to continue to work toward his or her treatment goals.

   AND/OR

3. New problems have been identified that are appropriately treated at this level of care. This level of care is the least intensive level of care at which the individual's new problems can be addressed effectively.

To document and communicate the individual's readiness for discharge or need for transfer to another level of care, each of the six dimensions of the ASAM criteria should be reviewed. If the criteria apply to the individual's existing or new problem (s), he or she should continue in treatment at the present level of care. If not, refer to the Discharge/Transfer Criteria.

SERVICE CATEGORY: SUBSTANCE USE DISORDER

SERVICE DEFINITION

Service Name	ASAM LEVEL 3.3 CLINICALLY MANAGED POPULATION SPECIFIC HIGH-INTENSITY RESIDENTIAL (INTERMEDIATE RESIDENTIAL CO-OCCURRING DIAGNOSIS CAPABLE)
Funding Source	Behavioral Health
Setting	Facility based
Facility or Professional License	As required by DHHS Division of Public Health
Basic Definition	Intermediate Residential Treatment encompasses organized services staffed by designated substance use disorder personnel directing a planned regimen of care in a 24-hour live-in setting. It is staffed 24 hours a day and serves individuals who need a safe and stable living environment in order to develop recovery skills. It is intended for individuals with a primary substance use disorder for whom shorter term treatment is inappropriate, either because of the pervasiveness of the impact of substance use on the individual's life or because of a significant history of repeated short-term or less restrictive treatment. Typically this service provides a high level of support and relies less on peer dynamics in its treatment approach. Services align with ASAM level 3.3 guidance.
Service Expectations	• A strengths based, substance use disorder assessment and mental health screening conducted prior to admission by licensed professionals, with ongoing assessment as needed. Assessment includes a relevant diagnosis and level of care recommendation for this service. If the clinician is a LADC or a PLADC and suspects a possible mental health condition, a referral is to be made to a clinician capable of diagnosing/treating co-occurring mental health and substance use disorders. • If a prior SUD assessment is determined to be clinically relevant and includes a current diagnosis, level of care recommendation and a discharge plan, it can serve as the admission assessment. If the prior assessment is not relevant or does not contain the necessary information, an SUD addendum would be necessary.

Service Name	ASAM LEVEL 3.3 CLINICALLY MANAGED POPULATION SPECIFIC HIGH-INTENSITY RESIDENTIAL (INTERMEDIATE RESIDENTIAL CO-OCCURRING DIAGNOSIS CAPABLE)
	• An initial treatment/recovery plan to guide the first seven days of treatment developed within 24 hours of admission. The comprehensive individualized treatment/recovery plan, including discharge and relapse prevention, is developed under clinical supervision with the individual within seven days of admission. • Review and update of the treatment/recovery plan under clinical supervision with the individual and other approved family/supports every 30 days or more often as needed • Therapies/interventions should include individual, family, and group substance use disorder counseling, psychoeducational groups, sober leisure skill development, motivational enhancement and engagement strategies provided a minimum of 30 hours per week • Program is characterized by slower paced interventions; purposefully repetitive to meet special individual treatment needs • Monitoring to promote successful reintegration into regular, productive daily activity such as work, school or family living • Other services could include 24 hours crisis management, family education, self-help group and support group orientation, drug screenings • Monitoring stabilized co-occurring mental health problems • Consultation and/or referral for medical, psychiatric, psychological, and psychopharmacology needs • On-call availability of medical and direct care staff and licensed clinicians to meet the needs of individuals served 24/7 • All services must be culturally sensitive
Length of Services	Length of service is individualized and based on clinical criteria for admission and continuing stay. The anticipated duration of the service will be documented in the treatment plan.
Staffing	• Clinical Director (APRN, RN, LMHP, LIMHP, LADC or Licensed Psychologist) to provide clinical supervision, consultation and support to all program staff and the clients they serve. This individual will also continually incorporate new clinical information and best practices into the program to assure program effectiveness and viability, and assure quality organization and management of clinical records, and other program documentation. • Appropriately licensed and credentialed professionals working within their scope of practice to provide substance use disorder treatment and are knowledgeable about the biological and psychosocial dimensions of substance use disorder and mental health conditions.

Service Name	ASAM LEVEL 3.3 CLINICALLY MANAGED POPULATION SPECIFIC HIGH-INTENSITY RESIDENTIAL (INTERMEDIATE RESIDENTIAL CO-OCCURRING DIAGNOSIS CAPABLE)
	• Direct Care staff shall have demonstrated skills and competencies in treatment with individuals with a behavioral health diagnosis, demonstrated by at least one of the following: two years lived experience; two years' direct care experience in a human service field; two years of training in a human service field; or a bachelor's degree or higher in psychology, sociology, or related human service field, which is preferred Other program staff may include RNs, LPNs, recreation therapists, peers or case managers • All staff should be educated/trained in rehabilitation, recovery principles and trauma informed care.
Staffing Ratio	• Clinical Director to direct care staff ratio as needed to meet all responsibilities • 1:10 Direct Care staff to individuals served during all waking hours • 1:10 Therapist to individuals • 1 awake staff for each 10 individuals during sleep hours (overnight) with on-call availability for emergencies, 2 awake staff overnight for 11 or more individuals served
Hours of Operation	24/7
Individual Desired Outcome	• The individual has substantially met the treatment plan goals and objectives • The precipitating condition and relapse potential is stabilized such that there is sustained improvement in health and psychosocial functioning • Individual's condition can be managed without the professional external supports and intervention at this level of care • Individual has alternative support systems secured to help the individual maintain active recovery and stability in the community

UTILIZATION GUIDELINES
INTERMEDIATE RESIDENTIAL: Level 3.3

I. Admission Guidelines:

1. The individual meets the diagnostic criteria for a Substance Dependence Disorder, as defined in the most recent DSM, as well as the dimensional criteria for admission.
2. Individuals in Level 3.3 Dual Diagnosis Capable programs may have co-occurring mental disorders that meet the stability criteria for placement in a Dual Diagnosis Capable program: or difficulties with mood, behavioral or cognitive symptoms that are troublesome but do not meet the most recent DSM criteria for a mental disorder.
3. The individual who is appropriately admitted to a Level 3.3 Dual Diagnosis Enhanced program meets the diagnostic criteria for a Mental Disorder as well as a Substance Dependence Disorder, as defined in the most recent DSM as well as the dimensional criteria for admission.
4. The individual meets specifications in each of the six dimensions.
5. The individual has a substance dependence diagnosis with functional impairments in each of the following areas: activities of daily living, employment/educational, and social which are the direct result of the diagnosis 6. The individual is expected to benefit from this level of treatment.

The following six dimensions and criteria are abbreviated. **Providers should refer to *ASAM Criteria – 3rd Edition* beginning on page 174 for complete criteria for each dimension.**

Dimension 1: ACUTE INTOXICATION &/OR WITHDRAWAL POTENTIAL:

- Not at risk of severe withdrawal, or moderate withdrawal is manageable at Level 3.2-D.

Dimension 2: BIOMEDICAL CONDITIONS & COMPLICATIONS:

- None or stable, or receiving concurrent medical monitoring.

Dimension 3: EMOTIONAL, BEHAVIORAL OR COGNITIVE CONDITIONS & COMPLICATIONS:

- Mild to moderate severity; needs structure to focus on recovery. If stable, a Dual Diagnosis Capable program is appropriate. If not, a Dual Diagnosis Enhanced program is required. Treatment should be designed to respond to the client's cognitive deficits.

Dimension 4: READINESS TO CHANGE:

- Has little awareness and needs interventions available only at Level 3.3 to engage and stay in treatment; or there is high severity in this dimension but not in others. The client, therefore, needs a Level 1 motivational enhancement program.

Dimension 5: RELAPSE, CONT. USE OR CONT. PROBLEM POTENTIAL:

- Has little awareness and needs intervention available only at Level 3.3 to prevent continued use, with imminent dangerous consequences, because of cognitive deficits or comparable dysfunction.

Dimension 6: RECOVERY ENVIRONMENT:

- Environment is dangerous and client needs 24-hour structure to learn to cope.

II. Continued Stay Guidelines:

It is appropriate to retain the individual at the present level of care if:

1. The individual is making progress but has not yet achieved the goals articulated in the individualized treatment plan. Continued treatment at this level of care is assessed as necessary to permit the individual to continue to work toward his or her treatment goals.

   OR

2. The individual is not yet making progress, but has the capacity to resolve his or her problems. The individual is actively working toward the goals in the individualized treatment plan. Continued treatment at this level of care is assessed as necessary to permit the individual to continue to work toward his or her treatment goals.

   AND/OR

3. New problems have been identified that are appropriately treated at this level of care. This level of care is the least intensive level of care at which the individual's new problems can be addressed effectively.

To document and communicate the individual's readiness for discharge or need for transfer to another level of care, each of the six dimensions of the ASAM criteria should be reviewed. If the criteria apply to the individual's existing or new problem (s), he or she should continue in treatment at the present level of care. If not, refer to the Discharge/Transfer Criteria.

SERVICE CATEGORY: SUBSTANCE USE DISORDER

SERVICE DEFINITION

Service Name	ASAM LEVEL 3.5 CLINICALLY MANAGED HIGH INTENSITY RESIDENTIAL (SHORT TERM RESIDENTIAL CO-OCCURRING DIAGNOSIS CAPABLE)
Funding Source	Behavioral Health
Setting	Facility based
Facility or Professional License	As required by DHHS Division of Public Health
Basic Definition	Short Term Residential Treatment delivers a safe and stable intensive treatment environment to treat complex biopsychosocial issues, facilitate the recovery process and the development of a supportive recovery network, promote successful involvement in regular productive activity, and prevent the use of substances. This service is highly structured and provides primary, comprehensive substance use disorder treatment. Services align with ASAM level 3.5 guidance.
Service Expectations	• A strengths based substance use assessment and mental health screening conducted by licensed clinician prior to or at admission, with a relevant diagnosis and level of care recommendation and ongoing assessment as needed • If a prior SUD assessment is determined to be clinically relevant and includes a current diagnosis, level of care recommendation and a discharge plan it can serve as the admission assessment. If the prior assessment is not relevant or does not contain the necessary information than an SUD addendum would be necessary. • All individuals are to be screened for co-occurring conditions throughout the assessment. If the clinician is a LADC or a PLADC and suspects a possible mental health condition, a referral is to be made to a clinician capable of diagnosing/treating co-occurring mental health and substance use disorders. • An initial treatment/recovery plan to guide the first 7 days of treatment developed within 24 hours • A nursing assessment by a RN or LPN under RN supervision, will be completed within 24 hours of admission with recommendations for further in-depth physical examination if necessary as indicated.

Service Name	ASAM LEVEL 3.5 CLINICALLY MANAGED HIGH INTENSITY RESIDENTIAL (SHORT TERM RESIDENTIAL CO-OCCURRING DIAGNOSIS CAPABLE)
	• Under clinical supervision, develop an individualized treatment/recovery plan, including discharge and relapse prevention, with the individual within 7 days of admission • Review and update of the treatment/recovery plan under a licensed clinician with the individual and other approved family/supports every 7 days or more often as clinically indicated • Drug screenings as clinically indicated • Interventions to include individual, family, and group psychotherapy, psychoeducational groups, motivational enhancement and engagement strategies, sober leisure skill building activities, medication management, and daily clinical services are to be provided at a minimum of 42 hours per week. • Individual psychiatric services as clinically indicated are provided consistent with co-occurring diagnosis capable treatment, including monitoring of stabilized co-occurring mental health conditions • Discharge planning to promote successful reintegration into regular, productive daily activity such as work, school or family living, including the establishment of each individual's social supports to enhance recovery • Other services should include 24 hours crisis management, family education, self-help group and support group orientation, all of which are included in the minimum of 42 hours per week. • On-call availability of medical and direct care staff and licensed clinicians to meet the needs of individuals served 24/7 • Medication management and education including monitoring of medication adherence as needed • Consultation and/or referral for medical, psychiatric, psychological, and psychopharmacology needs • All services must be culturally sensitive
Length of Services	Length of service is individualized and based on clinical criteria for admission and continuing stay. The anticipated duration of the service will be documented in the treatment plan.
Staffing	• Clinical Director (APRN, RN, LMHP, LIMHP, licensed psychologist or LADC) working with the program and responsible for all clinical decisions (i.e. admissions, assessment, treatment/discharge planning and review) and to provide consultation and support to care staff and the individuals they serve. This individual will also continually incorporate new clinical information and best practices into the program to assure program effectiveness and viability, and assure quality organization and management of clinical records, and other program documentation. • RNs and/or LPNs under the supervision of an RN with substance use disorder treatment experience preferred

Service Name	ASAM LEVEL 3.5 CLINICALLY MANAGED HIGH INTENSITY RESIDENTIAL (SHORT TERM RESIDENTIAL CO-OCCURRING DIAGNOSIS CAPABLE)
	• Other program staff may include recreation therapists, peers or care managers. • Appropriately licensed and credentialed professionals working within their scope of practice to provide substance misuse and/or co-occurring (MH/SUD) treatment and are knowledgeable about the biological and psychosocial dimensions of substance use disorder and mental health conditions. • Direct Care staff shall have demonstrated skills and competencies in treatment with individuals with a behavioral health diagnosis, demonstrated by at least one of the following: two years lived experience; two years' direct care experience in a human service field; two years of training in a human service field; or a bachelor's degree or higher in psychology, sociology, or related human service field, which is preferred • All staff should be educated/trained in rehabilitation, recovery principles and trauma informed care.
Staffing Ratio	• Clinical Director to direct care staff ratio as needed to meet all responsibilities • 1:8 Direct Care Staff to individual served during waking hours • 1:8 Therapist/ licensed clinician to individuals served • 1 awake staff for each 10 individuals during client sleep hours (overnight) with on-call availability for emergencies, 2 awake staff overnight for 11 or more individuals served
Hours of Operation	24/7
Individual Desired Outcome	• The individual has substantially met the treatment plan goals and objectives • The precipitating condition and relapse potential is stabilized such that there is sustained improvement in health and psychosocial functioning • Individual's condition can be managed without the professional external supports and intervention at this level of care • Individual has alternative support systems secured to help maintain active recovery and stability in the community • The individual is connected to the next appropriate level of care necessary to treat the condition

UTILIZATION GUIDELINES

SHORT TERM RESIDENTIAL: Level 3.5

I. Admission Guidelines:

1. The individual meets the diagnostic criteria for a Substance Dependence Disorder as defined in the most recent DSM, as well as the dimensional criteria for admission.
2. Individuals in Level 3.5 Dual Diagnosis Capable programs may have co-occurring mental disorders that meet the stability criteria for placement in a Dual Diagnosis Capable program; or difficulties with mood, behavior or cognition related to a substance use or mental disorder; or emotional, behavioral or cognitive symptoms that are troublesome but do not meet the DSM criteria for a mental disorder.
3. The individual who is appropriately admitted to a Level 3.5 Dual Diagnosis Enhanced program meets the diagnostic criteria for a Mental Disorder as well as a Substance Dependence Disorder, as defined in the most recent DSM.
4. The individual meets specifications in each of the six dimensions.
5. It is expected that the individual will be able to benefit from this treatment.

The following six dimensions and criteria are abbreviated. **Providers should refer to *ASAM Criteria – 3rd Edition* beginning on page 174 for complete criteria for each dimension.**

Dimension 1: ACUTE INTOXICATION &/OR WITHDRAWAL POTENTIAL:

- At minimal risk of withdrawal, at Levels 3.3 or 3.5. If withdrawal is present, it meets Level 3.2-D criteria.

Dimension 2: BIOMEDICAL CONDITIONS & COMPLICATIONS:

- None or stable, or receiving concurrent medical monitoring.

Dimension 3: EMOTIONAL, BEHAVIORAL OR COGNITIVE CONDITIONS & COMPLICATIONS:

- Demonstrates repeated inability to control impulses or a personality disorder requires structure to shape behavior. Other functional deficits require a 24-hour setting to teach coping skills. A Dual Diagnosis Enhanced setting is required for SPMI Severely and Persistently Mentally Ill patients.

Dimension 4: READINESS TO CHANGE:

- Has marked difficulty with, or opposition to treatment, with dangerous consequences; or there is high severity in this dimension but not in others. The client, therefore, needs a Level I motivational enhancement program.

Dimension 5: RELAPSE, CONT. USE OR CONT. PROBLEM POTENTIAL:

- Has no recognition of the skills needed to prevent continued use, with imminently dangerous consequences.

Dimension 6: RECOVERY ENVIRONMENT:

- Environment is dangerous and client lacks skills to cope outside of a highly structured 24-hour setting.

II. Continued Stay Guidelines:

It is appropriate to retain the individual at the present level of care if:

1. The individual is making progress but has not yet achieved the goals articulated in the individualized treatment plan. Continued treatment at this level of care is assessed as necessary to permit the individual to continue to work toward his or her treatment goals.

   OR

2. The individual is not yet making progress, but has the capacity to resolve his or her problems. The individual is actively working toward the goals in the individualized treatment plan. Continued treatment at this level of care is assessed as necessary to permit the individual to continue to work toward his or her treatment goals.

   AND/OR

3. New problems have been identified that are appropriately treated at this level of care. This level of care is the least intensive level of care at which the individual's new problems can be addressed effectively.

To document and communicate the individual's readiness for discharge or need for transfer to another level of care, each of the six dimensions of the ASAM criteria should be reviewed. If the criteria apply to the individual's existing or new problem (s), he or she should continue in treatment at the present level of care. If not, refer to the Discharge/Transfer Criteria.

SERVICE CATEGORY: SUBSTANCE USE DISORDER

SERVICE DEFINITION

Service Name	ASAM LEVEL 3.5 CLINICALLY MANAGED HIGH INTENSITY RESIDENTIAL (DUAL DISORDER RESIDENTIAL CO-OCCURRING DIAGNOSIS-ENHANCED)
Funding Source	Behavioral Health
Setting	Facility based
Facility or Professional License	As required by DHHS Division of Public Health
Basic Definition	Dual Disorder Residential Treatment is intended for individuals with a primary substance use disorder and a co-occurring severe mental illness requiring a more intensive treatment environment to treat complex biopsychosocial issues and prevent substance use. This service is highly structured, based on acuity, and provides primary, integrated treatment to further stabilize acute symptoms and engage the individual in a program of maintenance, treatment, rehabilitation and recovery. Services align with ASAM level 3.5 guidance.
Service Expectations	• A strengths based substance use assessment and mental health screening conducted by licensed clinician prior to or at admission, with a relevant diagnosis and level of care recommendation and ongoing assessment as needed • If a prior SUD assessment is determined to be clinically relevant and includes a current diagnosis, level of care recommendation and a discharge plan it can serve as the admission assessment. If the prior assessment is not relevant or does not contain the necessary information than an SUD addendum would be necessary. • All individuals are to be screened for co-occurring conditions throughout the assessment. If the clinician is a LADC or a PLADC and suspects a possible mental health condition, a referral is to be made to a clinician capable of diagnosing/treating co-occurring mental health and substance use disorders. • If a prior SUD assessment is determined to be clinically relevant and includes a current diagnosis, level of care recommendation and a discharge plan, it can serve as the admission assessment. If the prior assessment is not relevant or does not contain the necessary information than an SUD addendum would be necessary. • A nursing assessment by a RN, or LPN under RN supervision, will be completed within 24 hours of admission with recommendations for further in-depth physical examination as indicated.

Service Name	ASAM LEVEL 3.5 CLINICALLY MANAGED HIGH INTENSITY RESIDENTIAL (DUAL DISORDER RESIDENTIAL CO-OCCURRING DIAGNOSIS-ENHANCED)
	• Individual psychiatric services as clinically indicated are provided consistent with co-occurring diagnosis enhanced treatment, including treatment of co-occurring mental health conditions • An initial treatment/recovery plan to guide the first 7 days of treatment developed within 24 hours. • Under clinical supervision, develop an individualized treatment/recovery plan, including discharge and relapse prevention, with the individual (consider community, family and other supports) within 7 days of admission • Review and update of the treatment/recovery plan under a licensed clinician with the individual and other approved family/supports every 30 days or more often as clinically indicated • Interventions to include individual, family, and group psychotherapy, psychoeducational groups, motivational enhancement and engagement strategies, sober leisure skill building activities, medication management, and daily clinical services are to be provided at a minimum of 42 hours per week. Drug screenings as clinically indicated • Medication management and education including monitoring of medication adherence as needed • Consultation and/or referral for medical, psychological, and psychopharmacology needs • Discharge planning to promote successful reintegration into regular, productive daily activity such as work, school or family living, including the establishment of each individual's social supports to enhance recovery • Other services should include 24 hours crisis management, family education, self-help group and support group orientation, all of which are included in the minimum of 42 hours per week • All services must be culturally sensitive
Length of Services	Length of service is individualized and based on clinical criteria for admission and continuing stay. The anticipated duration of the service will be documented in the treatment plan.
Staffing	• Clinical Director is a licensed clinician (Psychiatrist, APRN, RN, LMHP, LIMHP, or Licensed Psychologist) with demonstrated work experience and education/training in both mental health and addictions who is responsible for all clinical decisions (i.e. admissions, assessment, treatment/discharge planning and review) and providing consultation and support to care staff and the individuals served. The Clinical Director also continually works to incorporate new clinical information and best practices into the program to assure program effectiveness and viability, and assure quality, organization and management of clinical records, and other program documentation. • Consulting psychiatrist or APRN if not in the Clinical Director position

Service Name	ASAM LEVEL 3.5 CLINICALLY MANAGED HIGH INTENSITY RESIDENTIAL (DUAL DISORDER RESIDENTIAL CO-OCCURRING DIAGNOSIS-ENHANCED)
	• RNs and/or LPN's under the supervision of an RN with substance use disorder/psychiatric treatment experience preferred • Other program staff may include recreation therapists, peers, or care managers • Appropriately licensed and credentialed clinicians working within their scope of practice to provide co-occurring (MH/SUD) treatment and are knowledgeable about the biological and psychosocial dimensions of substance use disorder and mental health conditions. • Direct Care staff shall have demonstrated skills and competencies in treatment with individuals with a behavioral health diagnosis, demonstrated by at least one of the following: two years lived experience; two years' direct care experience in a human service field; two years of training in a human service field; or a bachelor's degree or higher in psychology, sociology, or related human service field, which is preferred. • All staff should be educated/trained in rehabilitation, recovery principles and trauma informed care.
Staffing Ratio	• Clinical Director to direct are staff ratio as needed to meet all responsibilities • 1:6 Direct Care Staff to individual served during waking hours • 1:8 Therapist/ licensed clinician to individuals served • 1 awake staff for each 10 individuals during client sleep hours (overnight) with on-call availability for emergencies, 2 awake staff overnight for 11 or more individuals served • On-call availability of medical and direct care staff and licensed clinicians 24/7
Hours of Operation	24/7
Individual Desired Outcome	• The individual has substantially met the treatment plan goals and objectives • The precipitating condition and relapse potential is stabilized such that there is sustained improvement in health and psychosocial functioning • Individual's condition can be managed without the professional external supports and intervention at this level of care • Individual has alternative support systems secured to help them maintain active recovery and stability in the community • The individual is connected to the next appropriate level of care necessary to treat the condition

UTILIZATION GUIDELINES
DUAL DISORDER RESIDENTIAL: Level 3.5

I. Admission Guidelines:

1. The individual meets the diagnostic criteria for a Substance Dependence Disorder as defined in the most recent DSM, as well as the dimensional criteria for admission.
2. Individuals in Level 3.5 Dual Diagnosis Capable programs may have co-occurring mental disorders that meet the stability criteria for placement in a Dual Diagnosis Capable program; or difficulties with mood, behavior or cognition related to a substance use or mental disorder; or emotional, behavioral or cognitive symptoms that are troublesome but do not meet the most recent DSM criteria for a severe and persistent mental disorder.
3. The individual who is appropriately admitted to a Level 3.5 Dual Diagnosis Enhanced program meets the diagnostic criteria for a Severe and Persistent Mental Disorder as well as a Substance Dependence Disorder, as defined in the most recent DSM.
4. The individual meets specifications in each of the six dimensions.
5. It is expected that the individual will be able to benefit from this treatment.

The following six dimensions and criteria are abbreviated. **Providers should refer to *ASAM Criteria – 3rd Edition* beginning on page 174 for complete criteria for each dimension.**

Dimension 1: ACUTE INTOXICATION &/OR WITHDRAWAL POTENTIAL:

- At minimal risk of withdrawal, at Levels 3.3 or 3.5. If withdrawal is present, it meets Level 3.2-D criteria.

Dimension 2: BIOMEDICAL CONDITIONS & COMPLICATIONS:

- None or stable, or receiving concurrent medical monitoring.

Dimension 3: EMOTIONAL, BEHAVIORAL OR COGNITIVE CONDITIONS & COMPLICATIONS:

- Demonstrates repeated inability to control impulses or a personality disorder requires structure to shape behavior. Other functional deficits require a 24-hour setting to teach coping skills. A Dual Diagnosis Enhanced setting is required for SPMI Severely and Persistently Mentally Ill patients.

Dimension 4: READINESS TO CHANGE:

- Has marked difficulty with, or opposition to tx, with dangerous consequences; or there is high severity in this dimension but not in others. The client, therefore, needs a Level I motivational enhancement program.

Dimension 5: RELAPSE, CONT. USE OR CONT. PROBLEM POTENTIAL:

- Has no recognition of the skills needed to prevent continued use, with imminently dangerous consequences.

Dimension 6: RECOVERY ENVIRONMENT:

- Environment is dangerous and client lacks skills to cope outside of a highly structured 24-hour setting.

II. Continued Stay Guidelines:

It is appropriate to retain the individual at the present level of care if:

1. The individual is making progress but has not yet achieved the goals articulated in the individualized treatment plan. Continued treatment at this level of care is assessed as necessary to permit the individual to continue to work toward his or her treatment goals.

   OR

2. The individual is not yet making progress, but has the capacity to resolve his or her problems. The individual is actively working toward the goals in the individualized treatment plan. Continued treatment at this level of care is assessed as necessary to permit the individual to continue to work toward his or her treatment goals.

   AND/OR

3. New problems have been identified that are appropriately treated at this level of care. This level of care is the least intensive level of care at which the individual's new problems can be addressed effectively.

To document and communicate the individual's readiness for discharge or need for transfer to another level of care, each of the six dimensions of the ASAM criteria should be reviewed. If the criteria apply to the individual's existing or new problem (s), he or she should continue in treatment at the present level of care. If not, refer to the Discharge/Transfer Criteria.

SERVICE CATEGORY: SUBSTANCE USE DISORDER

SERVICE DEFINITION

Service Name	ASAM LEVEL 3.7WM MEDICALLY MONITORED INPATIENT WITHDRAWAL MANAGEMENT
Funding Source	Behavioral Health
Setting	Facility based
Facility or Professional License	As required by DHHS Division of Public Health
Basic Definition	Medically monitored inpatient withdrawal management provides voluntary and involuntary medical and therapeutic interventions in an inpatient setting. This setting allows for 24-hour nursing coverage for oversight of hourly monitoring of the patient's progress and medication monitoring as needed. These facilities are staffed by physicians or medical Advanced Practice Providers who are available by phone 24 hours per day and are responsible for treatment, policies and clinical protocols.
Service Expectations	• A biophysical screening (includes at a minimum, vital signs, detoxification rating scale, and other fluid intake) conducted by appropriately trained staff within the first four hours of admission with ongoing monitoring as needed, with licensed medical consultation available • An addiction-focused history is performed or available for a physician to review during the admission process or within 24 hours of admission • A physical exam is performed by a physician, physician assistant or nurse practitioner within 24 hours of admission. As part of this evaluation, appropriate laboratory and toxicology tests are ordered and interpreted. If a physical exam has been performed within the preceding 7 days at a higher level of care, that exam is available for review by the physician • Provide medications to ease the discomfort of withdrawal symptoms

Service Name	ASAM LEVEL 3.7WM MEDICALLY MONITORED INPATIENT WITHDRAWAL MANAGEMENT
	• Multidisciplinary biopsychosocial screenings are performed to allow for the determination of the appropriate level of care, to address treatment priorities identified in Dimensions 2 through 6, and to develop the treatment plan • Daily assessment of the patient's progress through history, physical or nursing exam as medically indicated and use with withdrawal scales are available. Treatment changes are made based on these evaluations • An individualized treatment plan is assembled utilizing an interdisciplinary team of clinicians. Based on this plan, individualized treatment goals are developed and treatment objectives and activities to meet those objectives are created • As part of the treatment plan, discharge and discharge planning are started on admission • Therapeutic interventions are available 24 hours per day to include a range of medical and mental health therapies administered to the patient on an individual and group basis • Services are provided to families and significant others. • All services must be culturally sensitive
Length of Services	Generally two to 5 days for individuals who are participating voluntarily. Individuals who are brought into care involuntarily will be released within 24 hours of admission unless they agree to continue services on a voluntary basis. However, length of stay is individually determined based on resolution of intoxication and withdrawal symptoms sufficient enough to allow for transfer to the next appropriate level of care.
Staffing	• Physicians or medical Advanced Practice Providers are available 24 hours per day to supervise the clinical practice and medically manage the care of the patient. • Physician assistants may perform assigned duties under collaborative agreements with the supervising physician. • Clinical Director (APRN, RN, LMHP, LIMHP, Licensed Psychologist or LADC) providing consultation and support to care staff and the individuals served. The Clinical Director will also continually incorporate new clinical information and best practices into the program to assure program effectiveness and viability, and assure quality organization and management of clinical records, and other program documentation. • A registered nurse or licensed practical nurse is on site for primary nursing care and observation 24 hours per day.

Service Name	ASAM LEVEL 3.7WM MEDICALLY MONITORED INPATIENT WITHDRAWAL MANAGEMENT
	• Appropriately licensed and credentialed staff should be available to administer medications in accordance with physician orders. • Licensed alcohol and drug counselors or licensed mental health practitioner with appropriate addiction training are available during waking hours to administer planned activities to allow individuals to complete objectives in the treatment plans. • Direct Care staff shall have demonstrated skills and competencies in treatment with individuals with a behavioral health diagnosis, demonstrated by at least one of the following: two years lived experience; two years' direct care experience in a human service field; two years of training in a human service field; or a bachelor's degree or higher in psychology, sociology, or related human service field, which is preferred • Special training and competency evaluation required in carrying out physician developed protocols. • All staff should be educated/trained in rehabilitation and recovery principles.
Staffing Ratio	Clinical Director to direct care staff ratio as needed to meet all responsibilities 2 awake Direct Care staff overnight
Hours of Operation	24/7
Individual Desired Outcome	The individual has successfully detoxified and has been assessed and referred for additional service/treatment needs

UTILIZATION GUIDELINES
MEDICALLY MONITORED INPATIENT WITHDRAWAL MANAGEMENT: Level 3.7 WM

I. Admission Guidelines:

1. The individual in a Level 3.7 WM detoxification program presents in an intoxicated state and meets ASAM dimensional criteria for admission. **Providers should refer to *ASAM Criteria – 3rd Edition* beginning on page 174 for complete criteria for each dimension.**

The individual who is appropriately placed in a Level 3.7 WM detoxification program meets specifications in (a) *and* (b):

(a) The individual is experiencing signs and symptoms of severe withdrawal, or there is evidence (based on history of substance intake, age, gender, previous withdrawal history, present symptoms, physical condition, and/or emotional, behavioral, or cognitive condition) that severe withdrawal is imminent. The severe withdrawal syndrome is safely manageable at this level of service (see examples pg. 164-169). **AND**

(b) The individual is assessed as needing medication and monitoring at this level of service to complete detoxification and enter into continued treatment or self-help recovery because of inadequate home supervision or support structure, as evidenced by meeting [1] or [2] or [3]:

- [1] The individual requires medication and has a recent history of withdrawal management at a less intensive level of care, marked by past and current inability to complete withdrawal management and enter into continuing addiction treatment. The individual continues to have insufficient skills or supports to complete withdrawal management; *or*
- [2] The individual has a recent history of withdrawal management at less intensive levels of service that is marked by inability to complete withdrawal management or to enter into continuing addiction treatment, and the individual continues to have insufficient skills to complete withdrawal management; *or*
- [3] The individual has a comorbid physical, emotional, behavioral, or cognitive condition (such as chronic pain with active exacerbation or posttraumatic stress disorder with brief dissociative episodes) that is manageable in a Level 3.7WM setting but which increases the clinical severity of the withdrawal and complicates withdrawal management.

II. Continued Stay Guidelines:

It is appropriate to retain the individual at the present level of care if:

1. The individual is making progress but has not yet achieved the goals articulated in the individualized treatment plan. Continued treatment at this level of care is assessed as necessary to permit the individual to continue to work toward his or her treatment goals.

   OR

2. The individual is not yet making progress, but has the capacity to resolve his or her problems. The individual is actively working toward the goals in the individualized treatment plan. Continued treatment at this level of care is assessed as necessary to permit the individual to continue to work toward his or her treatment goals.

   AND/OR

3. New problems have been identified that are appropriately treated at this level of care. This level of care is the least intensive level of care at which the individual's new problems can be addressed effectively.

To document and communicate the individual's readiness for discharge or need for transfer to another level of care, each of the six dimensions of the ASAM criteria should be reviewed. If the criteria apply to the individual's existing or new problem (s), he or she should continue in treatment at the present level of care. If not, refer to the ASAM Continued Service and Discharge Criteria.

SERVICE CATEGORY: SUBSTANCE USE DISORDER

SERVICE DEFINITION

Service Name	OPIOID TREATMENT PROGRAM (OTP)
Funding Source	Behavioral Health
Setting	Facility based
Facility or Professional License	As required by DHHS Division of Public Health and Substance Abuse Mental Health Services Administration (SAMHSA) Certification
Basic Definition	The OTP provides medical and social services along with outpatient substance use disorder treatment to individuals with severe opioid use disorder. This service is provided under a defined set of policies and procedures, including admission, discharge and continued service criteria stipulated by state and federal laws and regulations.
Service Expectations	Refer to SAMHSA's current Opioid Treatment Program and Medication Assisted Treatment Guidelines on the SAMHSA website
Length of Services	This service is recognized as long-term treatment, potentially for life. A range of 18 to 26 months should be the minimum time for physical and psychological recovery supported with at least one contact per month.
Staffing	See state and federal regulations
Staffing Ratio	See state and federal regulations
Hours of Operation	See state and federal regulations

Service Name	OPIOID TREATMENT PROGRAM (OTP)
Individual Desired Outcome	The precipitating condition and relapse potential is stabilized with Opioid Maintenance.

UTILIZATION GUIDELINES
OPIOID TREATMENT PROGRAM (OTP)

. **Diagnostic Admission Criteria:**

- The patient who is appropriately placed in opioid maintenance therapy is assessed as meeting the diagnostic criteria for Opioid Dependence disorder, as defined in the current DSM, or other standardized and widely accepted criteria aside from those exceptions listed in the *Federal Register* of the U.S. Department of Health and Human Services, *42 CFR Part 8*.
- Individuals who are admitted to treatment with methadone or buprenorphine must demonstrate specific objective and subjective signs of opiate dependence, as defined in *42 CFR Part 8.*
- Continued stay is determined by reassessment of criteria and response to treatment.
- The patient who is appropriately placed in opioid maintenance therapy is assessed as meeting the required specifications in Dimensions 1 through 6.

The following six dimensions and criteria are abbreviated**. Providers should refer to *ASAM Criteria – 3rd Edition* beginning on page 174 for complete criteria for each dimension.**

Dimension 1: ACUTE INTOXICATION &/OR WITHDRAWAL POTENTIAL:

- Physiologically dependent on opiates and required OMT to prevent withdrawal.

Dimension 2: BIOMEDICAL CONDITIONS & COMPLICATIONS:

- None or manageable with outpatient medical monitoring.

Dimension 3: EMOTIONAL, BEHAVIORAL OR COGNITIVE CONDITIONS & COMPLICATIONS:

- None or manageable in an outpatient structured environment

Dimension 4: READINESS TO CHANGE:

- Ready to change the negative effects of opiate use, but is not ready for total abstinence.

Dimension 5: RELAPSE, CONT. USE OR CONT. PROBLEM POTENTIAL:

- At high risk of relapse or continued use without OMT and structured therapy to promote treatment progress.

Dimension 6: RECOVERY ENVIRONMENT:

- Recovery environment is supportive and/or the client has skills to cope.

APPENDICES

Documentation Requirements

Clinical Documentation: Behavioral health providers must maintain a clinical record that is confidential, complete, accurate, and contains up-to-date information relevant to the individual's care and services. The record must sufficiently document assessments; any and all treatment, rehabilitation and recovery service interventions and associated plans and plan reviews; and clinically relevant provider discussion. The clinical record must document distinct contacts describing the nature and extent of the services provided, such that a clinician unfamiliar with the service can identify the individual's service needs and services received. The documentation must reflect the services provided, be consistent with the goals in the individual's treatment, rehabilitation, and recovery plan, and be based upon the comprehensive and other ongoing assessment(s). The absence of appropriate, legible, and complete records may result in the recoupment of previous payments for services.

Non-electronic records must be kept double locked when not in use. For purposes of confidentiality, disclosure of treatment/rehabilitation/recovery information is subject to all the provisions of applicable State and Federal laws. The individual's clinical record must be available for review by the individual (and his/her guardian with appropriate consent) unless there is a specific clinically indicated reason to preclude this availability. The specific reason must be documented in the clinical record and reviewed periodically.

The record must contain documentation that the individual and guardian, as applicable, has participated in the program orientation.

The record must contain documentation of the informed consent of the individual, and/or appropriate family members or guardians, as applicable, to treatment, rehabilitation, and/or recovery services, medication usage, and other services to be provided as stated in the individual's treatment, rehabilitation, and recovery plan. Consent to each of these services includes the concomitant right to refuse services, unless the treatment is court-ordered or required under the Nebraska Mental Health Commitment Act (Neb. Rev. Stat. §§ 71-901 to 71-962). The record must also contain documentation of signed Release(s) of Information in compliance with relevant laws and regulations.

The risks and benefits of every service for which consent is sought and the right to refuse the service must be explained to the individual at a level educationally appropriate to the individual.

The record must contain documentation of correspondence to and from the program regarding the services received. Signed and dated progress notes of all telephone calls concerning these services must also be present.
The clinical record must include, at a minimum:

1. Individual identifying data, including demographic information and any relevant psychiatric legal status;
2. Assessment and Evaluations;
   a. Pre-Authorization/Referral Screening
   b. Psychiatric assessment substantiating the individual's diagnosis, and referral for treatment/rehabilitation/recovery service; and
   c. Other appropriate assessments required by service definition.
3. Individual's Diagnostic Formulation;
4. Individual's Treatment, Rehabilitation, and Recovery Plan and updates to plans;
5. Documentation of review of Consumer Rights with the individual;
6. A chronological record of all services provided to the individual. Each entry must include the staff member who performed the service received. Each entry includes the date the service was performed, the duration of the service, the place of the service, and the staff member's identity and legible signature, name, and title. All record entries must be dated, legible and indelibly verified. In the case of electronic records, signatures may be replaced by an approved, uniquely identifiable electronic equivalent;
7. Documentation of the individual's participation in the service and involvement of family and significant others;
8. Documentation of treatment, rehabilitation, and recovery services and discharge planning;
9. A chronological listing of the medications prescribed (including dosages and schedule) for the individual and the individual's response to the medication;
10. Documentation of coordination with other services and treatment providers, including medical providers. Documentation of telephone calls, collateral contacts or other outreach activities that demonstrate continuing treatment/rehabilitation responsibility are considered services and require a progress note. Providers of multiple services must indicate how significant individual issues are shared between providers;
11. Discharge summaries from previous levels of care;
12. Discharge summary (when appropriate); and

13. Any clinical documentation requirements identified in the specific service. Documentation requirements for day rehabilitation and for residential rehabilitation must provide a daily summary of the individual's condition, treatment and rehabilitation interventions provided and individual's response to those interventions.

Medications: For each individual receiving medication management services, the record must contain a medication use profile. This profile must include:

1. A listing of all medications and dosages currently prescribed by the psychiatric prescriber (MD, APRN, or PA);
2. A listing of all medications and dosages currently prescribed by any other prescriber;
3. A listing of all over-the-counter medications, herbal preparations, or other alternative treatment being used by the individual;
4. Documentation from the program's medical provider (MD, APRN, PA, LPN, RN), including, upon discontinuation, the date and reason each drug is discontinued;
5. Documentation that medication education/health teaching has occurred and the individual is informed regarding each medication prescribed during treatment and that the individual understands the information; and
6. Documentation of the individual's response to the teaching and medications prescribed (e.g. adverse effects, therapeutic effects, adherence issues).

Individualized Treatment, Rehabilitation, and Recovery Plan: For treatment and rehabilitation services, a plan must be developed with the person served. Each record must contain a recovery-oriented individualized treatment, rehabilitation, and recovery plan for all services provided based on the individualized and person-centered assessment of the individual and the Behavioral Health Service Definitions. This plan must:

1. Be oriented to and apply the principles of recovery including but not limited to inclusion, direct and active participation, and a meaningful life in the community of one's choosing;
2. Incorporate and be consistent with best practices;
3. Include the individual's individualized goals and expected outcomes;
4. Contain prioritized objectives that are measurable and time-limited;

5. Describe therapeutic interventions that are recovery-oriented, trauma-informed, person-centered, and strength-based;
6. Identify staff responsible for implementing the therapeutic interventions;
7. Specify the planned amount, frequency, and duration of each therapeutic intervention;
8. Delineate the specific behavioral criteria to be met for discharge or transition to a lower level of care;
9. Include a component to avoid crises or admission to a higher level of care using principles of recovery and wellness;
10. Include the signature of the individual and/or guardian to indicate agreement with the plan;
11. Document that the individual treatment, rehabilitation, and recovery plan is completed within the time frame specified in policies and Behavioral Health Service Definitions;
12. Document that the plan has been developed, reviewed, updated, and revised with the direct and active involvement of the individual. If documentation shows that the individual is not achieving his/her goals, timely revision of the plan must be documented;
13. Be approved and signed by the licensed clinician.

Progress Notes: Each record must contain progress notes that document implementation of the individual's treatment, rehabilitation, and recovery plan. Progress notes must be completed within the time frame specified in the program's policies and procedures and document the unit(s) provided to the individual. Progress notes must document:

1. All services provided;
2. How services provided relate specifically to goals and priorities identified in the individual's treatment, rehabilitation, and recovery plan;
3. Individual's participation in the service and revision of goals and treatment activities as needed;
4. Individual's opinion of progress being made (in individual's own words, if possible).

Discharge Plan: Discharge planning is an ongoing process that occurs through the duration of service. The discharge plan must be strengths-based, recovery-oriented, trauma-informed and include participation by the individual and family/legal guardian as appropriate. The discharge plan must be documented in the individual's record. The discharge plan must:

1. Begin on admission and be updated on an ongoing basis with the direct and active participation of the individual and family/legal guardian, as appropriate and with the individual's consent;

2. Be a component of the Individualized Treatment, Rehabilitation, and Recovery plan and be consistent with the goals and objectives identified with the direct and active participation of the individual, family/ guardian as appropriate;

3. Address the individual's need for ongoing services to promote recovery. A crisis/safety/relapse prevention plan must be in place and address triggers, helpful intervention strategies, and contact information for resources useful in a crisis;

4. Document all referrals; and

    a. Document pre-discharge planning, recommendations, and/or arrangements for a post-treatment/rehabilitation/recovery plan including but not limited to:
    b. Any ongoing treatment and rehabilitative service needs.
    c. Accessing and using medication
    d. Housing
    e. Employment
    f. Transportation
    g. Social connectedness – formal and informal support systems
    h. Plans to address unmet goals

Discharge Summary: A discharge summary must be documented in the individual's record and contain the signature of the licensed clinician and date of signature. For individuals committed to a program by a board of mental health, the provider must notify the commitment board of the discharge.

The discharge summary must:

1. Be provided within the time frame specified in the program's policies and procedures which considers the prompt transfer of clinical records and information to ensure continuity of care;

2. Provide a summary of service provided;
3. Document the individual's progress in relation to the individual's treatment/rehabilitation/recovery plan, addressing recovery oriented goals identified by the individual and how strengths have been utilized;
4. Describe the reason(s) for discharge;
5. Describe referral information; and
6. Include recommendations and/or arrangements not limited to:
    a. Any ongoing treatment and rehabilitative service needs
    b. Accessing and using medication
    c. Accessing physical health care
    d. Employment
    e. Transportation
    f. Social connectedness – formal and informal support systems
    g. Financial resources.

MEDICAL AND THERAPEUTIC LEAVE

MEDICAL LEAVE DAYS: Beds in Psychiatric Residential Rehabilitation, Therapeutic Community, Intermediate Residential and Dual Disorder Residential Treatment and Secure Residential programs can be held up to 10 consecutive days per episode when an individual is hospitalized for a period of medical/psychiatric stabilization and expected to return to the facility.

Individuals in ACT are allowed up to 10 consecutive days per episode when an individual is hospitalized for a period of medical/psychiatric stabilization and the ACT team is actively involved in the planning for return to the community and the individual is expected to return to ACT.

Documentation of the need for stabilization is reflected in the treatment plan and file. The program will be reimbursed at the full program rate per day. This reimbursement is only available if the treatment placement is not used by another individual. More than 3 episodes in a calendar year will result in a Level of Care review. Leaves in excess of 10 consecutive days must be approved by the Division or its designee and documented in the Centralized Data System (CDS).

THERAPEUTIC LEAVE DAYS: Beds in Psychiatric Residential Rehabilitation, Secure Residential, Therapeutic Community, Intermediate Residential, Dual Diagnosis, and Halfway House programs can be held up to 21 days annually (from the date of admission) when an individual is on therapeutic leave for the purposes of testing ability to function at and transition to a lesser level of care. This reimbursement is only available if the treatment bed is not used by another individual.

Individuals discharging from Assertive Community Treatment (ACT) may be allowed a 30 day period of transition when discharging and moving to a lower level of service (outpatient therapy, medication management, community support mental health, community support substance use disorder or day rehabilitation).

The therapeutic rationale and leave time period must be indicated in the treatment plan. Documentation of the outcome of the therapeutic leave and the need for continued residential level of care must be indicated in the individual's record. The Division will reimburse at the full program rate per day. Leave in excess of established time frames (21 days or 30 days for ACT per annum) must be approved by the Division or its designee and documented in the CDS.

Service Delivery Chart

The chart below identifies services that may be delivered via telehealth and/or telephone and to which population group (adult or youth) each applies. Telehealth is allowable for some components of Residential Care. **The alternative service delivery allowances are extended through December 31, 2023**[i].

Mental Health Crisis Services				
Service	**Telehealth**	**Phone**	**Adult**	**Youth**
Emergency Psychiatric Observation			X	
Crisis Stabilization			X	
Emergency Protective Custody Crisis Stabilization			X	
24-Hour Crisis Line	X	X	X	X
Mental Health Respite			X	X
Emergency Community Support	X	X	X	X
Crisis Response	X	X	X	X
Hospital Diversion	X	X	X	
Mental Health Treatment Services: Hospital				
Acute Inpatient Hospitalization			X	X
Sub-Acute Hospitalization			X	
Mental Health Treatment Services: Outpatient				
Day Treatment			X	X
Medication Management	X		X	X
Mental Health Assessment	X		X	X
Multi Systemic Therapy	X			X
Intensive Community Services	X		X	
Outpatient Individual Psychotherapy MH	X	X	X	X
Outpatient Group Psychotherapy MH	X		X	X
Outpatient Family Psychotherapy MH	X	X	X	X
Peer Support	X	X	X	X
Therapeutic Consultation	X	X		X
Mental Health Rehabilitation Services				
Community Support MH	X		X	
Day Rehabilitation			X	
Recovery Support	X	X	X	
Supported Employment	X	X	X	X
Secure Residential			X	
Day Support			X	
Assertive Community Treatment	X	X	X	
Psychiatric Residential Rehabilitation			X	

Substance Use Disorder				
Service	**Telehealth**	**Phone**	**Adult**	**Youth**
Substance Use Disorder Assessment	X		X	X
Community Support ASAM Level 1	X		X	X
Outpatient Individual Psychotherapy ASAM Level 1	X	X	X	X
Outpatient Group Psychotherapy ASAM Level 1	X		X	X
Outpatient Family Psychotherapy ASAM Level 1	X	X	X	X
Intensive Outpatient ASAM Level 2.1	X		X	X
Halfway House ASAM Level 3.1			X	
Social Detoxification ASAM Level 3.2WM			X	
Intermediate Residential (Co-Occurring Diagnosis Capable) ASAM Level 3.3			X	
Therapeutic Community (Co-Occurring Diagnosis Capable) ASAM Level 3.3			X	
Short Term Residential (Co-Occurring Diagnosis Capable) ASAM Level 3.5			X	
Dual Disorder Residential (Co-Occurring Diagnosis-Enhanced)) ASAM Level 3.5			X	
Opioid Treatment Program	X	X	X	
Medically Monitored Withdrawal Management ASAM Level 3.7WM			X	

[i] As of December 1, 2022